



PIN Day VI

Lessons from the Phase 1 sites



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Agassiz Medical Centre



Agassiz Medical Centre

- Phase 1
 - Diabetes
 - Hypertension
 - Coronary Artery Disease
- First Steps
 - Registering of patients
 - Physicians rec'd lists of all pts and determined who was to be registered to each group
 - Collection of data
 - Data entered into EMR for specific tests
 - Data extract
 - Capturing of all entered data to give % of indicators met



Agassiz Medical Centre

- Phase 2 (13 physicians participating)
 - Collection of 27 indicators in the following “clusters”
 - Diabetes
 - Hypertension
 - Coronary Artery Disease
 - Prevention
 - Asthma
 - Congestive Heart Failure
- *there are indicators that overlap from one cluster to the other-BMI is needed for prevention, diabetes, hypertension, congestive heart failure, coronary artery disease for example (only collected once)



Agassiz Medical Centre

- Benefits
 - Full time dietician
 - Diabetes management
 - Dietary advice
 - Celiac disease counseling
 - Community displays/presentations
 - Smoking cessation clinic
 - Healthy living challenges within clinic (staff and doctors)
 - Increase in nursing hours
 - Support of primary care
 - Team approach



Agassiz Medical Centre

Results

| | May 08 | July 08 | Nov 08 |
|----------|--------|---------|--------|
| Diabetes | 66% | 78.3% | 83.2% |

Challenges

-EMR

- *learning after the fact of how info needed to be entered
- *data extracts (getting them to work)

-Workflow/Administration

- *learning who needs to do what (minimizing impact on physician)
- *indicators-CIHI not always matching MB Health guidelines

-Time

- development of the process
- identifying pts
- buy in



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Lessons from the Phase 1 sites

Dr. C.W. Wiebe Medical Centre



Dr. C.W. Wiebe Medical Centre

- **Winkler Manitoba**
- Currently:
 - 23 Family Physicians
 - 4 Specialists
 - 3 RN's
 - 3 LPN's
 - 1 Dietician
 - 1 Clinical Psychologist
 - 1 Excercise Consultant
 - 40 Support staff



Dr. C.W. Wiebe Medical Centre

- To improve access to primary care,
 - Having a growing community and providing appropriate access an ongoing challenge.
 - Recruitment to rural areas challenging.
 - Patient access to other services limited at times



Dr. C.W. Wiebe Medical Centre

- To improve primary care providers' access to and use of information,
 - Had seen the benefits of using an electronic medical record for a number of years but felt there were more benefits that we were not taking advantage of .
 - Being able to provide enhanced care by having more accessible and accurate information.



Dr. C.W. Wiebe Medical Centre

- To improve the working environment for all primary care providers,
 - Improves recruitment and retention efforts.



Dr. C.W. Wiebe Medical Centre

- To demonstrate high quality primary care with a specific focus on Chronic Disease management
 - Wanted to provide the best possible care for our patients.
 - Primary care reforming happening we wanted to participate from the start.



Dr. C.W. Wiebe Medical Centre

- Prevention

Felt would have the greatest impact on the greatest number of our patients.

- CAD

Wanted to take on one chronic disease management item.

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Dr. C.W. Wiebe Medical Centre

- Plan year one:
- Accurate and useful information
- Clear goals and objectives
- Maximize the use of other care providers and support staff.
- Use of simple and integrated tools
- Evaluation
- Hear positive patient feedback.



Dr. C.W. Wiebe Medical Centre

- Challenges
- Accurate and complete information
- Obtaining information from other health systems
- Addressing Health system challenges (Lab, diagnostics, surgical)



Dr. C.W. Wiebe Medical Centre

- **Progress on PIN objectives**
- Access to Primary Care Provider
 - Have improved access to some services such as dietician, exercise consultant, pap tests, mammography but have not improved access to primary care providers as such.
- To improve primary care providers' access to and use of information,
 - Have improved our information accuracy and use of information as decision making tool.



Dr. C.W. Wiebe Medical Centre

- Progress on PIN objectives
- To improve the working environment for all primary care providers,
 - To date we have not been able to determine if we have made (certainly not a significant change) any improvements to physician work life, but have also not made the situation worse.
- To demonstrate high quality primary care with a specific focus on Chronic Disease management
 - Have definitely realized an improvement based on chronic disease guideline info as well as a higher profile of the chronic disease guidelines.



Dr. C.W. Wiebe Medical Centre

- Looking Ahead

Would like to see additional integration of other care providers (mental health, pharmacist, etc)

See continued use of EMR info in related programs (Advanced Access, others) to improve primary care.

Reduce information barriers between primary care physicians and health system (hospitals, MIMMS, others).

Reduced barriers and clarity between primary care and regulatory groups like (pharmacy association, colleges etc.)



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Lessons from the Phase 1 sites

Assiniboine Clinic



Assiniboine Medical Clinic Inc.

- Located in Winnipeg in the St. James area. We are adjacent to the Grace Hospital.
- We have 25 physicians. Seventeen are family physicians.
- Services provided at the clinic are: full service laboratory, digital x-ray, audio, vision, spirometry and cardiology testing.





Assiniboine Medical Clinic Inc.

- Recently renovated our space. It is beautiful. We are always looking for more physicians to join us.





Assiniboine Medical Clinic Inc.





PIN Plan

- No formal plan upon joining the PIN project. New initiative, believed it was important to participate in process.
- Initially focused on diabetes and hypertension. Subsequently added CAD.



Challenges faced

- Existing system did not allow for extraction of data.
- Needed to convert our system to Windows version with Smart charts.
- Upgraded our servers, purchased new hardware for all physicians and staff.
- Train physicians, staff on new system.



Challenges faced

- Develop flow sheets for diabetes and hypertension.
- Develop reminders to physicians independent of current EMR.
- Data extract requires significant processing time



Lessons learned

- Government learned that not all EMR systems work the same.
- EMR can make life more difficult for physicians.
- Communicate, communicate, communicate.....



Progress on PIN objectives

- Introduced additional care givers, diabetic nurse educator, dietician, foot care nurse and mental health counselor.
- Comparative data helped provide a benchmark of care we should be aiming for.
- Surveys indicated patients happy with level and quality of care provided.



Looking ahead with PIN

- Group committed to PIN initiative.
- Need improvements in EMR vendor to meet goals.
- See need for other health care providers to be introduced into primary care practice to meet PIN objectives.



PIN Day VI

Steinbach Family Medical Center





Steinbach Family Medical Center

Steinbach – population of 11,066 with surrounding municipality of 11,871

South Eastman Health RHA – 65,000

Steinbach Family Medical Center

- EMR since 1999
- 16 family physicians currently
 - (lost 5 and gained 5 in 2008 – 2009)
- Approx 20,000 core patients



Steinbach Family Medical Center

- 2008 PIN “control site”
 - Core patients
 - Indicator definitions
 - EMR workflows
 - Physician / staff workflows eg. scales
 - Data collection / data presentation



Steinbach Family Medical Center

- 4 PIN objectives
 1. Access – participated in Advanced Access training in 2008 and continuing to work on implementation (physician panels, 3rd next appt measures, PDSA cycles)
 2. Information (IT integration)
 3. Work Life
 4. Chronic disease and prevention



Steinbach Family Medical Center

- Lessons learned
 - Organization in busy group practice is challenging
 - Graded uptake among physicians and staff
 - Integrating the “PIN agenda” to a pt visit
 - Data (individualized) helps to motivate
 - Strong platform for RHA communication / collaboration



Steinbach Family Medical Center

- Looking ahead
 - Shared Care model in mental health (Oct 09)
 - Diabetic Education integration?
 - RHA discussions around other integration areas
 - Data
 - Using to guide further intervention



Steinbach Family Medical Center

- Data

| Family Doc ID | Hypertension pts | FBG | % | LDL | % | Cr | % | BP | % | BMI | % |
|---------------|---------------------|-----|-------|-----|-------|-----|-------|-----|-------|-----|-------|
| 1 | 261 | 196 | 75.1% | 191 | 73.2% | 206 | 78.9% | 228 | 87.4% | 190 | 72.8% |
| 2 | 256 | 183 | 71.5% | 152 | 59.4% | 199 | 77.7% | 205 | 80.1% | 104 | 40.6% |
| 3 | 207 | 142 | 68.6% | 127 | 61.4% | 151 | 72.9% | 172 | 83.1% | 138 | 66.7% |