NEIGHBOURHOOD NETWORKS

WHITE PAPER
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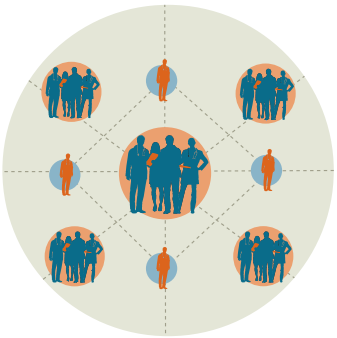
Acknowledging that Richmond is comprised of many smaller, unique neighbourhoods, each with distinct socioeconomic, cultural, language and healthcare needs, the Richmond Division's Neighborhood Networks strategy saw the creation of geographically clustered GPs. By supporting the independence and potential interdependence of neighbouring GPs, the Division began to trial a more systematic approach to coordinated multidisciplinary care, patient attachment, physician recruitment, peer support and practice coverage. This paper is part of a series that highlight our processes and learnings.



Envisioning and Evaluating Transformative Work

Introduction

The Richmond Division's Neighbourhood Networks was the defining strategy for achieving the three goals of the A GP for Me initiative, namely to:

1. Increase the capacity of the primary health care system;
2. Enable patients that want a family doctor to find one; and
3. Confirm and strengthen the GP-patient continuous relationship and better support the needs of vulnerable populations.

The Institute of Healthcare Improvement (IHI) framework, which was adopted by the GPSC, sets out three foundational goals of the triple aim that the Division also kept in mind as it developed its A GP for Me strategies. These goals (1) to improve the experience of care of both patients and providers including quality of care and satisfaction; (2) to improve the health of populations; and (3) decrease of per capita cost, were considered fundamental to achieving valuable and sustainable results against the A GP for Me goals.

An evaluation framework was designed to produce a broad set of data on the Neighbourhood Networks activities and overall operation vis-a-vis the A GP for Me goals. Though the term and scope of the project impeded the evaluation of achievements against the triple aim, wherever possible, efforts to build, test and evaluate the initiative against this framework were attempted. Further, the Neighbourhood Networks project which at its core was iterative and transformative work requiring a cultural shift of practice by established physicians, proved difficult to evaluate especially given the compressed implementation timeline. The Division was grateful for opportunities to capture Most Significant Change stories as they compelled the gathering of feelings and thoughts about emerging transformative change before system improvements could be achieved or measured.

Richmond Division of Family Practice
A GPSC initiative

Envisioning the Triple Aim in Action

During the assessment and planning phase, we learned that Richmond has a high proportion of solo and small practice GPs that largely work independently from their physician colleagues and without support from other health professionals or resources. With few Richmond GPs continuing to have hospital privileges, there has also been a loss in collegiality and peer interactions that used to be fostered through the doctor's lounge or informal corridor consultations (CMA, n.d.). These solo and small practice GPs also report feeling stressed and overworked due to large patient panels, inability to share workload or initiate practice efficiencies. They experience difficulties in securing locums and recruiting replacements. Because of the vital role GPs play in the healthcare system, they are often overwhelmed with the pressing day-to-day clinical health needs of patients and rarely find time to advocate on behalf of the larger community or invest in systemic and transformative change.

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Improve the Experience of Care for Both Patients and Providers

Early on, the Division recognized one substantial way for individual physicians to work toward the Triple Aim is for physicians to support one another. The strategy aimed to foster GP collegiality so that fee-for-service GPs working on their own could leverage one another for clinical and professional support and achieve things collectively that would not be possible as individual practitioners.

Neighbourhood Networks is a grassroots level solution developed by physicians for physicians. It is focused on enhancing the physician experience, recognizing the critical role that GPs play in the primary care system. While physician-centric, Neighbourhood Networks is also patient-oriented, with the belief that by enhancing support to physicians at the practice level, there would be parallel effects of enhanced patient experience and health outcomes.

Provider Experience

Coverage is one of the most significant issues for Richmond Division members. Cross-coverage highlights the collegiality and support that exists within the Neighbourhood Networks. The one successful experience of a shared locum within a Network we evaluated, offers insight into an area where a collective approach yields significant provider satisfaction. Solo practice GPs requesting shorter periods of locum coverage (1 week or less) typically have a hard time finding someone to fulfill those requests. In the Steveston Network, the large group practice of six GPs successfully recruited a locum and organized to share that locum within the Network. Since Jan 2016, this locum has covered nine of ten practices for approximately 170 days of coverage, where three solo GPs have been able to access coverage through this coordinated effort. Recognizing limited access to locum support, all four Neighbourhood Networks have GPs that cross-cover for one another for unplanned absences or when a locum has not been successfully secured. Anecdotal feedback from the

Steveston Network GP lead is that there is typically less paperwork to follow-up on and no unnecessary booked appointments when colleagues cover a practice and there are significant cost savings compared to retaining a locum.

The integration of health providers into the Neighbourhood Networks also offers examples of GP-to-GP and GP-to-health provider collegiality. GPs in the Steveston and Blundell Networks have organized to share office space to host health providers and appointed MOA leads to streamline pharmacist scheduling for the entire group. Historically, one of the challenges encountered when embedding health services in physician offices has been the significant degree of demand required to justify the location of one resource, such as a Chronic Disease Nurse, in a solo practitioner's office for regular clinics. Through Neighbourhood Networks, there are efficiencies in providing services to a collective group of GPs instead of individual GPs and this has increased their ability to support more patients in the community. With providers embedded in physician offices, both GPs and health providers remark on the increased collaboration and resurrection of corridor consults.

Overall, Neighbourhood Network GPs report they are benefiting from participating in a network. They feel connected to their colleagues, are glad to have one another for support, and see opportunity for accessing resources as a collective.

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Patient Experience

With GPs working collectively to leverage health providers in their Network, there are now more comprehensive and accessible health services available to patients in the form of clinical pharmacists, chronic disease nurses, and psychiatrists. In total, over 430 appointments with health providers have occurred in 28 physician offices through the Neighbourhood Network project. Patients have been surveyed, and most respondents felt it was important to access services in their physician's office (weighted average= 4.87/5.00 (n=76)) where it is more convenient and they are more comfortable. With care plans and care conferences, patients are benefiting from continuous and coordinated care between the different providers and their GP. The psychiatry and pharmacy services offer better support for patients with complex care needs, whereas the CDN service specifically promotes patient self-management of their conditions and 91% of survey respondents are a lot more confident in taking care of their health as a result of the service.

The City Centre Network primarily services a Chinese patient population with specific language and cultural preferences. As a group, they are able to make a stronger case for the deployment of Chinese-speaking chronic disease nurses and pharmacist to provide services in the language spoken by their patients. Patients in the City Centre and Westminster Networks also have a referral pathway to receive intimate exams from a physician of a preferred sex.

In a City Centre Network meeting, a GP identified challenges in having female patients agree to Pap smears because he is of the male gender. Through these discussions, two female GPs volunteered to complete Pap smears for this GP's patients. In the Westminster Network, this was taken a step further where two female GPs cover Pap smears and IUD insertions for two male colleagues and the male GPs provide rectal exam coverage for their female colleagues.

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Improve Population Health

Through the collegiality and commitment that exists within the Neighbourhood Networks, and given the strong interest for additional primary care resources, the CDN, pharmacy and psychiatry services have been integrated into Network GP offices. However, with services being deployed for under a year, metrics for health outcomes have not been collected although we have captured self-reported patient data (see Table 1). Overall, patients receiving all three services have articulated high confidence and motivation to improve health and we hope that this will translate to improved health outcomes.

Table 1. Self-reported data from health provider patient surveys (n= 77)

As a result of visiting the health provider, do you:	A lot more		A little more		Not at all		Don't know		Total
	n	%	n	%	n	%	n	%	
Feel more confident taking care of your health	63	83%	13	17%	0	0%	0	0%	**76**
Feel more motivated to make changes to improve your health	65	86%	10	13%	0	0%	1	1%	**76**

Improve Sustainability of the Health Care System Through Decreasing Per Capita Cost

For partners, the Neighbourhood Networks creates a more efficient and collegial group of GPs in which to pilot health services. For example, data from the Shared Care Psychiatry program indicates there is a minimum fifty percent greater efficiency when appointments are attached to a Neighbourhood Network office rather than a solo practice GP, where other Network GPs can step up and fill unscheduled appointments.

Because of the Neighbourhood Networks, health services are integrating in a way that supports the extension of GP capacity and increases the ability for patients to receive the right type of care, from the right type of provider, in a timely manner. The CDN service is focused on promoting patient self-management of chronic conditions to keep these patients healthier for longer and lower health care utilization costs. Our Division is in the early stages of developing group nutrition sessions with dietitians and group visits are an efficient and effective way to leverage limited health resources from the health authority. Furthermore, it reduces the need to repeat the same information and frees up time for patients who do require one-on-one care.

Evaluating Iterative Change

For the implementation phase, an external evaluator was retained to design a Neighbourhood Network evaluation framework that assessed the extent to which the strategy was implemented as planned (process evaluation) and the extent to which it achieved the three A GP for Me goals and, where possible, the Triple Aim (outcome evaluation).

To date, the Division has measured these outcomes and offer the questions asked and indicators in the chart below:

1. Strengthen/confirm the GP-patient relationship
2. Increase the capacity of the primary health system
3. Improve patient and provider experience

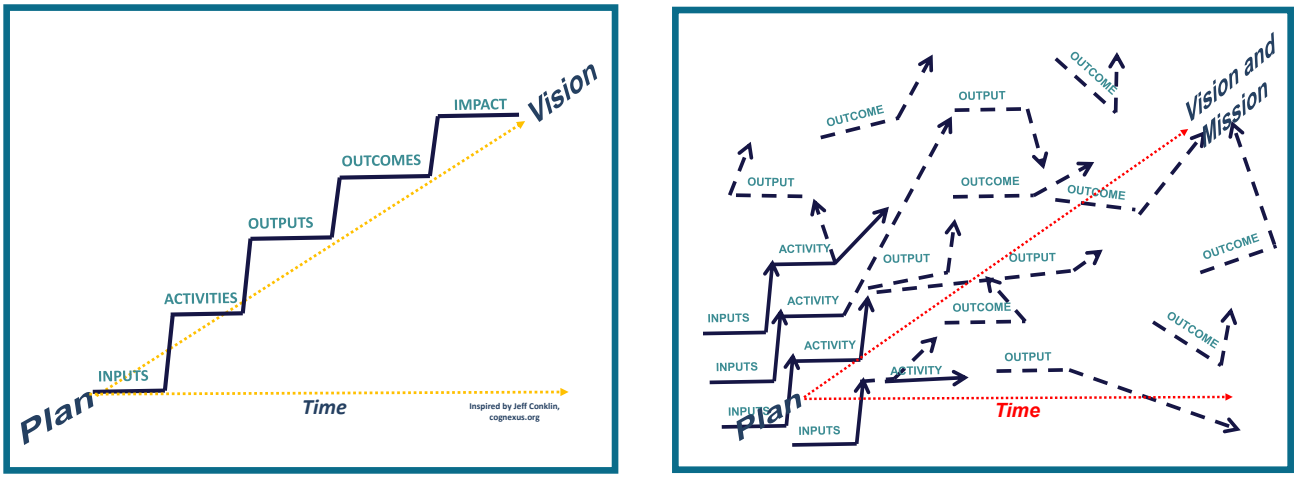
Deliverable	Evaluation Question	Indicators	A GP for Me Goals/Triple Aim
PROCESS – to what extent has the strategy been implemented as planned			
-Community assessment of neighbourhood-level data and alignment with existing resources/programs Pilot 2 Networks Develop a business case/white papers	Were the activities implemented as planned?	Documentation/existence of deliverables # members outreached method of engagement # networks and members # of interested members that didn't form networks # NN Newsletter MailChimp opens # NN Newsletter MailChimp clicks # NN Newsletter monthly surveys completed # check-ins completed # meetings/events # attendees # MOA leads # MOA attendees at events # MOAs engaging in PSP coaching # of partnerships	n/a
	Where there any changes in the planned deliverables? What data collection processes were put in place? Has this project faced any challenges in stakeholder engagement?	Perceptions Suggestions for improvement	n/a

Deliverable	Evaluation Question	Indicators	A GP for Me Goals/Triple Aim
OUTCOMES – To what extent did the Neighbourhood Networks achieve its intended outcomes			
Pilot integrating various allied health care resources	Are Networks integrating AHP resources?	# GPs referring # pts referred Type of visit No-shows Appropriate referral Reason for referral Care-conference	(2)
	Are AHPs satisfied with implementation and NN model?	Satisfaction Perception of NN model Suggestion for improvement	(3)
	Are patients satisfied with the service and NN model?	Confidence, understanding Importance of accessing service in GP's office Suggestions for improvement	(3)
Share locum coverage	Are Network recruiting and sharing locums?	# adverts # recruitment events $ spent # inquiries # matches # confirmed matches # locums recruited # GPs sharing a locum Dates of locum coverage # days requiring a locum but couldn't find one	(2)
		Satisfaction, equitability, perceptions, suggestions for improvement	(2) (3)
	Is the Neighbourhood Network model more attractive to locums?	Satisfaction, perceptions, suggestions for improvement	(2)(3)
		# matches to membership Date of locum coverage	
Trial cross-coverage	Are Networks cross-covering?	# networks with cross-coverage processes	(2)
		# cross-coverage matches # cross-coverage days	
Trial sensitive exam coverage	Have the Neighbourhood Networks increased access to colleagues that provide sensitive exams for patients?	# matches	(2)(3)
Engage in office efficiency/capacity building activities	Are GPs engaging in office efficiency/capacity building activities?	# GPs outreached by PSP	(2)
		# GPs participating in PSP coaching/EMR optimization	(2)
		Activities undertaken in practice coaching sessions	
		Time to 3rd next available appointment	
		Perceptions, experiences, areas for improvement	
Patient attachment to Neighbourhood Networks	Are Networks attaching patients?	# new patients # new G14074 patients	(1)
		# GPs accepting patients # referred patients # matches # confirmed attachments	
Neighbourhood Network model	Are participating GPs experiencing reduced burnout	Satisfaction with locum coverage, cross-coverage, work-life balance, practice Emotional exhaustion Depersonalization Personal accomplishment	(3)
	Are participating GPs satisfied with the NN model?	Time commitment Connection to colleagues Accessing colleagues for collegial support Benefited from participation	(3)
		Satisfaction Perception of NN model Suggestions for improvement	

The Limitations of our Evaluation Framework

The evaluation framework applied to the Division's entire A GP for Me implementation and was designed to collect both formative (process) and summative (outcome) data. Summative and formative evaluations are best applied in the context of established programs where there is a natural sequence of steps to move from inputs to impact. This traditional evaluation was appropriate for our four other A GP for Me strategies but because of the fluid, complex and transformative work undertaken, the Neighbourhood Networks project would have benefited from a developmental evaluation approach that focuses on "where things are, how things are unfolding, what directions hold promise, what directions ought to be abandoned, what new experiments should be tried – in other words, data-based decision making in the unfolding and developmental processes of innovation" (Westley, Patton & Zimmerman 2005 *Getting to Maybe: How the World has Changed*).

Figure 1. Traditional (left) versus developmental evaluations (right). Source: Patton, M.Q. (Aug 2014). Developmental Evaluation [PowerPoint presentation] http://bit.ly/2fuY7vt.



While we captured most inputs, activities and outputs, our measurements and analyses were sometimes delayed as evaluation attempted to keep up with real-time and often non-linear project activities. Additionally, there may have been opportunities to capture metrics that would have provided different insights. Given the narrow timeline for the project, our ability to capture outcomes was limited. Though we had a sense of how we were progressing against the project deliverables, we did not substantiate the extent to which Neighbourhood Networks, as a model for primary care, influenced the provision of care, the provider and patient experience, and the support required by the Division to lead, guide, and broker this effort. For example, while we measured cross-coverage processes, matches and days of cross-coverage, we did not measure the extent to which the Neighbourhood Networks impacted access to cross-coverage. We also did not identify appropriate outcomes that relate to improving the health of populations and reducing costs. The challenge with this type of work is activities are often complex and occurring simultaneously within PDSA cycles and measurable outcomes are often not realized accurately and/or inside the timeframe of the evaluation cycle. As a result, what is collected and measured might not accurately reflect the work and significant shifts taking place over the long term.

With the retention of an external evaluator, there was a lack of regular and timely feedback for various reasons:

- The evaluator attended monthly working group meetings but was not fully leveraged in conceptualizing, designing or testing new approaches.
- Our interest to not add additional tasks or expectations onto physicians or their staff and the arm's length relationship between the evaluator and the GP practices in the networks challenged the collection of on the ground realities.
- Activities were often trialed quickly and regularly that PDSA cycles were not always documented and evaluation reports were not generated.
- Mid-term and end-of-implementation reports did not offer real-time feedback at the project level. Instead, recommendations and opportunities were often no longer relevant or were already identified and acted upon by the project team.

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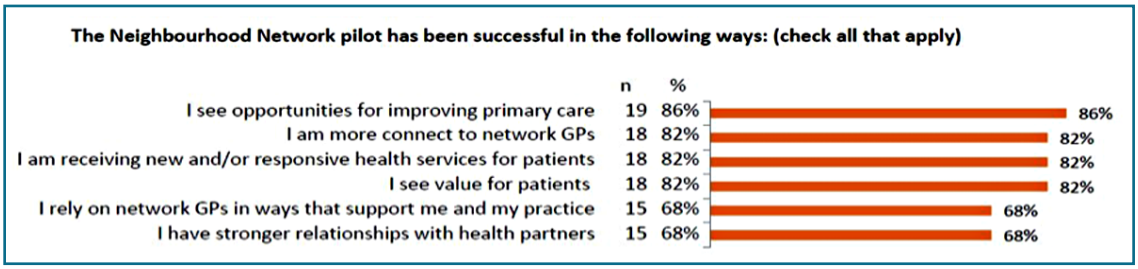
For the extension phase (April – September 2016), the Division decided to move evaluation activities in house so that evaluation became part of internal team functioning. With the emergent Patient Medical Home model, the Division considered how the existing evaluation framework could better capture formative and qualitative measures that amount to concrete outcomes that are also aligned with the PMH. Our evaluation efforts going forward will attempt to include measurements of outcomes related to the patient, GP/Network and health care system as a whole.

Conclusion

For the extension phase (April – September 2016), the Division decided to move evaluation activities in house so that evaluation became part of internal team functioning. With the emergent Patient Medical Home model, the Division considered how the existing evaluation framework could better capture formative and qualitative measures that amount to concrete outcomes that are also aligned with the PMH.
To date, we have adequately captured outputs relating to integrating health providers and have consistently sought feedback from participating GPs regarding their investment and perspective on the Networks as a whole.
In October 2016, the following positive feedback was collected from them:



Our evaluation efforts going forward will attempt to include measurements of outcomes related to the patient, GP/ Network and health care system as a whole.

To learn more, please contact:
Denise Ralph
Executive Director
dralph@divisionsbc.ca