

Physician Integrated Network (PIN) Workshop – November 17, 2006 Overview

A PIN workshop was held on November 17, 2006. Sixty-five participants attended representing each of the four demonstration sites (Brandon Clinic Medical Corporation, Agassiz Medical Centre in Morden, Dr. C.W. Wiebe Medical Centre in Winkler, Assiniboine Clinic in Winnipeg), the regional health authorities where each of these sites are located (Central, Brandon and Winnipeg Regional Health Authorities), Manitoba Health, the Manitoba Medical Association and other family medical group practices in Manitoba interested in the initiative.

The workshops objectives were to:

- Provide an opportunity to begin the development of a PIN Network,
- Identify potential activities for each objective,
- Identify the opportunities and requirements to achieve the potential activities for each objective, and
- Identify barriers to achieving the identified activities for each objective

Participants selected work groups to participate with for the majority of the date. Work groups were developed around each of the 4 PIN objectives.

- To improve the working environment for all primary care providers,
- To improve primary care provider's access to and use of information systems,
- To demonstrate high quality primary care with a specific focus on chronic disease management, and
- To improve access to primary care.

Feedback from the day was positive and indicated an interest and need to now begin specific planning for each of the demonstration sites.

A full report outlining key areas of discussion from each group has been prepared. As each of the PIN objectives is not mutually exclusive, common themes are apparent that need to inform the development of key PIN activities. These themes include:

- Use of additional primary care providers
 - Need to understand delegation of functions and liability issues
 - Need to develop funding supports
- Flexibility as each site has different characteristics and needs
- Need to focus on the intended outcomes of the objectives, namely access, quality of care and healthy work lives.

Summary

I. Worklife – “Ensuring a Supportive, Healthy and Sustainable Work Environment”

PIN Objective: To improve the working environment for all primary care providers

1. Participant Suggestions as to what improving the working environment means

Key Points

- “Relieving the chaos” (but can we define chaos)
- Managing stressful workload issues outside the practices
- Desire by some to continue to provide hospital care
- Access to general and critical care information, such as the U of M library and sharing information between providers
- Support expectations of Physicians
- Provide support for complex care
- Support autonomy of physicians
- Support flexibility, funding support for alternative work arrangements, working within capacity and interest
- Respect for family medicine by the health system, specialists, RHAs, government
- Increased access to specialists, diagnostic services, other providers and other physicians.

Challenges

- It is becoming increasingly more difficult to access specialties, diagnostics, etc.
- Fee-for-service clinics can't compete with Access Centre models (remuneration)
- Loss of autonomy workforce
- Payment issues don't keep pace with the work/practice issues;
- Overall workload issues
- Physicians are becoming the gatekeeper for everything.
- The demographic shift is demanding more attention
- Changing attitudes of the new grads who want to work 9:00 – 5:00 for the same income
- Difficulty recruiting physicians which has lead to personal costs (time commitment) and financial costs
- Complexity has added to the chaos

- Manitoba Health doesn't know what family physicians do; we all do different things
- RHAs don't know what family physicians do; this is especially true with the WRHA; at Victoria Hospital, the WRHA has thrown away a large chunk of their workforce; Family Physicians were not part of the decision making to implement hospitalist model; this has resulted in a great divide
- Physicians spend a large amount of their time doing non-physician work
- Each clinic in Brandon has a short list lab; they are at break-even or losing money and are having trouble with the Province and the MMA is not be helpful; the hp lab will not be able to accommodate the services being offered by the short list labs
- We are being pushed to more specialties; the system is saying that we should do less and yet you are saying that you can do more, for example in the rural area some specialists do the follow up with some patients that Family Physicians could do which is a waste of money; new psychiatrists are trying to be consultants only in order not to burn out
- Physicians shouldn't take a "hit" when delegating functions
- Our major expense is our staff; it's a challenge to remain competitive
- Keeping people working after 55 years of age
- The logistics of how to integrate other providers is an issue
- We can't work any harder, we need things so that we don't have to work any harder, something has to change
- What are all the paediatricians doing in primary care?
- Relationships with RHAs varies
- It is not good for quality of a physician's life if the project is successful and it does not receive ongoing funding; if you don't have ongoing funding don't bother going any further

Opportunities

- The key to improving the working environment is the need for Family Physicians to be respected.
- Many family physicians will not return to hospital care as remuneration is not lucrative; the best thing to do was to stay in office
- Need to get people to help us with the workload issues
- Need to work smarter
- Need for more control in what we do everyday
- Having our own urgent care
- Learning to become selective in my activities.
- Need more flexibility

- Need to work within capacity; not be stretched beyond your capabilities
- All of the above can be achieved by having a large enough work force and diversity of the workforce
- Accessing medical information i.e. U of M medical library
- The RHA should just put money to link/ connect the existing networks
- Family Physicians could take on more difficult patient care if they are able to control their environment
- There is a need to realign the remuneration model so that Family Physicians can do more and patients can be served closer to home
- Worked with a Nurse Practitioner has been a positive experience
- Good relationships with the RHA; does it matter

2. Suggested specific activities need to occur to attain this objective.

- Develop a model for integration
- Compensation for providers working under delegated function; need to look at litigation issues with regard to other providers
- Physicians should be compensated for delegated clinical functions under the Medical Act – i.e. physician hiring a NP to work in clinic – physician should be able to claim some remuneration for the work being done by the NPs
- Expanding the team to other providers makes sense; “it has taken 2 hours off my day”
- Introducing some private payments (3rd party) which would encourage 20 more physicians in Winnipeg; if a 3rd party source wants services they should pay 100% of cost
- Integrating providers into the practice to take away unnecessary activities from the physicians – supportive activities as well as providers such as Nurse Practitioners
- A navigator could be added to clinics to support physicians
- The support that is needed is connectivity, support and hardware to access information
- Having lab in the office is essential (point of care testing); patients don’t have to travel
- Improved access to consultants is needed
- Need some type of compensation in situations that you don’t see the patient
- Establish clarity around litigation
- Maintain physician/patient relationships

3. What is needed to support the identified activities?

- Physicians need to identify what extra help is needed and how it should be implemented
- Additional providers need to be cost neutral to the practice
- Need to identify what supports are needed for each of the PIN sites – they may all be different
- This is hard to visualize; e.g. we have lots of obese people and lots of private dieticians but need the funds to access these services
- There is a need to develop different paradigms about health care and apply this to the different areas of the province
- If everybody is developing different and successful solutions, is MB Health prepared to fund them
- Identify supports necessary, required training capacity and funding for training and ongoing support
- Need to identify some of these needs prior to the start of the project
- There is a need for locum service coverage such as the North East Winnipeg project where the locum worked well; with 4 sites a locum could easily cover these sites.
- We need more physician services.
- Reduce paper work
- Why are we delivering Well Baby clinics; other people can be doing it
- Virtual capacity /shared care outside clinic walls
- The PIN project may be able to go the RHAs and present the physicians' point of view, PIN could negotiate for the physicians
- There needs to be a policy commitment for ongoing sustainability
- The MMA negotiations is a key part and primary care physicians' voices needs to be at that table
- Sustainability has to be at the funding level, etc.
- As one of the goals is access; another part of the model deals with Chronic Disease Management; physicians already overwhelmed; this won't work unless we bring in other providers
- Manitoba Health staff are responsible for negotiations/sign off in MMA negotiations and need to have strong linkage/communication with the PIN team; both parties need to work toward common goal
- There is a need to support flexibility in the system – i.e. funds for unforeseen incidents similar to the Nurses Recruitment and Retention fund

4. How will these activities be measured?

- In/out migration of family physicians
- Consider life of PIN
- Access measures

II. Information Management - “Right information, right time to support effective decision making for the provision of care and for effective management of the group practice”

Pin Objective: To improve primary care provider’s access to and use of Information Systems

1. Participant Suggestions as to what improving providers’ access to and use of information system means.

Key Points

- The group was provided with an explanation of EMR, EHR
- Interaction between different systems, such as links with other care systems such as CancerCare, access to hospital systems, remote access to patient files, interface to labs and other diagnostic services
- Reduction in the cumbersome use of many systems
- What succinct information do we need from primary care, from elsewhere, and what do other systems need from primary care

Challenges

- Down time
- Interfacing with other systems
- Links with Winnipeg information systems
- Cost is a major barrier
- Privacy and access issues to information across the system
Substantial issues such as private clinics; who gets to access what?
- Need for standards; connectivity; software and hardware standards (we do not have to re-invent the wheel given work done in Alberta and BC)
- Need to have more fee-for-service physicians using an EMR
- Immediate need to link with Lab services and other diagnostic services
- Fragmented computer systems
- Accessing resources on the Internet without exposing the clinic office system to risks
- System wastage due to duplication
- Immediate access to a system manager
- Understanding how to access relevant information: understanding the right questions to ask
- Prescribing improvements
- Transient patients

- Tension between local and major provincial initiatives.
- Being automated when the rest of the system is not
- Time required to address issues; investigate systems to consider
- Lots of providers not interested in getting EMRs but MMA may be able to assist
- Developing skill and comfort in using an EMR takes time

Opportunities

- Make the EMR available to other providers to support cooperative care
- EHR linking opportunities
- MB Health can take a lead role in addressing issues
- Understanding what is available in the community
- Opportunity to think more broadly
- Having the Chronic Disease Management tool built in; will it be useful? Chronic disease protocols are already built into many EMRs
- The work being done with DSM in place in some areas, needs to be implemented across the province
- Decrease duplication of tests
- Ensuring accurate lab work that can be trusted
- Quality of care has been enhanced using the EMR
- Information systems like the EMR has contributed to improved physician worklife
- EMR is a sound business investment
- Patient access to their EMR (needs to be carefully considered); this is evolving nationally
- Need to get more physicians using an EMR
- EMR supports compliance with expected care and clinical outcomes; quality care indicators
- Most physicians are happy with existing function of their EMRs
- Many offices are running out of space for hard copy records, may be an incentive to automate offices

2. Suggested specific activities need to occur to attain this objective

- Need cash to make cost of practice more affordable
- Learning to ask the right questions
- Links with other parts of the system such as RHAs, access to subsets of information from other EMRs, CancerCare, diabetes education resources etc. (use a narrow set of clinical data (MEDS))
- Expand knowledge of the use of data
- Need leadership from Manitoba Health
- Identify what information is necessary for system to manage; needs to be value added for clinics

- Need to link billing to EMR
- Access to data from the rest of the health system
- Better 'data mining' support to get maximum value of the EMR
- Improved Network security to allow access to other resources (e.g. Internet) without exposing EMR to excessive risk.
- Ability of physicians to e-prescribe and submit to central prescription registry and have patient fill at pharmacy of choice.
- Need access to subset of primary care information for other EMRs
- Ability to obtain key information from other systems like CancerCare, Diabetic Education Resource etc.
- Address mental health data
- Develop a minimum data set for system management, policy development, research, etc.
- Invest in technology

3. What is needed to support the identified activities?

- Cash
- System linkages; Access to lab results, DI results/images
- Medication histories from other who prescribe
- Information from hospitals/regions
- Links to Community and Access Centres
- Privacy issues need to be addressed; scope of practice and access to information needs to be addressed
- Need to be practical
- Measure patient base; link to bonuses; link to quality, need MMA support
- Work with vendors
- Identify priorities
- Identify interface standards
- Develop audit management strategies
- Information on resources available (e.g. community resources, home care, support groups)
- Issues related to data ownership needs to be resolved before linkages are put in place
- Security issues related to accommodating students requires attention
- Pay for performance (service quality service, - may promote, provision of better care) and fee for service
- Promoting use of the EMR, pay for performance to work on better care
- Pay-for-performance to get online, using EMR to translate into better outcomes and fewer errors

4. How will these activities be measured?

- Quality care indicators
- Measure adoption of family physicians using EMRs (target 100%)
- Compliance with quality care processes
- Degree of interconnectedness – how to measure that? Perhaps measure what we accomplish, number of transactions across system,
- Qualitative surveys – ask physicians' satisfaction with system.
- Measure reduction in system mis-use
- Potentially measure business effectiveness pre and post EMR

III. Quality –“Doing the Right Thing at the Right Time to Achieve the Best Possible Results”

PIN Objective: To demonstrate high quality primary care with a specific focus on Chronic Disease management.

1. Participant Suggestions as to what demonstrating high Quality Primary Care) means?

Key Points

- Engagement of patients in the decision-making process; more of a partnership between patient and practitioner.
- Demonstrate measurable objectives such as regular pap tests, diabetes blood sugar monitoring, disease and injury prevention etc.
- Access to physician, tests
- Quality of life for providers

Challenges

- Not always enough time to coach and see chronically ill person enough to provide that kind of care
- Science versus human element of medicine; science can be measured to ensure quality, but harder to measure human element.
- Physician not sure what other practitioners are doing
- Reality is right now physicians don't have time
- Balance between focus on individual patient and population.
- Continuity of care
- Information system linkages; information not going back and forth within the system, e.g. discharge reports don't arrive for 4 to 6 weeks to physician, very vague. The bigger the hospital, the worse the communication.
- No communication between RHA, Clinics, Public Health etc.

Opportunities

- Getting another team member involved.
- Primary care physician not necessarily doing all aspects of care and could use a team, but physician coordinates all team participation for client. Communication among team important. (Don't want collaterals used to the exclusion of physician visits.) How does autonomy work within a multi disciplinary team approach? Do not want administrative meetings
- Community can also be involved in education and lifestyle change.

- Ideal situation might be group practice where providers have complimentary and varied skills. One region built a relationship between different practitioners.
- Getting patients connected to other forms of support like walking groups, cooking classes, etc.
- Getting 'orphan' patients connected to a primary care physician.
- Rostering for chronic disease patients.
- Clinic needs to be able to triage and assess quickly.
- Is there room in a quality primary care model to make outreach (house calls)?
- Getting physicians to get back into hospitals to treat their own patients to ensure continuity of care
- Support patient involvement in care
- Address gap between acute and chronic care
- Lack of funding and lack of providers

2. Suggested specific activities need to occur to attain this objective

- Develop teams using other providers; need to address liability issues; need to address trust issues, relationship building
- Compensation issues need to be addressed; need flexible approaches; funding models need to address collaboration. (Does the system need more money or do we need to spend the existing money differently?)
Could build incentive into the funding model to address prevention
- Address waiting issues in other parts of the system; waiting times is not just a physician issue
- Identifying what physicians can expect from other providers
- Partnership beyond Health

3. What is needed to support the identified activities?

- One electronic record for each patient in the Province
- Flexible compensation/funding mechanisms, Blended funding models
- Dedicated support for sites around change management. Involve clinic managers more
- Time needs to be freed for physicians to network, form relationships with alternate providers, etc., but not at the expense of their salary. Can't be additional responsibilities for physicians without them being compensated.
- Understanding of what we mean by Quality
- Patient feedback
- RHA support is needed
- Support to resume hospital care
- Better public health support to get information to patients.
- Ongoing feedback; realizing where we are when we get there.

4. How will these activities be measured?

- Frequency of admission and 'failed discharges'
- Tracking labs
- Monitoring clinical practice guidelines; better management of the disease
- Quality of life measures, living longer with the disease or better quality of life with the disease.
- Coordination of data, information sharing.
- Client satisfaction
- Physician quality of life.

Some measurement issues

- What are we measuring against? Comparative populations with no PIN Initiative. Measure access to multiple team members, i.e. Rate of referrals.
- Might need to measure process as well as practice.
- What does the physician have control of?
- Measurement could include focus group testing, surveys, patient evaluation
- Could measure the sites that applied for PIN but were not selected and compare to PIN sites.
- Are the demographics in the areas where the sites are being studied and evaluated, as well as the site clinic populations?
- Funding models. Need to be able to measure their success or not, and why?

Access – “Right Provider, Right Place, right Time”

PIN Objective: To improve access to primary care

1. Participant Suggestions as to what demonstrating Access means

- Every citizen has access to a defined provider
- Access to the most appropriate provider
- Balance between supply & demand
- Timeliness of access to physicians
- Physicians that are available 24/7
- Access to information of care
- Patients receiving results from diagnostic tests in a timely manner
- Navigation through the system as needs require a range of services; coordinated services across the continuum of care
- Locally available services

Challenges

- Not enough physicians
- Emergency rooms are filled due to lack of access to family physicians
- Fewer family physicians with hospital privileges; choosing quality of life
- Lack of information coming back to the family physicians from elsewhere in the system
- Access to specialists when referrals are made by the family physician
- The large number of people without an identified family physician
- Lack of trust between family physicians and specialists and with other services such as Home Care
- Funding sources are inadequate to support the use of other providers.
- ‘Musical Chair’ use of the system occurs (when patients are dissatisfied, they move to another area of the system)
- Non urgent access to some diagnostic services are faster if accessed through the ER rather than through family physicians
- Patients are not aware of services and when to appropriately access them
- Some services provided are not properly paid
- Patients may not wish to see other providers
- Maintaining the family physician identity
- Ensuring care is available for those patients that many physicians do not wish to care for
- Single practice offices

Opportunities

- Use of other disciplines
- Younger people seem to be more accepting of seeing alternate providers

2. Suggested specific activities need to occur to attain this objective

- Alternate funding options
- Need to recognize physician autonomy
- Don't re-invent the wheel, tweak the wheel
- Communication technology
- Could start assigning physicians to patients.
- Maybe physicians need to be better trained in what our system has to offer and where to find the options
- Use of other health providers to assist; explore option that allows for delegation of care that does not impact physicians income
- Charge for the work of other providers
- A more coordinated system – need to identify who is the quarterback or main care provider
- Need to make more use of the telephone
- A pre-arranged system needs to be available for patients; better referral options
- A pre-determined salary base needs to be assured
- A pre-determined client base
- Multiple models of services
- Advanced Access, same day access: physicians express more satisfaction with this system, office staff and patients enjoy this approach, and a decrease in 'no-shows' is noted
- Could consider rostering; many issues to consider
- Provincial standard to keep up with the Physicians office standards, as they are definitely lacking in quality.
- Extending office hours; Evening walk-in clinics
- More involved pharmacists

3. What is needed to support the identified activities?

- Integrate the system, free up the physician's time, provide physicians' salary, provide nurse practitioner services, public health nurses, community services, home care providers.
- System navigation support
- Wellness and prevention needs to be addressed
- Case management, coordination of services, the family physician needs someone to assist in providing services that he/she doesn't necessarily need to do

- Balance between work and quality of life
- Adequate resources to support a multidisciplinary team
- Funding sources that are reliable and secure to all the providers. (Blended, Equitable)
- Use the Facilitation Model
- Promote health literacy
- Promoting self care management (Stanford Model)
- Re-evaluating the recruitment and retention incentive.

4. How will these activities be measured?

- Needs to be small steps; incremental
- Patient satisfaction
- Wait times for appointments