Models of Primary Healthcare and Mental Health Delivery in Northern, Rural or Remote Settings:

Findings from Commissioned Syntheses

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Northern Rural or Remote Healthcare:
Enhancing Improvement through Collaboration
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…strengthening rural health through research

Acknowledgements

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Overview

- Objectives of commissioned syntheses

- Challenges to healthcare in NRoR settings

- Models of PHC and MH&A delivery

  - Model characteristics

- Funding/remuneration

- Traditional healers

- Key findings and recommendations

- Q&A

Commissioned Syntheses:
Main Objectives

1. **Mental health and addictions (MH&A) in interprofessional primary healthcare (PHC):**
   - Identify how jurisdictions successfully integrated/linked MH&A services into interprofessional PHC models
   - Method: Literature review

2. **Primary healthcare (PHC) models:**
   - Identify how the delivery of PHC can be reorganized to better meet the needs of northern, rural or remote populations
   - Method: Literature review, Key informant interviews (5)

Challenges to Healthcare in NRoR Settings

1. Health Human Resources
   - Difficulty with recruitment and retention
   - Provider shortages

2. Coordination across Sectors and Jurisdictions
   - Health care for Aboriginal communities
   - Practices/remuneration in silos

3. Geography
   - Travelling long distances for services
   - "Semi-rural" and "semi-remote" vs. rural and remote

Models of PHC and MH&A Delivery

Four broad model types identified for NRoR settings:

(i) integrated care,

(ii) comprehensive primary health care,

(iii) outreach, and

(iv) virtual outreach/telehealth programs

Rural
to
Remote/
Isolated
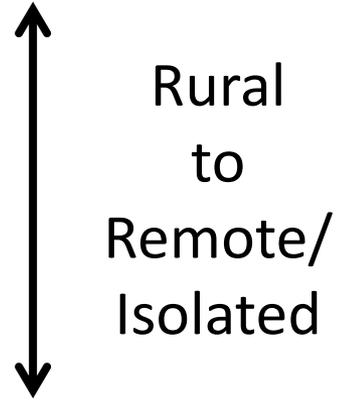
- These models are also used in urban areas
- These models are not mutually exclusive, nor are they prescriptive

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Model Characteristics

i) Integrated Care Models

- Comprise of a variety of models all aimed at providing mental health care from an allied team approach (e.g., shared care, collaborative care)

- Positive patient-related outcomes reported in terms of increased access; and mixed-provider outcomes in regards to the level of collaboration between them and their care partners

  - Example: Shared-care between PCP and MHW to "reduce the cost, morbidity, and mortality of mental illness and suicide in rural areas". A MHW on a PT basis costs less than $50K/yr for confidential, effective counselling. Counsellor was seen as more 'user-friendly' and was more likely to be accessed.

ii) Comprehensive Primary Health Care (CPHC) Models

- Provider services are broader in scope and include addressing aiming to underlying social determinants of health

  - Group Medical Visits (GMVs) in NRoR areas (incl. aboriginal communities)

"It doesn't make sense to see 20 patients in a row and repeat the same education that each of them need [...] so it's better to have it in a group and then have the part of the examination that needs to be private separately" (KI #4)

  - Patient-Centered Medical Home (PCMH) includes new practice innovations and reimbursement reform

Model Characteristics

iii) Outreach Models

- Communities rely on a periodic supply of services which may be centrally located ('hub and spoke' arrangements), or another arrangement where a health care professional visits a community for a short period of time

"The biggest point to make is the focus on community integration" (KI#1). "The community is the constant. By investing in the community, the continuity of care is assured by community-based staff, in which the transient professional workforce integrates into. By creating a paramedical role from within the community, a bridge is created between the community and a transient workforce" (KI#4)

iv) Virtual Outreach Programs

- Virtual outreach programs (VOP) are essential infrastructure elements that are designed to augment other delivery models. The most commonly used type is telehealth/telemedicine.

- Telemedicine is widely used in NRoR communities as a means of overcoming accessibility barriers to healthcare

  - Telehealth encompasses communication (email, telephone, videoconferencing, e-therapy, etc.); information management (databases and internet); and patient assessments and management (clinical consultations, case management, mental health video-conferencing, virtual clinics, etc.).

- Telepsychiatry is a key alternative to providing mental health care in rural and remote areas

Funding/Remuneration

- As models of primary healthcare evolve, payment methods that align with these systems are needed.

- Alternative payment plans (APP) for rural practices were rated (via surveys) as the most important solution for recruiting/retaining rural family physicians.

- A salary funding model was recommended by key informants, including new graduates.

"You don't want to have people [...] that will be paid on the number of patients, nobody will accept that." (KI#2) Under a salary model, "providers can concentrate on delivering the care that is needed for that population" (KI#1).

Traditional Healers

- In Canada, there has been a resurgence of Aboriginal traditional healing practices, as well as the desire to bring these practices into primary health care institutions.
  - Yet, there has been little research documenting how traditional medicine is being integrated with western practices and how these different perspectives collaborate in patient care
  - E.g.: Manitoulin Island AHAC traditional healing guidelines
- The inclusion of traditional medicine and healing has been found to enhance cultural identity and reconnect people to their community.

Key Findings and Recommendations

- **Primary healthcare models can be modified and adapted.** Providers and patients in NRoR communities recognize that geography limits the effective use of traditional primary healthcare models.

- **Investing in the community** is needed to build continuity of care by training local residents for paramedical roles. This creates a bridge between the community and a revolving primary healthcare workforce that will increase continuity, quality of care and efficiency.

Key Findings and Recommendations

- **Salary, with incentives** is the funding model that appears to best remunerate physicians practicing in NRoR settings. The fee for service funding model sets limits on integrated collaborative care as physicians earn income only on the services provided.

- **Ensure First Nations are receiving adequate healthcare funding** for programs and services through a cross-jurisdictional cooperative process.

Key Findings and Recommendations

- **Develop a primary care coordinator position** that can take a lead on regional public health initiatives in NRoR communities. This provides more opportunities for education, chronic disease self-management and health promotion that complement the work being done by existing NRoR primary healthcare providers.

- **Formulate guidelines on the integration of traditional medicine** in a clinical setting based on the local culture of each community.

Key Findings and Recommendations

- **Accessibility can be increased through technology.** Patient-provider communication does not need to rely solely on in-person visits. Phone consultations and various forms of electronic communication, such as secure messaging and web-based patient portals can increase access to healthcare professionals.

- **Move toward greater adoption of EMRs**. Population health information that emerges from EMRs can provide a greater understanding of evolving population needs and can help system managers fund services and programs that meet the needs of the population.

Thank You / Q&A

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