New Brunswick Primary Health Care Action Plan

Better Together

Department of Health

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Executive summary for Primary Health Care Action Plan

BACKGROUND

Ensuring robust access to primary health care was identified as a top priority and the first pillar of the Government of New Brunswick's provincial health plan, *Stabilizing Health Care: An Urgent Call to Action.* Strong primary health care is critical to ensuring that residents can get the health care they need at the right time and in the right place from the right provider. It is fundamental to helping citizens and their families better manage health conditions and to reducing pressures on more expensive and resource-intensive acute care service.

Improving access to primary health care is of particular importance for New Brunswick, as a result of demographic particularities in the province such as an aging population and prevalence of chronic disease that are both above the national average.

Currently, primary care in New Brunswick is delivered through a collection of moving parts rather than a cohesive system. Many challenges exist that impact the quality of health-care delivery: ongoing difficulties with the recruitment and retention of health care professionals, exacerbated by a rapid population growth in the province; compensation models for health professionals; and, related to compensation, the structure within which health professionals operate. The latter means that even those New Brunswickers who have a primary-care practitioner are less likely than the national average to access them in a timely manner, or have access to care during evenings and weekends.

THE NEW BRUNSWICK PRIMARY HEALTH CARE ACTION PLAN

The New Brunswick Primary Health Care Action Plan aims to provide tangible and actionable solutions as an important step to improving the health of New

Brunswickers and the stability of the health-care system in the province. This comprehensive plan is closely integrated into the broader provincial health plan and includes a number of priorities that encompass the compensation and practice models of health-care professionals; recruitment and training; modernization; and governance. Within these areas, high-level priorities include:

- Shifting to team-based care, and in particular, adoption of the Family Medicine New Brunswick (FMNB) model of practice and payment, will be a key priority under the action plan. In order to achieve this, a number of changes are planned including:
    - Adjusting the financial compensation model to make adoption of FMNB more attractive to physicians and nurse practitioners, and overall encourage a move to team-based practices where possible.
    - Updating compensation model to facilitate the addition of allied health professionals such as pharmacists, dietitians, physiotherapists and mental health counsellors.

- Increasing the implementation of electronic medical records (EMRs), with a focus on a single, interoperable system for practices across the province.

- Improving collaboration, accountability and supports:
    - Collecting and leverage data to evaluate progress and foster discussions on continuous improvement.
    - Strengthening governance structures, including the creation of two new tables that will ensure proper prioritization and accountability.
    - Increasing collaboration between the Department of Health and regional health authorities to ensure consistent coordination and accountability with and from health professionals cross the province.
    - Increasing resources available from the Department of Health to facilitate the change management required in the plan.

What is primary health care?

Primary health care (PHC), as a concept, has been reinterpreted and redefined many times over the past several decades, which has led to confusion about the term and its practice. The World Health Organization (WHO) has developed a clear and concise definition:

"PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment."[1]

How is primary health care delivered in New Brunswick?

The New Brunswick primary health-care sector is not a system, but rather a collection of moving parts. This sector has been confronted with many new challenges over the years. Key primary-care professions, such as family doctors, nurse practitioners (NPs), nurses, and pharmacists have all taken on new work. Comprehensive community-care providers, who were challenging to recruit over the last decade, are now even harder to find and retain. Primary health-care services in New Brunswick have been mostly delivered by family physicians operating in either solo or group practices and have been compensated either through a fee-for-service arrangement or salary. However, other models of care also exist in the province. The various models deployed in New Brunswick are reviewed below.

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[1] "Primary health care" World Health Organization, January 31, 2023, www.who.int/health-topics/primary-health-care.

SOLO FEE-FOR-SERVICE PHYSICIANS

Most primary health-care services in New Brunswick have historically been delivered by family physicians using a fee-for-service (FFS) model. Currently, 50 per cent of all family physicians in New Brunswick work this way. In this model, medical services are divided into individual codes and a fee is associated with each. Once a service is provided, fees are billed to the provincial government.

Most jurisdictions are moving away from this model.

Fee-for-service does not consider the severity of a patient's illness or medical condition, and it can encourage episodic-based care as services are individually priced rather than based on the general well-being of the patient. The most common expression of this attitude is “one problem, one visit,” still sometimes seen in primary health-care practices. In short, FFS does not encourage best practices of patient-centred care.

Most FFS physicians work in solo practice, which means that they practise alone with the support of a medical office assistant. According to the Canadian Institute for Health Information, 55 per cent of New Brunswick family physicians work in solo practices, the highest percentage in the country. Moreover, 35 per cent of family physicians using this model are within ten years of retirement age.

Another significant shortcoming of the solo model is that it is dependent on one practitioner. If the physician is not available, there is no access to services. Cross-system collaboration is also challenging since half of these physicians are still practising using paper charts as opposed to electronic medical records, putting New Brunswick last in Canada for EMR adoption rates.[2]

The contractual relationship between all FFS providers and the Province of New Brunswick is that of an independent contractor and not an employee, thus

[2] How Canada Compares: Results from the Commonwealth Fund’s 2019 International Health Policy Survey of Primary Care Physicians. Ottawa, ON: CIHI; 2020.

diminishing the influence the Province has on how services are provided. Influencing behaviour is challenging as accountability and reporting lines are not clearly defined. The College of Physicians and Surgeons of New Brunswick (CPSNB) is responsible for ensuring that minimum standards of practice are met, but there is no governance structure that directs expectations of after-hours access, appointment wait times, or minimum hours of operation.

GROUP FEE-FOR-SERVICE PHYSICIANS

An additional 5 per cent of physicians work using a fee-for-service model in a group practice. These groups have emerged independently, without using a common model or standards for integration into the overall health system.

Some of these small group models offer after-hours care, and group coverage for patients when their primary family physician is not available. This group model is also often early EMR adopters.

SOLO SALARIED PHYSICIANS

A small portion of family physicians (5 per cent) work in solo practices using a salaried model; this model is most commonly found in Moncton. This model is popular with new-to-practice family physicians and uses a FFS system to record activity. This model has had significant challenges with management and delivery of services.

GROUP SALARIED PHYSICIANS AND NURSE PRACTITIONERS

About 10 per cent of family physicians and most NPs (75 per cent) work in salaried group practices. These groups work mostly in community health centres (CHCs), some of which are interdisciplinary teams that include allied health providers like dietitians, physiotherapists, and occupational therapists. NP-led clinics were also implemented in Moncton, Fredericton, and Saint John. There have been several challenges with this model (lack of accountability, recruitment challenges) and the vast majority, despite being co-located, are practising as solo practitioners.

BLENDED PAYMENT MODEL PHYSICIANS AND NURSES

In addition to the models mentioned above, there is a hybrid system of practice and payment called FMNB. Launched by the Department of Health and the New Brunswick Medical Society (NBMS) in 2017, this system uses a combination of capitation. Physicians are paid a sum based on the age and gender of each patient rostered to them in their practice, and they receive a FFS payment that is adjusted to reflect rostering payment. This program also offers altered billing rules, which make it possible for the practice to bill for virtual inquiries and services provided by nurses, an annual overhead support payment, and free access to an EMR. These benefits are provided in exchange for physicians working in a group and providing extended hours of coverage. Physicians are also expected to support each other through vacations, illnesses, or time spent outside their practice to ensure patients have access to the care they need. Moreover, practice support for process improvement is provided. Despite the benefits, this model has not grown as expected. After five years in operation, it has enrolled 55 physicians (5 per cent of total workforce). This model has had especially low adoption rates in Francophone areas.

Snapshot of primary health-care models in NB and Canada		
Practice type	**New Brunswick**	**Canada**
Solo practice	55% (2019)	15% (2019)
Physician group practice	22% (2019)	65% (2019)
CHC-based	16% (2019)	12% (2019)
Use an EMR	50% (2022)	93% (2021)

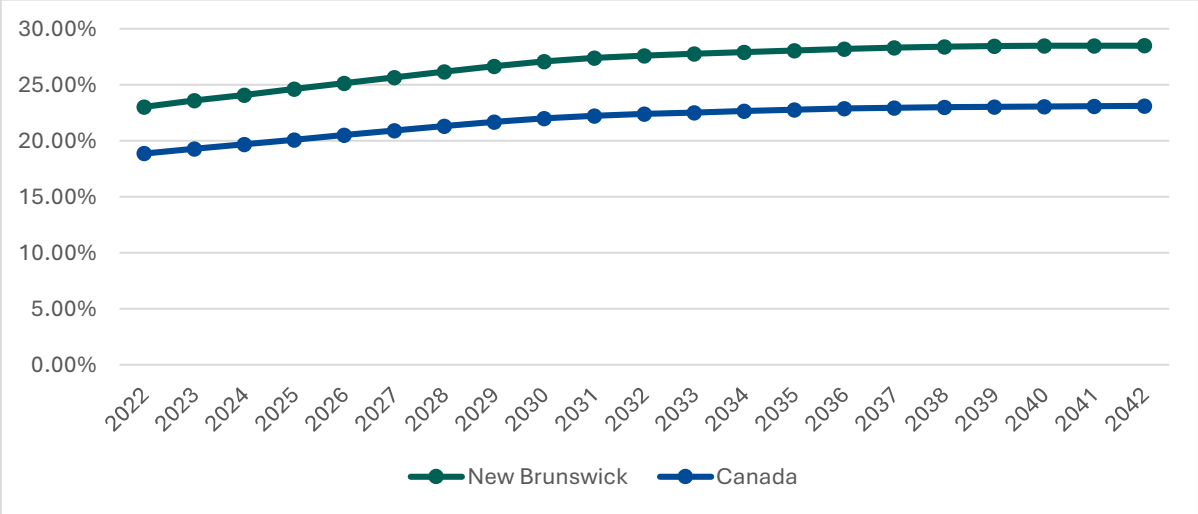
WHY IS PRIMARY HEALTH CARE IMPORTANT

The recent pandemic has highlighted the benefits of living in New Brunswick. While New Brunswickers are used to hearing about an aging and dwindling population, times have changed. New Brunswick is in the middle of the largest population increase in decades. Population growth does not change the fact that our current

demographic has higher health-related needs. In New Brunswick, **39.8 per cent of the population have at least one of the following chronic diseases:** arthritis, asthma, COPD, dementia, diabetes, heart failure, ischemic heart disease, stroke, and mood and anxiety disorders.[3]

In addition to the high prevalence of chronic disease, **22.5 per cent of the population is over 65 and two per cent of our population are over 85 years old and require a significant level of care.**[4] With a large cohort of baby boomers in New Brunswick's population, the percentage of adults over the age of 65 is only projected to grow over the coming years.

Projected percentage of the population 65 years of age or older assuming medium growth (M3)[5]



[3] Data retrieved from the Canadian Chronic Disease Surveillance System (CCDSS) (2017/18). *Only 2016/17 data available for Osteoarthritis.**Mood and Anxiety disorders data from Canadian Community Health Survey.

[4] Statistics Canada. Census Profile, 2021 Census of Population - New Brunswick. <www.statscan.gc.ca>;Canadian Institute for Health Information. "Your Health System - New Brunswick». <https://yourhealthsystem.cihi.ca>

[5] Statistics Canada. Table 17-10-0057-01. Projected population, by projection scenario, age, and sex, as of July 1 (x 1,000). The medium-growth (M3) scenario contains the following assumptions at the Canada level: the total fertility rate reaches 1.59 children per woman in 2042/2043 and remains constant thereafter; life expectancy at birth reaches 87.0 years for males and 89.0 years for females in 2067/2068; interprovincial migration is based on the trends observed between 2003/2004 and 2008/2009; the immigration rate reaches 0.83% in 2042/2043 and remains constant thereafter; the annual number of non-permanent residents reaches 1,397,060 in 2043 and remains constant thereafter; the net emigration rate reaches 0.15% in 2042/2043 and remains constant thereafter.

Lack of access and continuity in primary health care continues to be associated with poor health outcomes and higher costs. This can be measured according to mortality and hospitalization rates, screening rates for breast cancer and diabetes, and complications related to problematic substance use disorders and other mental health conditions.

Low continuity of care is associated with an increase in non-elective hospitalizations for persons with chronic illnesses, with hospitalization rates 60 per cent higher than the general population. When examined more closely for ambulatory care sensitive conditions (ACSCs), which are illnesses for which regular primary health care helps prevent hospitalizations including angina, asthma, COPD, diabetes, epilepsy, heart failure and hypertension, **the prevalence of ACSCs is 22 per cent higher in New Brunswick than the national average.**[6] Low continuity of care for people with ACSCs was associated with both higher hospitalization rates and higher urgent re-admissions after discharge (within 30 days). Given the high costs related to hospital care (the average stay in New Brunswick costs $6,640) and the overcrowding faced by most hospitals in the province, significant resources need to be allocated for early treatment of ACSCs to both decrease costs and human suffering.[7] **Low access to primary health care is also related to a 70 per cent higher chance of dying during the hospital stay.**[8] Research also shows that this group **is 50 per cent more likely to die within one year after the hospital admission.**[9]

Lack of access to primary health care results in lower screening rates for common conditions such as breast cancer and diabetes. Mammograms are recommended every two to three years for all women between the ages of 50 and 74. **Patients experiencing low access to primary health care are 50 per cent less likely to receive a mammogram within the three years.**[10] Given that breast cancer is the

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[6] Ambulatory sensitive conditions are defined by the Canadian Institute for Health Information (CIHI)

[7] Canadian Institute for Health Information. *"Your Health System - New Brunswick"*. <https://yourhealthsystem.cihi.ca>

[8] Chris Folkins, Madeleine Gorman-Asal, Vanessa Dairo-Singer et al. *Impact of physician access and continuity of care on health outcomes of New Brunswickers with chronic health conditions.* New Brunswick Institute for Research, Data and Training, University of New Brunswick. 2022

[9] Ibid.

[10] Ibid.

most diagnosed cancer among New Brunswick women, is the second leading cause of cancer-related death, and that the overall number of new cancer cases is increasing, it is critical to ensure timely access to screening.[11]

Diabetes is another common condition that requires consistent monitoring **(19 per cent of our population has diabetes, and when this is combined with pre-diabetic patients, the prevalence rises to 35 per cent).[12]** The best way to measure how diabetes is being monitored is by reviewing the number of persons receiving an HbA1C blood test, which is recommended every six months for appropriate monitoring in certain age groups. **For people with chronic illnesses and low access to primary care, tests are only being performed 25 per cent of the time.[13]** According to Diabetes Canada, in 2022, diabetes-related conditions produced a $110-million burden on New Brunswick's health system.[14]

Snapshot of population health in NB and Canada		
Condition	**New Brunswick**	**Canada**
65 years and older	22.5%	19%
Obesity rate	37.4%	28%
Smoking rate	14.6%	13.9%
Diabetes (Types 1+2, and 2 undiagnosed)	19%	14%

EVALUATING PRIMARY HEALTH CARE IN NEW BRUNSWICK

Compared to the acute-care sector, primary health care is notorious for its lack of management, oversight, and clear governance. Although minimum standards of practice and service are required for salaried physicians via contracts, these standards are not strictly enforced. A similar situation exists

[11] Department of Health. *New Brunswick* Breast *Cancer Screening Program* ; New Brunswick Cancer Network. *Cancer* System Performance *2019.* cwww gnb ca>

[12] Diabetes Canada. *Diabetes in New Brunswick- Estimated Prevalence and* Cost *of Diabetes.* <www.diabetes.ca>

[13] Chris Folkins, Madeleine Gorman-Asal, Vanessa Dairo-Singer et al. *Impact of physician* access *and continuity of care on health outcomes of New Brunswickers with chronic health conditions.* New Brunswick Institute for Research, Data and Training, University of New Brunswick. 2022

[14] Diabetes Canada. *Diabetes in New Brunswick- Estimated Prevalence and* Cost *of Diabetes.* <www.diabetes.ca>

for CHC employees (NPs and allied health professionals). As noted above FFS physicians operate as independent contractors with minimal oversight.

The Province of New Brunswick has not been idle in implementing primary health-care initiatives over the last several years. However, only a few initiatives have been sufficiently significant in terms of scope and investment to have an impact on access to primary health care for most New Brunswickers. A recent initiative is very promising: NB Health Link, a service for patients without a regular provider designed to provide access to care while they wait for a regular care provider, was launched in 2022 and was rolled out across the province in 2023.

PERFORMANCE INDICATORS AND CURRENT STATE

In 2021, 91 per cent of New Brunswickers were attached to a primary health-care provider. This rate is among the highest in the country. It would be logical to assume that high attachment to primary health-care providers results in robust access to care, but this is unfortunately not the case. One reason for this is that New Brunswick family physicians also perform many duties outside their practices (including, but not limited to hospital calls, nursing home support, oncology support, operating room assists, and emergency department work), limiting the amount of time available for clinic-based care. Fourteen per cent of New Brunswick family physicians spend less than 35 hours per week in their primary health-care practice due to other responsibilities. Also, in the two years after this data was collected, there has been a significant increase in the number of people moving to New Brunswick, all of whom are seeking attachment to a primary-care provider.

The second key performance indicator is timely access to care. The New Brunswick-accepted standard is that patients should have access to their primary health-care provider (or alternate coverage) within five calendar days of needing an appointment. According to the New Brunswick Health Council, **the percentage of providers meeting this benchmark has decreased from 56 per cent in 2011 to 51 per cent in 2021.** Given a delay in access, patients will seek services elsewhere: there was also a **decrease in patients seeking their family doctor when they needed care (from 62 per cent in 2011 to 57 per cent in 2021),** thus increasing pressure on emergency departments and walk-in clinics. Another important indicator is the availability of after-hours and weekend access to a patient's provider. In this area, **New Brunswick is second lowest in the**

country, at 28 per cent of primary health-care providers providing after hours care compared to the national average of 44 per cent. Regarding weekend care, New Brunswick is last at 16 per cent, vs. the national average of 36 per cent. EVisit NB has been an additional service put in place over the last year to mitigate some of the access issues New Brunswick residents face.

Patient reports of access to primary health care in NB and Canada		
Access type	**New Brunswick**	**Canada**
Has a family doctor	86% (2020)	86%
Can be seen after hours	17% (2020)	48% (2020)
Can be seen same day or next day	22% (2020)	57% (2020)

TRANSITIONING TO AN INTERDISCIPLINARY TEAM-BASED MODEL

Until quite recently, primary health care in New Brunswick was offered primarily by family physicians with occasional support from family practice nurses. This paradigm did not sufficiently consider the importance of other professionals in the delivery of primary health care. The COVID-19 pandemic has hastened the adoption of different practice models, which allowed for various allied health professionals to fully embrace their roles in primary health-care delivery. Nurse practitioners have an expanded scope of practice and maintain independent practices. Registered nurses (RNs) play a critical role in patient education, reproductive health, and mental health counselling. Licensed practical nurses (LPNs) can obtain vital measurements (blood pressure, heart rate, weight), sample collections (blood, urine) and aid in IV-related treatment and injections. Pharmacists are well-positioned to provide episodic care for minor ailments (such as urinary tract infections) and renewal of long-term prescriptions that do not require additional tests. Considering the importance of primary health-care service delivery within the context of our New Brunswick population; there is a critical need to evolve towards interdisciplinary team-based care at a much faster pace. Most provinces are making that transition. Most recently Nova Scotia, Newfoundland and Labrador, and Prince Edward Island have launched the Patient Medical Home, which uses an interdisciplinary approach to primary health-care delivery, as a

preferred model. New Brunswick must also prioritize interdisciplinary care teams.

This transition must be done in coordination with various other initiatives to strengthen the governance and oversight of primary health-care delivery. Various changes are required including evolving the current FMNB program to an interdisciplinary team model that meets the requirements of the Patient's Medical Home model created by the College of Family Physicians of Canada. Change management is necessary to transition solo practice physicians into this model, including the implementation of EMRs and new compensation methods. Also, more than ever, medical residents are wanting to do their residencies in a collaborative practice, and we risk challenges if those opportunities are not available in New Brunswick.

In late 2022, a consultation was conducted with multiple provider groups and system stakeholders. After a review of national literature and past provincial strategies, principles to guide the future direction of primary health care in New Brunswick are below.

Every patient in New Brunswick should have access to a primary health-care team who:

- Is their first point of contact within the system.
- Includes a family physician.
- Is available to them within five days of their primary care need.
- Uses an EMR, shared within the members of their team.
- Provides them with after-hours access.
- Regularly involves other community-based allied health professionals (like occupational therapy, social work, and pharmacists) in their care as needed.
- Provides access either virtually or in person. The modality must be clinically appropriate for their need; if that is satisfied, the choice of access should be whichever is most preferred by the patient.
- Provides equitable services in their community as are provided elsewhere in New Brunswick in communities with equitable needs.

- Provides physical space suitable for education, learning and ongoing training.
- Follows outcome-based system evaluation and performance measurements.

WHY FAMILY MEDICINE NEW BRUNSWICK?

Health-care professionals working under the FMNB model strive to provide care that is connected, accountable, accessible, and compassionate.

Under the current FMNB model, teams of physicians and RNs work together using an EMR that enables coordination of patient care and enhances communication between providers. The team has access to some practice support through the NBMS, which has been noted as a key enabler to team-based care in other jurisdictions. Prince Edward Island has been successful at establishing 10 teams across the island in the past year and noted that this success was largely facilitated by a practice support person who helped them truly function as a team.

Accountability is built in when the EMR is used, and patients are rostered to the team. Data and reports can be generated that include the patient journey and interaction with the broader health-care system. The number of services provided and the number of patients rostered to a provider within the FMNB model is generated on a regular basis, and payment is deducted if a rostered patient is seen in a walk-in clinic.

FMNB physicians often provide support to multiple services, such as emergency rooms, nursing homes, obstetrical care, OR assists or other specialty-type clinics. Patients rostered to FMNB will see the provider who is responsible, but other team members are able to step in to provide care for patients if their provider is away or otherwise unavailable. This is positive for

patients and the provider. Physicians have better work-life balance, are able to pursue special clinical interests, and have a team to share the responsibility of providing care when not in their offices. FMNB has demonstrated that it has provided quality care that includes

improved access with the help of extended hours. FMNB patients rely much less on walk-in clinics and have a positive view of the care they receive.

The advantages of the FMNB model can also be seen by comparing the results of 2021 FMNB Patient Satisfaction Survey to the 2020 New Brunswick Health Council Primary Care Survey results:

Indicator	FMNB Patients	NBHC Patients
% who see their physician most often when sick	86.2%	57%
% who went to a walk-in clinic in the last year	6.75%	35.1%
% who feel it's easy/somewhat easy to get through to their physician's office during regular hours	87.8%	72.7%
% who got an appointment to see their physician within five days	54.6%	50.8%

Evolving FMNB into a true interdisciplinary team model will build on the program's current success to better meet the primary health-care needs of New Brunswickers now and for the future. No other model currently used in the province offers as much accountability and potential towards more robust interdisciplinary team-based care.

Actions

The following actions include the activities necessary to implement the new vision for Primary Health Care delivery in New Brunswick.

Governance

INSTITUTIONAL LEADERSHIP

No province has a perfect recipe to manage and govern primary health care, as evidenced by the number of different models used in Canada today. The Province of New Brunswick will increase staff and capacity at the provincial Department of Health to help manage and lead policy change in the primary health- care sector. These staff will be brought on to work within the expanded Primary Health Care Branch (PHCB). This branch will create the enabling features to deliver on the policies contained within this action plan.

THE ROLE OF THE RHAs IN PRIMARY HEALTH CARE

The RHAs will continue to maintain governance of CHCs, salaried physicians, and nurse practitioners. The expectations of the Department of Health related to the management of these professionals will increase.

JOINT DECISION-MAKING AND COMMUNICATIONS

There is no joint table where leaders meet to solve problems in primary health care. Clear accountabilities are largely non-existent among those involved. Therefore, the Government of New Brunswick will set up two governance authorities to align accountabilities in this sector.

1. The first is a Leadership and Accountability Table, where the RHAs, EM/ANB, and the Department of Health will meet monthly to find solutions and get results.
2. The second is a Health Professionals and Patient Advisors Table, which will meet quarterly and involve representatives from each of the health provider groups active in the primary health-care system, combined with patient advocates, to identify priorities for the Leadership and Accountability Table.

Accountability and data collection

Data collection in primary health care is ineffective, and the data generated is rarely used. The first goal of the Leadership and Accountability Table will be to identify the data needed to inform decision-making related to primary health care which measures what matters: how well our system reflects the 2023 Primary Health Care Principles. After the data to collect are identified and tracking is in place, the Province of New Brunswick hopes to publish these data on primary health care on an annual basis to inform citizens of progress made.

USING DATA IN A MEANINGFUL WAY

Departments of Family Medicine across the province, operated by the RHAs, will receive specific data on a regular basis from the expanded Primary Health Care Transformation Branch. The data sets are intended to give the RHAs a better understanding of the state of primary health care.

In addition, it is recommended the New Brunswick Health Council conducts its primary care survey annually. These reports will become increasingly important to the accountability of the sector and provide information to the public on the results.

INCENTIVIZING FMNB/TEAM-BASED CARE

The major discrepancy with New Brunswick's access to health care compared to other provinces is timeliness of access, and the number of health professionals who work in teams. New Brunswick needs more interdisciplinary teams across the province.

FINANCIAL MODEL FOR PHYSICIANS

The first series of changes relates to the attractiveness of team-based care for physicians. Across the country, the recognized financial model that encourages physicians to work in teams is blended capitation, which the FMNB model utilizes. Updates are required to improve uptake, which were agreed upon by a working group of stakeholders that includes:

- A 15 per cent increase in the capitation rate of the FMNB payment model. Capitation pays a fixed amount to providers, based on the number of patients they have or see.
- Greater support for hiring nurses, including a $15,000 annual stipend for a full-time RN, and/or a $10,000 annual stipend for a full-time LPN. "Full-time" will be pro-rated and defined based on service levels.
- There will also be an overhead relief payment that varies with the size of the practice, which can go up to $40,000 annually depending on the number of patients who access care within the practice.
- The minimum guaranteed remuneration will be replaced with a transitional payment model, which will consider whether a physician is new to practice or an existing physician transitioning to FMNB.
- The creation of an extended hours premium to allow FMNB physicians to bill services a higher percentage of FFS, plus capitation, outside the hours of 7 a.m. – 6 p.m. and on weekends.

ALLIED HEALTH PROFESSIONAL (AHP) INTEGRATION

The second addition to the FMNB program is the addition of Allied Health Professionals (AHPs) into the teams. The targeted services include pharmacy, dietetics, physiotherapy, and mental health counseling. Payment will be structured to encourage longitudinal relationships among health providers, FMNB staff, and patients.

The role of pharmacist collaboration with FMNB groups will be expanded. Under a new arrangement similar to the above, pharmacists will have the ability to partner with FMNB groups. This will allow them to conduct team-based medication reviews and expand treatment of minor ailments within a team. They will also pursue new roles with respect to chronic disease management.

NURSE PRACTITIONER INTEGRATION

As there is a choice for physicians of where they work and how they do so, the Province of New Brunswick will extend choice to NPs by enabling them to work in FMNB groups, with a payment structure similar to how nurses are currently

paid in this model. They would roster patients in collaboration with a physician and also commit to after-hours requirements as members of the team. This enables flexibility in staffing roles, including part-time positions.

The main goal of the above is to increase the team-based care provision of NPs and other providers, while providing NPs with new working opportunities that are more flexible than current options - such as part-time or evening roles - that are not currently widespread.

COMMUNITY HEALTH CENTRES

CHCs and health service centres dot the province across 58 sites. These centres have not seen much innovation since their original creation two decades ago. Since that time, very few new centres have been opened; their health information technology is essentially the same as it was in 2003, and they have not developed into the comprehensive team-based care models originally planned. In fact, the hallmark of CHCs across Canada their use of AHPs in addition to doctors and nurses - is not evident in New Brunswick. Of 58 sites, 20 have AHPs working as part of a team, and nine of those have one full-time equivalent employee or fewer.

Additional investment will bring CHCs into the modern era. Their EMR is poorly developed compared to modern technology. The Province of New Brunswick will provide funding to the RHAs to use a single EMR across all CHC sites, like what has occurred in other provinces. Data can be collected which can inform the province on value for money, quality of care, and provide interesting opportunities for health system researchers. This rollout would occur over the next two years.

The Province of New Brunswick will also strike a CHC Modernization Working Group, together with the RHAs, to improve the services they offer. It will include a minimum standard of services offered in each location, with a specific focus on integrating other community-based services. These include rolling out sexual health and well-women clinics provincewide and providing services such as phlebotomy and access to AHPs for patients of the broader community, where appropriate.

In the past absence of a provincial vision, the RHAs have developed priorities which the CHC Modernization Working Group will further explore/expand.

There will be a focus on high users of the system. This project examines who is attending emergency departments and being hospitalized at a statistically disproportionate rate, and therefore could benefit from improved access to primary health care. The project then links back with primary health-care providers to inform them and works to provide services to those patients in the community to avoid high-cost, high-frequency ED visits and hospital admissions.

INVESTING IN TEAM-BASED PRACTICE

In addition to investing resources into team-based models of care, the province will align spending with its vision.

INCREASING PRACTICE STANDARDS

The Province of New Brunswick will ask the College of Physicians and Surgeons of New Brunswick (CPSNB) to establish standards for walk-in and after-hours clinics. Other provinces have already done this, which make the services available in walk-in clinics more accessible and more integrated for patients.

TRAINING TEAMWORK

Recognizing that new standards for training environments for family medicine residents will likely be in effect in a few years, it is important to ensure FMNB groups are attractive for medical teachers. While no specific measure has been identified, the Province of New Brunswick will consult with Université de Sherbrooke and Dalhousie University to examine how their needs for team-based training environments can be met within the FMNB Program objectives.

In addition, the Province of New Brunswick will fund a New Professional Training Incubator in Moncton for new-to-practice physicians, nurses, and medical office assistants that helps to orient new providers away from episodic care provision and toward community practices.

Health human resources

CLEAR DIRECTION ON WHICH MODELS ARE SET UP, AND WHERE

All partners involved in recruitment and retention need to understand that the Province of New Brunswick is prioritizing team-based care while respecting physician and NP choice. Moving forward, the Province intends for the following models to be deployed:

FMNB groups

To be the primary form of team-based care in the province, deployed in urban areas and rural areas where provider interest allows.

Physicians will be encouraged to join FMNB groups through an enhanced payment model and increased recruitment incentives, as outlined elsewhere.

Community health centres

Physicians will be replaced in CHCs but no new providers added without a justified case for expansion. CHCs can expand in geographic areas which:

1. are located in the most rural areas in New Brunswick.
2. have great difficulty with recruiting staff to provide care in other models; or
3. have a dedicated patient population that is vulnerable and/or underserved.

Health service centres (HSCs)

Exist only in rural and remote areas where physicians spend a limited portion of their week and do not wish for a salaried remuneration arrangement. Will not be expanded.

Nurse practitioner-led clinics

Intended only for urban areas. No expansion planned. Ideally, would be combined with currently solo salaried physicians to become an interprofessional team.

Solo salaried physicians

No expansion planned in urban areas but continue to recruit solo salaried physicians in rural areas where they are preferred by the provider involved. Wherever possible, support them to become a team i.e., multiple salaried providers working together with staff support.

Each physician hired under this model within the existing boundaries of one of the three cities, and particularly Moncton, must be formally approved by the Department of Health.

Solo fee-for-service doctors

ACCOUNTABILITY RELATED TO INCENTIVES AND DH/RHA COLLABORATION

The current employment contracts for physicians in all payment models are inadequate to support accountability. Once physicians have set up a practice, there is virtually no ability to hold them to the provisions of their contract. Improvements must be made in these areas and these contracts need to be re-written and re-defined.

This will require increased teamwork from the Department of Health and the RHAs to draft and enforce, but greater clarity will be welcomed from all involved parties.

SCOPES OF PRACTICE

There is a need to better articulate how each provider can be integrated into teams, and which tasks should be performed by different professionals.

Enhanced value for taxpayer dollars

THE NEW BRUNSWICK PRIMARY CARE PRACTICE SUPPORT PROGRAM

The Province of New Brunswick will fund a new Primary Care Practice Support Program. This program will be offered through the NBMS and offer expanded consulting and advice to physicians and team members. Staff employed by this program will include experts drawn from engineering, communications, health care, business, information technology, and data analytics sectors. The staff will offer a dedicated service to physicians who wish to engage them on a voluntary basis, who can help to modernize their operations.

THE PRIMARY CARE INNOVATION SYMPOSIUM

This new symposium will help to focus conversations among providers on practice management and the latest provincial and Atlantic innovations. With provider-specific group annual meetings sparsely attended and often with a clinical focus, this symposium would be different: it would bring together physicians, NPs, nurses, and pharmacists to talk about what efficiencies and innovations have been gained in their practices over the last year. Research groups would be welcome to participate as observers.

Action plan

	Initiative	Work
Enhance team-based care	Change funding model for physicians working in FMNB groups.	Launch new capitation rate in Medicare systems, provide terms to Medical Society.
	Hire nurses in FMNB groups.	Create incentive to hire nurses in community practice, define expectations.
	Create sliding overhead relief payment to drive patient attachment.	Create measurement processes, define expectations.
	Provide financial security to new physicians to encourage more to join groups.	Advertise to new grads, define expectations.
	Hire nurse practitioners to drive patient attachment.	Define a payment structure and process for the integration of NPs in FMNB teams. Define benchmarks and eligibility criteria for this program. Update system configurations to allow for the rostering of patients and any other requirements such as shadow billing
	Buy services from AHPs to provide better care.	Create payment model for allied health services, including associated processes for payments and reporting. Research any legal issues to be considered. Establish process for the integration of pharmacy partnerships with FMNB groups.

	Initiative	Work
Better management	Create a functional unit at the Department of Health to drive change focused on accountability.	Additional FTEs needed to enable to improve monitoring and data collection/analysis.
	Establish Leadership and Accountability Table comprised of both RHAs and DH.	DH to lead. Draft a Terms of Reference, establish goals and objectives and convene leadership group to action deliverables.
	Identify data needed to inform decision-making related to primary health care.	Define required data framework, identify data sources and processes. Collect and analyse data and prepare into internal dashboards and publishable reports.
	Re-define and re-write employment contract for salaried physicians and nurse practitioners.	Work with the RHAs to establish a mechanism to measure outcomes and ensure that terms of offers are being met.
	Establish a Health Professionals and Patient Advisors Table	Establish vision, goals and objectives and draft into a TOR. Identify members and convene meetings.

Recruit. clarity	Training of recruitment staff.	Prepare information packages and toolkits for RHA recruitment staff. Meet regularly with updated information
Modernise CHCs	Modernise CHCs to a provincial standard.	Strike a CHC Modernization working group together with the RHAs to improve services offered, including a minimum standard of service offered and focus on integrating other community-based services.
	Purchase modern electronic medical record for CHCs/HSCs.	Determine system requirements and work to implement. DH will plan and monitor, RHAs to support implementation.
Better value	Create practice support/ facilitation program.	Support physicians to transition from solo to group practices and to operate as efficiently and effectively as possible.
	Primary Health Care Innovation Symposium	Ensure primary care providers have a forum to transfer knowledge, share best and promising practices and drive innovation.
	Professional Training Incubator	Define program parameters and identify stakeholder to take on the work.
	Establish standards for walk-in and after-hours clinics	Write the CPSNB to request the creation of a new policy.