

# Physician Integrated Network (PIN) October 26<sup>th</sup>, 2007 Workshop Summary



## Workshop Objectives:

- ✓ To provide an opportunity to identify successes and issues related to the progress of PIN to date.
- ✓ Provide an opportunity for the PIN Demonstration sites to share their experiences and insights.
- ✓ To provide an opportunity to discuss next steps for the evolution of PIN.

Approximately 60 participants attended the October 26<sup>th</sup> PIN Workshop. Representatives from each of the Demonstration Sites, Manitoba Health, RHAs, the PIN Advisory Committee, and other interested clinics attended the full day event at the Canad Inn Fort Garry in Winnipeg. Overall, participants felt that the day met its objectives and agreed that another workshop day to update participants on the status of PIN would be beneficial in 6 months.

Arlene Wilgosh, Deputy Minister of Health & Healthy Living, joined the workshop briefly to thank participants for their hard work. She noted that “step-by-step we are making a change in Manitoba Health”. She commented that together with the work of Manitoba Health, the PIN Team, the MMA, the clinics, and other participants, exciting things are happening. Arlene reiterated the importance of primary care in the province and briefly outlined the department re-organization and the creation of an Associate Deputy Minister of Primary Health Care and Health Living.

## Summary of Issues/Themes Arising from the Workshop

During the course of the workshop participants engaged in open dialogue and in round table discussions. The following is a summary of themes arising from these discussions.

1. Electronic Medical Records (EMR) – The time and effort taken to upgrade/change the use of the electronic medical records in each of the sites has been far greater than initially anticipated but was felt to be time well spent. The sites have recognized the close connection between the EMRs and clinical practice. These changes have reinforced the need to define provincial EMR requirements in primary care.
2. Change Management – It has taken more time than groups initially thought to implement change. These changes include the consistent use of the electronic medical record, working with new team members such as nurses and dietitians, and ensuring that staff are able to function to their full scope of practice. Change is not painless and requires ongoing attention. Several sites noted that the costs linked to change have been difficult to track.
3. Physician Work Life – It was noted that this objective of PIN has not been specifically addressed to date. There is a need to ensure that this objective receives attention as PIN evolves.

4. Relationships with Regional Health Authorities – The working relationship with regional health authorities is evolving in some areas although service coordination, and roles and responsibility definition remain issues. In Central RHA, there is an increased understanding of roles and potential opportunities to expand collaboration.
5. Data and Information – Group practices have found that the information gleaned thus far regarding practice profiles has been informative, has increased awareness of specific practice issues and has led to plans for potential practice change within groups.
6. Access to Primary Care – Increased access to primary care is another objective of PIN that has not been specifically addressed to date. There is a need to ensure that this objective receives attention as PIN evolves.
7. Medical Remuneration – There remains an interest in new funding models and the recognition that this needs continued development. Many participants noted a desire to focus on quality care and not just volume.
8. Indicators – There is a desire to continue to ensure that indicators are valid and reflect priorities of the sites and the province. Significant further work is required on the development of indicators. The lack of mental health indicators is one example.
9. Primary Care in Manitoba – There is a need for ongoing provincial support and commitment to primary care in Manitoba.

### **Introduction and Overview of Workshop**

The day began with a brief introduction by Jeanette Edwards, Special Advisor to the Deputy Minister on Primary Care. Each of the four participating sites then provided participants with an update on their experiences thus far with implementing PIN within their clinics.

### **Participating Site Updates**

Agassiz Medical Centre from Morden began by describing the complex Electronic Medical Record (EMR) changes that needed to take place before the clinic could begin collecting data. Dr. Carol Holmes showed screen shots to participants on the various flow sheets the clinic has developed with Clinicare. Dr. Holmes explained the other changes taking place within the clinic, including adding a dietitian to the team. Physicians are referring patients with diabetes, obesity, metabolic syndrome, celiac disease and other diagnoses to the dietitian. Increased nursing hours have been approved by the clinic's physicians to help with blood pressure and BMI measurements.

Dr. Holmes closed her presentation by highlighting the various challenges the clinic is facing with introducing PIN such as ensuring proper data entry, and other EMR issues.

Assiniboine Clinic from Winnipeg began their presentation by highlighting that currently they are not collecting data and likely will not be collecting data until December 1<sup>st</sup>. They also noted that the clinic does not currently have other providers working with them, and there is some hesitancy from some of the physicians to incorporate other providers into the practice. Assiniboine explained that they too have had major EMR changes to undertake to upgrade their system to have the capabilities to collect data since the clinic was still using a text based system of Clinicare. The clinic's presentation ended outlining the various steps required by the clinic to fully implement PIN and the costs associated with these changes thus far.

Steinbach Family Medical Centre in Steinbach, the control group for PIN, was the next clinic to present. The clinic highlighted the various steps it needed to undertake to participate as a control site in PIN, including EMR upgrades and identifying core patients. The clinic then provided participants with screen shots of their EMR and the various components required for PIN. Steinbach posted some preliminary data on their physicians and raised the issue of data integrity. The clinic is excited about moving forward and "dreaming big about the future of PIN within their clinic".

Dr. C.W. Wiebe Clinic, in Winkler has been working with a dietitian for over three (3) months. So far the dietitian has seen over 100 patients and collectively these patients have lost 180 pounds! The clinic has also added more nursing staff to help provide quality care. During their presentation, the clinic noted the difficulty of tracking the costs of PIN but reinforced their continued efforts in understanding the "real" costs of PIN. Physician meetings have been introduced within the clinic to discuss PIN and the changes required. Similar to Steinbach, the clinic has been able to get some initial data. Winkler noted that there is some interest and surprise at the initial data. Overall, physicians are accepting of PIN but still unsure how it will affect them individually. The clinic closed their presentation by highlighting the various difficulties and challenges the clinic has faced and continues to face implementing PIN.

### **Evaluation Update**

Dr. Alan Katz from the Department of Family Medicine provided participants with a brief update on PIN Evaluation. Surveys with patients and providers have mostly been distributed and collected but the results have yet to be analyzed. Interviews with providers have also been undertaken, but again the results have not been analyzed. Dr. Katz noted that the EMR data has not been received yet for review.

### **Morning Round Table Discussion**

The Morning round table discussions focused on the changes that have taken place within the clinics and for other stakeholders as a result of PIN. Some tables brainstormed how Manitoba Health and the RHAs could better support PIN sites as they

continue with PIN. The ideas and issues discussed have been recorded and will be used to inform the future planning of PIN.

### **PIN + Beyond**

Jeanette Edwards began the afternoon with a presentation on PIN + Beyond highlighting the future of PIN in the province. She began by noting what PIN has already accomplished but then outlined what is required to ensure PIN continues beyond the demonstration phase. One of the major components required is building the infrastructure within Manitoba Health necessary to sustain PIN. There are four areas that need to be addressed: Indicator Development; Primary Care EMR Implementation and Support; Data Collection & Analysis; and Funding & Remuneration. Jeanette noted that the proposed plan during the next three years is for Manitoba Health to develop the necessary infrastructure to support PIN. During this period, it has been proposed that PIN will continue to support existing sites and expand to include more physician practices.

### **Working together to enhance Primary Care: The PIN Experience**

Kathy McPhail, CEO of Central Regional Health Authority, closed off the afternoon presentation discussing the linkages that have developed between the two PIN sites and Central RHA. Kathy noted several issues this new relationship has been addressing, including ensuring that RHAs and clinics are offering complementary services rather than duplicating services.

### **Afternoon Round Table Discussion**

The afternoon round table discussions revolved around PIN Evaluation and relationships with the RHAs. Tables brainstormed other evaluation techniques and new indicators that could be used as PIN moves forward. Some tables focused their discussions on how to improve the working relationships between fee-for-service physicians and the Regional Health Authorities. The ideas and issues discussed have been recorded and will be used to inform the future planning of PIN.

**PIN**  
**Physician Integrated Network**

## Round Table Discussions

The following comments are verbatim notes taken from participants.

For the morning round table discussions participants were separated into tables based on the organization/group they represented: PIN sites, MB Health, RHAs.

### 1. Change Management

**Demonstration sites have indicated that PIN has involved many changes.**

#### a) For the PIN sites:

##### i. What changes did you anticipate as a result of PIN?

- would be better able to identify people in system through the use of population data
- better physician work life;
  - reality is we don't see it getting better
  - don't want to work harder for less pay
  - don't want to give up easy stuff (20% of what I do could be done by nurses)
- better patient access
- expecting integration of providers that someone else funds
- RHA allied providers would be doing different things than fee for-service clinics
- trigger better utilization of existing software.

##### ii. What changes have surprised you?

- takes more time than anticipated
- physicians don't have to do everything; some patients seen better by other providers
- work life not really changing – no mechanism to measure work life changes
- That we would have to “stage” our software upgrades
- The lack of flowsheets to use ---others are doing this work, why aren't the flowsheets available to us?
- Lack of system know how---how much difficulty we had with the vender
- How slow our system would function as we added items to the flow sheet
- That this information wasn't being captured already
- When we looked at our outcome data, just how little we were doing in relation to some of the indicators
- Surprises - Time take to extract information. Have the information but have not had the capacity to retrieve it. So dependent on external providers. Time lines are depend on others
- EMR - Garbage in – Garbage out.

- No way to anticipate the effort involved in the change.
- Docs - Reluctant to change behaviour unless there is a purpose – either evidence or compensation.
- Urgent care – seeing the clinic, but not their family doctor. Need to figure out how to deal with patients to see their family doctor.
- Need to change patient behaviour - patients have become accustomed to using urgent care. How do you train the patients to return to their family docs?
- Recognize that medicine is more than an art.
- The data will improve patient care and direct the system.
- EMR was good on a specific patient but not on a collective planning.
- Interest in EHR and integration of lab, diagnostics...

**iii. What changes were easy to implement by your group and why?**

- Entering vital signs
- Ease of Implementation - Surveys were easier.
- Practice data - Winkler - Provide to be very useful

**iv. What changes were more difficult to introduce and why?**

- Most difficult – flow sheets
- Indicators are not the whole of patient care, we can't just focus on the indicators
- Frustrated at not having flow sheets to choose from in the beginning
- How does this improve patient care? So far it is not doing anything for me.
- Should be able to bill for giving advice

**b) For the other PIN Workshop Day III participants: (MB Health, RHAs and other)**

**i. How do you think PIN has impacted the group practices involved?**

- Significant process changes. Learning – realizing need to find efficiency to address data. Making process changes in clinics not painless, or pain free, worth it in the end (similar to childbirth).
- How do you adequately prepare them without freaking them out? Without being too soft or fear mongering.
- Data analysis = change in practice.
- Increased costs.
- PIN changes have made sites more aware of how well they deliver service, and how well the needs of certain populations (e.g. diabetics) are met
- PIN has changed clinic workflow
- PIN has made clinics aware of the need/opportunity to incorporate alternate providers within their service delivery
- The focus has been less on IT (as originally thought) and more on business transformation, the “what & why” of medical processes were discussed more.

- The Sites' presentations seemed to cover the change management processes fairly well; further discussion would have been redundant
- Assiniboine said if they'd known ahead of time what the EMR capabilities needed were, seen a sample, things might have been easier.
- Made them look at interdisciplinary models of care, and changes in roles
- Nurses doing paps, psychosocial aspects of care
- There are opportunities here for other interdisciplinary therapies to be introduced
- Innovative
- Needs to be encouraged in other offices, especially for single practitioners
- How does the individual practitioner fit in with PIN?
- Clinical WORKFLOW
- Introduction - advancement of technology
- Introduction or expansion of group practice
- More change than Anticipated
- Underestimated the technology impact
- Initial understanding of the need/value/availability of the data misunderstood
- Initial expectations do not = current understanding
- From the physicians – see benefits of using allied health. Increased uptake on this and desire to use allied health.
- PC nursing and dietitians - recognize need for these practitioners.
- There's been more communication/understanding of how the RHA works – it's an awareness, not yet sure if this has changed their practice. The relationship is strengthening x2.
- Excitement building about being part of this project – some prestige. This might help with recruitment of staff, especially if a clinic is seen as progressive.
- Still a lot of behind the scenes work going on – not yet sure if doc/client sees impact just yet.
- Comparison of peer-to-peer could be a powerful approach to practice change, more reason to meet and share and focus on practice not just business. There's definitely potential for this and still might be at the very early changes.
- Peer-to-peer feedback as change agents still need to be better understood, not yet aware of the impact.

**ii. What challenges do you anticipate the group practices will experience?**

- So far a few physicians bearing brunt of work. If it doesn't burn out physicians you do see the value.
- Clinics need to learn to use nurse resources to full efficiency. This will be evolution as clinics learn challenge of working in team and team dynamics.
- Make an impact for them financially, on workflow.
- Implementing a different point of view.
- Physician leadership role may not be well received.
- Every clinic will have learning curve. Training may burn out good leaders.

- If you don't have physician, champion needs to come from MB Health.
- Agreeing on and complying with standard ways to enter data/use the EMR
- Using the technology in ways required to meet the PIN objectives has been a major change management challenge - has required lots of support from Manitoba Health.
- Changing habitual ways of using the EMR has been a challenge - group raised and discussed whether it would be easier to introduce PIN in practices that had no EMR because desired habits could be formed from the outset.
- One thing that needs to be incorporated is the role patients will play in their own care.
- Each group uses allied health professionals differently – it would be nice to have standardization of PIN roll-out
- It would be nice to hear from other disciplines, not just physicians and clinic managers.
- Physicians may not be aware of all that Allied Health Providers (AHPs) can offer – need to set clear expectations
- How do physicians and AHPs work well together – how democratic a system is it?
- E.g. Access River East – the expectations were completely different than what is happening there. There is not as much collaboration as was expected
- One of the PIN objectives was to improve access – we can't miss this one.
- The care leader shouldn't always be the physician – it should depend on the medical issue
- Paranoia of what might be done with the data – need to keep it as a reward, not a punishment
- Workflow - seems to be an absence of proactive change management? analysis from this perspective
- Comparative data (standardization) appears to be limited
- How will you ensure that when new allied health care providers are introduced the balance doesn't become "easy cases" – allied, more complex – docs. Docs will not want this to happen.

### **iii. What are some of the changes that will impact you as a result of PIN?**

- Integrate data into follow-up and population education. Annual health report for RHAs.
- Allied health – where they fit, access to health care (e.g. dietitian)
- Clinic asked for one diabetes resource from Central RHA. Really good exercise for Central to do: pick one resource to give to clinic for patient care. Central found out gave multiple mixed messages, clarity and flow needed to be found for patient care.
- Supports and discussion needs to happen with what to do with Fetal Occult Blood Tests?. Impact on wait times technology cross over, etc.

- Other clinics aware of uses of EMR, e.g. Clinicare, more likely to use, awareness of product capabilities. Other populations interested in adopting EMRs.
- Need to look at broader and objective standards for indicators - should not just add them piecemeal
- Now – PIN is at a critical point. Can clinics handle the change?
- Wait times, and how these changes might improve access
- Practice changes can take up to 14 years to implement, which is scary
- There should be a focus on the new people who are coming through the education system and promote teams and interdisciplinary work as we want to see it.
- From an EHR perspective.
- Any advancement in use of data is beneficial.
- Any advancement in standardized practice and data capture is beneficial
- Broader (beyond PIN) understanding of the significance of data beneficial
- Lessons learned regarding change management and specifically workflow with the introduction of technology
- Financial incentive certainly will impact my practice. For example, money greater the number of paps I do. Money is a drug, sorry to say, but it's true.
- Need to also encourage, ensuring you are coordinating it with a system think.
- PIN will cause us to rethink how we do business for e.g. reviewing the chart before care is provided.
- Perhaps being centered on quality will mean we no longer have to worry about keep turning over volume – to allow the doc to spend the time that's needed.
- The practice model will be attractive for securing and retaining family doctors.

#### **iv. How can MB Health and RHAs support the changes needed for PIN?**

- Selected populations interested; how do you roll out province wide/northern community.
- Physical, human and financial resources – most important – targeted money to go to EMR, allied staff
- Encourage other sites to go to Clinicare smart chart, need tools and resources, or significant motivator to put in major changes. For example quality based indicator funding (QBIF) would be one way to motivate employees to turn it on, only way to collect data to get bonus funding.
- Blind spots? Solo physicians small physician practice, older physicians/northern practices
- Concern with indicator selection e.g. BMI already outdated.
- Need EMR model for making smart EMR choices, clinics showing how it works, increase billings with EMRs, etc.
- Regions need to build closer relationships with FFS physicians
- Regions need ability to use the data obtained from EMRs - data needs to be standardized so that it has a consistent meaning

- Likely need to deal with a perceived privacy issue if making EMR data available to Regions and MB Health
- More change management support/funding needs to be provided to the clinics and participating RHAs.
- Manitoba Health should bring sites to see different EMR's/providers in other provinces.
- Go forward – How do the RHA's and Manitoba Health support the 'champions' in group practices? Present to group? Educate the 'champion' physician? Are the champions going to wear out?
- Diabetes collaborative – how to staff? Physicians have access to endocrinologists. There are many strategies, how do we link them? ie, Diabetes Strategy
- Grace Hospital – ER sees many patients with no family physician. How do they link emergent and long term care?
- Example given of a hospital with a referral system to family physicians. They provide bus tickets and lunch money while waiting for appt. This reduced ER visits. Not sure this could work with mental health.
- Inventory of other RHA or MB Health projects that could support the PIN Clinics. Could use money and staff differently.
- Need to keep physicians in the loop and engage them. Keep them front and centre on an ongoing basis
- Disseminate the positive, better marketing, show off the successes
- Communicate best practices
- Investigate possibility of sharing anonymous results of surveys, change management challenges and successes - at a project and clinic level
- Practice Profile from MB Health: not sure the usefulness of these tools, MB Health should re-look at this – perhaps need to follow PIN and peer to peer comparison – perhaps when PIN takes off this practice profile report may no longer be needed
- Peer to peer = educational
- Practice profile = punitive
- MB Health/PIN/RHA will need to guide what will be the priority areas of health we want to address, so we are encouraging the right things, not duplicating or actually filling a need, e.g. used immunizations and partnerships with RHA.
- Build a pilot capitation model – where docs salaries are sheltered to allow them to introduce care providers, change practice, then once this becomes new practice go to capitation model, then the change will become permanent.
- Need support re: salaried allied registered care providers
- Doc practices will need to spend time in understanding the allied scope of practice – not hearing that nurses are working full to their scope, this still will involve a culture change.
- How about introducing social workers/nurse practices, mental health workers, we need to help them understand all their options.
- But we have to introduce the number of allied health providers slow with some staging and change management principles.

- Needs to be more support for integrated learning at the educational levels and at practice levels.
- Time for team meetings is going to be needed.
- The funding model for PIN sites needs to be identified and implemented.
- Acute care and community practice needs to be co-ordinated in relation to providing access for chronic care.
- In relation above- do we not need to explore extended hours in primary care – you can do this in groups – you can't do this if you are a single provider practices – perhaps within a capitation model you would be able to achieve this.

### **Afternoon Round Table Discussions**

Participants were randomly assigned to tables.

### **3. Evaluation Framework**

**The PIN Phase 1 Evaluation Framework has selected a subset of the CIHI Primary Care Indicators to measure the quality of care provided by sites, as well as employing physician and patient surveys and interviews to evaluate the success of PIN in meeting its objectives.**

#### **a) Indicator Development**

##### **i. What have been the benefits of using the CIHI Primary Care indicators? The challenges?**

- Able to compare nationally. Hope for change in practice – get incentive,
- Challenges – do more testing that is not needed, drive costs in lab, results drive costs in other parts of system, doesn't leave a lot of room for clinical judgment, not necessary to do.
- Could also mean costs to patients, nephropathy screening – recommending things that patient can't do because of costs.
- Would be interesting to get indicators that measured outcome, for interest sake.
- Hypertension – more closely aligned to Canadian guidelines, numerator important. Numerator reflective Canadian recommendation.
- More indicators, focus just on indicators, not time to focus on other care,
- CIHI indicators already developed, have some national credibility
- Will facilitate communication and comparability with other jurisdictions
- CIHI indicator combines mammography and clinical breast examination, but it would be better to have two different indicators because these procedures are performed by different providers
- Not clear that there is a lot of value in tracking data on clinical breast examination

- We need to be able to close the loop among indicators - e.g. to see whether screening resulted in a positive test result, and if so whether appropriate action was then taken on that test result
- Benefits of using CIHI Primary Care Indicators: screening, improve quality of care, being part of a study, consistency, encourage competition with peers.
- Has the pap rate gone up since the fee increased?
- Information gives the policy people the data to inform decisions, make changes.
- Challenges – easy tool, if a 35 year old female comes in then a page should come up to prompt, pop up ‘to do’ list for each patient. Jenoke has red flags on left side of screen of tasks to be completed.
- Vendor and software not sophisticated enough to simplify enough, put proper data in proper sequence. Clinicare can't keep programmers. Should be physicians on staff to provide input.
- How will data be analyzed once it's extracted? Data is stored, then retrieved and analyzed. Could a system do both retrieve and analyze? The British have a system where data analysis and reporting advises clinical decisions.
- Money!
- How do physicians fit in all the chronic disease management as well as deal with acute care cases?
- There should be a bring-forward mechanism for calling in overdue patients.
- More comes out of screening than goes into it.

**ii. What additional 3-5 types of indicators would you recommend be added to PIN in Phase 2.**

- Mental health – no sense how to address
- Abuse – spousal abuse, relationships around bullying.
- For patients with Depression, MD questionnaire to fill out, how many patients referred to counseling.
- Pediatrics – children core, unexplained bruising, hyperactivity, FASD
- Public health nurse should encourage visits with family physicians with children.
- Advising on safety – temp safety, prevention for kids, bicycle helmets. Well child programs.
- Pregnancy and pre-natal, not drinking, folic acid, avoid certain drugs, etc.
- Mental health indicators missing. Significant discussion about whether good indicators exist for mental health within primary care. Suggestion that there are some areas where primary care is very important in treatment of mental health and should be evaluated - e.g. post-partum depression
- Potential missing types of measures:
  - Comprehensiveness of care
  - Continuity of care

- Coordination of care
- Effectiveness of relationship between RHA and FFS clinic
- Physician quality of work life
- End of life care
- Breast cancer follow-up - care provided to survivors, good care makes a big difference
- Same with survivors of childhood cancer
- Other areas that could be added:
  - Renal disease
  - Sexually transmitted infections
  - Other infections (e.g. TB)
  - Indicators related to care of specific groups - e.g. adolescents, new immigrants
  - Addictions
- Areas where group would want to consider additional indicators, but not yet sure whether they would be appropriate.
- Question whether we should track socio-economic indicators
- Injuries (more practical for ERs to track?)
- Occupational diseases (might be falling between cracks, captured neither in primary care or workers compensation context)
- 3 To 5 Things: Depends on the type of practice. If you have mostly geriatric patients, then hypertension, Congestive Heart Failure.
- Hypertension, Diabetes, mental health, muscular skeletal (lower back pain).
- Prevention.
- What parameters would you measure around mental health? Depression? Can you deal with it once you find it?
- Wait time from visit to colonoscopy, from chest pain to stress test. There should be province wide EMR communication, even national. If you're in a car accident in Toronto, the ER should be able to access your medical record.
- Diet, exercise and not smoking. The RHA's, schools and primary care physicians should work as a community on these, then the others (hypertension, diabetes, etc.) will decrease.
- Smoking cessation sticker on chart to prompt the questions.
- The physicians ask the questions, then the RHA's provide education.
- Easier access to alternate care providers.
- Standardized forms for referrals to anywhere. Maybe one clinic comes up with a good one and then everyone else adopts it.
- The 3 to 5 should come out of Health Risk group. If those 8 things were done then lots of other things would be resolved, from doctor, school, community, parents, peers. Health Risk will lead to prevention. Drug use, sex, helmets.
- This will be the first generation of kids who will not live as long as their parents. Physicians are treating parents and their children who are both dying at the same rate.
- Public Health vs Primary Care.

- Maybe a system where the patients use a touch screen survey prior to seeing the doctor.
- Upgrade MIMS and make it available to docs.

## **B) Evaluation Framework**

### **i. What are the strengths of the overall project evaluation approach? The weaknesses?**

- CIHI framework comes from a broad consultative process
- Mix of data sources and linking them from both a population and patient perspective
- The above creates buy-in from providers. Results need to motivate, clinical outcome will come in the long term.
- MB could be able to link the data between PIN sites and RHAs
- Surveys:
  - Design can't be based on frequent and time consuming surveys---do recognize that this is the only way to get some data
  - Some of the indicators are esoteric, e.g. sedentary is not specific enough. The easier it is to do a y/n tick box, the easier it is to evaluate
  - Weakness in a few of the indicators
  - Someone has to define them first
  - Indicators change, BMI vs. waist circumference
- Who is responsible for health – the provider or the patient?
- Are we doing harm in measuring, e.g. an FOBT test – there is such a long waiting period to get a colonoscopy that the worry a patient experiences while waiting for a colonoscopy could be doing harm.
- Another weakness is that over time we focus on the indicators and don't focus on overall health
- People are surveyed-out and hate them. There are very few voluntary surveys completed
- There are a lot of non-English reading people in the Steinbach region, and when somebody has to translate, there is redefinition of the question through the translator's interpretation
- The dr. and patient need to develop a relationship and you can't always put a diagnosis on it – if they don't fit into a PIN indicator or a billing code, e.g. the 80 year old who is lonely and comes once a month for a visit, but doesn't necessarily have a medical reason to visit
- You can't measure relationships. We're paid on a business model, but our core is on a relationship model – how do you evaluate this?

### **ii. What additional evaluation techniques, would you recommend be added to PIN in Phase 2.**

- Focus groups
- The notion of a “mystery patient” was tossed around and tossed out
- Need to clarify the context of the technique: what is the purpose?

- Evaluation needs to recognize that sometimes success is that the care was offered, not that the care was accepted by the patient. 100% might not be a good thing---patient preferences, choice, there can be good reasons for not doing it.
- Can the data collection capture 'offered but declined'?
- Evaluation if capitation funding model with a mixed provider group
- Does the electronic medical record capture the unique contributions of other providers?
- Do the indicators capture the contributions of other providers?
- Look at the infrastructure over the next 5-10 years—what has happened to support it?
- The interface of the clinic with the “system” - is it improving? E.g., lab results, referrals, consults, connections with labs
- How are the small clinics going to get involved?
- Suggest creating a virtual clinic where they can go for an EMR on line. Don't need own server.
- Focus groups, where doctors / clinics can sit down with professional evaluators to sort out the issues – more qualitative evaluation approaches
- Maybe patient focus groups, but might not get a representative sample if you do too few
- What about the patients we're not providing care to? If you want healthcare, you have to have a family doctor. This could be a next step...who's not being evaluated by PIN and why? Are they only accessing every 3 years? Is it just through emergency or on a walk-in basis? Are they only visiting naturopaths or chiropractors?
- Look at MB Health **MRC** reports
- Make it more patient-centric – is the patient getting good value?
- Hard to compare PIN projects as long as we're doing such different things, .e.g. January start vs. 18 months of data vs. 2 years of data (Dr. Woelk)
- Need to compare apples to apples
- How do you evaluate teams, and what makes a good team – perhaps define 5-10 features of a good team and develop questions around team work
- Quality of team care vs. individual care – is this providing quality patient care
- More qualitative vs. quantitative evaluation

#### 4. PIN and RHAs

**As PIN evolves, the relationship between the fee-for-service group practices and the Regional Health Authorities has also evolved. From your perspective, (RHA, Demonstration site, Mb Health),**

- i) **What successes and challenges have been experienced? (Please provide examples)**

- challenges: EMRS – will be hard to go forward on a broad scale bases – will require a lot of support at each of the sites, PCISS may help address this.
- EMR lots of discussion about primary clinics – how about the other service levels such as acute.
- Docs are becoming more aware of services in Central than before, e.g. breast screening , coordinating FFS with Breast Screening program with Winkler, single point of notification vs multiple notification – success- system thinking, integration. This would not have happened if it wasn't for PIN.
- Data sharing – particularly community data is important to PIN and RHAs this is common ground.
- There are still trust issues between FFS and RHAs skeptical of regionalization.
- Turning point when we all met (RHA and Winkler) to discuss PIN – ability to have open conversations about concerns was very helpful, also means that you have to do what you promised, listen, offer resources that make sense.
- Perhaps we can also go to FFS clinics who aren't PIN sites and still establish relationships now – on the basis of offering some support via RHA providers and Services.
- Sharing the regional plan with FFS is important also as long as we stick to the plan.
- At the end of the day it really comes down to building relationships, PIN or no PIN that's a skill that needs to be built.
- Strengths (South-Eastman RHA/Steinbach)
  - Region found funding to support CDC information downloads/transfer from RHA facility to FFS Clinic.
  - Setting up information link (VPN) between clinic and RHA facilities.
- Weaknesses
  - Limited communication between RHAs/Sites.
  - Limited RHA input into process.
  - Segregation still exists between RHA/FFS sites.
- too early to determine successes or failures
  - PIN has created opportunities for success i.e. Mammography screening;
  - RHA and clinic developed a plan for the best possible patient service
  - Clinic provided information to the patients and the RHA conducted the screening
  - Clinic now able to book screening appointments
  - Because there are many patients that have English as a second language the clinic has been able to reassure patients about the screening
  - Because the RHA and clinic are collaborating they can determine when an initiative and/or process breaks down and develop the appropriate interventions
  - Future planning underway i.e. PAP screening
- Issues:
  - Sometimes it feels as though Public Health and fee-for-service clinics are in competition

- It's difficult to determine how well clinics are doing with regard to immunizations, flu shots, screenings when patients can access many different locations for these services
- Public Health does not consult with fee-for-service clinics
- It's hard to break into a different system when other areas (Public Health, etc.) are providing the same services
- Sharing of information between primary care and hospitals sometimes is difficult:
  - If physicians were able to access hospital records it would avoid duplicate testing and reduce costs

**ii. What issues and ideas should/could be addresses as PIN continues to develop?**

- Opportunities (General)
  - A potential PIN budget line for RHAs would reinforce region's focus on primary care/FFS collaboration should be explored.
  - Information sharing (VPN linkages, Shared Data bases, etc.) is costly but has long-term benefit of reducing duplication of test costs.
  - Greater RHA (Leadership, Medical, Technical) participation in PIN development process would be beneficial.
  - Potential for another form of PIN pilot focusing on collaboration between Sites/RHAs around immunizations, etc., should be explored.
- Threats (General)
  - "Culturally", Primary Care is a low priority for the RHAs (they seem to invest more resources into tertiary facilities/programs).
  - 80% of medical interventions occur at the primary care level, yet regional data collection has no way of capturing this (no links). Poses a real evidence legitimacy issue when planning for regional needs, etc.
  - Perceived PHIA concerns with sharing of data among providers/institutions.
  - Indicators (and the systems required to capture them) should be flexible to allow for continual change/upgrading.
- Better access to information between hospitals and clinics
- Better program coordination between RHAs and clinics (attitude of them and us needs to change)
- Need to have better communication re program implementation
- Need better collaboration on how to provide services to clients (need to jointly encourage patients to participate)
- Need to better adjust programs to local communities
- Need to be more outcome oriented
- Need better sharing of information from ER departments (clinics need better records and reports from the ER departments)