Kootenay Boundary Division of Family Practice
A GPSC initiative

Interior Health
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Boundary Proof of Concept Patient Medical Home/Primary Care Network:
A summary of evaluation findings

The Boundary Proof of Concept (PoC) is a Patient Medical Home/Primary Care Network initiative. It forms part of work towards the vision of Patient Medical Home in British Columbia, which aims to achieve patient-centred primary care across the province and prioritized outcomes of both the B.C. Ministry of Health and Doctors of B.C. The Boundary PoC introduced team-based care (TBC) by bringing three full-time equivalent (FTE) nurses and one FTE social program officer into primary care in five clinics in the Boundary area of the Kootenay Boundary region. A unique feature of Boundary PoC is the delivery of $500,000 in annual funding from Interior Health Authority (IHA) to a physician cooperative to employ the nurses and social program officer. This document draws on the GPSC case study of the Boundary PoC in 2018.

Intended benefits

The Boundary PoC was intended to achieve a number of benefits. Existing literature and team-based care (TBC) experiences across B.C. suggest TBC can result in the following short- and long-term outcomes:

Short term

- A reduction in low acuity visits to emergency departments (ED);
- Increases in patient satisfaction;
- Better patient access to same- and next-day appointments;
- Improved patient care, particularly with regard to chronic disease management and mild to moderate mental health issues;
- Improved physician/nurse practitioner satisfaction;

Long term

- A reduction in total hospital days for urgent/emergent hospitalizations;
- Better population health; and
- A reduction in the total costs of care.

The findings of the Boundary PoC evaluation suggest that all of the short-term outcomes have been achieved to date. In the first year, low acuity ED visits decreased by 13.7%, and total hospital days decreased by 3%. At present, the implementation of the Boundary PoC within Kootenay Boundary is in its Maturing phase.

Key Boundary PoC activities to date:

- Collaborative development of the PoC model with physicians, IHA and Division of Family Practice;
- Establishment of initiative outcome targets and clinic-level indicators;
- Development of the Boundary Health Care Cooperative (incorporation, insurance, bank accounts, Canada Revenue Agency registration);
- Recruitment of nurses and social program officer;
- Nurses and social program officer (SPO) start work in practices;
- Baseline outcome and clinic-level indicator data collected;
- Establishment of working group to work on outcome achievement and PCN implementation.

Key findings and recommendations

Don't rush the development phase and be realistic about the time commitments

The Boundary PoC development phase had to be completed in 90 days. While time limits are important, the short time frame for PoC development meant that the group did not sufficiently develop a joint vision, assess practice readiness, or develop a sufficient and collaborative understanding of some of the outcome data.

Developing a collaborative vision and language, understanding the data, and creating a workable model take time, and are critical steps that will facilitate the implementation phases of a project.

Physicians are limited with regard to the amount of time they have to engage in primary care transformation. Even when sessionals are provided, physicians must continue to meet their clinical responsibilities during the development phase of primary care initiatives. The support of a semi-retired local physician leader in the Boundary was critical to PoC success.

Be strategic about how to engage physicians and realistic about how much time they can devote to primary care transformation. Identify and support local physician leaders who have more time to offer to the process.

Ensuring the meaningful participation of community and indigenous peoples takes time and is challenging. Although a community representative sat at the table during the development phase of the project, and indigenous representatives are part of the implementation working group, earlier and more meaningful engagement of community members and indigenous stakeholders would have been desirable.

Have a robust plan for community and indigenous engagement and ensure that there are enough of them at the table that their voice can be heard and that there are meaningful opportunities for them to engage.

Alternative employment structures can be effective in delivering team-based care

The nurses and social program officer in the Boundary PoC are employed by a provider cooperative. Boundary providers wanted to be able to manage the staff working in their clinic and have the flexibility to determine what the coop staff did within their scope of practice, enabling them to meet the needs of patients. At the same time, the provider cooperative took a significant effort to establish and requires ongoing administration by the physicians/nurse practitioner to maintain.

Carefully weigh the pros and cons of alternative employment structures. A cooperative structure with a multi-organization board could allow for maximum effectiveness in team-based care while maintaining diverse oversight.

Divisions, Health Authorities, and focusing on outcomes play a critical role

Strong relationships between Divisions and Health Authorities are critical. Despite different cultures and historical conflict, the Kootenay Boundary Division and IHA have forged a highly collaborative relationship via their Collaborative Service Committee (CSC) through deliberate team building. This was essential to IHA's willingness to undertake the Boundary PoC. Division and Health Authority leadership and partnership were essential to the Boundary PoC success.

Support relationship development at the CSC level across the province and understand that primary care transformation requires considerable goodwill, flexibility and commitment from physicians and health authorities.

Divisions of family practice are in a unique position to link local physicians and health authority representatives, and appropriately resourced, can support the change management required for primary care transformation. The Kootenay Boundary Division played a critical role in the development and implementation of the Boundary PoC, bringing all of the stakeholders together and developing the model. This required over $400,000 in funding over two years.

Provincial stakeholders should work through Divisions using their local knowledge, change management expertise and capacity for doing the work to engage physicians and health authorities in primary care transformation.

Identifying outcome targets and having a Quality Improvement (QI) Framework creates a concrete focal point for collaborative project design and implementation. The outcome targets for the Boundary PoC serve as a clear reference point for understanding whether the initiative is bringing about the desired change, and reinforced the health authority's support for the project. They also drive action and continued discussion regarding how implementation can be improved.

Promote the establishment of clear outcome targets and a commitment to using data to understand the effects of primary care transformation.

There is a need to clearly establish physician and practice readiness for primary care transformation

There is a bell curve of readiness of practices, and of physicians within practices. The work of primary care transformation requires buy-in to the end goals. Optimal team functioning requires ongoing commitment to team-building processes and communication.

Clearly lay out the prerequisites for primary care transformation participation, including a commitment to QI and optimizing TBC, and work with early adopters.

Physical space is critical for optimal flow in TBC and many practices lack the required space for TBC. Fee for service TBC billing opportunities do not appear to cover the overhead costs associated with new team members.

Provincial bodies should consider programs or incentives for capital builds that add physical space to practices, enabling participation.

A note on method

The Boundary PoC case study included a detailed literature review, interviews with Division, IHA, provider, coop staff and patient representatives. Surveys of providers and patients, clinic access data and IHA administrative data were also used.