



A Vision for Primary Health Care

A vision for primary health care in our community was developed based on feedback from vision meetings held in November 2003 and information gathered from community partners at the two day forum *Creating Synergy in Primary Health Care* held in February and March, and literature searches on primary health care visions.

At this time, the vision is being introduced to staff councils to gain their feedback and insights on the effects of the vision on their work at Trillium. This vision will provide a platform to move forward in our community with primary health care initiatives.

The Vision

In 10 years time, through the combined efforts of individuals, government and non-government organizations alike, the health of individuals, families and communities will be improved. This will be achieved through greater integration of hospital care, primary health care, home and community care, by putting more emphasis on health protection and promotion, and through more effective information sharing within and across jurisdictions. Our communities will be supported to

maintain and improve health status through a primary health care system that is:

Community-based, family-focused, and person-centred

This means that:

- There is full community collaboration, engagement and participation in primary health care planning, delivery and evaluation
- Individual and community health needs are recognized and responded to accordingly
- Focus is on providing the most appropriate service, at the most appropriate time in the most appropriate location

Comprehensive

This means that:

- The many factors that influence health are considered in primary health care planning and delivery, including but not limited to income, social status, education, employment, healthy child development, genetic endowment, gender, culture, spirituality and race.
- The primary health care system provides a balance between activities that promote health and provide health care services.

- A wide range of services is offered by the primary health care system, including but not limited to primary care, continuing care (long term and home care), rehabilitative care, public health, emergency care, community mental health, addictions, nutrition services, palliative care and pharmaceutical services.
- Activities that promote health are supported by the primary health care system and include but are not limited to community capacity building to promote health, individual health education, disease and injury prevention and advocacy for healthy public policy

Accessible

This means that:

- Every individual has an ongoing relationship with a primary health care provider/coordinator through whom they can access health services
- There is equity of access for groups who have traditionally faced barriers including but not limited to race, culture, language, poverty, disability, gender, geography or illness

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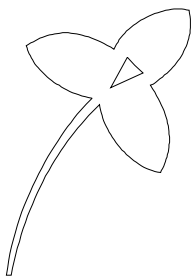
The Vision cont'd.

- Every individual will have access to a defined range of primary health care services, including access to urgent care, 24 hours a day
- Individuals will have access to the primary health care services within their immediate community
- Access to health services is coordinated and linkages made with services outside of the health care system

Accountable and Sustainable

This means that:

- Services/programs are monitored to assure a standard of quality is maintained
- Measuring, tracking and reporting on performance
- On-going resources and education are available to support innovation and service delivery in primary health care
- Those who receive and provide care are clearly defined and specific areas of accountability
- Health information and data are available to individuals, families and communities to inform decision making governments and health professionals
- Those who govern the health system and work on behalf of communities ensure the delivery of services that are efficient, effective, affordable and acceptable to the community



Problem Drinking Assessment Tool

The Department of Family Practice Assessment Tools Working Group has dedicated their time and effort to the development of another assessment toolkit. Their focus this time has been on identifying and managing problem drinking. The toolkit includes flowcharts, a reading list, screening tools, treatment protocol, community resource information, a self-management support tool and patient handouts. The Identifying and Managing Problem Drinking toolkit is available for download from the Trillium website at www.trilliumhealthcentre.org under the section For Family Physicians: Tools for Family Physicians.

If you would like a copy of the 'Identifying and Managing Problem Drinking Toolkit' and do not have access to Trillium's website, please contact Nicole Gaertner at ngaertner@thc.on.ca, by MOX or at (905) 848-7580 x 5210.

Consultant Referral Pilot Project

The purpose of the Consultant Referral Pilot Projects is to identify ways by which the current family physician to consultant referral process could be streamlined and/or made more efficient for both physicians and patients alike.

The pilot projects' development team received a number of favorable responses to the proposal of a revised referral process using predominantly faxed communication. This led to the development of a standardized family physician to consultant referral form that could be used by family physicians pilot group. This process is currently underway and is being piloted with a small group family physicians and consultants for two months.

At the mid point of the pilot project, a survey was conducted of all participating offices. Through the survey we have gathered feedback including that the project is working well, the process is easy to follow and easy to understand, and that written referral needs to be legible. This information will be incorporated into the pilot's evaluation process, which will determine whether the new referral process has the potential for widespread applicability and acceptability.

The project duration will be from Thursday, April 1, 2004 to Monday, May 31, 2004 inclusive and details about the evaluation will be available at a future Family Practice business meeting.

Primary Care & Community Health Initiative News

If you are interested in participating in or learning more about the Primary Care and Community Health initiative at Trillium Health Centre, please contact Nicole Gaertner, Primary and Community Care Initiative Office at Trillium Health Centre at 905-848-7580 ext 5210.



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FOR YOUR INFORMATION

National Home Care and Primary Health Care Partnership Project

In November 2003, the Canadian Home Care Association (CHCA) received a Primary Health Care Transition Fund for \$2.6 million for the project officially entitled, *Augmentation of Primary Health Care System by Enhancing Provider Partnerships Through a Strengthened Role of Home Care Case Management*.

The goal of this project is to enhance the integration of home care and primary health care services with a mandate to enhance and augment primary health care provider collaboration through a strengthened role of home care case management for clients/patients with chronic diseases.

This initiative will be implemented in home care programs in the Halton and Peel Region of Ontario (non-regionalized) and in Calgary, Alberta (regionalized). Within Peel Region, family physicians associated with family health groups at Trillium Health Centre have been identified as potential participants.

One of the key components of the Project is to foster collaborative partnerships between Home Care programs and family physician practices through strengthened traditional Home Care case management roles. This project will bring home care case managers in closer contact with Trillium family physicians, and raise the profile of team collaboration in primary health care across Canada. Look for more information via MOX as this project gets underway.



NSAID (DIS)CONTINUATION PRIOR TO SURGERY - POCKET CARDS FOR GPs

Over the past year, the Orthopaedic Team has been working on a Best Practice Project for Total Knee Arthroplasty patients. A major focus for the project has been improving pain control prior, during and after the surgical event. In particular, the team has identified that patients' pain was exacerbated by stopping Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) pre-operatively. After a thorough literature search, the team has created pocket cards for primary care providers which standardize when NSAIDs should be taken in relation to the orthopaedic surgery. You will soon find the pocket card with a letter in your Trillium mailbox.

The full report of the Total Knee Arthroplasty Best Practice project will be available in the Fall. Please contact Kathy Elliot, Manager of Orthopaedics or Vir Sennik, Orthopaedic Surgeon if you need clarification or more information.

Family Physician Involvement with Inpatient Care

The following is a précis of a report from the Canadian College of Family Physicians: Family Physicians Caring for Hospital Inpatients, October 2003:

Public surveys continue to show that Canadians hold family physicians in high regard for the quality of care they provide. According to Statistics Canada, 92% of Canadians believe the quality of care they receive from their personal family doctor is good to excellent!

In a Decima survey commissioned by The College of Family Physicians of Canada (CFPC) in the fall of 2002 to explore the public perception of FP shortages, over 80% of Canadians rated the quality of care they received from their family doctors as good to excellent. Nevertheless, with the evolution of community-based family practice and the changing roles of family physicians and hospitals in our Canadian health care system, it has become increasingly challenging for family physicians to care for their patients in hospital.

Many family physicians wonder if they should and how important this is to the continuity and coordination of

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Family Physician cont'd.

care that they have traditionally provided their patients.

The Challenge

Traditionally, family physicians have played an active role in managing hospital inpatients. Their roles have ranged from being the most responsible physician caring for patients, to caring for patients concurrently with specialists, to paying courtesy visits to help coordinate care and supports for their patients.

There are other challenges in retaining the involvement of FPs in inpatient hospital care.

The CFPC study found that significant numbers of FPs have decreased their involvement in hospital work in the last few years. The pressure of managing other doctors' patients combined with inadequate remuneration and access to consultant services is prompting an increasing number of FPs to withdraw. Involving family physicians in hospital care promotes continuity and coordination for patient care.

The involvement of FPs in hospital care remains very important to patients. In an editorial in *Canadian Family Physician (CFP)*, the Executive Director and CEO of the College of Family Physicians of Canada, Dr. Calvin Gutkin, wrote:

“The value to hospitalized patients of having skilled and knowledgeable family physicians providing bedside care, coordinating the services of other health care workers, advocating for them, and ensuring that all hospital caregivers understand them as people with an important past and a meaningful ongoing role within their families and

communities cannot be underestimated.”

The Canadian health care system has undergone significant change in the last few decades. This includes restructuring, regionalization, changing physician and patient population demographics and advances in technology.

The CFPC commissioned a study on the status of family physicians providing inpatient hospital care. A comprehensive search of the literature and semi-structured interviews with 27 informants from across the country were conducted. A focus group involving 40 physicians was held in an Ontario community.

The purpose of the study was to find out why family physicians were withdrawing from inpatient hospital care. The study generated a series of recommendations that address the issues it raised.

Recommendations

1. To improve the continuity and coordination of patient care:

A. Hospitalized patients should have their own family physician participating in their hospital care whenever possible.

B. Appropriate communication should be maintained by hospitals with family physicians in the community, including timely notification of their patients' hospital admissions, progress and discharges.

2. To improve the continuity and coordination of patient care:

A. All hospitals should have privileging criteria that recognize and support the role of family physicians in caring for their patients in hospital.

B. Family physicians should be permitted and encouraged to apply to any hospital in their community for medical staff privileges, enabling them to carry out appropriate roles in the care of their hospitalized patients.

C. Family physicians should be represented in the development of hospital policies that affect their patients.

3. Family physicians should organize themselves into networks or groups of an appropriate size to share the responsibilities and workload of managing hospital inpatients.
4. Appropriate remuneration and/or incentives for all hospital responsibilities should be available to family physicians to support their ongoing involvement in inpatient hospital care.
5. The role of family physicians in hospital should be augmented in all medical schools, ensuring family physician role models for all medical students, family practice residents and specialty residents.
6. All family practice residency programs should include training in hospitals with family physician role models, as a condition for full program accreditation.
7. The CFPC's accreditation standards should require all family medicine programs to provide family medicine residents with the

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Family Physician cont'd.

opportunity to acquire the acute care skills needed for both rural and urban inpatient hospital care.

8. Medical schools and university departments of family medicine should offer enhanced skills training and accredited CME/CPD programs in areas related to in-hospital care for family medicine residents and practicing family physicians.
9. Where hospitalists are required:
 - A. Hospitals should actively encourage and welcome family physicians to maintain their privileges and care for their own hospitalized patients.
 - B. Family physicians who choose to work as hospitalists should be encouraged to practice in the community and to work as hospitalists proportionate to their available practice time.
 - C. Both hospitalists and community family physicians should be supported and welcomed as members of multidisciplinary patient care teams.
 - D. Consideration should be given to the role of a hospital coordinator whose responsibility is to ensure appropriate liaison between community family physicians and hospitalists.
 - E. Hospitalists should be a CME/CPD resource for family physicians seeking further education in inpatient hospital care.
10. Upon discharge, patients should continue to be cared for by their

own family physician. If they do not have a family physician, they should be supported in finding a community family physician for their ongoing care.

11. Inpatient hospital care should be considered an integral part of a patient's continuum of care that includes office-based care, home care, rehabilitation and long term care provided by interdisciplinary teams with family physicians in leadership and key caregiver roles.
12. More research, both qualitative and quantitative, should be conducted to evaluate the involvement of family physicians in inpatient hospital care in Canada.
13. The CFPC should promote the importance of family physician involvement in inpatient hospital care to the public, hospitals, medical schools, governments, and all other stakeholders in the Canadian health care system.