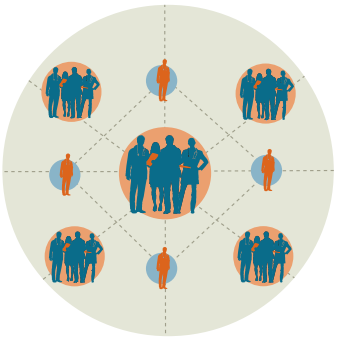
NEIGHBOURHOOD NETWORKS

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.



Integration of Health Professionals

Other white papers in the series include:

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

Introduction

From the A GP for Me assessment and planning phase, the Richmond Division members reported they felt overworked and were interested in leveraging specialty and allied health professional support. Identified areas were psychological counselling (80%), geriatric community service coordination (73%), chronic pain management (68%), social services coordination (55%), lifestyle coaching (54%) and condition-specific teaching and/or follow-up (49%) (GP Practice Survey, 2014). One of the goals of the Neighbourhood Networks was to trial the integration of other health providers into a GP's offices. The long term interest was intended to pilot this integration with an emphasis on (1) evaluating the benefit for GPs and their patients, (2) determining how integrating other health services can be shared amongst neighbouring GPs, and (3) an opportunity for cost sharing of resources. These goals are well aligned with plans to establish Patient Medical Homes (PMH) and afforded the Division the opportunity to begin tackling substantial challenges of developing comprehensive care and coordinated care, information technology enabled care, and evaluation and quality improvement, all of which are attributes of the PMH.

Integration of Care into GP Offices

Our initial implementation plan earmarked $200,000 to pay for shared health resources for the two pilot networks. One early plan was for the Division to hire the provider and deploy the resources in ways that complimented existing health authority-led and community programs and services. We soon identified a number of significant challenges, all of which were highlighted by the compressed implementation timeline. There was limited marketplace availability of health providers for shorter term project work; a lack of clear role assignment or ability to control the right level of engagement and number

Richmond Division of Family Practice
A GPSC initiative

of patients to be seen; significant liability and privacy considerations; and the need for timely sustainability planning. Additionally, the Division felt unsuited to manage the structural requirements of hiring and managing clinical staff.

Early on, the Division sought to leverage VCH's interest in placing resources in primary care settings and the Division collaborated with VCH on how to deploy available health authority resources. Simultaneously, the Division began exploring a partnership with the UBC Pharmacists Clinic and looked at realigning existing efforts already underway through the Division's Shared Care – Psychiatry initiative. Currently, one or more health professional is integrated in all four Neighbourhood Networks. Two models of integration are being utilized depending on the resource and requirements of the providing partner. One model is for GPs in a Network to share the offered resource that is made available in one of the network GP offices (one-provider-to-many-GPs model). The second model occurs when one GP utilizes one provider on a particular day (one-provider-to-one-GP model). A third model, GPs sharing resources in the same group educational visit, is being planned.

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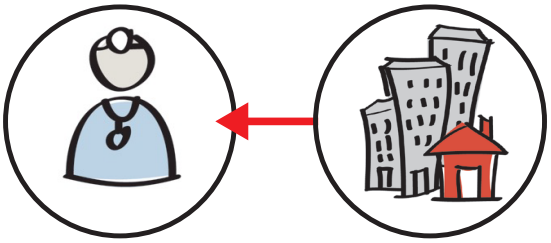
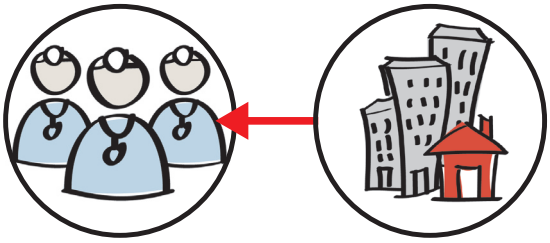
Vancouver Coastal Health (VCH)

The Division approached VCH-Richmond, and with a redesign of services underway, the health authority partner become interested in deploying chronic disease nurse (CDN) resources to the pilot Networks. Pressure to see early success saw VCH and the Division trialling the service before there was clarity in the scope and roles. VCH leadership gaps and limited change management expertise impacted the roll out and coordination of the service. Initially piloted in one network, clinic days for the CDN were scheduled and initially showed strong uptake but then slowly tapered off over several months. Due to the pilot phase approach, the CDN also saw non-target patients and engaged in activities out of scope. The scope of practice for the CDN and the roles and responsibilities of the CDN, GP, Division and health authority were slow to solidify and caused confusion. Additional issues included (a) expectations of the role of CDNs in some GP offices based on historic efforts that focussed on different patient populations and interventions by the CDN; (b) GPs wishing a broader scope of (nursing) support that was outside of the service scope; and (3) nurses that are deferential to support relationship-building. Finally, just as GPs practice differently, there were differences in skill sets and interests within the deployed CDNs.



one-provider-to-one-GP model



one-provider-to-many-GPs model

As the work unfolded, a clear articulation of the CDN service was negotiated and communicated amongst all stakeholders: (1) clinically assess and follow-up of patients with specified chronic conditions; (2) educate and coach the patient to enhance positive behaviour change; (3) provide support to patients to acquire skills for self-management and set personal health goals; (4) coordinate referrals and/or linkages to appropriate community services; and (5) partner with the patient and GP to create a personalized care plan.

Recognizing the skill and time required to identify appropriate patients for the service, the Division worked in partnership with VCH and Practice Support Program (PSP) to build capacity for case finding. With trial and error, the goal to utilize CDNs at their fullest capacity and within their specific and specialised skill set was, in large part, achieved. With the spread to other networks, we introduced a formal orientation to the service and the providers, which led to smoother integration. Additionally, rather than starting with a CDN spending a full day at a GPs office, CDNs scheduled a limited number of clinic blocks based on initial identified GP need and expanded from there.

The Division hopes to see the expansion of VCH integrated services through group education visits led by VCH dietitians on nutritional topics related to patient self-management of chronic diseases. GPs and the deployed CDNs will help to identify appropriate patients for the group visits within each Network.

The Division worked in partnership with UBC Pharmacy to adapt the existing model and develop necessary workflows. In time, the service spread to other networks successfully.

UBC Pharmacists Clinic

The UBC Pharmacists Clinic operates a co-location model where clinic pharmacists are physically located in physician offices on an intermittent basis and work collaboratively with physicians in the care of complex patients. When the service was first offered, it was a one-on-one GP service where one GP would refer a full day of patients. Some GPs did not have a spare exam room open for a full day or feel like they could find a full day of patients to refer. Additionally, the Division recognized that expanding this service to other Network GPs and Networks would be difficult based on limited capacity of the UBC Pharmacy Clinic. In response, the Division proposed having the pharmacist see patients of more than one network GP in the clinic visit, articulating the value to primary care provision. The Division worked in partnership with UBC Pharmacy to adapt the existing model and develop necessary workflows. In time, the service spread to other networks successfully. The Division approached UBC Pharmacy with another suggested adaptation to best support Networks where a full day of office space is unavailable. The Division proposed scheduling a morning site and different afternoon site for the pharmacist, requiring a mid-day shift in location. The current policy that the pharmacist spends the full clinic day at one site remains preferable to UBC Pharmacy and shifting that remains outside of their service parameters.

Richmond Division Shared Care Program

As the Neighbourhood Networks launched, the Richmond Division's Shared Care psychiatry program was already underway. The project consisted of placements of VCH psychiatrists to GP offices to improve patient access to psychiatry consults, improve capacity for GPs to provide ongoing care for their patients with mental health needs, and improve collaboration between GPs and their psychiatry colleagues. This presented a fantastic opportunity to integrate and align an existing Division activity with the Networks. Like UBC Pharmacy, Shared Care was amenable to trialling the service in a one-to-many GPs model, proving successful in the Steveston, Blundell and City Centre Networks. However, referrals began on the part of some Network GPs without

first notifying the Division of their intention to participate and GPs who did not receive formal orientation were not using the service as intended.
The Division recognizes that scaling a service of this nature is not fast work. Expanding across GP practices, within networks, with a Health Authority provider and multiple psychiatrists must recognize and acknowledge that each stakeholder has systems and specific requirements to feel success. All the steps introduced at the commencement of the service, are required going forward. These necessary steps include: formal introduction and orientation for GP, MOA and psychiatrist to ensure fit; clarify expectations for all involved; and, promote as much standardization of the service as possible. With this service in such high demand and limited capacity of psychiatrists, there was some perception from the general membership that there was prioritization of Neighbourhood Network GPs for service enrolment of the Shared Care project that needed to be addressed. While Network GPs were offered the service, deployment within a Network offered more GPs access to the service since multiple GPs could book patients on a single day. The Division was able to see at minimum 50% greater efficiency in utilization because more GPs could be served with the same allotment of time in the one-to-many GPs model vs. the one-to-one GP model. This greater efficiency with appointments attached to a Network did not take from the offer to non-Networked GPs but highlights how limited resources can be shared in effective and efficient ways.

Fee-for-service physicians must be presented with not only expected health outcomes but also a viable business case for integrating a service.

Addressing Challenges

Comprehensive care and coordinated care, as required within the Patient Medical Home model can be achieved through partnership with the health authority, however integration of VCH health resources into Richmond's fee-for-service, private practice GP offices highlighted some broad challenges. In fact, any partnership with groups that work outside the fee-for-service model must develop an understanding of how this financial structure will operate within integrated care delivery. Fee-for-service physicians must be presented with not only expected health outcomes but also a viable business case for integrating a service.

Integrated care, on a neighbourhood level, requires responsiveness to the realities of each neighbourhood. For a city like Richmond, language needs can be at the heart of the primary PMH goal of patient-centred care. Thirty-six percent of Richmond residents indicate Chinese as the primary language spoken at home, with that number jumping to 52% for the City Centre neighbourhood (City of Richmond Language Hot Facts, 2014). The City Centre Network GPs primarily provide services in Cantonese and Mandarin and the integration of a health provider that could meet these language requirements was significant. While VCH and UBC have deployed Chinese-speaking CDNs and pharmacists to this Network, the Shared Care Psychiatry program is still looking to recruit a Chinese-speaking psychiatrist, which has discouraged uptake and left a large proportion of their patient panels unable to access the service. While the use of telephone based translation services has been encouraged, patients, GPs and psychiatrists wish to avoid them for psychiatry assessment. For Neighbourhood Networks to expand within Richmond, providers who

speak languages other than English will be an ongoing issue. The Division and its partners will have to identify ways to more effectively use language-specific providers within the constraints of external policy directives such as certification of foreign trained physicians and language requirements for unionized workers.

The integration of health resources into GP practices is new for many GPs and the "team" aspect of team-based care is only starting to materialize with time, relationship building and effort.

Integrating care services by other health professionals into GP offices have created numerous infrastructure-related challenges, some of which have been addressed by the Division. Early on in the deployment of the chronic disease nurses, the Division identified case-finding as a significant challenge for many GPs. By leveraging the expertise of PSP, the Division hosted an event to discuss practices and opportunities for case finding among its network GPs. PSP has been working with a number of network GPs since then to update patient statuses (active/inactive); create chronic disease patient registries, ensure appropriate and similar codes are being used across EMRs and paper-based practices; and establish appropriate patient recall processes. Through the work, GPs and MOAs are increasing their EMR proficiency and have a better understanding of their patient panel profiles and what resources would further benefit their practice and patients (PMH attributes relating to Information technology enabled, evaluation and quality improvement, and internal and external supports).

When resources are shared in a one-to-many GPs model within a Network, coordinating schedules was an issue to be resolved. The Division worked with GPs to identify an existing MOA who could take on the additional work of liaising directly with GPs (or their MOAs) within their network, and allied providers, to coordinate bookings for all the Network GPs. This small but significant coordinating role is outside the existing GP and MOA contractual relationship since the MOA is serving the larger GP Network. As a result, during the pilot phase, the Division has provided a small stipend to the coordinating MOAs. The longer-term goal is for the Network GPs to share the stipend cost or identify another solution to scheduling the integration of the service (for example: rotate MOAs to undertake the task).

Most solo GPs utilize all their exam rooms so hosting health providers at the same time that they practice is a continuing challenge. Office lease costs in Richmond are at a premium and few offices have unused clinical space. Further, none of the health providers have availability for early mornings, evenings or weekends which are increasingly times that GPs are seeing patients in their office. One of the advertised benefits of participating in a Network was the ability to share office space or utilize space within a neighbouring GPs office. While several GPs have opened their extra office space to accommodate VCH and UBC service providers, there are inquiries about compensation. This is a concern that has not yet been addressed. An alternate arrangement that is being considered is to utilize local community centres, leveraging our partnership with the City of Richmond, and using existing VCH space.

Challenges not yet addressed are numerous. With comprehensive and coordinated care, there have been privacy and security concerns when multiple

people, teams and organizations, apart from the primary GP, provide care and access medical records. The lack of system inter-operability between VCH's PARIS (Primary Access Regional Information System) and community-based GP EMRs mean that the deployed CDNs chart twice, a time consuming and wasteful undertaking. Faxing of results and consultations to the GP remain a common practice. Evaluation and quality improvement (a PMH attribute) has been challenged when one group (UBC Pharmacy) sets evaluation metrics on its own (because the service pre-existed the Neighbourhood Networks), collects (non-identifiable) data, and is unable to easily separate the data for purposes of clinical quality improvement on a practice and community level.

For some GPs, there was a lack of time or interest to integrate resources. A lack of interest may relate to a history of the health authority trialling various health services such as case managers, dietitians and chronic disease nurses into GP practices and then removing them, often with little notice. With some histories of GP disenfranchisement and/or disillusionment with health authority services, there was some reluctance to partner. The integration of health resources into GP practices is new for many GPs and the "team" aspect of team-based care is only starting to materialize with time, relationship building and effort. Each GP within a Network has their own practice style and operates with some distinct processes. Both health providers and physicians must adapt to meet individual needs, be open to adopt new styles and processes and help standardize integrated services.

The Division was successful in negotiating small changes to promote partner alignment for the deployment of existing health resources within the Networks. Regular check-ins with GPs and on the ground providers and leads were beneficial to discuss successes, challenges and test Plan-Do-Study-Act (PDSA) cycles. While we have accessed and analyzed neighbourhood-level data to understand differences in socio-demographics, health behaviours, health service utilization and health outcomes, we see a great opportunity to leverage this data to support the best-suited health resources for Network integration. Additional work to measure the effects of the Neighbourhood Networks model on service provision and integration is required. Impact here would align with PMH attributes related to networks supporting practice and communities.

Because the Division leveraged partnerships with existing VCH programs and services, the direct costs to the Division when integrating these health providers were project management and coordination time. Investing in partner relationships supported early momentum and built trust where it did not always exist. The Division's relationship to partners - from clinical providers to senior leadership - was critical to the success of the integrated care service.

While there were no direct costs to GPs, there were indirect costs borne related to overhead, for example, rent and utilities for the health provider's use of office space. GPs that make their office space or waiting room space available to Network GP colleagues to host health providers or group visits at no cost will accept a disproportionate amount of overhead costs that should be noted. Additionally, MOAs, who are responsible to their GP employer(s), are asked

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to support the new service without undue negative impact to GPs or their patients. Though it is unknown whether this is a substantial burden on MOAs, sensitivity to and a corresponding response to these new demands should be considered going forward.

Health integration is a considerable task for GPs and while there are various fee codes that incentivize GPs for this work, significant consideration regarding the value proposition for fee-for-service GPs should occur. Care conferencing is a core value of all three integrated health services and all GPs are able to bill G14077, the Attachment Conference Fee ($40 per 15 minutes). When group education visits with the VCH dietitians are piloted, GPs that participate or co-lead the visits are eligible to bill P13763/81, where the code relates to the number of participants and ½ hour portion. While group visits are an effective way of leveraging resources, increasing GP and health provider capacity, increasing patient access to care and reducing costs, there is not much incentive for GPs to participate when factoring in travel time and limit of claims to ninety minutes per patient per day, where visits with large numbers of participants may easily run over this time.

High levels of collaborative and regular engagement with GPs, on the ground providers and leads, meant that the Division could address emerging issues. Though time intensive at the outset, relatively nimble responses to challenges were possible.

Conclusion

Efforts to leverage existing health resources, through internal and external partnerships for our four Neighbourhood Networks have largely been successful and if scaled, might afford integrated care between primary care, specialty care and specialized services rooted in the family physician's office. High levels of collaborative and regular engagement with GPs, on the ground providers and leads, meant the Division could address emerging issues. Though time intensive at the outset, relatively nimble responses to challenges were possible. Each GP, Network, provider, service and partner are different and the integration of health resources required unique, creative and adaptable solutions for each situation. 'Planning until perfect' may appear compelling, but with a limited implementation timeframe, the Division's 'give it a shot' mentality meant that we could test, revise and revisit our solutions, supporting the fast and high uptake of services within the Networks. With equally invested partners and GPs prepared for trial and error, the Richmond Division saw many early successes in integrating services.

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