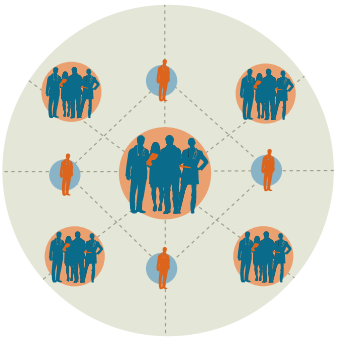
NEIGHBOURHOOD NETWORKS

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.



Parameters of an Optimal Network

Initiating Networks

In conceiving of the Networks, the Richmond Division of Family Practice did not know what an optimal network might look like. Research on self-forming groups indicated a lengthy timeline for establishing a network amongst motivated participants. To achieve results within a short timeline, the Division posited that certain parameters would support the development of viable Networks. When groups of GPs came forward to be considered for a Network, the Division wished to quantitatively assess their potential to ensure that the selection was equitable and supported networks most likely to establish themselves and thrive.

With support from literature related to self-forming groups, and based on our ideas of what Networks would strive to accomplish (that also met *A GP for Me* initiative requirements), a number of criteria were developed within the matrix to assess each GP within a prospective Network or the group as a whole. All criteria were scored out of 5 and weighted based on import. The matrix intended to support our deliberations -- a higher score meant higher Network viability.

The criteria for assessing each Network were:

- Strong connection amongst physicians ..... (weight – 5)
- Willingness to cross-cover for one another ..... (weight – 5)
- Willingness to take on vulnerable patients..... (weight – 4)
- Physician champion present ..... (weight – 3)
- Willingness to take on new patients ..... (weight – 3)
- Provision of services in the same language..... (weight – 3)
- Experience with an allied health provider ..... (weight – 2)
- Numbers of EMRs being used ..... (weight – 1)
- Use of GPSC incentive billing codes ..... (weight – 1)

Other white papers in the series include:

Envisioning and Evaluating Transformative Work

GP Engagement

Infrastructure Challenges

Integration of Health Professionals

Key Partners: Promoting Alignment and Readiness

Leveraging Data

Role of the Division

Richmond Division of Family Practice
A GPSC initiative

Though the weighting assigned to each was not arbitrary, neither was it scientific. The Division discussed and ranked the importance of the criteria and attempted to craft a tool that would support the challenge we faced to pilot the creation of Networks most likely to succeed in a short period of time.

While the scoring matrix was utilized, in reality, networks were selected based on (the limited) interest rather than how well any group of GPs met the pre-determined parameters. As the two pilot networks moved forward and the project expanded to include two additional networks, the Division identified some parameters that lead to better network development, some of which we predicted and others that we did not.

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Assessing Viability

Early in our network implementation phase, we saw differences between our two pilot networks, Steveston and City Centre. Essentially, the two groups of GPs were at very different stages in their Network journey, and were progressing at different paces. This afforded us an opportunity to understand their differences and the impact on the Neighbourhood Network model. The addition of two new Networks, Blundell and Westminster, better support our hypotheses of what parameters support viable Networks.

The Pilot Networks: Steveston and City Centre

Even in the early stages of our project implementation, it was clear to the Division that one network's GPs held a connection to one another and the capacity to nurture that connection more than the other networks GPs. The Steveston Network came forward as a group of 10 GPs, all practicing in the same building. Many had worked together for a number of years (in some cases, upwards of 20). Eight of the 10 GPs already had coverage arrangements in place and they had experience piloting different services amongst themselves, for example, 6 group practice GPs were employing a practice nurse and had previously shared locum coverage. Finally, a Network GP Lead naturally emerged to organize this Network since the Physician Lead of A GP for Me was a member of this group, easily and comfortably assuming the role.
These pre-existing elements were relevant- the seeds of collaboration were firmly in place and this supported early traction with the group to support the goals of the network, one of which was to trial health resources in the Network rather than amongst individual GPs. Co-location meant a (non-GP) health professional could see patients of multiple GPs in one location. This group was also well positioned to trial opportunities to expand shared locum and cross-coverage to both solo and group practice GPs. The challenge in Steveston relates to infrastructure where the GPs operate with different workloads, workflows, EMRs and MOAs.

In City Centre, it was a different landscape. From the beginning, there was not a strong drive to initiate a network, rather, GPs were persuaded by the Division to form. Largely, these physicians are soloists, have large patient

panels and practice at full to beyond full capacity. Most of them had tangential relationships to one another, with some never having met in-person and in some cases previously competing for patients. Individually, there was a constant struggle to secure locum and cross-coverage support. Another notable factor was that these GPs were not co-located. While some were a short walking distance away from one another, overall, busy city streets dissect the offices and the Network spans a few kilometres. Since collaboration was a new concept for this group of GPs, determining how they might work together and how they might rely on one another saw incremental and slow progress. Because these GPs have similar patient panels, including patients with specific Chinese language needs, health professionals that spoke Mandarin and/or Cantonese were deployed. This group also found a solution to an identified challenge by creating a mechanism for female GPs to provide male GPs with coverage for intimate exams (i.e. Pap smears).

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Two New Networks: Blundell and Westminster

When we put the call out to our membership to form additional networks, our biggest take-away from the selection of the pilot Networks is that groups that had established relationships and/or are currently collaborating was an essential parameter of creating successful Networks. Examples of these relationships can include participation in call groups, focused areas of practice such as maternity or residential care, membership in journal clubs, EMR user groups or even shared sporting or social interests. Indeed, with the selection of the Blundell and Westminster Networks based, in part, on this parameter, the Division observed greater ease in moving the network concept forward. Both the Blundell and Westminster Networks were comprised of GPs with established relationships and some experience with (informal) cross-coverage arrangements. Access to office space to accommodate the addition of health resources for a network's patients also emerged as an important element of success.

The Blundell Network shared office space and had available space to host other health professionals and services. The Westminster Network, on the other hand, was comprised of practices within walking distance of one another with GPs that largely practice at full capacity with limited available office space. With four networks established, it became apparent that co-located GPs with available office space were best able to leverage the opportunity of additional health resources within their Network. Within a short period, all Blundell Network GPs were referring to and sharing scheduled visits for the Clinical Pharmacist. In the same period, the Westminster Network, GPs opted not to pilot the Clinical Pharmacist, based on the discomfort with referring patients to another physician's office (since only one network GP had meeting space available) and concern with how to provide the pharmacist access to medical records. With existing interests related to shared locum and cross-coverage, as well as emerging plans for hosting group medical visits (to expand health resource capacity), co-location and shared office space for additional services

are seen as critical elements for network viability and success.
The value of a GP champion was also tested though the establishment of the 4 networks. Where one GP emerged as a coordinating voice, as an ambassador and lead support to collective efforts, the network proved to be more responsive to development. While this 'Network GP Lead' role appears instrumental, the Division and the Networks have not solidified the role or responsibilities in a definitive way.

Parameters of Optimal Networks

The Steveston, Blundell and Westminster Networks were each established within 2 months, whereas several one-on-one meetings and two (difficult to schedule) group meetings from May to Oct 2016 were held before the City Centre Network formally came together. Even then, the City Centre Network was tenuous and participating was largely based on GP interest to access health resources. The Division worked with this team of GPs for over a year before trialling cross-coverage. This helped solidify our understanding that network GPs require time to build trust and establish relationships before collaboration is possible and likely to be sustained.

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To date, the Division has learned there are several parameters that support the creation of optimal networks. They are:

- Established relationships and/or existing collaboration
- Co-location (GPs located in the same office or building)
- Available office space in which to engage and share additional health providers and services
- A willing GP to champion each Network

Additionally, to optimize opportunities related to shared locum and cross-coverage, GPs that provide services in similar language(s) and utilize the same EMR are better able to integrate service provision to patients.

With an interest to scale initiatives that best support the provision of primary care, parameters can be standards to effectively identify, initiate and develop networks. Still, the Division learned that while there are parameters that might facilitate better network development, each Network is individual and a level of customization is beneficial. Where a group of GPs have limited or no relationship to one another, it is still possible that a network can develop though it will require a higher investment of support and a longer period of time to allow the relationships to develop. In these cases, the Division not only project manages activities but can facilitate conversations between the GPs. Oftentimes, with opportunities to connect outside of clinical space, GPs develop the necessary relationships and overcome barriers to working collaboratively. Incremental gains in one neighbourhood network can have significant impact for primary care. To forward the Neighbourhood Network model, Divisions can be prepared to meet the needs of different groups of GPs and support all parties to appreciate the value of the significant change that is underway.

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