Building the Rural Health Care Team: Making the Most of Available Resources

KIRKLAND LAKE FAMILY HEALTH TEAM

PRENATAL CARE

INTEGRATED CO-ORDINATED CARE PLANS (ICCP)

MULTI-DISCIPLINARY MEETINGS

Presenter Disclosure

- ***Presenters***:
- Tina Woollings-Nurse Practitioner
- Julie Moody-OTN RPN
- Mandy Weeden-Executive Director
- Dr. Brian McPherson-Lead Physician
- Sandra Dal Pai-Nurse Practitioner

Disclosures continued

- ***Relationships with commercial interests***
- none
- ***Disclosure of commercial support***
- None
- ***Potential for conflict of interest***
- None

Objectives

- How do we do what we do with few resources; sharing of allied health providers, meeting transportation challenges, and collaboration.
- How have we maximized the use of Ontario Telemedicine Network to expand our service provision?
- We have a population that is aging and has multiple co-morbidities. How do we meet the demand with few providers and ensure client-centered care?

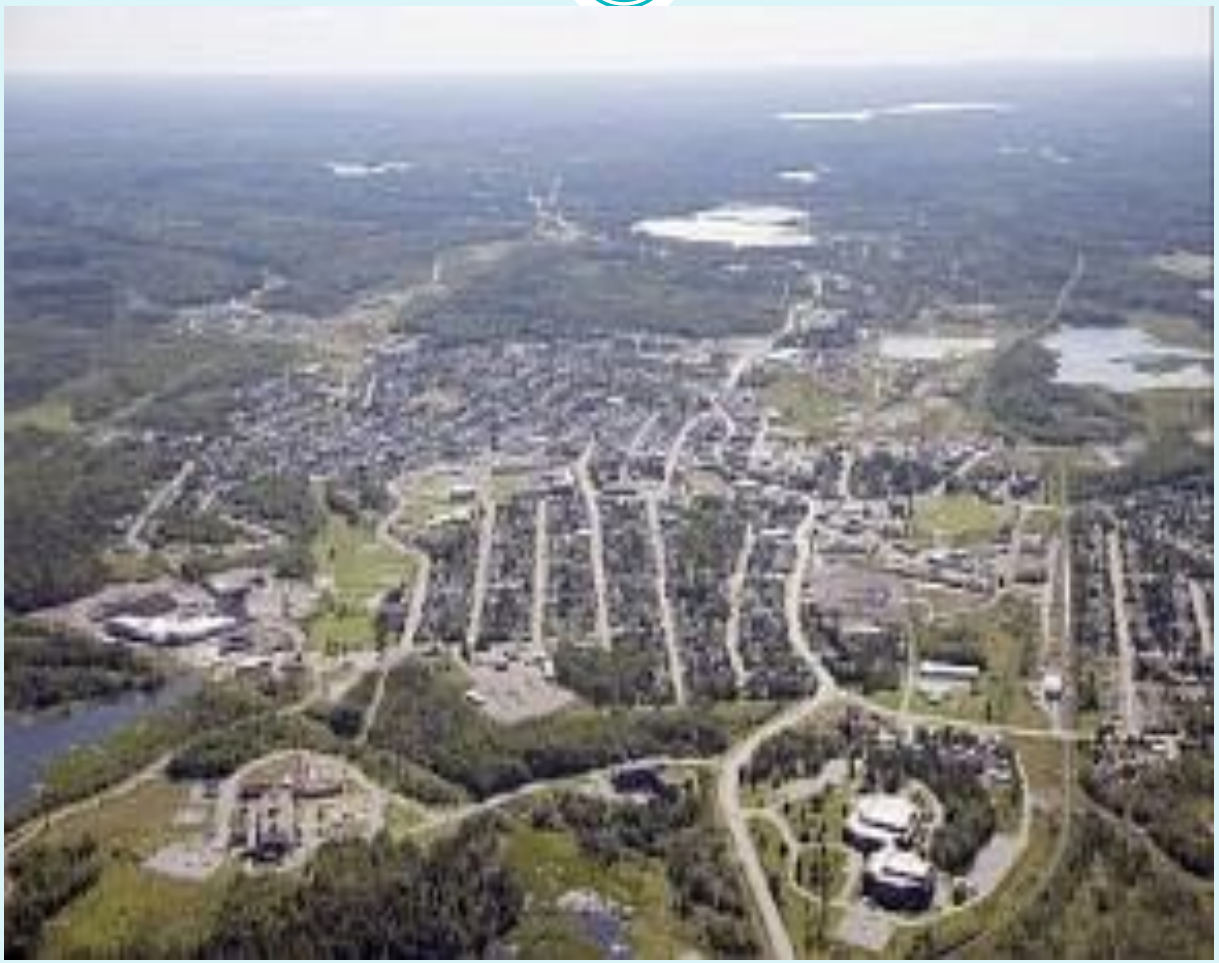
Partnerships

- Town of Kirkland Lake
- Kirkland and District Hospital
- Working on development of a charitable foundation so we can receive further support from our community. i.e.. Donations in memory etc.
- Local Business very supportive with in kind donations and monetary support.
- Laurentian University, Northern Ontario School of Medicine and Northern College providing placements for students in Nursing, Nurse Practitioner and Medicine.
- Local Mining Community

Where is Kirkland Lake?

GTA Community

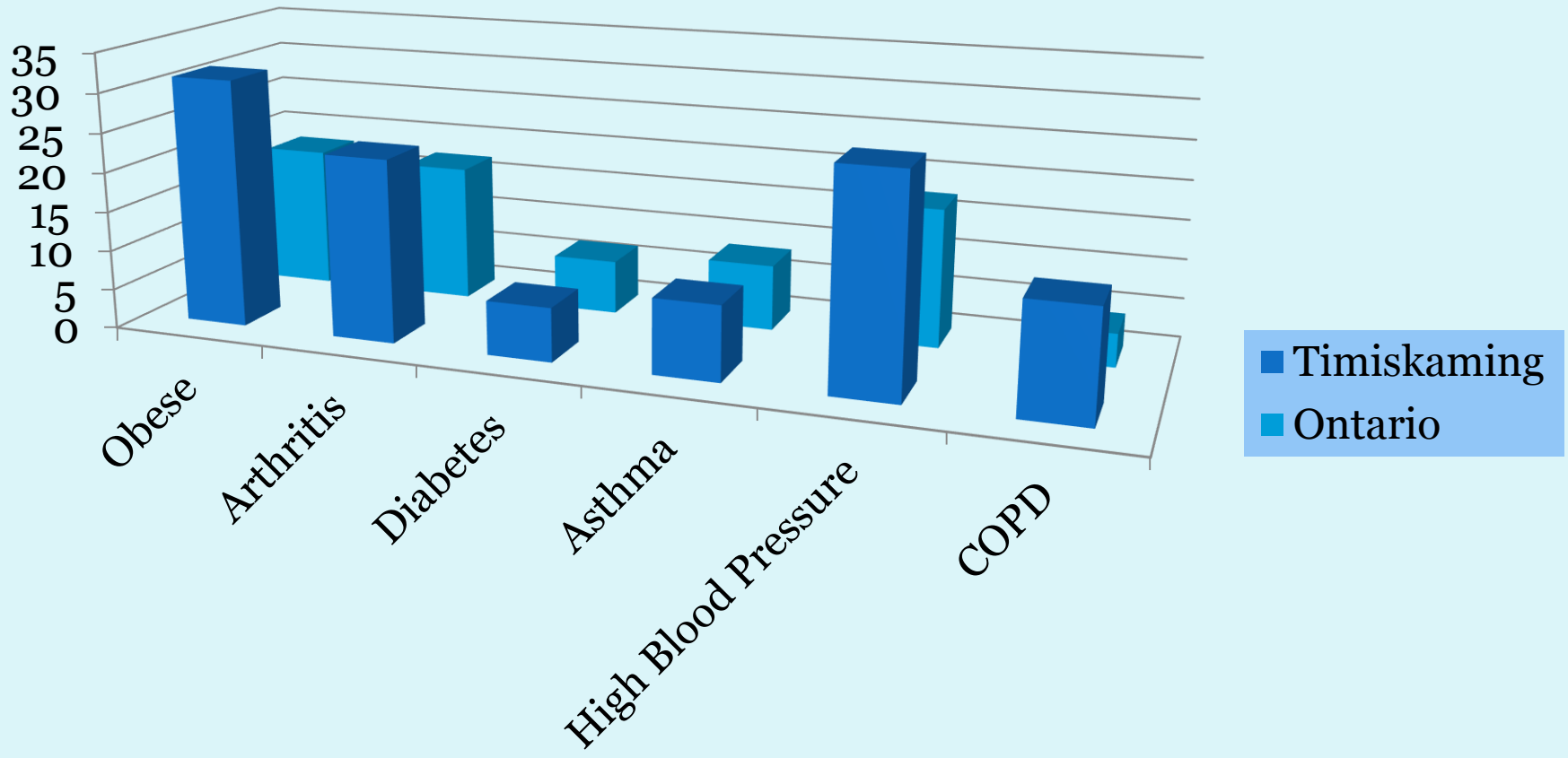
Our Community



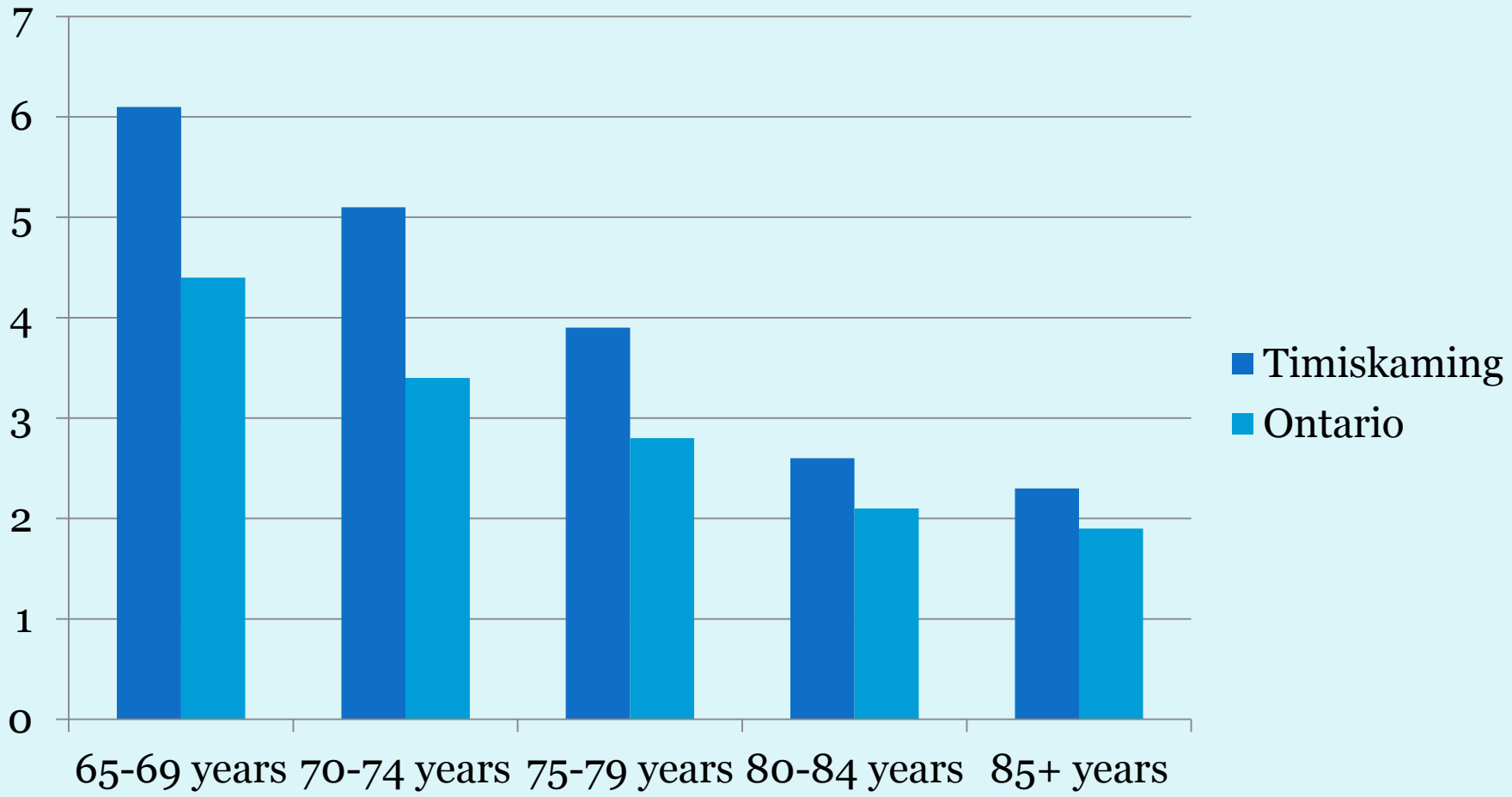
What are the demographics?

- Higher than the provincial averages of diabetes, CAD, smoking, obesity and an aging population
- Significant co-morbidities
- High unemployment rates
- Lower than provincial average education levels
- Lower than provincial average income-$21,113 compared to provincial median of $24,604.
- 17.8% of earnings from government transfers vs. 9.8% for the province.
- Catchment area of 11,000 people.

Let me get to know you….
Chronic conditions rate comparison



Older Adults as percentage of Population (2011)



Our Community Beginnings

- 2 Nurse Practitioners
- 1 RN
- 1 GP anesthetist
- 1 ER Doc, and one general surgeon
- 2 GP's with full practice
- No delivering physicians for obstetrics
- No formal prenatal program
- No female physicians
- No focused women's healthcare
- Many clients with multiple chronic co-morbidities, and no primary care provider
- 8000 residents without a primary care provider

First Steps to Improving Primary Care

- Women's clinic established and staffed by NP's on rotating basis with the No Family Doctor Clinic (2001) (staffed with locum MD's)
- Eventually secured funding for 3 more NP's through women's clinic and No Family Doctor Clinic.
- Family Health Team initiative started.
- Community fundraiser resulted in $750,000.00 raised through partnership with the Frog's Breath Charitable Foundation and the help of 500 volunteers from our community.

If we build it, they will come…

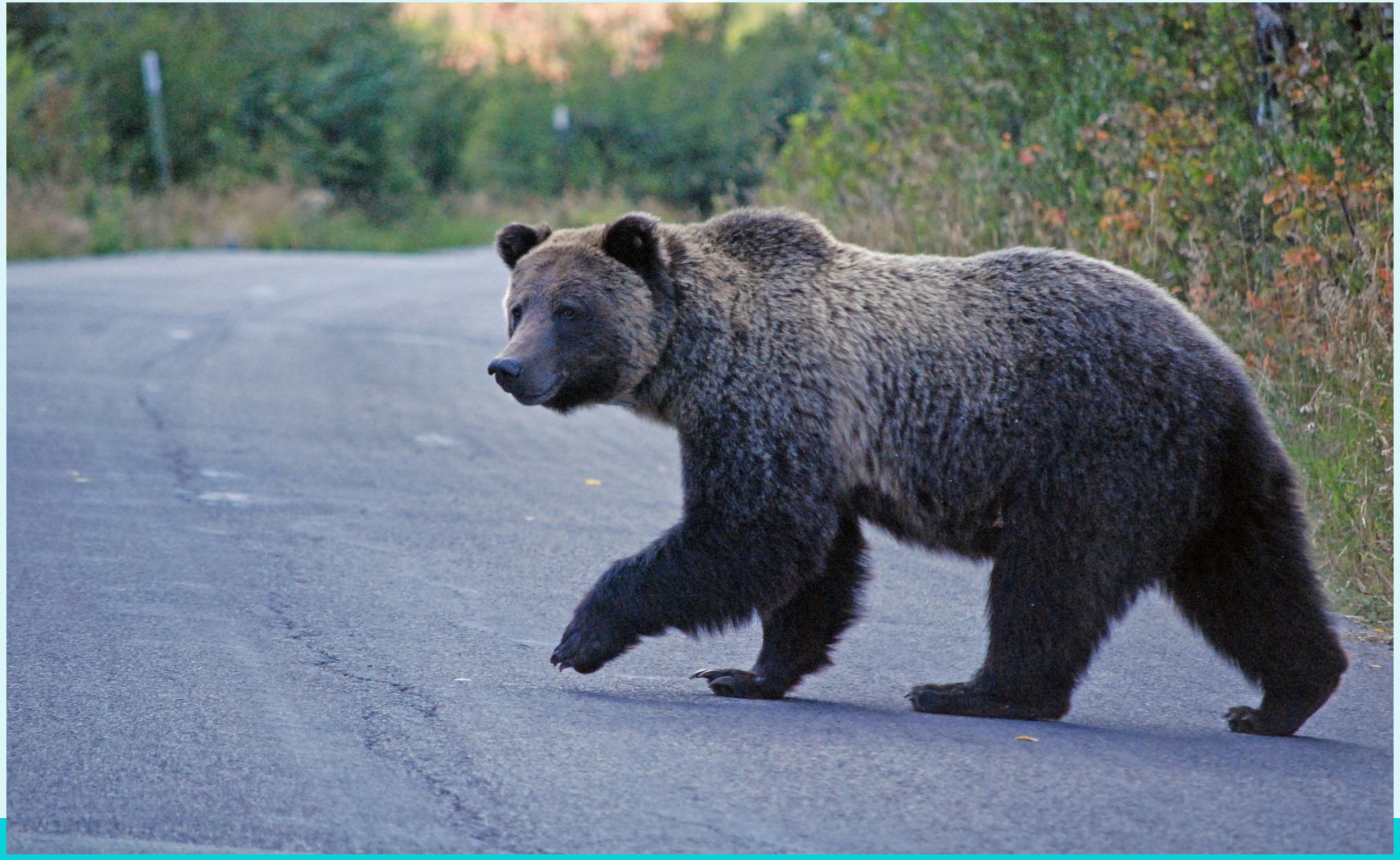
Prenatal Care--Can we work together?

- Increased number of perinatal deaths
- No organized prenatal clinic
- Women arriving to deliver with little or no prenatal care
- Approached by main delivering physician in New Liskeard.
- ?? Can we partner and see the clients together?

Can we work together….

- After working with the Nurse Practitioners for a few weeks, the physician realized there was no need for a physical presence.
- There still remained all the issues we were dealing with as a community such as low income, lack of transportation, and driving hazards.

Natural Hazards……



Where a Moose goes once hit…

Road Closures

Poor Visibility, Transports and Ice

The Beginnings of a New Visit Modality

- Brainstormed about the best way to provide the optimum care to our clients with the most productive use of time, and minimum need for travel.
- How about a virtual visit?

Maintaining Standards in Antenatal and Intrapartum Fetal Surveillance:

- Quality Improvement and Risk Management
  - To ensure a standard approach in patient management basic quality improvement principles must be followed. These principles form the foundation of a quality improvement program, and their effectiveness (or lack thereof) could determine the program success or failure. Quality control or quality improvement programs based on these principles have been shown to have some effect on the outcome of perinatal and medical care.

Fetal Health Surveillance: Antepartum and Intrapartum Consensus Guideline

- The principles include the provision of the following: a multidisciplinary team approach to care, champion leadership, a no-blame culture, a systems approach to complex organizational structure, a respect for individual confidentiality, a client focused environment with patient safety being the highest priority, evidence-based care, and a program evaluation and outcome monitoring/reporting system with implementation plans for improvement. Outcome monitoring should include quality performance outcomes and effectiveness and efficiency measures. (SOGC Sept. 2007)

How does this program look?

- Initial intake and routine prenatal care until 28 weeks in FHT. At 28 weeks, Mom is referred to delivering Dr., and OTN request for appointment is made.
- Arrangements are made for a pre-admission visit and a consultation with the delivering physician the same day.
- OTN is used whenever there is consultation required, otherwise, the NP follows until delivery.
- After birth, the Mom and babe return to our care ensuring a seamless experience with a known provider.

Benefits to Patient

- Cost effective
- Time effective
- Safety
- Continuity of care
- Improved access to care
- Improved prenatal care
- Seamless postpartum transition

Benefits to Nurse Practitioner, and Now our MD's

- Readily available delivering physician for consultations (utilize texting for things like NST strips, and general queries)
- Shared care—more rewarding for mother and the NP
- Ongoing learning and clinical expertise
- High risk obstetrical patients referred to larger center where shared care also became our model, unfortunately without the use of OTN

Comment from Dr. Steve Sears…

- *"I have been using OTN for the past 18 months to see prenatal patients from the Kirkland Lake area. This is an invaluable service for our region. OTN allows me to see people while they stay in their own area and often allows me to see them with their primary care provider which would not be possible if they had to travel. This enables a team approach to care and gives everyone an opportunity to learn. Minimizing travel also decreases costs and the risks associated with travel. I certainly hope we can continue to utilize this technology even more in the future."*

Cons

- Loss of some human interaction that would occur with an actual visit
- Technical issues—which have truly been very few
- Precipitous deliveries, snow storms and closed highways result in deliveries in the ER—not the best, but we are prepared, and now the Moms have had good prenatal care, and the records are accessible in the ER through the EMR.
- Some patients do not want to travel an hour to deliver, and have figured out that if they wait long enough, they will be delivered here. Reality-some do not have the means to travel an hour away.

Pearls

- OTN saves time. 986 OTN visits saved 9817 clinic hours and 1972 hours of travel.
- OTN saves money. $121,278.00 in travel cost, and the avoidance of significant lost time and income at work.
- OTN is safe. Reduced risk of MVA due to winter weather and wildlife.
- Extended and maximized use of OTN for various needs such as post-op follow up, mental health, dermatology, and cardiology amongst 102 different consultants in 28 different specialties.

Applying what we learned

- How could we maximize our resources to meet the needs of complex patients with a relatively small staff of professionals?
- Similar issues to Obstetrics-patients requiring intensive follow up, specialist appointments, travel challenges, who also had unique quality of being high system users—frequent flyers so to speak. Same principles of care delivery and quality improvement apply, so….

Health Links

- A collaborative group was started in our district in 2011-2012. In 2013, we were granted funding for being an early adopter of Health Links.
- The initial goal was to identify high users of the system and our resources.
- This population has been estimated to consume 80% of the resources, yet they comprise 20% of the population.
- As a result of this, ICCP (Integrated Co-Ordinated Care Plan) was suggested as one of the ways of managing our high needs and highly complex care patients.

What are the goals of an ICCP? Integrated Co-Ordinated Care Plan

- ***For the system***:
- To identify and reduce demand from high users of the system
- ***For the patient***:
- reduce ER visits, readmissions, referral time to specialists
- ***For both***:
- Enhance collaboration and communication between patient and care providers

How does it work?

- Hospital does initial screening using LACE tool, and refers patient back to clinic.
- Patient meets with primary care provider and allied health members to determine goals and an action plan ensuring patient centered care.
- Teaches patient accountability.
- Includes provision of the plan to the patient to bring to specialist appointments.
- Helps patient to plan and self manage their care.

A Case Study Success!!

- Clinic calls reduced from once daily to once monthly.
- ER visits decreased from every three days to one in 90 days.
- Monthly admissions decreased to 0 since development of plan (9 months).
- Biweekly MD and clinic visits reduced to quarterly.
- Much improved patient and provider satisfaction and respect.
- Currently have 6 ICCP's with a significant impact on workload demand.

Outcomes—survey says!

- ICCP Patients:
  - As a result of the ICCP and meeting with the case manager and providers together, our ICCP patients said they feel very confident they are able to manage their symptoms and prescriptions.
  - Patient Testimonials:
    - *"Very informative."*
    - *"Good explanations that I understood."*
    - *"The health care team gave me the time that I needed."*
    - *"Liked the opportunity for the appointment, they accommodated me and came to my home."*

Pearls

- Need to have a team, and work as one.
- Need a lead, and the lead has to have the time to initiate and monitor the plan. We have a clinical NP lead. In our clinic, all the planning and implementation has been done by the NP's and our nursing staff.
- Managing high system users requires human resources not currently funded.
- Patient has to have the cognitive ability and desire to actively participate in the development of the plan.
- We need sustainable and ***equitable*** human health resources.

What about the *almost* complex patient?

- Identified another group of patients who were also high system users, and either outside ICCP parameters, or declined ICCP.
- How could we apply the concepts of ICCP to this almost complex patient?
- How do we maximize the expertise we have to reduce the load on the primary care provider?
- How do we communicate who does what?

Multi-Professional Appointments

- Problems realized: post hospital visit not timely resulting in delayed med reconciliation and referrals to allied health providers.
- Readmissions related to care gaps.
- Discharge lists were sent to MD only, leaving a huge data gap for NP patients.
- Examples included patients with end stage COPD, brittle diabetics, heart disease, renal failure, mental health issues, or all of the above.

Process…..

- January 2015, we started a pilot project to tackle this problem
- FHT pharmacist attends weekly Multi-D at hospital to identify potential clients.
- One clinic appointment weekly reserved for FHT multi-disciplinary meeting to assess patient needs and ensure supports initiated.
- Each allied provider is pre-booked for this slot, and if not filled by Friday, is booked for other appointments.
- Patient name is inserted to allow each provider to review patient history and plan care prior to the meeting.
- Providers check daily hospital admission and discharge lists to target patients for review.

Process…

- ***Booking criteria include:***
- Patient is 2 weeks or less post discharge.
- Complex health issues that require more interventions than the Primary Health Care provider can offer.
- ***Hurdles:***
- Providers tend to be stuck in old patterns, and are not filling the slots.
- Time management-often conflict with appointment times and other commitments outside the FHT.

Outcomes—survey says!

- Multi-Professional Appointment Patients:
  - 100% said they found it helpful to have all of the providers attend their appointment together.
  - 100% reported the date of their appointment was well-timed after their hospital discharge.
  - As a result of the appointment, 100% said they feel very confident at being able to manage their symptoms and their prescriptions.
  - Patient Testimonial:
    - *"Appreciate that the health care team are all on the same page."*
    - *"Care is well organized."*

Pearls

- Communication is very important in order to keep patients informed about process and intent of the appointments so they realize this is a client centered initiative.
- Communication between/amongst providers needs to be consistent to ensure the client receives a similar message so they don’t become confused with instructions.

Hurdles and Challenges

- **Time demand** is still an issue for the primary care provider-especially for physicians with scheduling conflicts with ER and hospitalist responsibilities
- Needs to be absorbed into already busy schedules
- **Inequality and serious funding issues** making staff retention of Nurse Practitioners and allied health providers very difficult
- ***Geography***- remains a challenge because when virtual care is not enough, or when specialists don't use telemedicine, travel is still necessary.

Looking to the Future…

- New committee to look at *How* we work; how can we maximize staff skills and service provision and how does this integrate with QIP? Changes already implemented include switching injectable B12 to oral saving 778 nursing hours annually.
- Organizing clinics to try to consolidate similar assessments—well baby and immunization clinic, well women's clinic, allergy and injections clinic
- NP-IUD insertions decreasing travel and wait times from 6 months to less than 1 month
- In house endometrial biopsies, as well as lumps and bumps- avoiding travel, saving money and decreasing wait times as NP's doing majority of the care.

Looking to the Future….

- Joint injections done on-site instead of having to wait for appointments out of town.
- Morning huddles to review workload and cover absences or manage increased demand.

If we build it, they will come…

Our team now….

- 5 Dedicated and team oriented Nurse Practitioners
- 7 full time MD's and a GP anesthetist with 2 more MD's coming.
- One General Surgeon
- Total of 9 female primary care providers
- Referring to 3 Ob/Gyn's and partnering with 6 delivering MD's
- 1 RN and 1 RPN as well as an RPN OTN co-ordinator
- 1 Quality Improvement Decision Support Specialist
- 1 Physician Assistant
- 1 Certified Diabetes Educator (also and NP) and Dietician shared with community
- Shared Respiratory Therapist with hospital
- Dietician
- Social Worker
- Pharmacist shared with French clinic
- 2 admin staff who work as our Clinic assistants
- On-site lab
- QIP operationalized
- Formal prenatal care program
- All patients being absorbed into the team.

People's choice award for health care, 2013 and 2014

How does a FHN collaborate with a FHT?

- A strong physician leadership role within the FHN that works with the Board of Directors and the Executive Director of the FHT.
- A working and written relationship agreement that highlights mutual respect and utilization of services to enable client centered care.
- A shared approach to enhance service delivery and communication that includes the FHT, FHN and hospital.
- Physicians here also work as hospitalist for a week at a time, and are responsible for scheduled ER shifts.
- A joint MAC (MD and NP) to focus on team based approach to troubleshoot treatment and service delivery and discuss clinical issues.

Final Pearls

- Need a strong belief in quality improvement and it needs to be an integral part of the organizational work supported by the Board, management and staff.
- Decreases work load for the primary care provider by sharing with allied health
- A clinical lead needs to be someone who has the time to commit to the initiatives, and follows through with implementation and evaluation.
- Geography is important. Having the team under one roof facilitates communication, collaboration and co-operation.

Conclusion

- We have shared our process for employing OTN to stretch our virtual boundaries resulting in improved and enhanced prenatal care for our community
- We have shared our process for identifying and co-ordinating the care of very complex need patients through the use of ICCP, and Multi-D meetings.
- We have shared our process for maximizing the expertise of the allied health team.

Final Thought

- “Even if you’re on the right track, you’ll get run over if you just sit there.” (Will Rogers)

You can find us at.....