A journey to an integrated team-based care model in northern rural settings

Interviewees:

Dr. Richard Moody Physician Lead, North Peace Division of Family Practice

Mary Augustine Executive Director, North Peace Division of Family Practice

Joanne Cozac North Peace Health Services Administrator, Northern Health

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1. What were the driving forces for creation of team-based care in your community?

Dr. Richard Moody *"Team-based care in North Peace stemmed from a 'need' and a 'dream.' The need was to resolve the crisis situation in Fort St. John where the number of unattached patients increased from 0 to 17,000 in a short period of time due to the exodus of some community physicians. This got us thinking, 'How can we provide services efficiently to our vulnerable and high needs patients?' The crisis situation inspired our dream to provide integrated and holistic care to our community."*

The work that the North Peace Division and Northern Health did around the prenatal clinic provided information and learning for designing team structures and processes in the other team-based clinics. Since the clinic opened its doors in January 2014, Doctors have delivered babies for 1,315 patients and 1,040 moms and babes have been attached to a GP. Moreover, the caesarean rate has decreased from 31% to 21%. The work in the prenatal clinic led to an outcome of having the lowest C-section reduction rate in the province.

Joanne Cozac said "*In acute care, we have always worked in teams."* She spoke about how it was not a new concept in acute care and stressed the importance of working together to create a seamless experience. Joanne gave an example of how patient has mental health issues and if there is a mental health clinician embedded in the physician practice, it is one less visit for the patient and saves them the hassle of going to the hospital to see the mental health clinician. Patient-centred care is important and this definitely prompted a need for team-based care in the community.

The Division played a key role in the development of team-based care. They provided a place to engage physicians, resources, and coordination support. The formation of the local collaborative services committee (CSC) also helped in discussing common areas of development between the Health Authority, community, and Division of Family Practice.

Mary Augustine commented, "*This task is too big for any one physician and stakeholder*."

2. How did you engage with different partners in the community and what did your stakeholder engagement process look like?

Dr. Richard Moody and Mary Augustine said that the focus, most importantly, was to engage family physicians. *"In any change, there will always be a core group who are early adopters; there will always be some fence sitters, and some who will not want to be engaged in the process. We had open discussions with our GPs across all the three clinics. We engaged with Citizen Health group, our work in senior care got us the traction we needed, and we even had the opportunity to have a meaningful dialogue with key decision makers such as Deputy Health Minister Stephen Brown, who endorsed the concept of the new model. The process was a long one and our relationship with Northern Health was challenging at times, but we know that everyone was working towards a shared vision. We were committed to get this going and because the process was a long one, we were almost at risk of disengagement from physicians. At the same time, Northern Health was realigning their nursing staff and they were moving into more of a generalist model and so the timing was perfect to discuss having nursing and other staff in physician offices to support primary care."*

3. Can you elaborate on the team structure of the clinic, how you work collaboratively with patients to provide an integrated system of care, and whether patients understand the different models of care being provided?

Joanne Cozac *"There are three clinics; one is operating under the traditional fee-for-service model while the other two are working on the newly introduced population-based funding model. The intention is to have one primary care nurse per physician in every clinic, have mental health and addiction clinicians, occupational*

therapists, dietitians, licensed practical nurses (LPN), and clinical nurse educators to provide a wide range of services to patients. We have not yet recruited for all of these positions but the process is underway."

Joanne gave a wonderful example proving how all community partners are sensitive to patient feedback and are making a conscious effort to incorporating that to improve the quality of care. She said, *"When we launched the prenatal clinic, we called it antenatal not realising the word 'antenatal' could offend people. When a patient provided us feedback through our simple evaluation process, we changed the name to prenatal clinic. This is an example of how we want to incorporate patient voice and make sure we wrap care around patients."*

Mary Augustine provided a candid response saying, *"Patients do not really understand different business models in the three clinics. We will have to observe and see how that develops but for now, with the crisis situation we were in after the mass exodus of physicians; patients are happy to have a GP. We have made tremendous progress in recruitment and retention of physicians. We have moved from walk-in clinics to same day access at each of the clinics therefore access has improved significantly, and wait times have decreased from two months to just three weeks.*

4. It is important to remember that *the journey is as important as getting to the destination*. Can you explain in more detail about your journey to bring the idea of team-based care to life and the challenges you faced?

The Clinics are ahead in the IT area since all the physicians are on Medical Office Information System (MOIS).

Dr. Moody and Mary Augustine *"Information sharing agreement is one of the main ones. Monitoring access to patient information is definitely a challenge when we have Northern Health employees in the physician's office. An important question for us was who owns this information? Space was another problem.*

In two of the clinics, the Division struggled with ended up having two clinics in a site owned by Northern Health – seen as more sustainable. The building is purpose-built for health care and can accommodate the primary care home (PCH) where physicians and allied health professionals (AHP) are co-located. In the other clinic- they are not co-located - however health services are wrapped around the patient care.

"What is important to understand though is, co-location does not mean integration. With the lack of space it becomes challenging to provide integrated multidisciplinary care. The contract with the Ministry of Health (MOH) was another challenge. Working on the contract to pilot a new funding model took a lot of time. We consider this is the first iteration of the contract and don't know what the costs of maintenance will be, but our partner Northern Health has assured us of their support. Transformation of policy and systems takes time and though the language was very fee-for-service-related in the contracts, we were able to adapt it enough to get going. We have a practice coach who is working with our dedicated physicians to understand their panel and this is an ongoing piece as well which requires a lot of work."

5. How have you addressed the cultural differences and would you please share some learnings with us?

Joanne Cozac *"There was a transition for employees within a unionized work setting.*

However, staff was given a choice of which clinic they would like to work in as there were concerns about fit. Initially the staff did have issues with change because their scope of work was changing from being specialised to more general and they had a different work setting. Some understood why we were doing this but yes, change is hard. The important piece for us has been to support and educate them on why we are doing this and to listen and address their concerns to make the transition as smooth as possible. We have created a system where we have team leaders for each clinic and we have weekly huddles with the Division where we address any operational issues and concerns. We have a committee that meets weekly to work through challenges, continuity, and coordination. By engaging in communication, we want to ensure that staff always feels supported and we can foster a strong partnership with the Division as well."

Mary described this further saying, *"The team is small and the recruitment of NH staff is an ongoing process. We have hired a practice coach who is currently working with physicians on understanding their panel. The initial response from Northern Health employees who have begun working in the clinics has been extremely positive and the physicians too are very excited. Another thing to understand is that if we are moving to something new, therefore old policies and systems need to adapt to support the change. The new population-based funding model is one such example and has been designed to be cost neutral to the system. This has created less pressure for physicians to be volume driven and doctors are open and committed to work with a multidisciplinary team to improve the overall quality of care."*

Dr. Moody *"Transformation happens through those who do the work. If there is going to be a big system transformation, it cannot be done alone by the Division; we need buy in and support from Ministry of Health and the Health Authority as well. There needs to be trust and collaboration at all levels to get the ball rolling.*

It was a humbling experience for me to learn about who my patients are as I thought, I knew my panel. I have learned a lot through the process and good staff support is essential as this is very labour intensive. Having the same EMR really helped us.

Do not wait for everything to be perfect to begin; our contract for the population-based funding model is good enough - not perfect - and we are open to revising it in future as things evolve.

Lastly, primary care medicine is always about the doctor-patient relationship and we need to align our services, systems, and policies to strengthen that."