Building the PMH

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Disclosure

• Speakers: Dr. Susan Byers & Dr. Janine Karpakis

• Relationships with financial sponsors: none
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Who is Chinook PCN?

Demographics

**Urban/rural:** 17 Lethbridge clinics, 14 rural clinics in 12 rural communities

**Member Physicians:** 150

**Clinics:** 31 (5 solo practitioner clinics)

**Patients:** 176,339
Vision
A diverse population living healthier, fuller lives, receiving exemplary, patient-centered primary health care delivered by engaged, integrated teams.

Mission
We collaborate with physician clinics, community partners, and Alberta Health Services to optimize the delivery of accessible, exemplary, patient-centered primary health care.
Who is Chinook PCN?

Historical Context

- Founded in 2005
- Culture of Quality Improvement and Evidence Based change
- Education for all teams on principles of office practice re-design
- Funding – decentralized model with majority of funding flowing directly to clinics
 Primary Care Clinics (31)

PCN budget allocated based on panel size, which clinics use to build their improvement teams.

Clinics are responsible for:
- Hiring and management of staff
- Implementation of network priorities
- Local improvement work

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Decentralized Model

Central Support Office

Executive Director & Medical Director
Administration/Finance
Analytics and Quality Improvement staff

MENU of Services

□ QI
□ Leadership
□ Teamwork
□ Integration
□ Information Management
□ Clinical Education

□ Administration
□ Data Analytics
□ PAIR
□ Finance
□ Communications
The Patient’s Medical Home

Chinook PCN strategy for PMH building
Board Structure
- Representation from all clinics via physician directors/leads
- Opportunity for all clinics to be part of decision making

Board Decisions
- Approves initiatives based on fiduciary duties to the PCN
- Directors act as clinic leads to implement decision at their clinics

PCN Leadership
- Executive Director and Medical Director conduct yearly clinic site visits
Capacity for Improvement

Integration Leads (Practice Facilitator)
- Attend all improvement meetings (minimum 6/year)
- Promote PCN initiatives and support clinic process re-design

Clinical Care Coordinators
- Hired by each clinic to help move daily improvement work forward
- Provide clinical leadership
- Liaisons between PCN central support and clinic teams

Data Analysts
- Assist clinics in establishing searchable documentation methods
- Provide analysis of clinical indicators on a yearly basis
Patient Attachment for Improved Relationships (Data repository)

- Remote access to all member clinic EMRs
- Allows PCN to track patient encounters in member clinics, and AHS facilities across the network
- Physician-level reports for quality improvement

Two-Step Panel Management

- Clinics manage their panels on an ongoing basis
- Panel data is updated regularly to the data repository
Percentage of Multi-Panelled Patients at Chinook PCN 2013-2020

<table>
<thead>
<tr>
<th>Year</th>
<th>% of patients</th>
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<tbody>
<tr>
<td>2013</td>
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<tr>
<td>2015</td>
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<td>2016</td>
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<td>2017</td>
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<td>2018</td>
<td>3.14</td>
</tr>
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<td>2019</td>
<td>3.59</td>
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<td>2020</td>
<td>2.26</td>
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Team Based Care

• Variety of team members selected to serve each patient panel (e.g. nurse, NP, dietician, pharmacy, physio, social work, mental health...)
• Hired by clinic
• Funded based on panel size
• PCN requires funds be used for value added services
Clinical Data Assessment Indicators

- BP monitoring
- Diabetes monitoring & control
- Diabetes screening
- BMI measurement
- Cholesterol screening
- Tobacco cessation
- Pneumococcal immunization
- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- dTap immunization
- HPV immunization
- Exercise indicator
CPCN Indicators vs. Provincial Averages

2018 Data

- Diabetes screening
- Lipids
- Colorectal Cancer
- Breast Cancer
- Cervical Cancer

- CPCN
- Prov Average
% of eligible patients (50-74 years of age) with evidence of a FIT (<24 months), sigmoidoscopy (<60 months) or colonoscopy (<120 months)
% of eligible patients (50-74 years of age) with evidence of a FIT (<24 months), sigmoidoscopy (<60 months) or colonoscopy (<120 months)
Patient Centered Interactions

Clinical Care Coordinators
• Lead clinic team in improving clinic processes
• Provide clinical leadership and ensure all team members are working to their full scope of practice
• Work alongside team members to spread changes throughout their clinic

Clinical Team Members
• Inform patients regarding screening and monitoring tests
• Communicate with physicians when patients have questions or concerns
**Patient Centered Interactions**

**Allied Health Professionals**

- Chosen by each clinic based on the needs of their unique patient population
- Provide education or clinical care directly to patients based on their training
- Patients receive the support they need without leaving their Medical Home
- Warm handoffs
Enhanced Access

• Each clinic measures time to Third Next Available appointment (TNA) on a weekly basis for each physician
• Reviewed at each improvement meeting
• Strategies are employed when needed to improve TNA
• Goal is same day or next day access to each provider
• Education for new teams in office practice redesign
Centrally Managed Care Resources

- Shared mental health (3 FTE mental health clinicians – rotate through clinics)
- Pelvic floor physiotherapy clinic
- Hospital admission and discharge notifications emailed to providers via PAIR data repository
Culture of Quality Improvement

- PCN Charter (commitment to improvement work and values of the PCN)
- Accountability → Unblinded data sharing
- Spirit of the Hive award
- Yearly Events
  - Clinic Showcase
  - Family Practice Summit
Barriers and How We’re Overcoming Them

- Rely on physician buy-in
- Lack of control
- Appropriate use of funding

- **New policy**: addressing physicians with lowest indicators – have central office staff work with them to improve performance
Advice to Other PCNs

• Decentralized model works
• Strong leadership is needed
  • Representation
  • Board Development
  • Common Vision
• Initiation of improvement work:
  • Invest in education for teams in office practice redesign and quality improvement methods
  • Have required team meetings
  • Have a Care Coordinator in each clinic
Questions?
Thank you!