NEIGHBOURHOOD NETWORKS

WHITE PAPER
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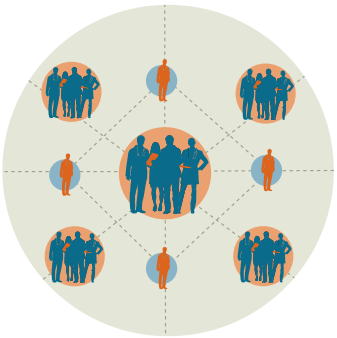
Acknowledging that Richmond is comprised of many smaller, unique neighbourhoods, each with distinct socioeconomic, cultural, language and healthcare needs, the Richmond Division's Neighborhood Networks strategy saw the creation of geographically clustered GPs. By supporting the independence and potential 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.



GP Engagement

Introduction

Like all Division efforts, when the opportunity of a new initiative arises, there is an interest to fully engage membership in a transparent and equitable manner. There are also the practical realities of busy GP schedules and differing abilities and interests to engage. In establishing the Neighbourhood Networks, these realities were coupled with the challenge of communicating what was initially a conceptual project that offered GPs an opportunity to transform primary care in their community. The Richmond Division of Family Practice is always weighing how it can outreach to ensure the fullest possible engagement in a manner that is responsive to project timelines and without creating more than necessary work for our members. The communication and engagement challenges in the early stages of the Neighbourhood Network project were formidable.

Engaging members at the outset and during project implementation were substantial undertakings but with longstanding benefits toward building Patient Medical Homes (PMH) in the community. As a constituent group that will be significantly involved and impacted by the PMH model, fee-for-service GPs within Richmond have a burden to manage existing workloads while simultaneously adopting new workplace systems, practices and workflows. In the words of one physician, "I'm being asked to rebuild the plane as I fly the plane." The Neighbourhood Network implementation supported an incremental, trial-based approach to GP engagement with two core directions, one revolving around GPs supporting one another and the other relating to comprehensive care and coordination of care, both of which are important attributes of the PMH.

Richmond Division of Family Practice
A GPSC initiative

GP Engagement

Implementation of the Neighbourhood Network project occurred from February 2015 to September 2016 and GP engagement can best be described around three discrete phases: Phase 1 – pre-network establishment; Phase 2 – launch of pilot networks; Phase 3 – expansion of networks. Additionally, the Division identified and nurtured specific roles for the GPs to support implementation and sustainability of the networks and offered critical, though not substantial, incentives for participating.

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Phase 1 – Pre-network establishment (Feb 2015 – Aug 2015)

Although only a plan, once the Neighbourhood Network strategy was conceived, the Division introduced the concept to membership where and when opportunity struck. While our other more concrete and actionable strategies became operational early on during implementation, the Division was engaged in information gathering and stakeholder consultation in order to formulate a solid roll out for the Neighbourhood Network strategy. A number of member physicians were devoting time to our other strategies and initiatives and this planning time for the Neighbourhood Networks offered the Division a chance to see where potential networks might lie.

When it was time to engage our membership to identify interest and select the pilot network sites, we discussed three different strategies: (1) informal, informational sessions bringing together GPs in close proximity to one another to gauge interest in forming a Network, (2) informal, informational meetings with groups of GPs that come forward together or (3) a member-wide event. While informal meetings for any curious members were considered preferable, all of these options created significant timing and scheduling barriers. While some informal one on one conversations were occurring, the general membership were alerted to our search for pilot sites in limited ways, namely through the May and June e-newsletter and then in June 2015, the Division additionally faxed and emailed a letter to our membership, giving them a very limited time to come forward as individuals or with a group of interested GPs. It was far from an ideal engagement roll out but the short implementation phase created significant pressure to quickly identify and launch the pilot networks.

Individual physicians that came forward were invited to reach out to GPs in their practice neighbourhood and were provided with a list of GPs located within the City's planning area. Some physicians outreached to colleagues, others did not. Largely, identifying interested members required a higher touch by the Division. Once GPs identified themselves as interested in learning more, the Division undertook some outreach to neighbouring physicians but again, because of tight implementation timelines and limited human resources at the Division, the interested GP was required to invest in outreach as well.

Several meetings were held (Division staff and Neighbourhood Networks Physician Lead attending) with individuals or small groups. Members had reasonable questions about required investment of time, resources that would

be allocated, additional work expectations, etc. By this point, the Division was still unable to offer definitive plans. Negotiations regarding allied health providers were occurring simultaneously and the iterative nature of many other elements were requiring GP involvement in order to set more specific goals.

One challenge during this somewhat rushed process was the perception that the pilot sites had already been pre-selected. The Division did have some sites in mind that it felt could meet the requirements, and had several conversations with GPs that supported this belief, but these sites were not pre-selected. In reality, very few GPs came forward and even fewer were willing or able to invest in their own outreach to neighbouring GPs. Perhaps as a result of this limited outreach by the Division and GPs, only two sites – Steveston, with 10 GPs and City Centre, with 6 GPs – were identified as showing enough interest and capacity to move forward.

GP engagement was occurring but not in a standardized manner as intended. Instead, numerous side meetings were held.

Phase 2 – Launch of Pilot Networks (Sep 2015 – Mar 2016)

In early Fall 2015, two pilot networks officially launched when members of a network signed a letter of agreement. This non-binding document intended to explicitly confirm participation, articulate the project goals, and the broad expectations of both GPs and the Division. Each Network was confirmed at a different time, and readiness to engage in pilot activities differed between the two groups. Engagement of each network was planned to occur through bi-weekly teleconference huddles and monthly in-person Network meetings. The Division intended to use these opportunities to capture feedback about participation and offer specific information to implement new resources and project initiatives. Organizing meetings for the groups proved to be more challenging than anticipated and only one teleconference huddle took place with the City Centre Network and each Network met twice in-person (see table 1 below).

GP engagement was occurring but not in a standardized manner as intended. Instead, numerous side meetings were held. Since Neighbourhood Networks is not one discrete project, but instead involves engagement in multiple activities often simultaneously, these disparate conversations, though unplanned, were not surprising. The Neighbourhood Network model served as a bridge, so dovetailing all of the Division's A GP for Me strategies and other activities were planned. Meetings occurred between (a) GPs; (b) the Network team members and individual GPs; (c) GPs and health resource professionals; and (d) GPs and Division team members leading other activities (namely those working on the Psychiatry Shared Care project and other A GP for Me strategies that aligned with the networks). These meetings helped the Division, partners and GPs to best determine how to increase and strengthen attachment, recruit, retain and responsibly transition GPs, create new practice coverage solutions and integrate primary care services.

As the pilot phase progressed, the Division determined that while the initial plan to have regular touch points or check-in meetings with the network GPs was a good one, the expectation that the project team meet with each GP bi-

weekly was not feasible particularly at this stage, during Network formation, when the value of participation was still being defined and multiple activities were being introduced and piloted over several months.

Phase 3 – Addition of New Networks (Apr 2016 – Sep 2016)

To further engage and test the Neighbourhood Network strategy, the Division sought a six-month extension and project expansion to engage new Networks. For this phase, armed with experience and more concrete information about services and supports, we attempted to develop clear and consistent messaging about goals, value and requirements of participation to non-participating Division members. We developed different multiple engagement tools including a FAQ and short video, where our Physician Lead described the Neighbourhood Network concept and shared examples of how this has positivity impacted his practice already. Through the e-newsletter, the Division invited interested members to come forward as individuals or within a group.

Over the previous months, information about Network activities reached membership and several individual GPs or groups of GPs had already expressed interest and met with the Division and Physician Lead. Again, because of tight implementation timelines and a busy event season for members, member-wide informational meetings did not take place. Individual GPs who expressed interest were invited to outreach to neighbouring colleagues. In the end, two groups of GPs came forward to initiate new networks, resulting in the emergence of the Blundell and Westminster Networks. Each of these Networks had a unique characteristic that supported the Division's investment. In one network, co-location and cross-coverage were in place, and in the other, call coverage. These existing relationships and collaboration helped tremendously in solidifying the concept of a network and supporting GP engagement.

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Drawing on lessons learned during the initial launch of the first two networks, the Division designed and implemented a more robust and standardized GP engagement plan for all four Networks that included the following elements determined to be viable for both the Division team and GPs:

- Monthly Neighbourhood Network Newsletters – an all networks electronic-newsletter to introduce new resources and activities, provide partner updates, share upcoming opportunities and data pearls on existing efforts and invite feedback
- Monthly check-ins with individual GPs, which is comprised of:
  - Survey – test new ideas; gather output data on health resource integration, coverage, attachment and network GP collegiality to inform future activities and support evaluation
  - In-person office check-in – between a Division consultant and individual GP. This allows for an individual needs assessment, check-in and probe on successes, barriers and opportunities for improvement. Necessary onboarding to new resources and activities can be provided and face time builds and fosters a strong relationship between GPs and the Division
- 1-1.5 hour Network meetings – occurring on an as needed basis, these

needs-driven agendas bring together all the GPs within a specific Network to introduce a new activity, forward activities where discussion or negotiation are required, and build and foster relationships between a network of GPs

- Bi-monthly 1.5-2 hour all-Neighbourhood Network meetings – provide a venue for shared learning across Networks; builds and fosters relationships of GPs within each Network, as well as between GPs and partners.

All-Neighbourhood Network meetings provide a venue for shared learning across Networks.

GP engagement in all outreach methods was tracked and is summarized in the table below.

Table 1. Summary of Neighbourhood Network GP engagement in Division-led outreach methods

Month	# of GPs	NN Newsletter (opened)	Monthly surveys completed	Monthly in-person check-in	Bi-weekly teleconference huddle / # of participants		Network meeting held / # in attendance		All-NN meeting (attended)
May 2015							1 - CC	4/6	
Jun 2015							1 - CC	5/6	
Jul 2015									
Aug 2015									
Sep 2015	17						1 - ST	10/10	
Oct 2015	17						1 – CC	5/7	
Nov 2015	17				1 – CC	3/6			
Dec 2015	17								
Jan 2016	16								
Feb 2016	16								
Mar 2016	16								14
Apr 2016	16	11	12	13			1 - WE	5/6	
May 2016	28	25	16	7			1 - BL	6/6	17
Jun 2016	28	25	17	16			1 - WE	6/6	
Jul 2016	28	21	15	12			1 - CC	3/6	17
Aug 2016	28	24	13						
Sep 2016	28	24	11					21** 1 – BL 3/6; 1 – CC 6/6 1 – ST 5/12; 1 – WE 5/6	
BL – Blundell; CC – City Centre; ST – Steveston; WE – Westminster									

*Shaded boxes indicate no offered engagement
*Engagement summary does not indicate emails or phone calls between Division and participating GPs
** A longer event allowed for specific Network meeting time

The in-person check-ins and meetings take a considerable amount of time to coordinate and conduct but, overall, early inquiries indicate GPs agree that the in-person check-ins are a valuable use of their time and all-Neighbourhood Network meetings (held over dinner) make GPs feel more connected to their Network and the project overall. With standardized and regular GP engagement,

there is the risk of communication becoming stale, so as engagement in a network becomes embedded, in-person check-ins could occur less frequently to reduce member fatigue. As well, with strong and engaged attendance at the all-Neighbourhood Network meetings (average 71% attendance rate), extending the meeting time slightly allows for the inclusion of Network-specific breakout sessions that can capitalize on network specific engagement and planning since each network faces unique challenges or points for consideration.

Not captured in the table above are the numerous engagement activities related to onboarding, pre/post case conferencing, logistics, etc. taking place between GPs and the allied health providers directly. In addition, occurring simultaneously with Division-led GP engagement activities is PSP outreach and practice coaching to support network GPs in panel cleaning and case-finding for the three integrated health resources. Outreach to all 28 GPs has occurred and to date, 12 GPs have worked with PSP and are now sustaining workflow changes and 8 are currently engaged in practice coaching with an explicit goal of adding value to the integration of services within networks. With both the Division and PSP engaging members, the Division and its PSP partner are working carefully to ensure members are not overwhelmed or that duplicate or uncoordinated services are underway.

The increased GP engagement during phase 3 is supported by additional Division resourcing. The core network team is comprised of a full-time project manager, full-time project coordinator who are supported by a part-time project lead.

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Physician Leadership as a Tool of Engagement

Success of the Neighbourhood Network project requires a clearly articulated value proposition for GPs. Without their buy-in and desire for wanting to make change, the project would neither engage them as participants nor yield success. Over the years, GPs in Richmond have been approached to participate in projects, invest time and then have projects shift course, lose funding or be abandoned. Given these previous experiences, GPs are often reluctant to participate. At the outset, in order to make this initiative move forward, the Division did its best to offer clear direction and explicit value and benefits for the physicians and their patients. Critically important was having an enthusiastic Physician Lead to 'sell' the project to potential GP participants. This GP champion was crucial and as the project grew in scope and size, other GPs needed to join in and champion the cause.

Physician Lead

The Neighbourhood Network Physician Lead, also the A GP for Me Physician Lead is a passionate champion who spent significant time debating the concept, wrestling with anticipated challenges, analyzing data, engaging with stakeholders and meeting with fellow GP colleagues to encourage their participation.

The Physician Lead's knowledge of historic projects undertaken in Richmond also proved invaluable. The Division team and stakeholders were not always familiar with the cause or level of GP trepidation or reluctance. Additionally, the

Physician Lead identified mistakes from past initiatives and offered lessons that allowed the Division and our partners to avoid pitfalls and challenges. Success in the first phase of the project – outreaching to physicians and successfully organizing two networks – was very much due to the Physician Lead's tireless efforts. A strategic and forward-thinker, he was able to shed light on how GPs think (reactive and short-term) and balance that with a longitudinal and strategic focus. With each phase, the Physician Lead provided critical leadership and ensured the project was physician-led and responsive to physician need.

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Network GP Lead

While critical to have the Physician Lead rally the entire membership, it is burdensome and time-consuming for one physician and, for implementation, any one GP is limited in how they can impact efforts within a particular Network. With the expansion of the networks, the Division realized that each Network would strongly benefit from having a Network GP Lead, a physician that advocates on the Network's behalf, supports coordination of the network and points out issues and challenges specific to their network. This in turn improves the Divisions ability to tailor its approach to each Network in timely ways, rather than implement blanket responses for all the Networks. Determining the roles and responsibilities of a Network GP Lead emerged over several months. The project's Physician Lead, who is also part of a network, provided a comprehensive list of tasks he felt a Network GP Lead should undertake and the Division was able to offer operational tasks, along with timeframes for this network role. Having two pilot Networks operate without formal Network GP Leads offered many insights as well –at times we would have benefited from different perspectives on issues and we lacked a strong advocate from each network to support buy-in.

The roles and responsibilities for the Network GP Lead include:

- Provide leadership and champion the adoption of change within their respective network
- Attend Neighbourhood Network Working Group meetings and share ideas and insights to help guide the project
- Promote Network member engagement, alignment and collaboration
- Where required, act as the GP representative for the group of network physicians, speaking on behalf of the Network and giving the Network a coordinated GP voice

While a formal role description for the Network GP Lead was developed, the Division has not yet recruited physicians for the role or fully tested the role within each Network. Each of the four networks is different in their composition and their partnership. Where some networks have worked collectively in a variety of ways for many years, Network GP Leads have emerged naturally. Other networks have just come together, lacking familiarity and collegiality. Building a Network and establishing a (fixed or rotating) lead, ought to emerge without force and at the speed of trust. While the Division has introduced the concept of a Network GP Lead, at this stage, it has not been required of any network. Formally trialling the role would be a beneficial next step.

GP Champion

Within each Network, it is also valuable for different GPs to lead specific efforts. If every GP has a discrete task they lead, it will ensure that all the Network activities are supported and maintained without the burden resting on the Network GP Lead. This collective responsibility will support collegiality, and allow for a trusting and collaborative team that supports several aspects of the Patient Medical Home (notably attributes relating to team-based care and timely access).

GP Champions can effectively support the integration of any Network activity. For instance, one GP can champion cross-coverage and ensure that a system for managing coverage is working well. Where process improvements are required, the GP Champion can bring challenges to the group and/or to the Division and support trialling improvements. Though the Division helps facilitate cross-coverage for one Network, over time, a robust cross-coverage system is likely one element of networks that is easily maintained with little leadership. Still, without a GP champion, it may fall to the wayside, or be underutilized. Sustained attention to the entire system by one GP, will allow others to pay less attention to its overall success.

Another area that may benefit from a GP Champion is shared locum support. If one GP is tasked with testing the extent of the need with colleagues, recruiting the locum and coordinating their engagement, it is a job that other GPs can partially relinquish with confidence. The Division can provide support in numerous ways but working with one select GP will streamline activities for efficiency and effectiveness.

Finally, to add any health service or professional within a network, it may be helpful for a GP Champion to guide integration. While the Division can lead negotiations with partners, identify solutions to potential challenges and articulate pathways and processes for the integration, having a GP point person to test plans and initiate integration will ensure care is comprehensive and coordinated (PMH, Attribute #5) and that quality improvement measures (PMH, Attribute #9) are undertaken.

Acknowledging the Time Required by GPs

Appreciating the significant time required from GPs to engage in change projects, the Division reimbursed participating GPs at the sessional rate for certain activities. For participating in monthly check-ins with the Division, through an online survey and face-to-face, GPs are reimbursed one hour at the sessional rate. GPs can also bill for work that is focused on aligning systems, care integration issues within the Network context and other feedback mechanisms. This has historically occurred at Network meetings and bi-monthly all-Neighbourhood Network events. On the balance, the Division anticipates that GPs likely invest 1-2 additional hours/month of non-compensated time to provide less formal feedback to the Division and our partners and to discuss network activities with other GPs.

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The Division assumes that a Network GP Lead ought to serve in the role for a (minimum) one-year term. As these Networks become self-sustaining, this role is one that can be shared and rotated amongst members. Given the busy professional lives of GPs and the time required to invest more broadly in Network activities, undertaking the Network GP Lead role is not without a time commitment. While the Division has sought to trial the Neighbourhood Networks without unduly imposing on GPs, establishing and sustaining a Network does require time and energy and the Network GP Lead role is an additional effort.

At a time when fee-for-service GPs are feeling stretched by the responsibilities of their existing practices, inviting system change must be introduced and broken down into manageable parts.

Avoiding Preferential Treatment or Conflict of Interest

One potential challenge is many network GPs also participate in other leadership roles such as our divisional Board of Directors, or as leads in other physician-based organizations. This may lead to conflicts of interests or the appearance of conflicts of interests. In either case, members of the Division must anticipate any perception of preferential treatment or conflict, declare this potential and, where appropriate, remove themselves from deliberations and/or decision-making. By ensuring fair and equitable engagement and a structured approach to participation, the Division was able to mitigate potential challenges around involvement or allocation of resources.

Conclusion

At a time when fee-for-service GPs are feeling stretched by the responsibilities of their existing practices, inviting system change must be introduced and broken down into manageable parts. Engaging GPs that will build some initial success and then investing in additional GPs that can continue to mobilize around an innovation or practice pathway is neither simple nor fast. Having a clear value proposition for GPs to engage, articulating the time and financial investment required for moving forward, and reimbursing participants for time spent building and trialling activities, strongly aid in supporting ongoing GP engagement.

Additionally, in any endeavour, it is important to determine what roles are required and what responsibilities must be met. GP leadership is critical for the initiation, development and ongoing sustainment of Neighbourhood Networks. Though fulfilling the roles requires time and attention, there are indicators that the responsibilities for networks can be distributed amongst participating GPs in ways that build collegiality, trust and enhance primary care provision.

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