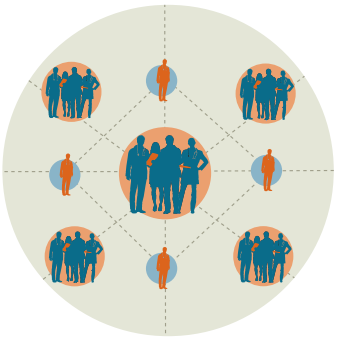
NEIGHBOURHOOD NETWORKS

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.



Key Partners: Promoting Alignment and Readiness

Introduction

Neighbourhood Networks have leveraged a variety of partners - partners who could provide services, partners who could provide information and partners who could link to other people or organizations. Ensuring that the right partners are engaged and ready is critical and requires attention, patience and adaptability. The Richmond Division of Family Practice recognizes the importance of different levels and kinds of partner relationships and has, where necessary, nurtured relations between senior leadership as well as operational team members. By investing in day-to-day leadership and front line providers through multi-partnered steering committees, working groups and one-on-one connections, the Division improves the likelihood of a positive outcome. Having aligned with strong partnerships in the development of the Neighbourhood Networks dovetails with efforts to achieve the Patient Medical Home, which in turn, supports Health Authority efforts to develop a sustainable and accountable Primary Care Home. To date, the Division and its partners have mobilized to provide a solid foundation for the many refinements that will be necessary as well as providing a strong basis in which to trial and create new pathways for comprehensive and coordinated team-based care.

Our Approach

Early engagement of partners during our A GP for Me assessment and planning phase ensured that at its conception, the Neighbourhood Networks involved partner expertise and buy-in. The health authority, VCH-Richmond, is a key partner and having senior leadership at the Assessment and Planning Advisory Committee table was critical. The Practice Support Program, City of Richmond, Health Link BC and representatives from NGO's such as SUCCESS and CHIMO Community Services were regularly consulted, contributed to and endorsed our implementation proposal. This early investment supported the building

Richmond
Division of Family Practice
A GPSC initiative

of relationships, the alignment of efforts and identified strong and trusted champions to help forward the goals and deliverables of the Neighbourhood Networks. These champions were also engaged in the strategic development and oversight during implementation as members of the Neighbourhood Network Working Group and included:

Implementation Phase (Jun 2015 – Mar 2016)	**Extension Phase** (Mar 2016 – Sep 2016)
Director, Population and Family Health, VCH-Richmond	Director, Population and Family Health, VCH-Richmond
Manager, Community and Family Health, VCH-Richmond	Manager, Community and Family Health, VCH-Richmond
Project Manager, VCH-Richmond	Director of Primary Home and Community Care, VCH-Richmond
Manager, Practice Support Program – Vancouver Coastal	Manager, Practice Support Program – Vancouver Coastal
Manager, Community Social Development, City of Richmond	Vancouver Medical Health Officer, VCH (former Richmond MHO)
Medical Health Officer, VCH (Richmond MHO transitioned portfolios to Vancouver during the project but continued to participate)	City of Richmond (until June 2016)
Patient Voices Representative from Richmond Health Advisory Committee	Patient Voices Representative from Richmond Health Advisory Committee

During our implementation, other key partners emerged including the UBC Pharmacists Clinic, the Ministry of Health and VCH Public Health Surveillance. Additionally, the Division leveraged its existing project partner, Shared Care, by aligning its existing Richmond pilot with the Neighbourhood Networks model.

Partner Details

VCH-Richmond

Early on, the Health Authority was enthusiastic to test the redeployment of existing chronic disease nurse (CDN) resources to the pilot Networks, aligning with their work to implement resources in primary care settings. Though deployed to work in GP offices, leadership gaps, interim roles and limited change management expertise impacted the roll out and coordination of the service, and scope of practice, roles and responsibilities were slow to solidify. These challenges were not the only factors impacting a smooth CDN deployment, but they were consequential. For example, one CDN, when asked by a GP, engaged in activities that did not match up with the intended chronic disease self-management focus. Additional GP and CDN education was required and, with our partner, we came to better understand the multiple issues and interests that were at play, namely, historic CDN integration in some GP offices; GPs seeking support to ease their burden beyond specific CDN scope; and nurses focused on relationship-building – all of which contributed

to a particular dynamic within early integration efforts. After some trial and error, the goal to ensure that CDNs utilized their specific and specialised skill sets was pursued more actively and deliberately and the Division and VCH worked in close partnership to identify appropriate patients for the service through GP, MOA and CDN education and by leveraging PSP panel supports. The Division, the CDNs, and Manager for Home Health set bi-weekly meetings to check-in about service provision within the Networks. Ongoing challenges relate to the alignment of evaluation frameworks and absence of robust outcome metrics and data. Additionally, there remain some gaps in terms of quick response to emerging issues and shifting resources.

Through our check-ins with network GPs, the Division heard of an interest in dietitian support. With an alignment with patient needs within specific neighbourhoods and with an awareness of existing chronic disease programs and services, the Division began exploring the possibility of dietitian support. Though the CDN deployment had been challenging, trust is well established and there is a strong commitment to collaborate and integrate care for the Division and Health Authority. We connected with one of our VCH-Richmond Public Health partners, and were, in turn, connected to VCH-public health dietitians. Based on the emerging need, we are launching a series of group education visits led by dietitians on nutritional topics related to chronic disease prevention. These sessions will be supported by CDNs in case-finding appropriate patients for referral and patient follow-up. The Division is working collaboratively with the dietitians to outline goals and deliverables, and support orientation, communication and the development of referral tools and pathway documents. Linking various VCH-Richmond teams to one another is an added benefit of our work with this key partner as we see the CDNs and dietitians connect to ensure the best patient care. These teams are working together, and with GPs, to ensure knowledge transfer and will increase the capacity of the CDNs and GPs to support their chronic disease clients with nutrition-related conditions.

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Practice Support Program

The Practice Support Program (PSP) was a key partner for many of our A GP for Me strategies and though engaged in the Neighbourhood Networks Working Group, there was a lack of clarity in the early months of implementation on their role in supporting the Neighbourhood Networks. The importance of case finding emerged once Networks began integrating allied health resources and a plan to appropriately engage PSP and leverage their expertise in panel assessment, identification and management emerged. We invited PSP to lead small group discussions at an all-Neighbourhood Network meeting to understand what case-finding processes GPs currently had in place. This was followed by PSP outreach to all 28 GPs and practice coaching sessions began with some and have been encouraged for all. With this support, a number of GPs have created chronic disease patient registries and established appropriate patient recall processes. Where Network GPs had not previously participated in PSP coaching, we invited PSP to leverage our relationships with these GPs to make inroads toward practice efficiency.

Recognizing that neither partner had a mechanism to communicate and understand what activities were being undertaken that influence the other's work, the Division and PSP are reporting out to each other on a bi-weekly basis the outputs, successes, challenges, and opportunities to align our member outreach and work. The Division and PSP report out on alternating weeks, promoting responsiveness to any issues raised. At times, there has been some conflation of roles but open communication mechanisms have helped to ensure that we are leveraging one another's scopes and strengths appropriately. With PSP's recent shift in focus to support family practices to realize the full potential of the Patient Medical Home (PMH) and Primary Care Home (PCH), our existing partnership, areas of focus, and systems for communicating will serve the Division and PSP to maximize efforts and minimize duplication.

Points of mutual interest and value that are being explored include ways to build better linkages between Network GPs and the City's health and wellness programming and supporting GPs to include more health promotion into their practices.

City of Richmond

During the assessment and planning phase, the City of Richmond provided the Division with useful sociodemographic information to support the Neighbourhood Networks concept. We then chose to align our Networks with the City's planning areas. While VCH and the City organized service delivery based on different areas, aligning with the City was with future development and demographics in mind. Similar to PSP, while the City engaged early on in our A GP for Me initiative, there was no clear idea of where that partnership could be leveraged for the Neighbourhood Networks. Still, strong and early engagement, and a presumptive belief in leveraging jointly held interests meant that as opportunities arose, the City was ready to partner. Points of mutual interest and value that are being explored include ways to build better linkages between Network GPs and the City's health and wellness programming and supporting GPs to include more health promotion into their practices. In a survey to our Network GPs (n=13), 90% were either not at all familiar or only somewhat familiar with the City's health and wellness services which has led to plans to make GPs aware of the City's relevant programming and resources at an all-Neighbourhood Network meeting. As we educate GPs, in turn, the Division will ensure that there are opportunities for network GPs to inform local community services.

The Division is also exploring utilizing local community centres as a creative solution to address the space barriers many of our GPs and Networks face in hosting group medical or education visits. While VCH has meeting rooms on offer and without cost, the Division is hoping to leverage community centres because of the close proximity to GP offices, existing patient familiarity and comfort with neighbourhood centres, and the association of community centres to health and wellness rather than illness. All of these factors may reduce the stigma of being referred to and accessing group services, and may increase participation and make way for improved primary care outcomes.

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

first offered, the service was for individual GPs to refer a full day of patients for the visiting Pharmacist. For some GPs, finding a full day of patients to refer was onerous and additionally, the Division wished for the service to benefit as many Richmond GPs as possible despite limited capacity by UBC Pharmacy. In response, the Division proposed having the pharmacist see patients from GPs within specific Networks in a single clinic visit to align with the Neighbourhood Network model of sharing resources and supporting a greater utilization of the service. The new model was adopted; workflows were developed, tested, refined and spread to other networks. While successful, because of office space limitations, one network can only accommodate a half-day Pharmacist service but the provider partner has articulated that full day visits to one GP office is most efficient and effective.

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UBC Pharmacist Clinic has already established evaluation processes and metrics that are difficult to adapt. This has caused some challenges for the Division to measure and analyze activities and outcomes in terms of the role clinical pharmacists play within a Network. The Division is currently working to capture appropriate data, without duplication or increasing the burden on providers or practice staff.

Richmond Division Shared Care program

Concurrent to the A GP for Me implementation was the Richmond Division's Shared Care psychiatry pilot, consisting of community placements of VCH psychiatrists in 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 an emergent one. Like UBC Pharmacy, Shared Care was amenable to trialling the service in a one (psychiatrist)-to-many GPs model, proving successful. With this service in such high demand and a limited number of psychiatrists and capacity, the deployment of the service within a Network allowed more GPs to access the service and greater efficiency for scheduling appointments. While the Shared Care program is an internal initiative, there were times when collaboration and communication were not as streamlined as they could have been. This exemplifies the challenges of consultants that work remotely and programming that functions in project silos.

Ministry of Health and VCH Public Health Surveillance

VCH Richmond's then Medical Health Officer (MHO) was interested in using data to understand differences in how Richmond residents were accessing medical care. As early as 2006, he had developed the concept of family physician networks at the neighbourhood level to better meet the needs of Richmond residents. The intention was to provide more tailored, responsive and preventative care alongside better allocation and greater capacity of medical care services for vulnerable clients and those with chronic and/or complex conditions (Lu, 2006). Working from this transformative early work, we were able to obtain the Ministry of Health's Blue Matrix health status and health

service utilization data and engage with the Ministry of Health to analyze the data on a micro (neighbourhood) level. It was reported by Ministry of Health staff that this was the first time they had undertaken this type of analysis. As well, the Division recently invited the VCH Public Health Surveillance Lead to share with Network GPs neighbourhood level health behaviour survey data from its My Health My Community research. Key findings were presented so GPs can identify how they would like to see and use the data to inform their practices.

Conclusion

Collaboration between and with partners has proven to be the key in forwarding Neighbourhood Networks. Our experiences to date lead us to believe that to advance Patient Medical Homes and Primary Care Homes, collaboration will remain the linchpin on which we can build and support the key features of these primary care models. Whether to outline goals and deliverables; develop required pathways, tools and resources; assign responsibility; or ensure two-way communication regarding project updates and implementation refinements, active and direct participation supports partner alignment, readiness and action. Adaptability in partnerships is vital as is recognizing and respecting the limitations of each party, its resources and interests.

Some key partners were involved early and supported readiness to leverage opportunities as they arose. Other partners were identified as needs became apparent. In some instances, existing partners helped build new relationships while in other cases the Division identified and initiated relationships. In all cases, investing time to nurture relationships at all applicable levels is understood to be of critical importance. The Division sees its early engagement of senior level champions as a critical part of our success to date. Building trust over time and embedding that trust ensures it is institutional, and not personal. This is ongoing work and a level of vigilance is necessary as a continuous connection and fundamental interest to find and forward, common goals supports momentum.

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To learn more, please contact:
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