Red Deer Primary Care Network:
Dr. Peter Bouch
Lorna Milkovich – Executive Director
Carol Maskowitz – Program Manager/Lead Improvement Facilitator
Margo Schmitt-Boshnick – Evaluator
Esther McNeely – Support Nurse
Faculty/Presenter Disclosure

• **Faculty:** Dr. Peter Bouch

• **Relationships with financial sponsors:**
  • Board Member, Red Deer Primary Care Network
Faculty/Presenter Disclosure

• **Faculty:** Lorna Milkovich, Carol Maskowitz, Margo Schmitt-Boshnick, Esther McNeely

• **Relationships with financial sponsors:**
  • Employees of Red Deer Primary Care Network
Mainpro+ Credits – Session Survey Completion

This Group Learning program has been certified by the College of Family Physicians of Canada and the Alberta Chapter for up to 8.5 Mainpro+ credits.

• For this program we ask that you complete a very brief survey for this session provided within the event app.

• Here’s how (it’s super simple):
  1. Open the “AttendeeHub” app on your phone/device
  2. Log in to the PCN Strategic Forum event
  3. Tap the Schedule icon at the bottom of the page
  4. Select My Schedule or All Sessions from the top of the page
  5. Scroll through to find this specific session
  6. Tap, then scroll and tap the Session Survey icon
  7. Complete the survey in less than a minute

If you need assistance installing CrowdCompass AttendeeHub or accessing the PCN Strategic Forum page, please see one of the tech support staff at the registration desk.
Red Deer Primary Care Network

- 124,000 patients
- 86 physicians
- 18 clinics, 3 with satellite locations
- 64 staff
- 25 programs and services
- Community focus
Fun Facts about Red Deer

Red Deer had the first court case in Canada to include female jurors - 1922

Source: https://images.theconversation.com/files/113095/original/image-20160226-27003-ttoptd.jpg?auto=format&q=45&w=1356&h=668&fit=scale
Fun Fact about Red Deer

Carmel Surprise is the Red Deer official cookie!
A Few Other Facts about RDPCN

AB Programs – Partners in Health

• 21 PCNs
• 4 health or social service agencies
• 3 post-secondary institutions

Health Promotion Canada Organizational Award Recipient 2019!
Scaling the Medical Home Mountain – Our Story
Vision/Mission/Values

VISION

• A healthy community where all people have access to innovative, comprehensive, appropriate and continuous care.

MISSION

• To provide excellent patient-centred care and promote the health of our community through primary care physicians and integrated teams.
Vision/Mission/Values

Values

• RESPECT: Treat everyone with compassion

• ENGAGEMENT: Collaborate with patients, colleagues and partners

• HEALTHY COMMUNITY: Enable and promote healthy lifestyles

• COMMITMENT TO EXCELLENCE AND INNOVATION: Apply evidence-based practices and continuously strive for excellent patient care

• ACCOUNTABILITY AND ADAPTABILITY LEADERSHIP: Guided by principled adherence to values
Why scale MH?
What is our destination?

- Physician Lead - *Champion*
  - PCNe provincial committee
  - PCNe.2.0

- How will it work in clinic and PCN?

- Start small and grow

- *This is Good Medicine*
Anchoring the Medical Home – Planning

PCNe CoP –
- Driving force for PMH
- Endorsed by Board

Team Based Care Model
- Early days - no paneling and no screening
Anchoring the Medical Home – Engagement

1. Clinic road show

2. Presentations
Physician reaction

I sense skepticism...

Health care reform

http://lh4.ggpht.com/_r4RxAPvEduQ/Sy6cYVCikBI/AAAAAAAAIEo/xAI1hs-WTRs/w1200-h630-p-k-no-nu/skept.jpg
Scaling the Medical Home Mountain – Timeline

- 2006 – PCN Established
- 2009 -2011 Team Based Care
- 2014 ASaP Improvement (Practice) Facilitator
- 2014-2015 – Evolution of PMH staffing model
Anchoring the Medical Home – Evolving Staffing Model

1. Program Manager

2. Support Nurse
   First ascenders (2 SNs)

3. PCN Evaluator
Pilot – June – September 2016

• 3 clinics piloted MH model – *Early Adopters*

• Process
  • Medical Home Assessment
  • Health Team Effectiveness Survey
  • Paneling
  • Screening

RDPCN MH Pilot Clinic Team
Pilot Results – Physician Perspective

Physicians reported no delay in their work

Physicians reported the Support Nurses

• Saved them time

“Systematized” their work
We focused on a phenomenon referred to as the "valley of death"; the point where innovations commonly fail to spread to the wider population.

To take an innovation to scale, the valley must be bridged so the tipping point can be reached.

The tipping point requires engagement of most of the early majority, who tend to think differently about change compared to innovators and early adopters who are eager and less risk-adverse to try new things.

Our research sought to understand how early majority "do" CDM and how they take on new ways of working.

| RDPCN Board and CoP | 3 Pilot Clinics | 11 clinics | 2 clinics plus 1 moving from paper to EMR | 3 of 18 clinics not engaged |

Source: EnACt and AMA. (2019). Scaling Up: Primary Care Transformation
Early Adopters

Avoiding the Valley of Death

Early Majority
Spring 2016 – Fall 2017

• Evolving staffing model:
  • Leadership
  • SN role expansion

• Growing clinic interest

Improvement Teams

- Composition
- Facilitators:
  - Buy in
  - Support Nurse training
- Challenges
  - Time
  - Champion commitment
  - Start - Stall

https://jodiscurruculumcorner.files.wordpress.com/2014/01/leadership-153250_1280-1.png
Support Nurse Team

- Rapid expansion of team
- Role of SN developing
- Team development
- Weekly meetings
Support Nurses

• Teamwork
  • Trouble shoot
  • Communicate
• See the health needs
How to engage physicians

• Approach
  “Here is what I can do. What do you think would fit into the way you work?”

• Embrace their pace
  small steps are okay

• Creating a presence
  healthy communication

Direction and ideas from PCNe CoP
PCN Evolution Menu

RDPCN supports physicians and clinic teams with PCN evolution and their patient centered medical home. Support Nurses, education and improvement facilitation make up the support. This menu provides a customizable list of supports.

<table>
<thead>
<tr>
<th>PCNe Process</th>
<th>Goal</th>
<th>Team member roles (activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building relationships and clarifying roles.</td>
<td></td>
<td>Check all that apply. SN is Support Nurse</td>
</tr>
<tr>
<td>✓ Relationship Building</td>
<td>Highly functioning team</td>
<td>□ Support Nurses meet all staff</td>
</tr>
<tr>
<td>Panelling and EMR Optimization</td>
<td></td>
<td>□ MD introduce role to their staff</td>
</tr>
<tr>
<td>Panel ID and verification process</td>
<td></td>
<td>□ MD or designate identifies workspace for SN</td>
</tr>
<tr>
<td>EMR Optimization and Standardization</td>
<td></td>
<td>□ MD identifies improvement team</td>
</tr>
<tr>
<td>Screening</td>
<td></td>
<td>□ MOA asks Family Dr., Address &amp; Phone # every visit</td>
</tr>
<tr>
<td>□ Outreach Screening</td>
<td>Increased screening rates for the 30% of patients who do NOT regularly book appointments.</td>
<td>□ Other ________</td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td>□ MD uses 32 standardized codes (on opposite side)</td>
</tr>
<tr>
<td>□ Time to third next appointment (TNA)</td>
<td>Improved Access (TNA)</td>
<td>□ SN calls to remind patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ SN sends requisitions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ SN asks lifestyle questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ SN books appointments</td>
</tr>
</tbody>
</table>

SN is Support Nurse.
Tools and Resources

- Menu – used by TOP to create STEP tools
- Top 33 codes
- Use of TOP tools
Tools and Resources

• Measurement tools to target screening needs

• EMR Standardization across clinics

• Our team
How to engage **clinic teams**

- Supportive Leadership
- Encouraging Mentorship
- Building Relationship
- **FOOD**!
Measurement and the Medical Home

*Schedule B a facilitator!

- Screening
- TTNA
- Health Team Effectiveness Surveys
- Patient Experience Surveys

https://bpmforreal.files.wordpress.com/2012/05/8552899_s.jpg
Using our experience to help clinics in novel ways
From Walk-in to Medical Home

- Pioneering this transition
- Quality vs Quantity
- Growing panels
- Building on success
Support Nurses lead clinic EMR adoption

- Ready for Change
- Connections
- Trusted relationships
- Ready for the next step
- Ongoing support
Support Nurses and other initiatives

- Opioids
- Frailty Research
- CII/CPAR
Scaling up – Next Steps
Early Majority to Late Majority

• Medical Home Engagement

• 88% with panel ID

https://jenjaynewilson.wordpress.com/
Some Perilous Routes

• Communicate *before* engagement

• Trust takes time

• Role clarity

• Medical Home Assessment
Reflecting on the Journey

• Hire LPNs
• Space
• Shadow
• Role clarity
• Physician *talk*
• Champions
• Take initiative \textit{“Docs don’t know what they don’t know.”}
Scaling the Medical Home Mountain – Timeline

- 2020 – 88% of physicians with panel ID
- 2019 CPAR Physician Workshop
- 2018 – 10 of 19 clinics adopt MH
- 2016-2018 Expansion of Support Nurse Team
- 2015-2016 First Support Nurses Hired and Pilot
- 2014-2015 – Evolution of PMH staffing model
- 2014 ASaP Improvement (Practice) Facilitator
- 2009 -2011 Team Based Care
- 2006 – PCN Established
To a lesser extent

To a greater extent
Questions????

Contact: Lorna.Milkovich@rdpcn.com