NEIGHBOURHOOD NETWORKS

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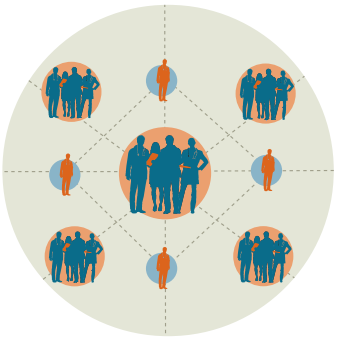
Acknowledging that Richmond is comprised of many smaller, unique neighbourhoods, each with distinct socioeconomic, cultural, language and healthcare needs, the Richmond Division's Neighborhood Networks strategy saw the creation of geographically clustered GPs. By supporting the independence and potential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



Value and Role of the Division in Supporting Neighbourhood Networks

Introduction

The intention is for Neighbourhood Networks to be 'self-organizing' groups but research indicates a lengthy timeline for establishing a network even amongst motivated participants. Networks do not just appear but rather need to be fostered and supported. Though GPs identified and helped shape the concept of Neighbourhood Networks, they are limited in time and capacity to drive comprehensive system change. GPs lack knowledge of infrastructure opportunities and of change management processes. The Richmond Division of Family Practice plays a specific and critical role in supporting the strategic and day-to-day operations for early success and momentum.

The Solution

Hearing from members regarding their needs for their practices and recognizing the new direction of primary care in B.C., the Richmond Division invited interested GPs to lead the way through the creation of Neighbourhood Networks. The Division's role in implementing the Neighbourhood Networks cannot be underestimated. By offering everything from strategic coordination to administration, the Division offers a steady guiding hand to implementation. With member GPs as the primary stakeholder, the Division is able to support their collective interests, and respond to their individual and collective concerns while forwarding triple aim goals. To forward complex multi-partner efforts requires the Division to act as strategic overseer and manager, convener, facilitator, researcher, process and system developer, data collector and analyzer, motivator, project negotiator, translator, and capacity builder.

Richmond Division of Family Practice
A GPSC initiative

Strategic Overseer and Manager

The Division created the implementation and workplan for Neighbourhood Networks with leadership from member GPs and other key stakeholders. While GPs hold vision of what is possible to reform primary care, they are often lacking time and change management expertise to bring an idea into fruition. This is particularly true when it involves shifting the practices of independent GP colleagues. Ensuring that goals were broken down into tangible and implementable stages was a key role of the Division. As well, providing oversight for all aspects of network development supports ongoing momentum and accountability.

The Division, unlike the GPs, have an understanding of competing timelines, partner limitations and readiness and may be better able to distinguish between GP needs versus wants. When a program or service is identified for potential integration within the Neighbourhood Networks, the Division has undertaken the primary management role for all the involved parties. Partner programs and services largely have not come with project management and related support (process engineers, change managers, etc.) and so the Division held this management role for the partners as well.

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Convener

The Division convened network GPs and facilitated network meetings. Some Networks were comprised of established GPs that previously did not know one another despite practicing within a few blocks of each other. In these cases, convening a specific network offered relationship-building time. Meetings of all participating GPs support relationships between different networks. This provides network GPs the chance to learn what was working or challenging to other Network GPs. During a pilot phase, this connection can be a powerful motivator and support. Additionally, all of the meetings provide the Division a chance to introduce programs/services, test new ideas and capture feedback. Most importantly, despite busy schedules, GPs have indicated that they walk away from these encounters feeling more connected, having shared learnings, leveraged one another for collegial support and reduced feelings of isolation, especially amongst soloists.

Facilitator

The Division acts a facilitator in developing relationships with stakeholders and partners. The Division can meet and explore opportunities separately with potential partners, with lead GPs and networks to see if joining efforts will support GPs in achieving the goals of the Neighbourhood Networks. When Network GPs meet with a prospective partner, the Division can facilitate conversations by leading the development of agendas and supporting documents, bringing in appropriate resources and creating evaluation tools. As facilitator, the Division responds to the 'how people work together'. When case-finding was identified as a significant barrier to successful integration of allied

health resources, the Division engaged with PSP to lead a session with network members on data entry, data query and patient recall tips and tricks for EMR and paper-based offices.

Researcher

Both in the creation of a network service or when a roadblock arises, the Division acts as the researcher to explore process and possible solutions and leverage partnerships where needed. For example, a Network suggested that PharmaNet would support cross-coverage activities. Because of EMR incompatibility issues, PharmaNet could provide covering GPs with some information relating to a patient who they see for the first time. The Division took on the task of researching PharmaNet, comparing vendor functionality, costs and support, and discussing options with GPs, before landing on a vendor that could best meet their needs. The Division tested this idea of piloting PharmaNet with all Network GPs to gauge interest before moving forward.

Process and System Developer

Where possible, the Division assists with standardizing processes and aims to do so in a way that is also responsive to individual Networks. At the beginning, the Division was responsible for scheduling the pharmacy service in response to the request from UBC that it liaise with a single coordinator for all GPs within a Network. This day-to-day involvement allowed the Division to understand the service and how it rolls out for GPs and patients. With this knowledge and recognizing that this was neither scalable nor sustainable, the Division transitioned the role to a designated MOA lead for each Network. After seeking feedback from all partners, the Division drafted a GP, MOA and UBC workflow that outlined a timeline of related tasks. This was tested in one Network, refined through regular check-ins, and then spread to other Networks.

Data collector and analysis

The Division plays a key role in collecting, analyzing and interpreting data to support Network evaluation and quality improvement activities. When the Division first embarked on this project, we worked with the Ministry of Health and VCH Public Health to access (respectively) Blue Matrix and My Health My Community data at a neighbourhood-level. The data demonstrated that, across Richmond, there was a high prevalence of low to medium chronic disease and supported our request to VCH-Richmond for the deployment of chronic disease nurses to our networks. As the Networks move forward, we will use this data to support the responsive deployment of specific resources to the Networks and neighbourhoods where there is a current or future need.

Monthly surveys, administered through our Neighbourhood Network Newsletter and face-to-face GP check-ins, provide opportunities for the Division to collect qualitative data about what is working and what is not, what PDSA cycles have been or could be implemented and gather feedback on new ideas that might be trialed by the network. This formative evaluation

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supports data driven decision making to improve our project and processes. Quantitative outputs measure concrete ways network GPs are supporting one another (for example, through cross-coverage and sharing locum coverage) and allied health resource integration through numbers of patients seen. What is also measured are offerings that have not been leveraged within a Network, for instance, GPs willing to cross-cover, share a locum or share available office space. These Division efforts, at the neighbourhood and community level, are well aligned with the Evaluation and Quality Improvement attribute outlined within the Patient Medical Home.

The Division assists with reducing and eliminating real and perceived barriers.

Motivator

Participation in the Neighbourhood Networks means that GPs agree to integrate and trial some or all of the services and resources on offer through the Neighbourhood Networks. While some GPs easily welcome opportunities, others are reluctant when it comes to execution or feel overwhelmed by the potential disruption and mounting requests on their time. The Division assists with reducing and eliminating real and perceived barriers. The Division supports uptake and utilization by encouraging services as risk-free – "try it for one patient, if you are unsatisfied, you can stop" and offers support, through pre- and post-consult check-ins with GPs and office staff along the way. Even where a pilot is imperfect in execution, the Division encourages GPs to see the positive aspects of the change and rally further trialling. The Division helps GPs see the long-term goal and lessons the pressure to achieve immediate results. The Division recognizes and commends participating GPs on the incremental progress that is underway.

Project Negotiator

For our primary partners, VCH-Richmond, UBC Clinical Pharmacy, Richmond Division Shared Care Psychiatry, the Practice Support Program, the City of Richmond and Ministry of Health, working collaboratively to articulate and refine services and supports to meet partner, network and Division needs required negotiation to best align offerings. When the UBC Clinical Pharmacy co-located service was first presented to us, it was a one Clinical Pharmacist-on-one GP service where one GP would refer a full day of patients. Some GPs did not feel like they could find a full day of patients to refer and we recognized that we would be limited by their capacity to expand this service to other Network GPs and Networks. In response, we proposed having the pharmacist see patients of more than one network GP in the clinic visit (provided the GPs were co-located), articulating the value to primary care provision and, with discussion and efforts largely by the Division to develop new workflow systems to accommodate the shift, this new model was adopted, and spread to other networks. As an additional step, the Division sought to schedule the pharmacist in two different sites within a day to support Networks where a full day of office space is not available. For the time, the current policy, for the pharmacist to spend the full clinic day at one site, remains preferable to our partner.

Capacity builder

Community GPs are often quick to identify how their reach and capacity can be extended through additional health resources. While pursuing these resources, the Division has additionally drawn attention to ways GPs can build capacity by leveraging neighbourhood colleagues. Cross coverage and joint locum coverage are tangible ways to ease the chronic pressure felt by GPs while expanding their service beyond what is possible alone. This family practice network support is aligned with several attributes of the Patient Medical Home (namely, Team-based care, and Contact -Timely Access).

Through monthly surveys and check-ins with GPs across Networks, the Division can refine offerings, expand service and increase capacity. One opportunity that emerged though these points of contact was the need for dietitian services. With limited capacity in the dietician service of VCH-Richmond Public Health, the Division is developing a series of group education visits (GEV) on nutritional topics related to enhancing patient self-management of their chronic diseases for the Networks. The Division facilitated a knowledge transfer meeting between the dietitians and CDNs to increase CDN skills and capacity when helping patients self-manage their nutrition-related conditions.

CDNs and GPs are working together to case find and refer patients to the GEV. In some networks, there is a real lack of space in many GP offices for any additional service or provider, and this is especially the case for group education visits. As such, the Division has investigated opportunities within the community centres that will support primary care service provision at the centres and allow allied health professionals to encourage patients to utilize the City's health and wellness programming. If successful, this GMV concept can spread to other services.

Translator

The Division acts as a translator by refining each challenge into manageable and actionable parts. We engage in conversations with all parties and develop plans, goals and outcomes, deliverables, timelines, risks and limitations, action items and accountabilities. As a structural enabler of care (see PMH model), the Division works to ensure that all stakeholders are working with a common vocabulary and are working to forward underlying common interest which sometimes are obscured by a narrow perspective or competing interests. As an example, GPs and their office staff can engage in ongoing CDN service delivery while the Division works with CDN leadership on the challenges of the referral process.

Division Expenditures to Pilot Networks

The Division assumes the financial cost of meetings (i.e. venue, catering) and provides sessional fees to GPs for activities that are required beyond care delivery. By paying approximately 2 hours per month, per GP, the

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Division ensures that network members are providing ongoing feedback, communicating their coverage practice needs to the group and deliberating on care delivery opportunities and challenges. The Division, as part of the piloting of the networks, is covering costs that while perhaps not substantial, might act as a barrier or disincentive for GPs. For example, the Division is paying GP PharmaNet fees for one year to support coordinated and responsive cross-coverage within Networks. Additionally, the Division reimburses one MOA within each Network for coordinating the pharmacy service for all the Network GPs. For group education visits that will be held within local community centres, the Division will incur the room rental fees to test the concept of chronic disease prevention-focused group education visits in the very spaces that are related and linked to health and wellness.

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Conclusion

The Division holds a unique and vital position to support this transformative move toward collaboration and integration among private practice fee-for-service GPs. Instead of GPs having to do the legwork, Division consultants with dedicated time and necessary project management skills support speed of implementation, especially important in projects with a short timeframe. The intended long term goal is for Networks to self-manage many of the activities and opportunities that they undertake. In these early days, the Division's ability to articulate and quantify need, substantiate the value to primary care provision and negotiate with partners offer critical support for building and furthering the Neighbourhood Networks, and their ability to meet many aspects of the Patient Medical Home.

To learn more, please contact:
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