The Saskatchewan Medical Association Primary Care Working Group is a collection of dedicated physicians tasked with helping the province establish the best primary health care framework for Saskatchewan. The group has evaluated work already underway in other parts of Canada and throughout the world, as well as drawing on their own unique experiences working in Saskatchewan to come up with the following framework. The SMA would like to acknowledge the work of the Multidisciplinary Collaborative Primary Maternity Care Project (MCP), the Canadian Medical Association, the College of Family Physicians of Canada, and others who helped lay the foundation for the SMA framework.
The primary health care framework

Primary health care must encompass a harmonious coexistence of health care providers working in a collaborative, flexible and adaptable partnership with the patient-family centre to achieve the common goal of better outcomes for all. It is clearly accepted that not everything tried will work, and that ongoing change, flexibility and adaptability is inevitable.

The physicians of Saskatchewan recognize that Saskatchewan is unique, as are its communities and people. The health regions and the rural, urban, and northern municipalities within them each have unique health care needs. A cookie-cutter, one-size fits all approach to primary health care will not work. Saskatchewan requires a multidisciplinary collaborative primary health care framework based on flexibility, adaptability and ingenuity.

Just as it is clear that no community in isolation can address all the health care needs of its patients and their families, it is also clear that no one profession can effectively address all the health care issues in isolation of the skills, expertise, and experiences of other professionals. The evolution of a collaborative framework is grounded in the local needs and realities of communities. Providers need to work together to develop collaborative relationships and look ahead at longer-term societal benefits for their communities.

Primary health care is the foundation for the subsequent health of patients. The purpose of a collaborative framework in Saskatchewan is to recognize and respond to the unique challenges as well as the common health care needs throughout the province. A collaborative framework has the potential to increase the availability and quality of health services for all people in Saskatchewan.

A collaborative framework by definition must be designed to promote the active participation of each discipline in providing quality care. It is patient-centered, respects the goals and values of patients and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines.

Collaboration is about working together for a common purpose. It is a joint communication and decision-making process with the goal of satisfying the health care needs of patients and their families. The belief is that quality patient care is achieved by the collaborative contribution of all care providers. The contribution of each participant is based on the knowledge or expertise they bring to the practice.

While collaboration of the providers, patients, and their families is essential, so is the ability to assess, adapt and overcome the challenges unique to each particular setting. The system needs a basket of services and professionals to draw upon. There will be some common components used throughout the province. However, not all of the components will be required or appropriate in each practice setting. What will ensure success is the ability of the community, the health care team, and the patient and his or her family to pick the right components for their particular circumstances and needs.
Principles of the framework

Patient-centred care
Health care providers must be responsive to patients, while enabling them to make informed choices and decisions. The framework must respect the needs, goals, and values of patients and their families.

The SMA adopts the essence of the framework for patient-centred care outlined in the CMA document Healthcare Transformation in Canada: Change that works, care that lasts, but with modifications and qualifications to better reflect the situation in Saskatchewan.

1. Help providers help patients
   • In order for any primary health care framework to work in Saskatchewan, we simply must ensure that we have an adequate supply of health human resources. While the provincial government has done well addressing shortages in the nursing professions, the province is still short of physician resources, especially in many rural areas. It thus becomes essential that Saskatchewan has a sound strategy for physician retention and recruitment, while utilizing physicians and other health care professionals to optimum capacity.
   • Expedite effective adoption of health information technologies.

2. Build a supportive culture of patient-centred care

3. Provide incentives for enhancing access and improving quality of care

4. Enhance patient access along the continuum of care
   • Universal access to prescription drugs
   • Continuing care outside acute care facilities

5. Build system accountability and stewardship at all levels (patient charter)
   • A patient-centred charter is a very good patient-first mechanism to articulate system goals. However, for a patient charter to be effective in improving health care there would have to be a five-step process of:
     i. Drafting
     ii. Acceptance
     iii. Compliance
     iv. Accountability, and
     v. Consequences

A patient-centred charter for quality must have adequate accountability measures if it is to result in improvements to Canada’s health care system. Therefore the question becomes: What kind of teeth do we give a charter and how deep is its bite? Until we deal with the issues of supply and demand regarding physicians, it is going to be very difficult to honour the spirit of a charter. The ability to evaluate progress towards our goal of better health outcomes, and to change and adapt care plans as required, are better initial measures of accountability and stewardship.

Quality care
Quality care is achieved by the contribution of all health care providers. Quality care is based on equity of access to, and integration of, services, timeliness, continuity of care, patient safety, and valuing different providers’ expertise.

Safe care
A culture of patient safety is inherent.

Best evidence and practice guidelines
Commitment to care based on best evidence and practice guidelines.

Professional competence
The competence of all health providers working on the team is assumed, greatly valued, and required.
Commitment to the framework
Willingness to devote time and energy to the collaborative framework and to openly discuss differences.

Mutual trust and respect
For each other’s perspective and way of thinking, as well as values, goals, and visions.

Honest, open, and continuous communication

Shared responsibility and accountability
Recognizing each profession’s standards of practice.

Scope of practice
Understanding and respect for different professions’ full scope of practice.

Common protocols
Common protocols for clinical and administrative purposes.

Mutually supportive environment
Unified front and mutual support by team members.

Acceptance to discuss financial issues
Open and frank discussion of financial issues.

Locally-based
Patients receive primary health care as close to where they live as possible.

Effective, integrated regional provision of services
To ensure patients are cared for in the most appropriate environment.

An enhanced focus on illness and accident prevention, and health promotion

One patient, one record
All providers share one Electronic Medical Record (EMR)/Electronic Health Record (EHR) for the patient.

Knowledge of available services
Patients and their families should be informed of the range of services and supports available to them, especially in rural and remote areas where some aspects of care may not be available. Patients should be provided with appropriate written information about the different options of care available to them (in terms of cost, continuity, transition between hospital and their home, and other information required as identified by patients). Education of all parties is required in the framework.

Physician/patient connection
There must be a viable group of physicians to support each other. For patients, generational differences need to be recognized. For example, older patients may prefer a connection to a specific physician, whereas younger patients may be comfortable being connected to a group practice.

A learning and change culture
There needs to be a willingness to quickly identify things not working and make changes. Continuous learning and ongoing change are embraced.

Basket of services and providers
The core or essential providers and services are always available, with the ability to select optional components according to need.

Consultation and collaboration
All health service providers, as well as the community, are consulted early in planning and/or implementing changes in service delivery or care models.
Primary health care team composition

The framework is centered on a group of individuals with diverse training and backgrounds who work together as an identified team. The framework develops the concept of collaborative team practice and is flexible to address the needs and concerns of the respective stakeholders providing and receiving care. This means the patients, their families, and their communities are drivers of the team. The flexibility allows for variations that best suit the different contextual needs of care providers and patients. Under the team approach, care is provided by the most appropriate team member working to the full scope of their competence and capability.

Team members
Team members determine the group’s mission and common goals. They share leadership and create formal and informal structures that encourage collaborative problem solving. Each member has a high level of interdependency, learns to accept and use disciplinary differences and overlapping roles, is community-focused, and provides patient- and family-centered care.

The core team
The framework is based around a core team of health professionals that are the direct and continuous contact point for patients. The core team members are the family physician (or clinic of family physicians), the clinical nurse, and the administrative assistant. In some well-functioning teams, such as South Central in Alaska, a behavioral consultant is also part of the core team and should be considered when available. Nurse practitioners can work as part of a core team for minor cases when there is a direct attachment to a family practitioner. Patients may see some or all of these professionals in the framework, depending on the context and their care needs. Several core teams can share the services of other health professionals and care providers making up the extended collaborative care team. A patient won’t always need to see the family practitioner, but must be attached to one that oversees their care plan.

Other health professionals and care providers
While two or more professionals may belong to the core framework team, the team uses additional individuals, groups, and/or methods of practice, depending on the particular need or concern. Other health professionals play a vital role in the provision of primary health care depending on the specific needs of the patient. These may include pharmacists, physical therapists, public health nurses, dietitians, and others.

Collaboration beyond the framework
Collaboration also occurs with providers outside the framework. Ideally the collaborative framework is regarded positively by other health providers who see the potential for providing more effective, integrated care at a systems level. Continuity of care is most visibly recognized through the interaction and ongoing relationships of the core team members with professionals outside the framework. Attention to effective communication and knowledge exchange is paramount.

Many providers collaborate even though they do not have any formal ongoing structured means for doing so. Multidisciplinary collaborative practice takes on additional meaning when there is not only an increase in shared experiences, but also an increase in shared responsibility and accountability. All team members under their shared vision share this commitment.

Central themes include continuity, responsiveness to needs, and the ongoing improvement of care and health outcomes through evaluation. Ongoing evaluation and improvement is based on the overall goals and objectives of the framework as espoused in the mission and principles of the collaborative team approach. The expected outcomes of the collaborative framework incorporate the dimensions of improved care, healthy outcomes and responsiveness to community needs.
Potential abounds

Once we start down the road of a collaborative primary health care framework, the possibilities and choice of routes are almost limitless. We must be open to supporting both providers and patients interested in embracing patient-centred care and doing things differently. Our ability to recognize and manage the needs of the patient and family, as well as our ability to cope with the demands of the system, is essential for success. It is our hope that in the years ahead every citizen in Saskatchewan will have a family practitioner or an attachment to a family practitioner clinic working in a primary health care network where multiple health provider skill sets exist to meet the needs of the patient.

For more information, or to discuss the features and benefits of the framework, please contact Dr. Brian Geller, director of professional affairs for the Saskatchewan Medical Association at (306) 244-2196.