The Boundary Proof of Concept PMH/PCN

A GPSC Case Study
December 2018

GPSC
General Practice Services Committee

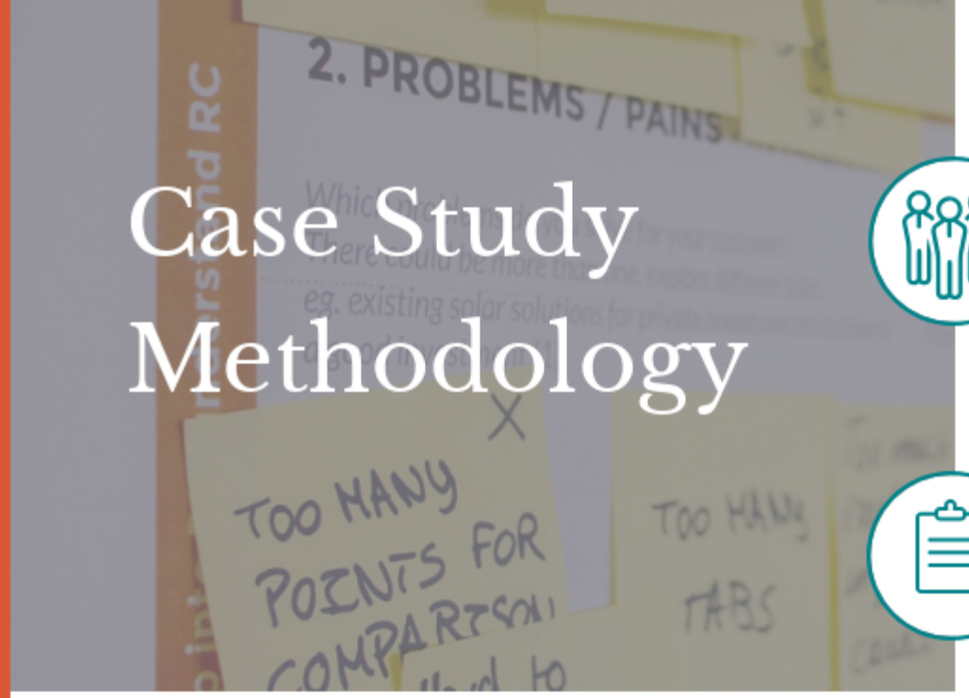
Kootenay Boundary
Division of Family Practice
A GPSC initiative

Interior Health
Every person matters

Introduction

Collaborative initiative to implement a patient medical home/primary care network in the Boundary region. Key features include:

- Introduction of 3 FTE nurses and 1 FTE social worker into five primary care clinics
- Robust Outcomes and QI framework
- Physician cooperative to employ the team members utilizing funds from IH
- Initial focus on team-based care and PMH implementation followed by focus on PCN integration



Case Study Methodology

Interviews

33 in-depth interviews with Division staff, providers, coop staff and IH staff

Surveys

Baseline patient survey (n=200), Follow-up patient survey (n=264), Baseline provider survey (n=8), Follow-up provider survey (n=7), Coop staff survey (n=5)

Direct observation and document review

Attendance at meetings during design and implementation phases, review of relevant documents

Administrative data

Administrative data from IH on ED visits, scheduled visits, and hospitalizations

Goal of Case Study

To help us understand successes and challenges, key enabling factors, and potential outcomes of patient medical home /primary care network implementation for future primary care transformation, locally and provincially.

PoC Timeline

January 2018 to now

Maturing phase: Meetings to examine outcome achievement, in-clinic meetings to improve TBC.

May 2017 to December 2017

Implementation phase: Development of Boundary Health Care cooperative, contract signed, nurses and social worker hired.

December 2016 to May 2017

Design phase: Collaborative design phase to set outcomes, establish QI framework and develop model.

May to November 2016

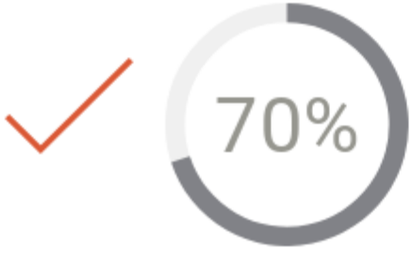
Pre-design phase: Engagement of communities; Review of data; Identification of preliminary outcomes; Submission of proposal

Key Results

Progress towards Outcome Targets

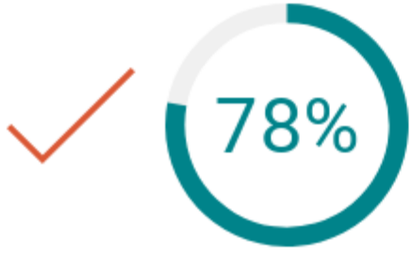
CTAS 4/5 Visits

Target: 25% reduction in yr 2
Low acuity visits by Boundary residents to EDs 22% lower in pds 1-7 of 2018/19 over baseline



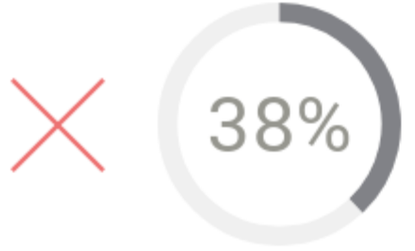
Scheduled Visits to BDH ED

Target: 90% reduction
Scheduled visits to BDH ED 63% lower in pds 1-7 of 2018/19 over baseline



Scheduled Visits to BDH

Target: 50% reduction
Total scheduled visits to BDH 39% lower in pds 1-7 of 2018/19 over baseline



Total Hospital Days

Target: 8% reduction
Total hospital days decreased by 3% in year 1 but was back up by 12 in quarter 1 of year two

Mental Health Supports

Target: 160 unique patients supported
Social worker provided mental health supports to about 180 patients in the first half of year 2.

Total Costs of Care

Target: 5% reduction
No data available for total costs of care.

Key Results

Access

Mixed results: Qualitatively improving, but time to third next available appt is still 12-14 days and only 39% of patients can get same or next day appts.

Provider and Staff Satisfaction

Mixed results: Qualitatively mostly improved but not for all physicians; Quantitatively improved for team-based care measures. Coop staff satisfaction high.

Patient Care

Anedotal results: Evidence of improved chronic disease care, mental health supports and form completion supports.

> “I think the care has improved quite a bit. You can talk more. You feel like they want to listen more. It feels more like a group effort than an in and out kind of thing to find out more what is going on with you whether it is emotional or physical.”

Boundary Patient

Other Successes

Partnerships

Built and improved relationships for future work, particularly the relationship between IH and KBDoFP

Learning

Learned about PMH/PCN implementation and primary care transformation

Team-based care

Staff working to full scope of practice in high functioning teams

Patient medical home

Moved forward with patient medical home implementation

Things to think about

Resources

System changes take time and money - there is no magic sauce

Commitment

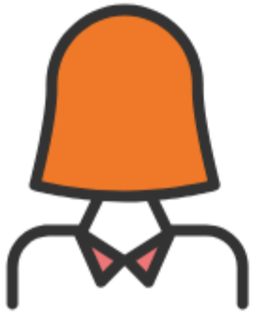
Without the commitment, perserverence and flexibility of all parties, the PoC would not have succeeded

Complexity

In a complex system, changes ripple through the system affecting all parts in unexpected ways

Data

Data helped ground the process from pre-design through implementation



"Tremendous improvement! Walk-in clinic and subsequent care from nurse were far preferable to having to go to ER, or waiting for condition to be serious enough to require ER.. "
- Patient

My satisfaction has gone up. I really enjoy working with nurses. It is nice having extra colleague. It has taken a load off.

- Provider

"I feel like I am just doing more on the chronic disease management just to make sure everything is touched on, they are getting their feet checked. That is really important to me."

"Patient access to counselling is improved because they can get in to seeing me very quickly and the flow of info between me and family physician is very strong and there are no barriers financially there are lots of patients who need counselling but can't afford it."

- Coop staff

"I think I can take a bit longer and get into the weeds more with some of them, for example, diabetes I can go into nutrition and exercise and what exactly does what."

- Coop Staff

" A couple of times I have dropped in to see a doctor to see me and a nurse was able to see me and take care of the small matter.... It was just so handy."

- Patient