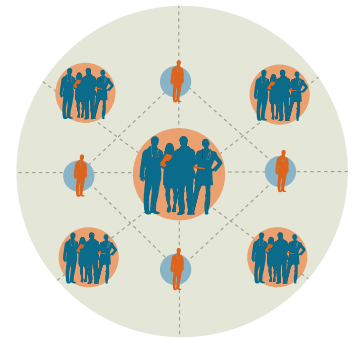


NEIGHBOURHOOD NETWORKS

WHITE PAPER
October 2016

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.



Infrastructure Challenges

Introduction

From conception and throughout implementation, the Richmond Division of Family Practice and participating GPs confronted many infrastructure-based challenges to optimize the potential of Neighbourhood Networks and successfully support practices to provide effective patient-centred care. Some challenges were addressed directly or a workaround was identified so that the momentum of the Networks could continue. Others were only acknowledged and remain unresolved.

The Division groups these infrastructure challenges as operational, technological or physical. These categories are not absolute but act as a means to understand the roadblocks and address the challenges. It should be noted that these three areas present a way of grouping some of the most significant challenges and do not represent all infrastructure challenges experienced to date in the Neighbourhood Networks project.

Operational Challenges

Scheduling health professionals

As of September 2016, there were 4 Networks, comprised of 28 GPs, and 3 health services comprised of or staffed by upwards of 8 health professionals. All of the deployed health professionals have time in their schedules dedicated to clinical support within Neighbourhood Networks. Services are provided to practices within Networks or to Networks as a whole and each Network has their own scheduling and referral processes in place. It can be challenging to track which patient is booked with what provider and when, and what information needs to be relayed to the provider and how. Timely scheduling and schedule revisions between physician practices and with health authority systems compounds this challenge. This ongoing issue is substantial and creates a frustrating and far too time-intensive response for all involved parties.

*Other white papers
in the series include:*

Envisioning and Evaluating
Transformative Work
GP Engagement
Integration of Health
Professionals
Key Partners: Promoting
Alignment and Readiness
Leveraging Data
Parameters of an Optimal
Network
Role of the Division

Efforts to manage the challenge to date, have been largely low-tech. Since the Steveston and Blundell Networks share the pharmacists' time on a particular day, our partner, the UBC Pharmacist Clinic, pressed for a more efficient and coordinated scheduling process. The solution was to have a MOA Lead within each network support appointment booking and offer some oversight for referring GPs. The Shared Care Psychiatry program piloted a web-based booking tool with hopes to streamline booking between the psychiatrist and GP office. The GPs that tested the calendar provided feedback that a booking tool not already integrated with EMRs adds a complicated layer on top of an already complex primary care clinic environment. Indeed, integrating a tool for only one service, that can only succeed if used by all parties (all participating GPs within a Network and the psychiatrist) is inefficient and laborious. GP offices tended to book a cluster of clinic days rather than book according to need and this created limited psychiatry capacity to expand the service more broadly. Finally, several privacy issues were identified (namely, whether the software server hosts data within Canada, the level of confidentiality of entering patient information, and the use of secure internet connections) and all together, viability of this web-based tool became untenable. Networks and integrated health professionals continue to face this challenge.

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Schedule Awareness for and between GPs

To help GPs keep the various Neighbourhood Network efforts in mind, the Division would email a reminder one week in advance of any providers visit to their practice. For one co-located Network with a common lunchroom, a paper calendar was created where GPs can note their absences to facilitate awareness around cross-coverage needs, and provider visits are also articulated as an additional reminder of scheduled visits. In Blundell, this low-tech solution is both effective and efficient. GPs communicate time off with a request for cross-coverage directly on the calendar. The six GPs work in teams of three and the MOA will refer urgent patients to the covering and (daily) rotating GP. Steveston utilizes a cross-coverage form to communicate with one another regarding coverage and share the document in their shared lunchroom.

Scheduling cross-coverage for non-co-located Networks is particularly challenging. Without shared physical space within which to communicate, and avoiding email that has proven ineffective for timely correspondence among GPs, impacted Networks have brainstormed possible solutions. One Network is trialling the use of a cross-coverage form and is also exploring the viability of a shared online vacation and cross-coverage request calendar.

Case finding

Early on in the deployment of the chronic disease nurses, the Division identified that case-finding appropriate patients for the service was a challenge for many GPs. The Division leveraged the expertise of PSP to lead paper and electronic medical record system-based discussions at one of our all-Neighbourhood Network events for GPs and MOAs. Participants shared processes they employ for case-finding for the CDN, psychiatry and pharmacist services. As a follow up, PSP visited GP offices to offer practice coaching sessions with GPs in all

four networks. PSP activities have been focused on supporting the updating of patient statuses (active/inactive), creating chronic disease patient registries, ensuring appropriate and similar codes are being used across EMRs and paper-based practices, and establishing appropriate patient recall processes. Through these activities, the Division hoped that GPs and MOAs could optimize their EMRs through data maintenance and clean up. In turn, GPs would have a greater appreciation of their actual panel size (which might allow for new patient attachment) and have a better understanding of their patient panel profiles and what resources they may need to leverage (all of which contribute to the Patient Medical Home attributes relating to information technology enabled and internal and external supports). In reality, and as previously discovered in efforts to optimize EMR-enabled practices, this is intense work for GPs to undertake and is not labour they take to naturally or willingly. Currently, GPs are not paid for these activities which may contribute to the low uptake. The type of data analysis and clean up required is extensive and largely administrative. While this is critically necessary work, if GPs are to undertake it, it might, for a period, reduce their time to see patients.

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Technological Challenges

EMR connectivity

Richmond GPs utilize a diversity of medical record systems (8 unique systems) and that diversity exists within each Network where a mix of EMR and paper-based practices are maintained. With cross coverage occurring within all four Networks, a lack of EMR connectivity between the different EMRs and to larger health authority record systems is a barrier to accessing patient information. While this lack of connectivity seems inconsistent with the Patient Medical Home model, this challenge is not one the Division has sought to address in any comprehensive way.

Though far from ideal, cross-covering GPs sometimes see or provide on-call support to a colleague's patients with no background information on the patient. Where appointments are planned, MOAs of the primary GP can provide the patient's summary sheet. In an attempt to bridge the potential gap in information and to be in better compliance with the College of Physicians and Surgeons of BC's recent update regarding safe prescribing (See Professional Standards and Guidelines: Safe Prescribing of Drugs with Potential for Misuse/ Diversion), the Division offered Network GPs one-year's worth of reimbursed access to Pharma-Net, so that the covering GP can know the medication profile of a colleague's patients when their full health record is not available. The extent to which this tool is utilized, and its value in supporting cross-coverage, will be evaluated.

Charting and Documentation

Another significant technology-based challenge results in part, from a lack of interoperability between community GP and health authority record management systems. The chronic disease nurses and Shared Care psychiatrists are VCH employees and are required to chart patient information in PARIS (Primary Access Regional Information System). Recording information into

PARIS is subject to charting guidelines and PARIS limits access to secure network servers and VCH sets terms for how and where employees access it. Addressing hardware/software challenges that allow for remote access to PARIS would increase the efficient use of a health provider's time in GP offices. At the moment, CDNs double chart - in PARIS and in the physician's paper chart or electronic medical record to bridge this gap but confront challenges regarding different charting protocols between VCH and each GP. Psychiatrists chart in PARIS and then dictate and send a consult letter to GPs. Similarly inefficient, the Clinical Pharmacist, using a virtual private network (VPN) charts into their own Oscar EMR and provides the GP with a consultation note with detailed recommendations and implementation plans. It is up to the GP to enter the information into their EMR as a note or PDF attachment. Additionally, the way GPs and other health providers share information, chart and document activities, often will include faxes and photocopies. Not surprisingly, these communication methods are not aligned with most efficient or effective information technology enabled health care. Overall, the lack of system interoperability creates significant system-wide challenges and concerns for team-based and comprehensive care as required in the Patient Medical Home.

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All of these challenges have resulted in some physicians purchasing additional EMR licenses for other health providers to chart directly in their EMR. This is expensive for GPs and is not without its own challenges for health authority employees vis-a-vis health records and privacy requirements. Differing charting practices means charting details can be inconsistent for the GP's records and some health providers are (not unreasonably) disinterested in charting twice.

Privacy

With Network GPs integrating health professionals and supporting one another with cross-coverage, there are multiple people, apart from the primary GP, who might benefit from having access to primary care medical records. Without patient consent, granting others access to an EMR is a substantial breach in confidentiality. Beside this significant issue, EMR licencing agreements do not always make this efficient or affordable for GPs within a Neighbourhood Network. Again, in an attempt to bridge this privacy gap for cross-coverage, the Division is offering Network GPs PharmaNet, where patient consent does not need to be gathered by the primary or covering GP with the signing of the Community Practice agreement (COMPAP) and Community Health Practitioner PharmaNet agreement, respectively.

Each entity providing their services for the Networks – VCH and UBC – has their own privacy compliance policy. This is in addition to GPs and their mandates as per the College. There are different privacy requirements for different environments. It is challenging to understand what privacy thresholds are applicable when. The inability to securely communicate by email or text, for instance, creates significant inefficiencies between GPs and between GPs and other health providers. The Division appreciates the extent of the privacy challenges that must be addressed in order to achieve fully functional Neighbourhood Networks and Patient Medical Homes and will look to work with partners to find efficient and secure ways in which to operate together.

Physical Challenges

An important parameter for trialling health resource professionals within Network GP offices is having space available to host these professionals. Some solo or full time Network GPs do not have additional office space available and to accommodate a health provider would alter their workflow by removing a clinic room and/or office space.

With the co-location of Blundell and Steveston Networks, GPs are better able to share a chronic disease nurse, psychiatrist and clinical pharmacist, as a provider can see patients of multiple GPs in one location. This model supports the expansion of services to a greater number of GPs in a more equitable and sustainable manner and allows a health professional to efficiently see patients from various GPs without moving locations. Through Division outreach and negotiation, VCH public health dietitians are now developing group education visits on topics that address chronic disease prevention and management. For Networked GPs that share office space, this service can be provided in a shared waiting room after hours and oftentimes can accommodate up to 12 patients.

For City Centre and Westminster Networks, practices are spread across city blocks, and health resources have been deployed in a 1:1 model, where the health professional sees patients of only one GP in one visit. Efforts to coordinate appointments for patients of multiple GPs in one location have not come to fruition. GPs prefer to receive services in their office, where patients are most comfortable and familiar. With advance care conferencing, a requirement for the psychiatry service, a patient seeing this clinician outside of the primary care physician's office creates barriers to achieving this requirement. The clinical value of face-to-face corridor consults allow for co-development of care plans and for effective and efficient continuity of care. For the Westminster Network specifically, many of the GPs work full time and, at most, have only a half-day of office space to dedicate to hosting and integrating an additional health resource. Where the Blundell Network was able to integrate and share a Clinical Pharmacist after a short planning period, the Westminster Network began planning for the service but after considerable discussion and planning, decided not to pilot the pharmacy service. Though interested, the requirement by the health resource provider (UBC Pharmacy Clinic), that the pharmacist provide services in one site for a full clinic day, was untenable. Though one GP had meeting room space available for the full day and offered it to network GPs at no cost, network GPs were uncomfortable with referring patients to another physician's office and did not identify a secure way to provide the pharmacist access to medical records.

The Division has not yet trialled care where GPs refer their patients to a neighbouring GP's office to access health professional services. Outstanding challenges include supporting patient adherence to visits at a different site and providing access to medical records for the health professionals. A financial consideration also arises when one GP incurs indirect costs above and beyond their network colleagues by providing office space to the group. The Division and networks have yet to determine whether compensation to the hosting GP is appropriate and how this might occur, given funding limitations.

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Some of the networks are comprised of GPs that are part of group practices, and in some cases, not all of the practice group GPs are members of a network. With that in mind, if networked GPs within a group practice wish to host services in jointly held space, it is possible that group practice colleagues that are not part of a network may wish to access these services for their own patients. The Division anticipates this challenge but has not yet determined a way to address it that respects all impacted GPs and the Neighbourhood Network model.

As an alternative location for group visits, the Division is exploring holding sessions at local community centres. This allows the Division to leverage its partnership with the City of Richmond and addresses the physical space challenges for non-co-located networks. The City Centre Network, requiring external space for group educational visits, has identified their local community centre as the ideal location. The local centre is in close proximity to the practices, many patients are already familiar with it, and because community centres are associated with health and wellness, holding appointments there may reduce stigma and therefore, facilitate patient attendance. Additionally, related City of Richmond programs and services can be highlighted to attending patients.

Expenses Incurred by the Division

In the start-up phase, the Division budgeted for nominal expenses that might support the testing of Neighbourhood Network concepts and to ensure momentum is maintained in the face of costs GPs would otherwise incur to pilot initiatives. For example, the Division covered meeting costs (venue, catering) to bring together GPs, MOAs and PSP to share case finding practices. The Division is providing network GPs with a year's worth of reimbursed access to Pharma-Net (approximately \$120/year/GP) to test whether this tool supports cross-coverage activities. Because UBC Clinical Pharmacy requires that there be one contact person in each Network to organize scheduling, the Division offers gift certificates to the designated MOA, appreciating that the work is done on behalf of the Network and extends beyond activities carried out for their employer alone. Typically, the MOA provides 1-2 hours of coordinating work per week. These costs, though appropriately covered by the Division in the initial phase, require longer-term consideration for sustainment.

Conclusion

The Division encounters various operational, technological and physical infrastructure challenges as part of the Neighbourhood Network roll-out, some of which can be managed head on, others which require a temporary work around while others require interference by partners. GPs within Networks realize that current systems and practices will require adaptation and have been willing to consider available options. Simultaneously, for issues that are beyond their control or outside of the Division's scope, GPs feel frustrated by the changing environment. Though GP patience is tested by slow moving change, infrastructure challenges will continue to arise and the Division can help to bridge these gaps by leveraging its partners, by convening GPs to create solutions or advocating for system changes outside of our control.

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