Divisions Webinar Learning Series
January 22nd 2020, 5:15 pm - 6:15pm

Principles and Approaches to Best Practice Team Based Care and Organizational Excellence – Reflections from the Nuka Symposium, August 2019

Divisions of Family Practice
A GPSC initiative

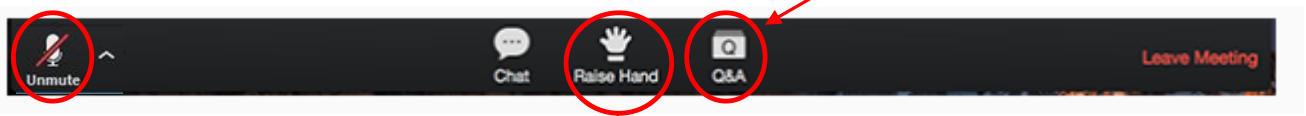
BRITISH COLUMBIA
GPSC General Practice Services Committee
doctors of bc British Columbia Medical Association

Technology Overview

The webinar controls will auto-hide. Move your mouse to the bottom of the screen to make them appear.

You will be muted when you join the webinar.

To send a question to the panelists, click on the Q&A icon and type out your question.



To raise your hand, click on the Raise Hand icon

Presenters:

Bonnie Bagdan - Family Physician, Comox Division of Family Practice PCN Lead

Dan Horvat – Family Physician, Medical Director, Western Communities, Island Health; Quality Initiatives Lead, Rural Coordination Center of BC

Alan Ruddiman – Family Physician, Oliver; Co-Chair Joint Standing Committee on Rural Issues

Tim Troughton – Family Physician, Victoria; Co-Chair, Victoria Division of Family Practice

Nuka System of Care Symposium August 19-21, 2019

- BC context
- Assist with PCN/PMH
- 19 participants
- 2.5 days

Why Southcentral Foundation?

- First Nations ownership
- Sustained improvement across wide range of areas
- Started in Atco trailer
- Listening exercise
- Priority - culturally appropriate relationship with their own primary care provider

Whole System Transformation

- Relentless commitment to measurably improving the health and wellness of their customer-owners
- De-siloing providers to create well defined primary care teams that focus on supporting caring relationship with customer-owners
- Structuring the organization and other programs and resources to support effective relationships in primary care
- A learning organization approach:
  - Seeking and carefully applying evidence
  - Tight-loose-tight management
    - agreement on what's needed and empower - local autonomy/community driven
    - Global funding
    - Continual measurement of outcomes, experience (quadruple aim) and use of that information to inform further service improvement and development (feedback loops)
  - Leadership that "stands in the gap" (CEO, Katherine Gottlieb)

Results

Also:

- 30-40% less pharmaceutical costs
- 30% less lab and XR costs
  - 65% less specialist visits
- 4,235 visit requests from around the world

Culture & Structure are Keys to Success

Culture

- Relentless commitment to addressing the health & wellness needs of customer-owners through best practices
- Supportive, empowering, relationship based approaches that achieve a team based, family-like approach across all parts of the organization
- An expectation of all to be involved with innovation, measurement & improvement

Structure

- ICTs with clearly defined roles
- Specialized support for teams and targeted programs
- Integration of care across sites (IT enabled)
- Learning & Development, IMIT & Data
- Integrated, flat structure
- Innovative HR practices
- Leadership

The SCF Integrated Care Team (ICT)

1,100 – 1,400 Empaneled Customer-Owners

Integrated Care Clinic Team

2 Behavioural Health Consultants
1 Pharmacist
1 Registered Dietician
1.5 Certified Nurse Midwife
2 Coverage Physician Assistants/Nurse Practitioners

6 Primary Care Teams

Core Clinical Team – A Different Approach to Care

- Panel of 1100-1400, based on complexity
- 80-200 patient 'touches' per day
- 80% virtual patient contacts
  - 50% asynchronous visits (text, e mail)
  - 30% synchronous, virtual visits (phone, videoconference)
- 20% in person visits - 12-15/day - 'max packed'
- Additional time and attention, care planning for 'fragile' patients/high users (largely driven by behavioural health consultants)
- Other 'in house' providers support continuity/relationships with ICT

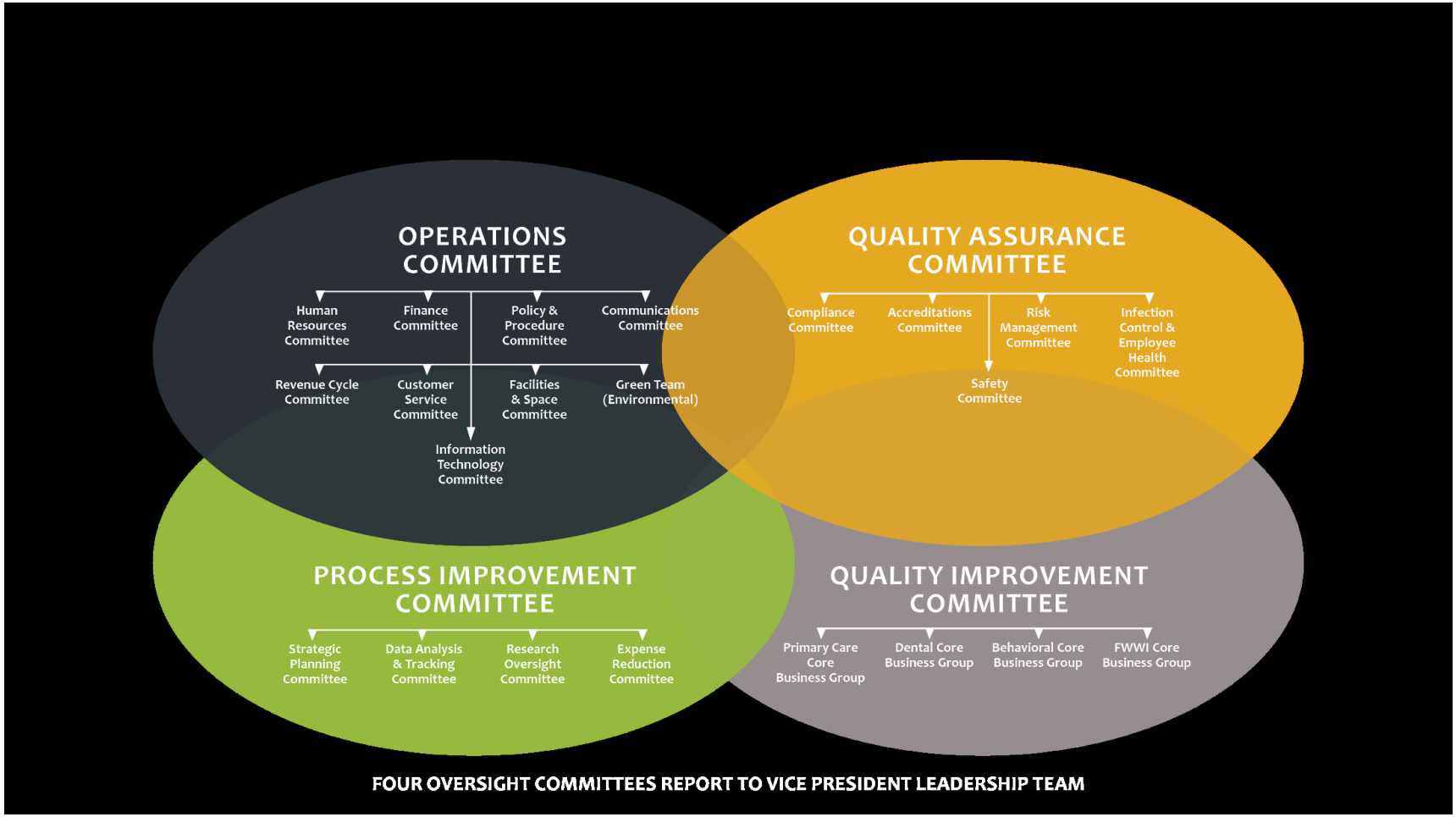
Other 'In House' Support

- Chronic pain specialists
- HIV specialist
- Addictions specialist
- Aging well in place specialist
- OB/GYN
- Complex adult and pediatric specialists
- Psychologist
- Physiotherapy
- Acupuncture
- Chiropractor
- Traditional Healer
- Lactation Consultants
- E.H.R. Coach

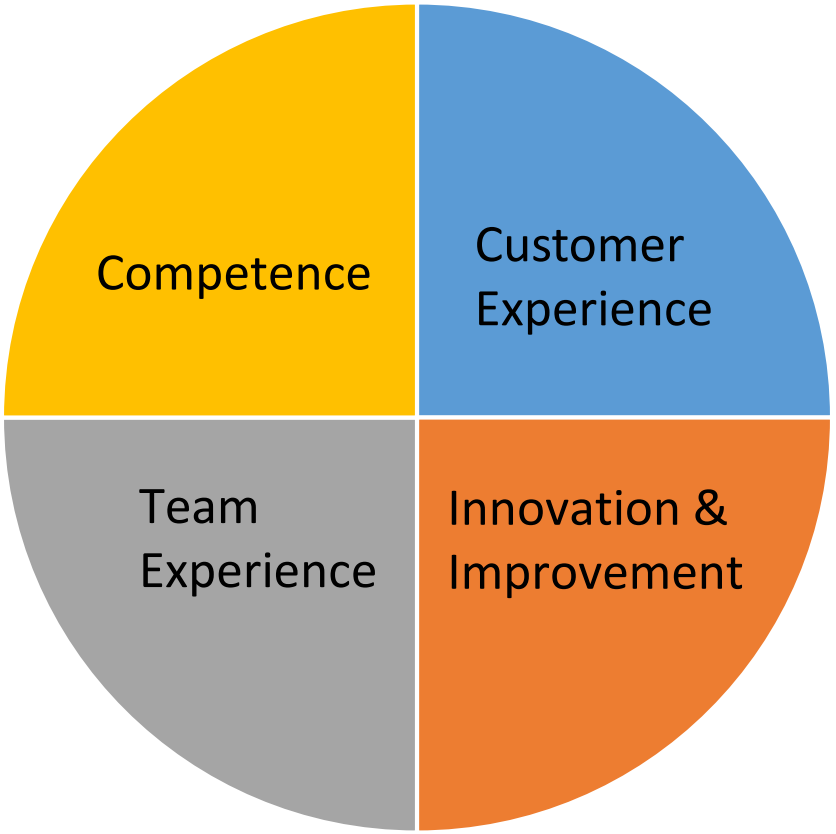
Many Innovative Programs, Capabilities & Services

- Dental and optometry services
- Medications
- Behavioural health (redesign circles, urgent response team, inpatient treatment, suicide prevention)
- Three Year Gestation Program
- Family Wellness Warrior Initiative
- Soldiers Heart
- Addiction Services, including residential programs for pregnant women & youth
- Chronic Pain & Palliative Care Programs
- Programs for those who have been incarcerated
- Youth, Elders & Aging Well in Place Programs
- Women & Men's Wellness Programs
- Home visiting & Meal Services
- ICT and expanded team
- ED fast track
- Adult severe mental illness, home based services, patient transfers, health education
- Village initiatives
- Exercise With Elders, Bingo, Movies, Live Music
- Annual gatherings
- Leadership, management, HR, financial, public relations and medial relations, communications, etc.
- Board, Tribal relations
- Employee and leadership development, succession planning
- Legal services
- Information technology
- Data capture, manipulation and analysis
- Patient feedback
- quality improvement, process improvement and quality assurance programs including the Development center, Learning & Wellness Institute, Evaluation, Research
- facilities, including exercise facilities

Atypical (Flat) Organizational Structure



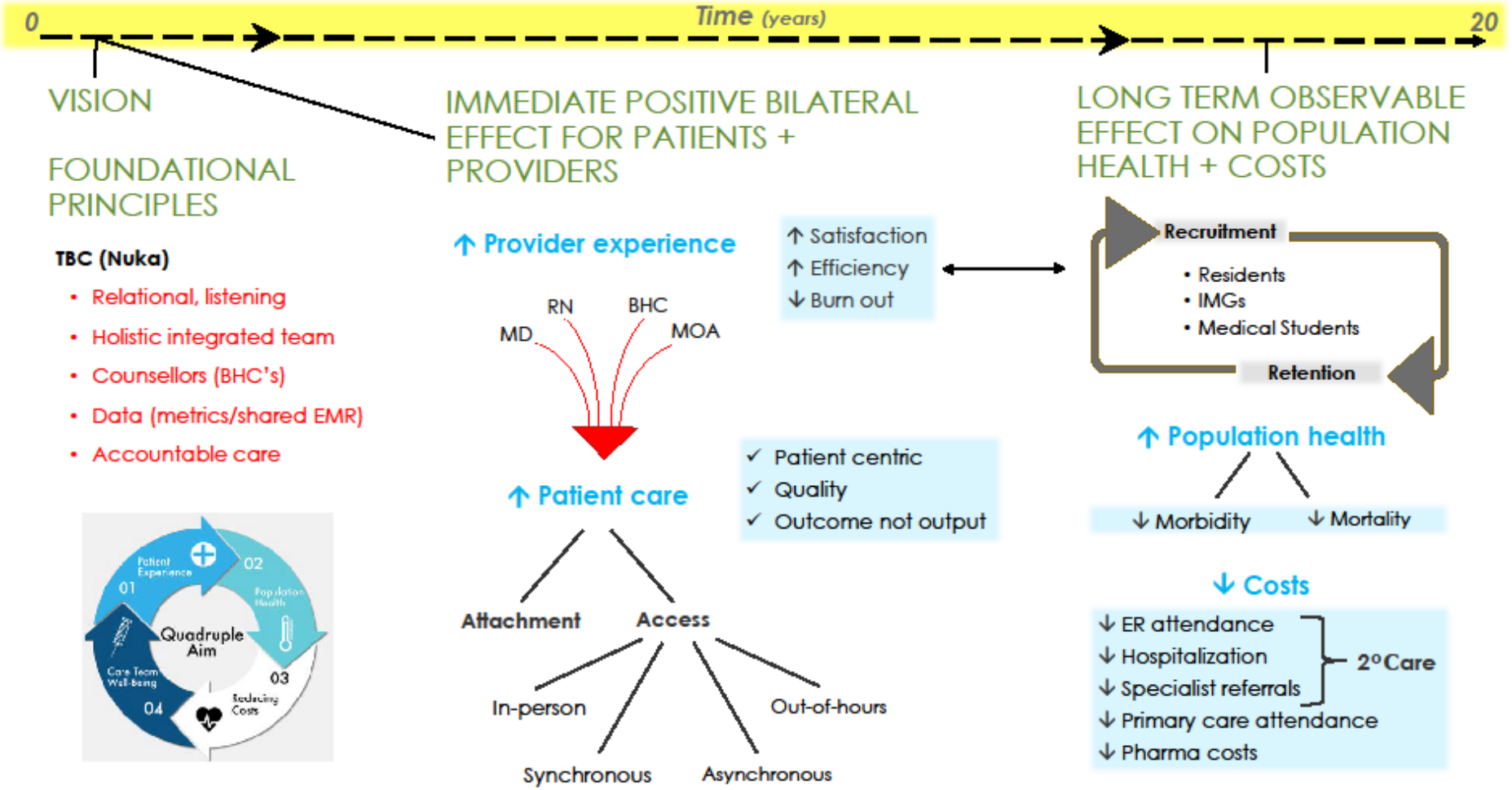
Annual Assessments



Weighted 25% Each

50% Relationship Based

Cost


0
Time (years)
20
VISION
FOUNDATIONAL PRINCIPLES
TBC (Nuka)
• Relational, listening
• Holistic integrated team
• Counsellors (BHC's)
• Data (metrics/shared EMR)
• Accountable care
IMMEDIATE POSITIVE BILATERAL EFFECT FOR PATIENTS + PROVIDERS
↑ Provider experience
RN
BHC
MD
MOA
↑ Satisfaction
↑ Efficiency
↓ Burn out
↑ Patient care
✓ Patient centric
✓ Quality
✓ Outcome not output
Attachment
Access
In-person
Out-of-hours
Synchronous
Asynchronous
LONG TERM OBSERVABLE EFFECT ON POPULATION HEALTH + COSTS
Recruitment
• Residents
• IMGs
• Medical Students
Retention
↑ Population health
↓ Morbidity
↓ Mortality
↓ Costs
↓ ER attendance
↓ Hospitalization
↓ Specialist referrals
2°Care
↓ Primary care attendance
↓ Pharma costs
Quadruple Aim
01
02
03
04

BC Participants - Critical Enablers of Success

- Clarity of vision
- Common purpose

BC Participants - Vision

Family & patient centered

relationship based and coordinated primary care

provided in the context of community governance and

an organization that supports data driven, continual improvement.

BC Participants - Key Messages

- Primary care transformation in BC does not go far enough
- We need more input from patients/the population
- We need to develop a high trust environment
- Our efforts need to be data/QI driven and take a systems approach (we need the capacity to do this)
- We need to learn from best practices

Take-Aways

- Need to act with intention to improve alignment of values, vision, resources, processes at macro, meso, micro levels
- Tight-loose-tight management
- Clarity of approach and roles in team based care
- Integrated EMR, sensitive use of data
- Integrate our many services (including specialists) to support relationship & team based primary care
- Improve capacity/expectation to innovate, improve, measure, learn from failure
- Innovative HR processes
- Cultural sensitivity built in
- Can't apply what SCF has done lock-stock and barrel
- Start with what you have
- Limitations – scale, mandate; our relative complexity
- We can realize the promise of improved primary care, SCF has done the proof of concept
- FNHA has done a lot of work with SCF already

Next Steps

- BCMJ article
- Document to go to GPSC as ‘feedback from the profession’

Questions/Discussion/Next Steps

- Do you see benefit to applying elements of the Nuka model to our PCN/PMH efforts in BC?
- Are you involved with/aware of practices applying elements of the Nuka Model in BC, please *briefly* (1-2 minutes) describe
- How can we work within our context to achieve best practice results?