Healthcare Excellence Canada

Excellence en santé Canada

Petawawa Centennial FAMILY HEALTH CENTRE

Promising practices to strengthen primary care in northern, rural and remote communities in Canada

If you are looking for strategies being used in other northern, rural and remote communities in Canada to improve access to safe, high-quality, team-based primary care, then this promising practice will be of interest to you.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability, and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaborations with patients, essential care partners and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence.

HEC focuses on improving care of older adults, bringing care closer to home, and supporting pandemic recovery and resilience – with quality and safety embedded across all our efforts. We are committed to fostering inclusive, culturally safe, and equitable care through engagement with different groups, including patients and essential care partners, First Nations, Métis and Inuit, healthcare workers and more.

Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement. We are an independent, not-for-profit organization funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Integrated Virtual Care

What is the promising practice?

Integrated Virtual Care (IVC), currently based in the rural community of Petawawa in Renfrew County, Ontario, is an innovative model of comprehensive, team-based care with family physician leadership.

Established in October 2021, IVC has improved equity in access to primary care in a traditionally underserved population. Funding for IVC is provided by the Ontario Ministry of Health.

IVC permanently attaches patients to a named family physician who works predominantly remotely (allowing access to a larger pool of family physicians). The patient is then embedded within an existing, local physician group and family health team (FHT) at the Petawawa Centennial Family Health Centre (PCFHC). Each IVC family physician is responsible for all aspects of their patients' primary care.

PCHFC is a community sponsored FHT (similar to a community health clinic) with a full complement of interdisciplinary health providers (nurse practitioners, registered practical nurses, pharmacists, dietitians, social workers, midwives, administration, etc.) and embedded home and community care and health links system navigators.

IVC patients receive comprehensive, team-based primary care with family physician leadership, through a blend of in-clinic, at-home and virtual care options, depending on their individual needs and preferences. Virtual care includes secure messaging, telephone and video encounters from the patient's home and enhanced telemedicine options at the PCFHC. Partnership with the existing community paramedicine program allows for a range of at-home care options for vulnerable, housebound patients. At all times, the named family physician retains overall responsibility for the patient's primary care. Patients who are enrolled with IVC physicians have access to the full suite of services and allied health professionals provided by the PCFHC; additional nurse practitioner time is protected for IVC physicians to request in-person assessment for specific issues as required. Patients book appointments with their physician by calling the front desk, or through a recently introduced online booking platform.

IVC is associated with improved preventative care measures, as well as improvements in the care experience of both providers and recipients of care. Additional evaluation includes work to further define the unattached population of the Ottawa Valley Ontario Health Team (OVOHT), through the Ministry of Health funded, Applied Health Research Question (AHRQ) program.

Evaluation and impact

Evidence shows that IVC improves access to high-quality, safe, team-based primary care for patients who live in rural communities in Renfrew County. Example outcomes include:

- over 2400 unattached patients permanently attached to a family physician and local family health team
- over 6000 physician appointments
- over 3000 allied health professional appointments
- over 800 cancer screening tests completed
- 43 patients connected to a smoking cessation program
- IVC is replicable in northern, rural and remote communities provided the following is in place:
    - local allied health and in-person care options
    - compensation mechanism for IVC family physicians (salaried models or sessional fees)
    - for maximum impact, internet access and additional telemedicine equipment

Access, costs, safety and equity of care are all monitored for unintended outcomes. Improvements made based on patient and provider feedback include:

- the patient enrollment process
- digital consent process
- internal communication between physicians and team members
- care options available to patients including video encounters and secure messaging
- care options available to providers including digital otoscopes and stethoscopes

An extensive evaluation program is ongoing, led by the IVC medical lead, who is also an assistant professor at the University of Ottawa and clinician researcher at the Institut du Savoir Montfort. Research partners include experienced primary care academics, post-doctoral fellows, data support specialists and other researchers. Evaluation is based on the Quintuple Aim framework and includes patients, community members, providers and local healthcare partners.

What do the providers who deliver the innovation think?

Two researchers conducted one-on-one semi-structured interviews with health providers working within IVC, working with IVC patients and administrators who support the program. Quotes from providers included:

- “We provide such availability and flexibility to patients, which is cutting a lot of acute care business that is not required, from the emergency room ... In general, I feel like IVC is actually very comprehensive.”
- “I find for all of our patients the transition to a more virtual option has been so positive because it's more flexible for their life ... They're more comfortable, they can be at home. There's less, demand on patients in terms of leaving work, come sit in the waiting room, come get checked-in, you know, sit for 10 minutes and then leave.”
- “… most of them [patients] have been orphaned for a chunk of time and they're so grateful to be connected. And then because IVC is still under the umbrella of a family health team, also with full OHIP coverage for us allied health, and that's a big deal for a lot of them when they didn't have that before.”

What do the patients and care partners who have received the innovation think?

Over 90 percent of patients were very satisfied or satisfied with care from their IVC family physician:

- “I am genuinely excited to have a doctor who will care and listen to my needs for my body and health.”
- “The enrollment process was very quick, and everyone has been very helpful and friendly.”
- “This has been one of the best experiences of obtaining a doctor, including the initial contact and follow-up appointments, thank you! Excellent service!”

Key success factors that support sustainability

- Making an impact on improving attachment to a family physician and comprehensive, team-based primary care in a community that has traditionally had thousands of people rely on the emergency department for any form of healthcare.
- Improving the experience of working in the family health centre for reception staff; no longer spending large amounts of time fielding calls from frustrated residents with no access to primary care; now routinely offering and arranging care for patients who desperately need it.
- The energy created within the team to be part of an innovative local solution to a national crisis.
- The use of new digital technology to enhance not just the IVC program but more generally across the whole family health centre.
- Support, interest and advocacy from many local, regional, provincial, national and international partners.

Opportunities for spread

Given that IVC has been successfully adapted to fit needs of a rural population in Renfrew County, it is clear that this innovative program could be successfully implemented and adapted to fit needs of other Canadian and international communities. A research partnership is currently underway with a team in Queensland, Australia to compare findings on a remarkably similar program being implemented there.

The IVC leadership team would be willing to explore partnership with other Canadian communities to consult and provide support to help them adapt IVC to meet the needs of their communities and providers.

A national community of practice could be developed to share learnings and support spread. To some extent, this has already started with IVC findings being discussed and shared at national and provincial conferences and with health policy leaders and decision-makers.

Facilitators of spread

The following can be utilized to facilitate the scale and spread of IVC:

- Partnerships and interconnecting workflows with existing local and regional healthcare resources.
- Funding from provincial governments and national or provincial organizations.
- Policy agreement to facilitate flexible physician compensation within existing models or through alternative funding arrangements.
- Intentional, extensive engagement and relationship building with the communities who will be served, to ensure that IVC meets their needs in a culturally safe way.
- Tools exist that can support implementation elsewhere, for example the Virtual Care Playbook.
- IVC is replicable in northern, rural and remote communities provided the following is in place:
    - local allied health and in-person care options
    - compensation mechanism for IVC family physicians (salaried models or sessional fees)
    - for maximum impact, internet access and additional telemedicine equipment

Costs

The cost of planning and implementing an IVC program is between $200 to $300 per patient in addition to existing physician and family health team costs, depending on the scale of the IVC program being implemented.

For more information

To learn more about IVC, contact:

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