Welcome to CHNET-Works! Fireside Chat # 357

December 19, 2013 1:00 – 2:30 PM Eastern Time
(Teleconference open for participants at 12:50 ET)

Interprofessional Teamwork in Primary Care: *Case Study of the Chinook PCN and the Taber Clinic*

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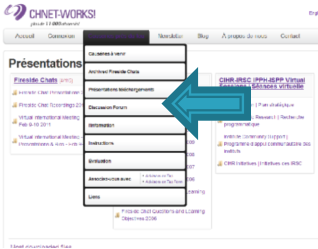
Housekeeping : how a fireside chat works…



Step #1 : *Backup PowerPoint Presentation*

- *www.chnet-works.ca*

Step #2 : Teleconference

All Audio by telephone

- If your line is 'bad' – hang up and call back in
- Participant lines muted
- Recording announcement

Step #3: The Internet Conference *(via 'Bridgit' software)*

From our computer to yours

No audio via internet

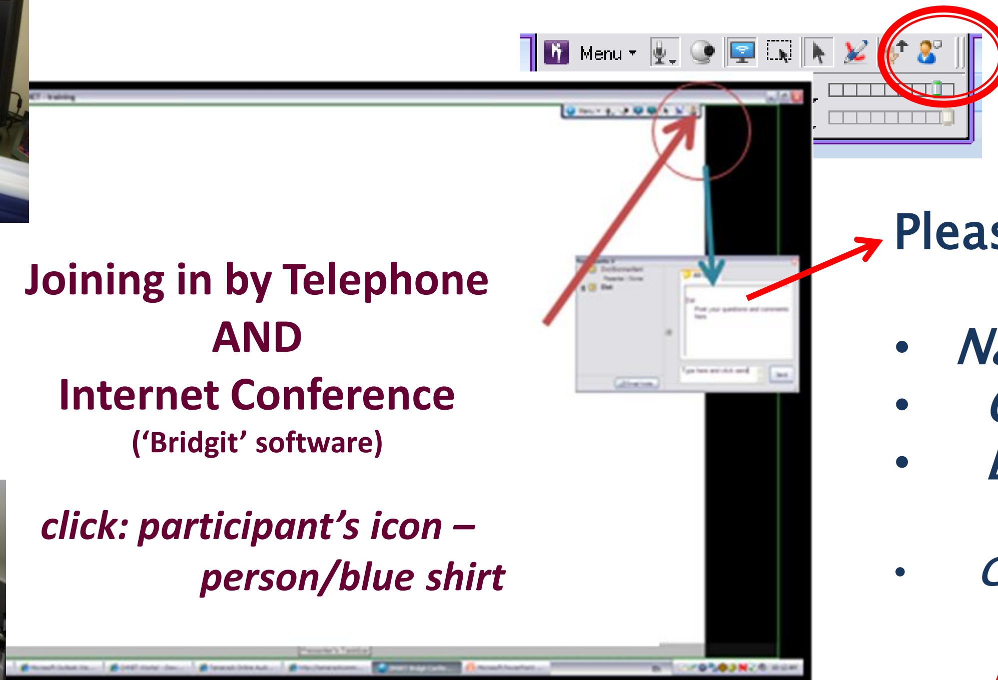
A transmission delay of 2-4 seconds is normal

Difficulties? Firewalls – slow reception, disconnection :

Use the Backup PowerPoint Presentation (Instruction Step #1)

For assistance: animateur@chnet-works.ca

How to post comments/questions during the Fireside Chat



Joining in by Telephone
AND
Internet Conference
('Bridgit' software)

click: participant's icon – person/blue shirt

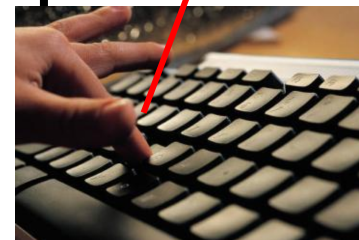
Please introduce yourself!

- *Name*
- *Organization*
- *Location*

- *Group in Attendance?*

Joining by Telephone only?

By email:
Respond to the 'access instructions email
animateur@chnet-works.ca



Agenda

- Description of Primary Care Networks in Alberta
- Interprofessional Teamwork in Primary Care
- Interprofessional Teams in the Chinook
- Primary Care Network
- Taber Clinic

Where are you located?   Où habitez-vous?

√ on your province/territory

√ sur votre province ou territoire

NU

YK

NT

BC

AB

SK

MB

ON

QC

NF

PE

NB

NS

5

What Sector are you from?

Put a √ on your answer (or RSVP via email)

Primary Health Care Organization	Academia	Provincial /Territorial Government/Ministry
Health Canada	**Front Line Health Care**	**Other**

Research on Interprofessional Teams in Primary Care Networks

Research Objectives

- To better understand the structure and functioning of interprofessional (IP) teams in select PCNs in Alberta
- To identify strategies for improving the effectiveness and functioning of IP teams in primary health care
- Funded by Alberta Health
- Completed by Workforce Research and Evaluation, Alberta Health Services (AHS)

Research Team: Dr Esther Suter (AHS), Dr Nelly Oelke (UBC), Dr David Moores (U of A), Shannon Erfle (AHS), Karen Jackson (AHS)

Researchers: Renee Misfeldt, Gail Armitage, Jana Lait and Shelanne Hepp (AHS)

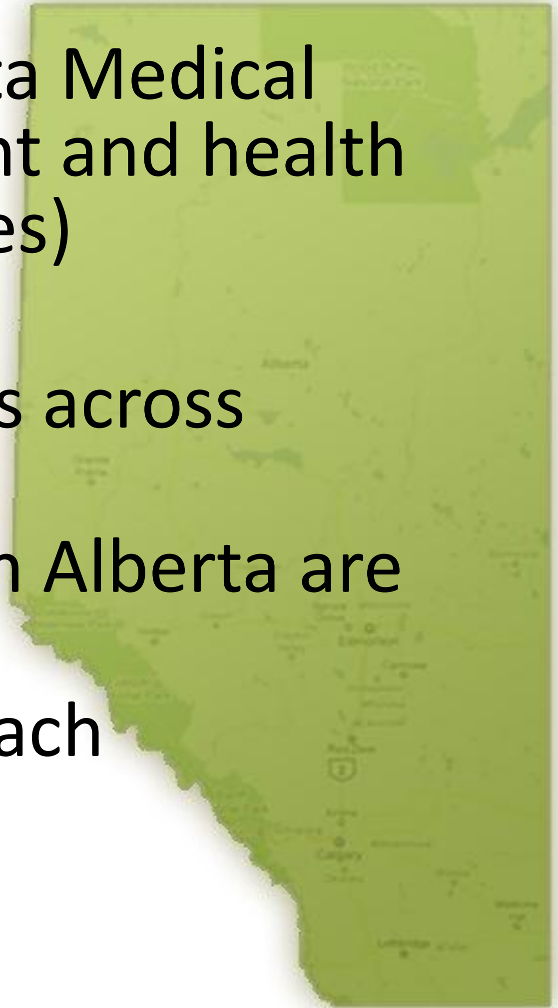
Methodology

- Exploratory qualitative research
- 7 Primary Care Networks participated in 2012
  - Group interviews with 2 teams in each PCN
  - Individual interviews with physicians, leaders, IP team members and patients
- Total interviewed
  - 118 staff, managers, and physicians
  - 11 patients

Full report will be available online in the new year at:
http://www.albertahealthservices.ca/wre.asp

Alberta's Primary Care Networks

- Original agreement between Alberta Medical Association, the Alberta government and health regions (now Alberta Health Services)
- Physician led and governed
- Currently 41 Primary Care Networks across Alberta
- More than 2800 family physicians in Alberta are currently working in PCNs.
- One PCN goal: Foster a team approach



Teams in Alberta's Primary Care Networks

- Teams configured to meet local population needs and demographics
- Disease prevention screening, surveillance
- Chronic disease management, weight management, mental health services, maternity care, etc.
- Decentralized, centralized, hybrid

Chinook Primary Care Network

- Located in southern Alberta
- Established in 2005
- 130 physicians participate in the CPCN
- 146,945 rostered patients.
- 26 clinics
  - 11 clinics in the city of Lethbridge
  - 15 serving rural communities

- Diverse population including on-Reserve First Nations, urban Aboriginal peoples, approximately 50 Hutterite colonies, "Low German Speaking" Mennonite immigrants, Butanese immigrants and post-secondary students

Teams in Chinook Primary Care Network

- The majority of the PCN resources are allotted to Clinic Family Practice Teams (determined by needs of clinic patients and community setting)
- Staff mix: based on population needs and determined by the clinics
- Funding Model

External Factors Impacting Teams in Chinook PCN

- Mixed perceptions about physician compensation.
  - Not a critical factor in the way clinics are run

    vs

  - Fee for service impedes teams

"That's a huge financial hit to go from 12 visits a year to 2 visits a year [because patients are being seen by another team member]. The payment structure does define the way you work"

- Staffing

Organizational Factors Impacting Teams in the Chinook Primary Care Network

- Primary Care Network Vision
- Culture

"We try to be as positive as we can, definitely 'cause we're all here for the better of the patients, so we all have a common goal"

- Physician Involvement

"Once you have the physicians all on board everything else seems to go a little more smoothly…"

- Quality improvement and performance management

Organizational Factors Impacting Teams in Chinook Primary Care Network

- Infrastructure
- Electronic medical records
- Team education
- Improvement Facilitators

Team Factors Impacting Teams in Chinook Primary Care Network

- Physician team leadership and shared leadership
- Team accountability
- Communication
  - Formal
  - Informal
- Roles and Responsibilities of team members

Interactive Question #1

- What factors raised by the PCN teams, leaders, and physicians in the Chinook PCN resonate the most with you and/or your organization?

RSVP

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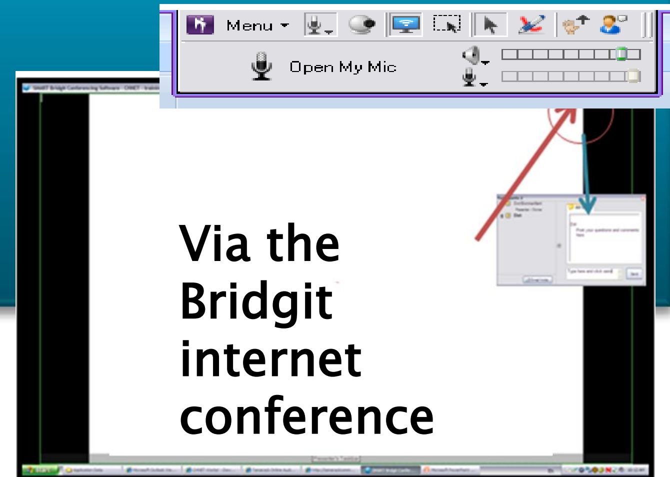
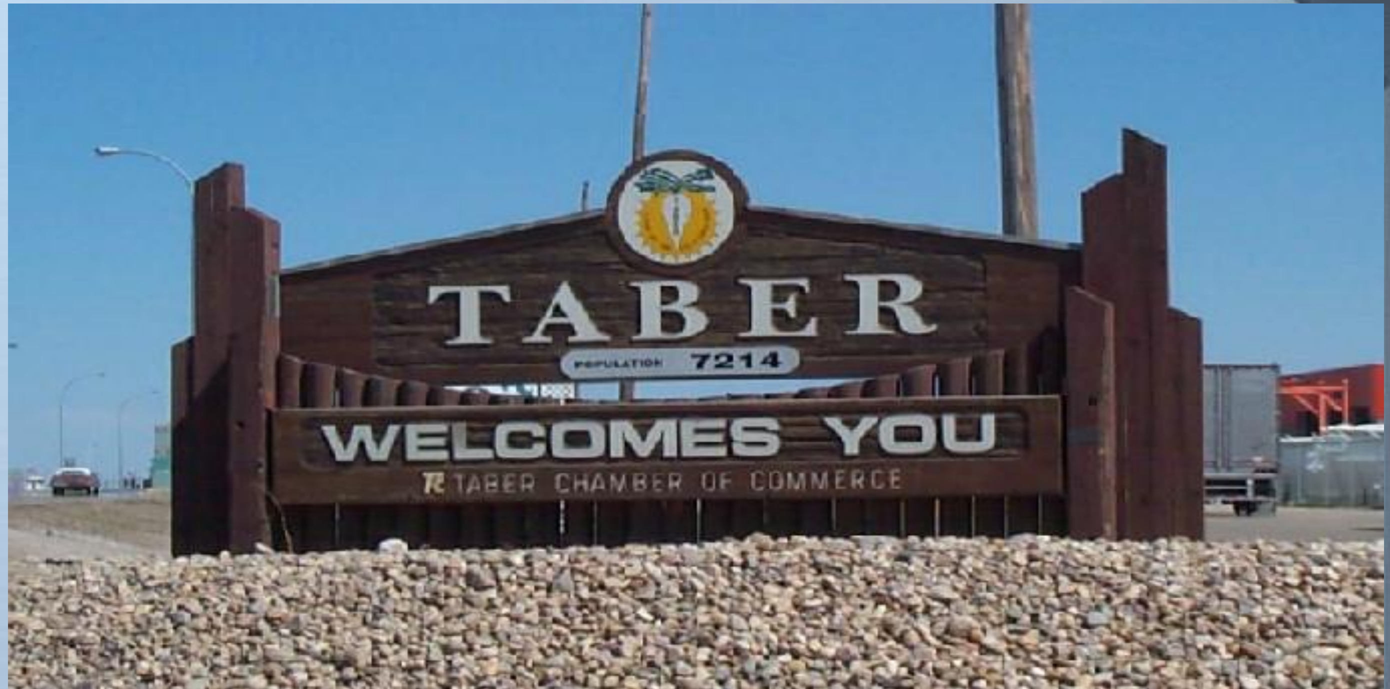
OR Text Chat...

Via Bridgit Internet Conference:



Taber Integrated Primary Care Project



Taber Health Project

2000-2004 – CHSRF, AHS, AMA Funded Demonstration project

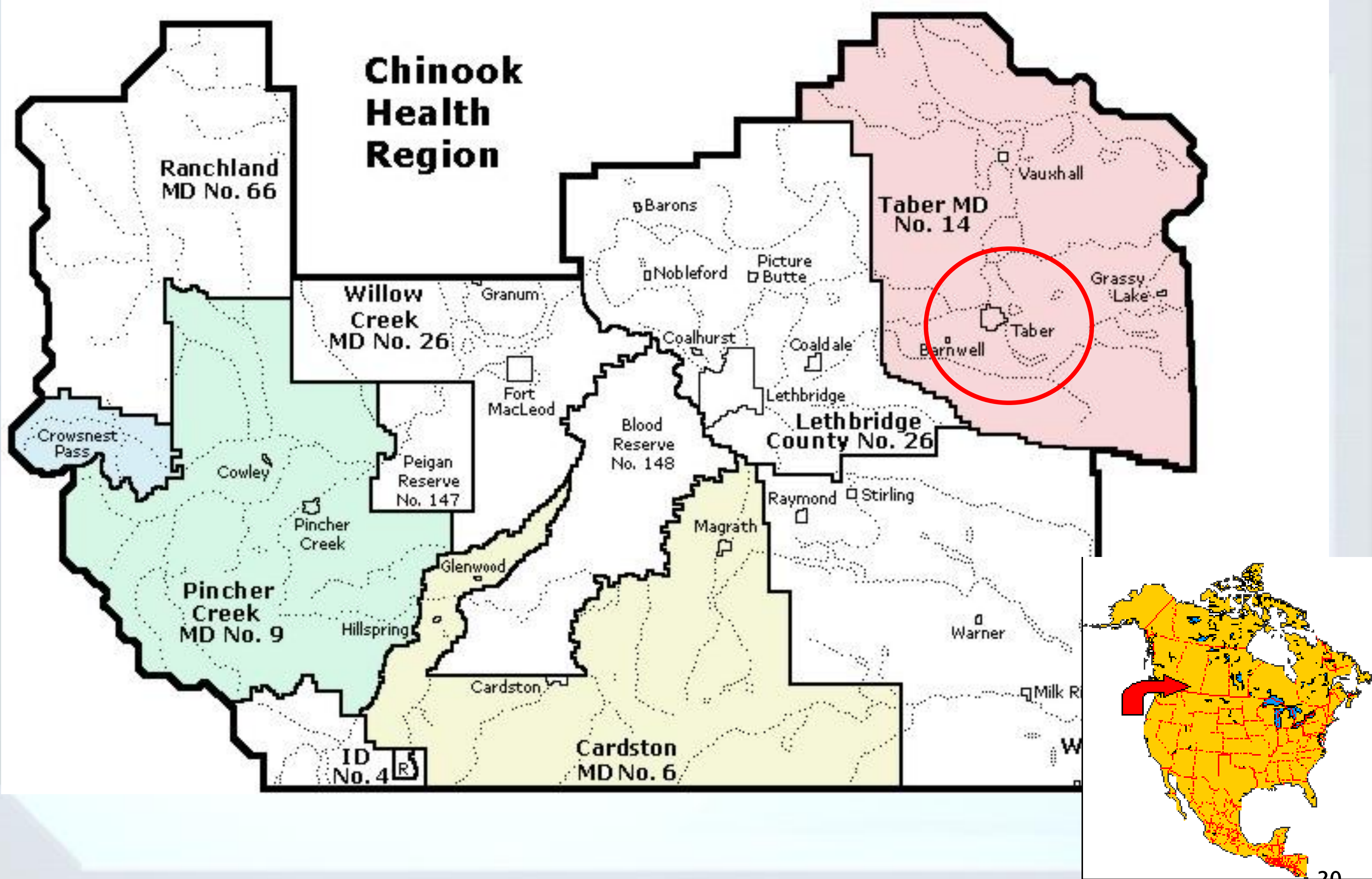
2005- present – Chinook PCN funded clinic

The Taber Clinic

Who We Are…

- Rural Community with 8,000 in town & 12,000 in surrounding rural area (20,000 total)
  - Local hospital with 24 hr ER, Acute and Long Term Care, surgery, Obs
  - Community based Ab Health Services programs
- 1 of 23 clinics in Chinook PCN
- Our Family Practice Team:
  - 11 Physicians (9 FTE) - ~1 MD/2,000 patients
  - Clinical staff – 1.7 FTE/ physician
    - MOAs, LPNs, RNs
    - NPs, Reg Psych Nurse, Behaviorist, RT, Dietician, Diabetic RN, Lab & X-ray.
  - AHS staff integrated in physician clinic - 3 FTE
  - Admin staff - .7 FTE/ physician

Taber Integrated Primary Care Project



What We Did…

The Taber Clinic

"Building the Plane as we fly…."

(Lessons Learned)

- ***"Don't confuse the Means as the End"***

  While strong infrastructural changes are crucial, the goal is strong service delivery

- ***Leadership must be real and visible***

- ***Vision – both from the top down and from the bottom up***

The Taber Clinic

What We Did…

Lessons Learned…

- ***Definition and Clarity of Roles***

    How many team members do we need?

    What types of team members do we need (or can afford?)

    WHAT do we do? (Clinical Teams)

    HOW do we do it? (Operational Teams)

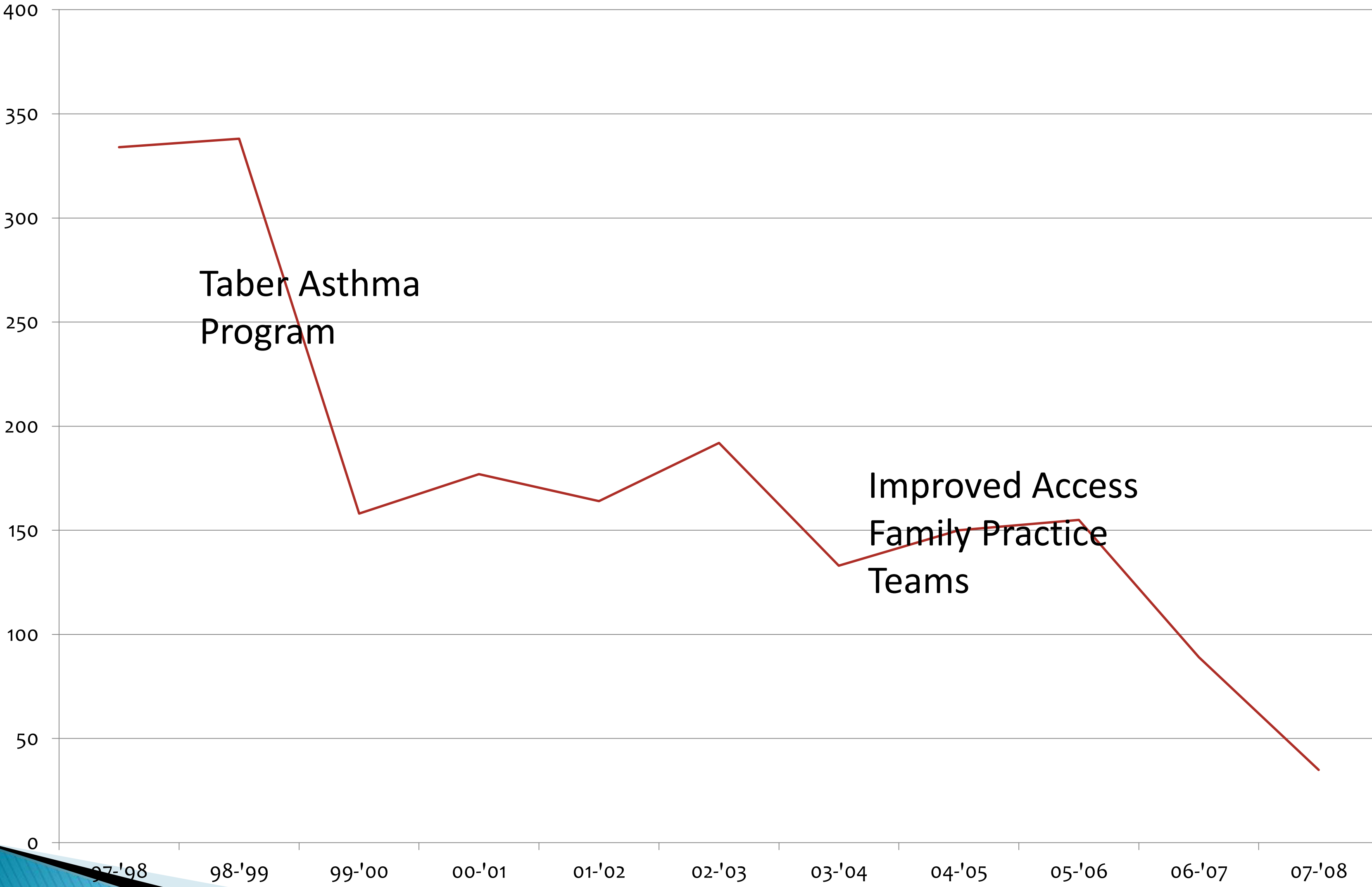
What We Did…

The Taber Clinic

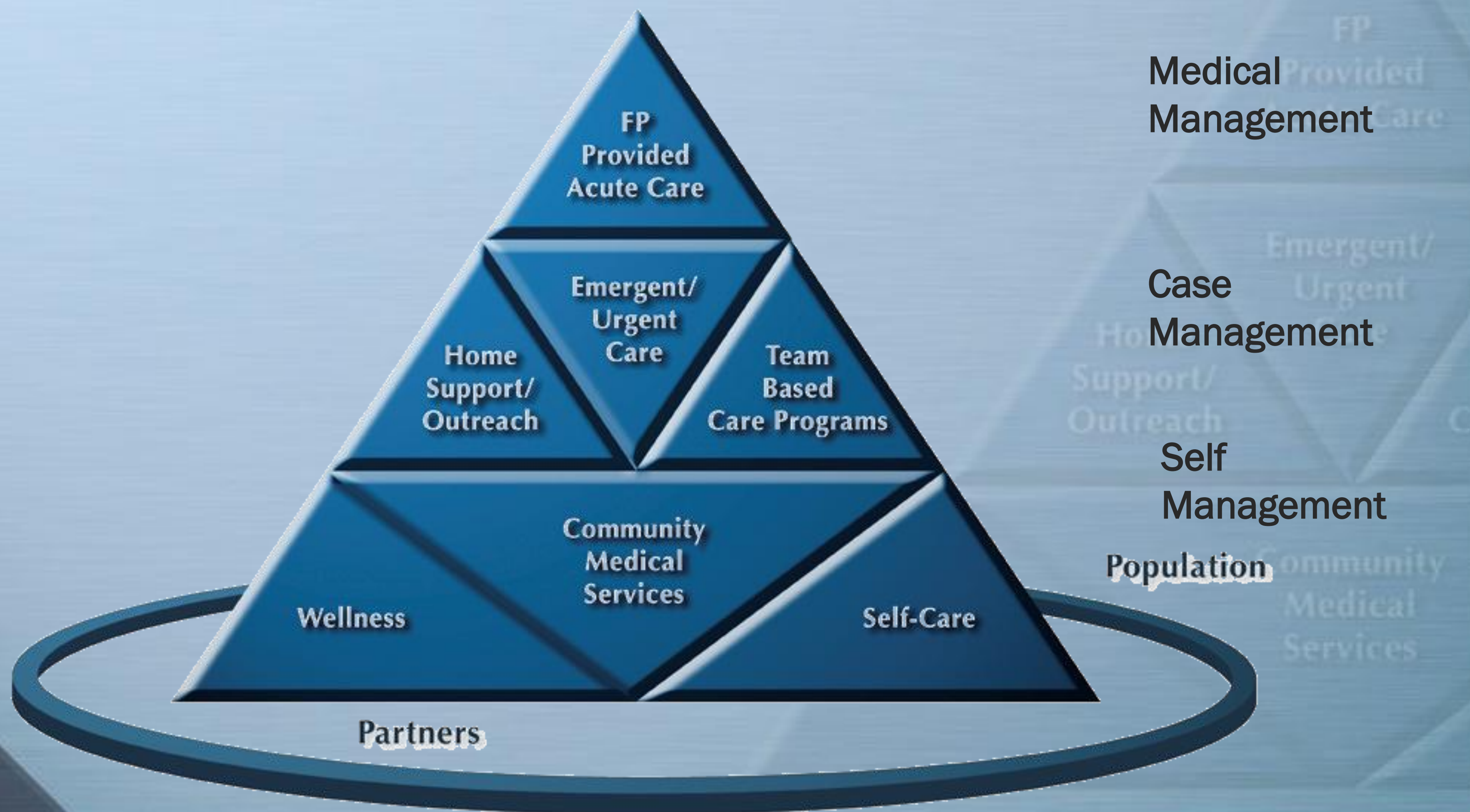
Lessons Learned…

- ***Commitment to Panel and Continuity***
- ***Commitment to Access and efficiency***
- ***Proactive prepared evidence based team based care***
- ***Systematic approach to CD like asthma, Hypertension, mental health***

ER Visits for Asthma: Taber



Service Delivery Changes



What We Do…

The Taber Clinic

- We have a sound knowledge of our patient population, and of our community resources.
- We enhance our capacity through effective patient flow processes, focusing on eliminating delays for appointments and at appointments.
- We have pre – planned and prepared for patient encounters, using protocols and guidelines to support collaborative team-based care, whether co-located or not
- We have a strong emphasis on self management
- We use and share sophisticated electronic medical records that include clinical decision support, prompts, reminders, registries, communication tools for other providers, etc
- We use continuous measurement and evaluation to inform change

How We Do It…

The Taber Clinic

- **Physician specific panels with population needs defined**
  - Continuity to Physician and the "Team"
  - Same day access, in person or by phone
  - Proactive Disease Prevention Screening (ie Cancers), Chronic Disease surveillance, Health Promotion (smoking, weight) –all embedded in EMR via Rules & Alerts
- **Pre-Planned, proactive, prepared team based care**
  - Well developed, evidence based protocols enabling all providers to work to their "Full Scope"
  - Systematic approach to Chronic Disease like asthma, mental health
  - Patient choice for provider (MD, NP, RN, etc as appropriate)
- **Engaged, educated patients**
  - Group visits, educational opportunities
  - Patient coaches for translation and system navigation assistance

How We Know how Well we Do It…

- **Quarterly monitoring of indicators through EMR**
  - Access, Continuity & Efficiency
  - Screening & Prevention, immunization
  - Clinical care around Chronic disease (Process & Outcome)
  - Smoking Cessation, Lifestyle issues
- **Annual review of indicators through central PCN evaluation**
  - Clinic comparisons within CPCN for learning and adapting best practice
- **Significant, positive improvement in all indicators**
  - Trend to reduced utilization of ER & admissions
  - High patient understanding of system process
  - Strong patient, community and provider satisfaction

Mary's New Story

- 55 yr old woman with a sore knee all summer
- Calls for an appt with her family doctor
- Reception identifies in the EMR that she has several 'rules' outstanding, and asks if she would speak to the nurse first
- The FPN sees in the EMR that she has diabetes and hypertension, and finds that several screening tests are due.
- Her EMR record is updated, including her history, medication list, and her problem list
- A mammo, bone density, FIT, and lab (chol, blood sugar, etc) are booked, and an appt is scheduled after the results are in (9 days) for her pap and to look at her knee

Mary's New Story

- On arrival at the appt, she is seen within 10 min of arrival, the MOA 'rooms' her, opening the EMR and updating her bp, wt and Waist circ, and checks to see all results are back.
- The doctor has all tests available to discuss a plan, not only for her knee, but for all her problems.
- Her bp is high, but her HgA1C is normal.
- An appt is made with the 'bp nurse' for followup re lifestyle issues, surveillance, and medication review with the doctor if necessary.
- A complex care plan for the next year is developed with the patient and the team.

Interactive Question #2

- What are the lessons learned in implementing interprofessional teams from your organization?

RSVP

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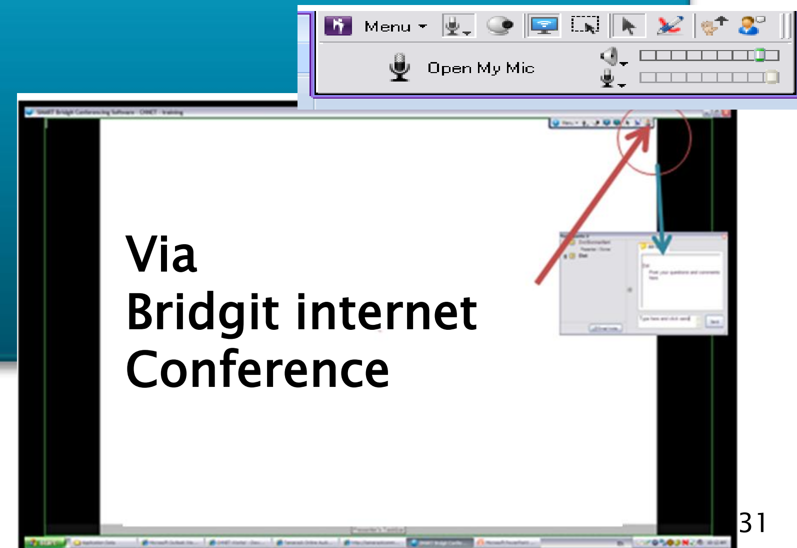

Thanks for joining in!

- Related resources:
  Chinook Primary Care Network:
  http://www.chinookprimarycarenetwork.ab.ca/primarycare/

Workforce Research and Evaluation, AHS:
http://www.albertahealthservices.ca/wre