

DAILY SUMMARY

Day One – April 17, 2007

Year two for the conference. Accelerating primary care. Gaining momentum. Over 300 delegates from across Canada and the United States gathered to learn about the *how* of accelerating primary care reform – there was no doubt in the audience about *why* primary care is so important.

The day opened at 8 a.m. with greetings from David Hancock, Alberta's Minister of Health who talked about the importance of primary care in improving the health of individuals and how primary care is at the heart of supporting people in managing their health. Mayor Mandel followed with a warm welcome to Edmonton.

The University of Alberta and Capital Health co-sponsored the conference. Tom Marrie, Dean, Faculty of Medicine and Dentistry, University of Alberta, talked about how their relationship is critical in helping transform the way health care professionals are trained and can work within the system. He stressed the importance of underpinning primary care reform with research, which the U of A is supporting by establishing a chair in primary care research.

Sheila Weatherill, President and CEO of Capital Health, stressed that primary care reform is a must have for the health system and needs to focus on improving the experience for patients and families – are patients and families having a better experience? Is the care provision a better experience for providers?

KEYNOTE PRESENTATIONS – DESIGNING FOR SUCCESS

Designing for Success: Optimizing Care

Dr. Mark Murray, Principal, Mark Murray and Associates

Dr. Murray talked about the journey he's taken in looking at what optimized primary care looks like, the assumptions he initially carried into his practice and how those changed as he looked at restructuring care to bridge the gaps between the optimal delivery of primary care and the reality.

Takeaways:

- Care and satisfaction gaps exist, including an efficiency gap – it costs us a lot to deliver what we do – and a satisfaction gap – people aren't satisfied with their care.
- Patients define good clinical care as choosing their primary care doctor, seeing them when they want to and having a positive interaction with their physician. The highest correlations between care and satisfaction occur when patients are seen by their own physician – continuity – and the second correlation is access – often same day access to their physician. *See your own. Don't make them wait.*
- The most effective and satisfying systems work without a waiting time. A long waiting time doesn't always mean lack of resources, it means care isn't delivered fast enough.
- Waiting times are not cost neutral:
 - It takes longer to say no to someone calling for an appointment
 - The longer people have to wait, the more 'no shows'.
 - The longer people have to wait, the more we have to triage.
 - When people see their own doctors and don't have to wait, more preventive services are delivered.
- Physicians shouldn't do all the clinical work. Think of the team as a supplement and support to the patient/physician dyad.

- In systems when we do the work without waiting time, you reduce the number of visits per patient per year.
- If we focus on the flow, we can pay per visit and still get better outcomes. By giving the physician the right kind of team and right kind of support, clinical care will improve.

Designing for Success: Practical Experiences in Change Management

The U.S. Experience

Ms Margo Jamieson, Senior Operations Director, Regional Specialties, Kaiser Permanente
 Dr. S. Scott Smith, Associate Medical Director, Primary Care and Service, Kaiser Permanente

Jamieson and Scott explained their role in Kaiser Permanente in Colorado (KPCO) and the work they've done in implementing the primary care system, what it means to panel patients and provide care. KPCO has 450,000 members, almost 5000 staff and 775 physicians.

Takeaways

- Quality medicine without good access is not quality health care.
- Primary care principles include a focus on the patient and knowing that the key relationship for the patient is with their primary physician, and that the team enhances this relationship.
- The electronic medical record keeps team members informed.
- Empowering the team i.e. getting past the 1:1 doctor patient visit model, takes trust building and providing new models of care. At KPCO, those models include:
 - the use of e-mail
 - scheduled phone appointments of which 85% don't turn into office visits
 - medical advice over the phone by the team
 - lab results available to patients online (eliminating phone work and duplication)
 - seeing groups of patients with same disease condition at one time to optimize educational sessions and use of adjunct team members
- When people see their practitioner, their health is better, emergency department visits are lower, hospitalization is lower, etc. Routine non urgent access is within 14 days.
- When changing over to an automated medical record, do it quickly and go the distance - *rip the Band-Aid off fast*. KPCO went completely paperless and took the step of taking the paper records offsite. All clinical notes are in the chart, labs and radiology on the chart, there's a computer in each exam room and all nurses have own station
- Know that when any change is implemented, people will resist and feel like victims, then they'll react and do some incremental change. At the third stage, the change can be given to the team to creatively address.
- It's critical to provide written goals and written evidence, give people the best practices and reliable tools to improve.
- KPCO no longer measures their service by visit; they look at patient satisfaction, care to the panel, etc.

Designing for Success: Practical Experiences in Change Management

The Canadian Experience

Marianne Stewart, Vice President and Chief Operating Officer, Primary Care Division, Capital Health

Marianne Stewart spoke about key learnings in Canada on delivering primary care coming out of the national Primary Health Care Transition Fund, which was funded by the Government of Canada from 2000 to 2006. Out of the findings, six elements necessary for primary care reform emerged, both foundational and transitional. The foundational elements include primary care

teams, IM/IT and knowledge gathering and diffusion. The transitional elements were leadership, being patient-centered and focusing on outcomes.

Takeaways:

- We need to move beyond the arguments of who should be in charge of primary care teams – teams won't be able to deliver primary care without physicians and primary care won't be successful without other team members.
- If we put the needs of people at the centre, turf issues resolve themselves.
- Change management is an ongoing job because teams will continue to change.
- Electronic health records are critical for team functioning.
- There are pan-Canadian structures in place that are effective vehicles for knowledge gathering and dissemination.
- Look at expanding accreditation to include primary care - it can ensure common standards and embed quality measures.
- Leadership is critical to the success of primary care reform. Leaders need information to support them in staying the course and allocating more resources to primary care.
- Patients have to be the driver in their own care and the system has to connect with them where they are and when they need care.
- Measurement is critical, but most of what is measured in the system are failures in prevention – surgeries, cancer care, etc.
- When the Primary Care Initiative was announced, Capital Health and family physicians in the region worked together to bring about primary care networks (PCN). Both had to change how they thought about their relationships and found that missteps are common and that it's important to just regroup and learn from the change experience.
- Capital and the PCNs are finding new ways of working with each other. For example, Capital Health's diabetic nurses teamed up with nurses in PCNs, taught them how to do insulin starts and support them, with the result that patients now start insulin within a day.
- New leadership models and information sharing are linked – PCNs are their own knowledge transfer structure.

CONCURRENT SESSION ONE

The Primary Care Improvement Process

Session Chair: Ann Medina

Tools for Optimized Care

Dr. Mark Murray, Principal, Mark Murray and Associates

Process: If the aim is to see your own patients and not make them wait, then there is a process to bridge the gap between performance and possibility. It won't happen because we will it. It happens because we do it.

The Process for Optimized Care

- Team: The people who do the work don't always know the right direction. They need to be provided with the 'corridor', the way you do it. The team is supported with leadership, permission and the authority.
- Aim is always to reduce or eliminate the waiting time. If we have other aims, they always end up pointing to reducing the waiting time.
- Change: If we want change, we have to change. We can't do things the same way and expect different results.

- Measure: We need to measure to find out how and if the system is working.

Principles for Optimized Care

- Understand, measure and achieve a balance between demand and supply.
- Eliminate backlog: If supply and demand are balanced but we have a wait, then the backlog has to be cleared.
- Standardize work as much as possible by reducing appointment types.
- Develop contingency plans for taking care of the variations in demand – most are predictable.
- Reduce demand by using alternate methods of delivering care.
- Enhance supply by subtracting unnecessary work.

Office Flow Principles

- Balance demand and capacity for non-appointment.
- Synchronize the components and have them converge at the same place, on time, every time – the doctor, the nurse, the record, the patient.
- The teams that communicate the best have the shortest cycle time.
- Optimize the environment – exam rooms that facilitate the visit, etc.
- Take as much of the non-appointment time away from the clinician.

On the Journey: The Capital Health Experience

Dr. Janet Craig, Physician, Edmonton West Primary Care Network

Dr. Ernie Schuster, Physician, Edmonton West Primary Care Network

Janet Craig

- The Edmonton West PCN is in the process of coming together; they got involved because they couldn't see their patients and work was piling up.
- The goal is to optimize primary care service and provide continuity of care to patients. The other thing they're working on is deciding who can best do the work – about 80 % of what physicians are doing could be done by someone else.
- They decided they wanted to provide same day appointments by May 1, 2007. They started at 15 days and are down to about 5 providers.
- Continuity data is better. Only seeing other physician's patients when they're away.

Ernie Schuster

- It's hard to believe that in 20 years of practice, we didn't look at how we were running our practice.
- The aim is to offer any patient a same day appointment with 100% by March 31, 2008 and decrease the cycle time. They had a 35 day delay for next appointment and reduced the backlog by working harder and have also worked to prevent repeat visits – someone who came in for a sore ankle might end up with getting BP done, rectal exam, etc.
- Practical interventions
 - Do today's work today
 - Reduce the backlog
 - Redefine the complete checkup: Call them periodic health exams
 - Combine weekly meetings with lunch
 - Look at the exam room setup and the flow of patients
 - Analyze measures and make changes to things like Rx refills
 - Set one appointment time
 - Decreased sources of interruptions while seeing patient
 - Look at having patients do pre-visit questionnaires

- Working to get EPIC EMR
- Considering email/telephone service, but want to get paid for it.
- Have conducted group sessions, which are appreciated by the patients.
- Increased efficiency will not result in empty slots in Alberta's growth climate.
- Need to help staff understand the concepts
 - Reassure them that they won't lose their jobs
- Patients need to understand
 - Explain why they can get in, that it's important to keep appointments
- Need more clinical support FTEs for each doctor
 - Now have .2 CDM nurse for each physician

How We Did It: The Chinook Health Region Experience

Arvelle Balon-Lyon, Primary Care Planner, Chinook Primary Care Network

Dr. Tobias Gelber, Physician, Chinook Primary Care Network

Dr. Rob Wedel, Physician, Chinook Primary Care Network

- The Chinook Primary Care Network has been part of the Alberta Practice Improvement Process supported by improvement advisors, Dr. Mark Murray, Dr. Mike Davies and Barb Boushon.
- The network's vision is to deliver reliable, patient-centered, evidence-based quality care every time, on time, to every patient.
- By working together and talking about processes, they've gotten more efficient without getting into the complexities of scopes of practice.
- Operational teams are how care is delivered; clinical teams determine what care is provided.
- Patients notice good teams. People are very satisfied and start helping determine who they should see on the team.
- If you can see people, you improve your reliability and safety.

Measure

- If you routinely measure what you're doing, it can validate your work.
- How you show results is up to the practice – pooled data or individual data.
- Measurement is critical. In a situation where the measured backlog is getting worse, drill down into what can be done. Ask serious questions about why you don't have the staff.
- If there is a true supply-demand mismatch, measurement becomes your friend.

CONCURRENT SESSION TWO

Interprofessional Education and Practice

Session Chair: Marion Relf, Director of Primary Care Initiatives, Capital Health

Interprofessional Education for Collaborative Patient-Centered Practice: What does it mean and how are we addressing it?

Dr. John Gilbert, College of Health Disciplines, University of British Columbia

Dr. Gilbert opened by stating that health care is a collaboration, not a competition and outlined a working definition for primary health care as incorporating personal care with health promotion, the prevention of illness and community development.

Takeaways

- All levels of educational and continuous training programs need to incorporate primary care practices and modalities.
- Opportunities to advance interprofessional health education include:
 - Repatriation of role and authority from specialists to generalists.
 - Democratization of roles and decision-making among physicians, nurses, pharmacists, for example.
 - A major shift to determinants of health away from the sophisticated repair shop model to home and community care.
- The talk is wellness model, health promotion; the walk is that money flows to high tech and acute care. The talk is accountability and performance; the walk is unconditional funding, poor information systems and inadequate evaluation. The talk is integration, coordination, collaboration, teams; the walk is professional rivalries, lingering fragmentation, boundaries, political battles, and educators maintaining their fiefdoms.
- When two or more professions learn *with, from and about* each other, they significantly improve collaboration and the quality of care. This is a testable definition.
- Interprofessional education faces inherent barriers--interpersonal differences, fear of change, stereotypic rivalry, models of practice, power, income and status, and language.
- The only two things that count in the end are quality of care (which includes access) and value for money.
- Support for change must come from providers, educators, the public and government.

From the Trenches: Real Life Experiences of Interprofessional Teams

Pamela Fald RN, Nurse Practitioner, WestView Primary Care Network

- The model and philosophy at WestView PCN is right patient, right provider, right time, right place.
- Patients book with the nurse practitioner who conducts the visit. Then the physician sees patient, allowing 10-20 more patients to be seen per day and an additional access point.
- An additional benefit is increased time spent with patients. For example:
 - Provides more time to gather information, i.e. history, medication reviews,
 - More time for education and teaching of patients and families especially with regards to chronic disease diagnosis and management
- Team member are unfamiliar with scope of others and often full scope of practice isn't utilized. Trust is an issue.
- Fee for service is a limitation to full integration with the care team.
- The program is evaluated regularly by physicians but there is no input at the evaluation level by other care providers (such as NP or RN). When a solution is reached, input is sought from other providers to refine the solution.
- An education program is being developed to educate the team on licensing levels, collaboration and team building, and education at the post license level for nurses to facilitate the standard of care and competencies by all RNs and NPs providing care.

Living on the Learning Curve

Holly Brown, Registered Nurse and Mental Health Coordinator, St. Albert and Sturgeon County Primary Care Network

Takeaways

- Mental health was identified by St. Albert-Sturgeon PCN doctors as a high priority.
- A mental health coordinator was set up to help physicians navigate the system and provide consultation for assessment and resources

- The mental health coordinator works as part of the PCN team so there is access to the chronic disease management nurse, pharmacist and dietitian.
- The team includes two mental health coordinators, dietitian, complex assessment nurse, pharmacist, chronic disease management nurse, lactation consultant, and 40 primary care physicians.
- Team members are really starting to understand each others' role and scope.
- Relationship is everything. Now we trust each other.
- Documentation is critical for collaborating and ensuring continuity of care for patients.
- True collaborative care results in faster recovery times, decreased relapse rates and improved total health status.

Primary Care – A Pharmacist's Perspective

Kevin Neumann, Pharmacist, Oliver Primary Care Network

Evolution of the Pharmacist

- The traditional pharmacist has a 'shop keeper image', focus is patient/pharmacist relationship, largely isolated from other professions, limited patient information.
- The pharmacist consultant provides general drug information to other professions, develops physician/pharmacist relationship.
- The pharmacist as collaborator - patient/pharmacist/physician, move to quality-of-care, patient-centered reimbursement schemes.

Many pharmacists have moved to a consultative role. Few get to the collaborator role. It is imperative that we move to collaboration. It has to start at a grassroots level. Students need to understand the value of collaboration. We need to move more to the collaborative mentality.

Takeaways

- The focus is on the elderly in the Oliver PCN. The role of the pharmacist is to conduct structured medication reviews. The role of the Physician is to review the advice of the pharmacist and determine the management approach in consultation with the patient.
- An electronic medical record is critical to getting a patient's history.
- Next steps will include:
 - Health Promotion/Prevention
 - Anticoagulation clinics
 - Diabetes clinics
 - Facilitating Blue Cross SA medications
 - Networking with Home Care
 - 'Pharmaco-economics - seniors don't want to be on drugs that cost too much. They need cost effective alternatives.

CONCURRENT SESSION THREE

Information Technology

Session Chair: Dr. Nicola Shaw, Research Chair, Health Informatics, University of Alberta and Capital Health

Panel Management, Innovation and the Electronic Health Record: The Kaiser Permanente Experience

Ms Margo Jamieson, Senior Operations Director, Regional Specialties, Kaiser Permanente
Dr. S. Scott Smith, Associate Medical Director, Primary Care and Service, Kaiser Permanente

Margo Jamieson

- Kaiser Permanent moved 775 physicians and 450,000 patient records over to EPIC in four weeks.
- Panel sizes vary between 1900 and 2300 patients. Physicians see between 14 – 22 patients per day. The care team is there to support the physician's practice.
- Needed to change our philosophy from counting visits to "how do we manage the health needs of your panel of patients".
- Found that approximately 8 appointments needed to be reserved for same day access, per physician. This in turn drove down the length of time it took to get a scheduled visit.

Scott Smith

- When we went from counting visits to managing the panel, overall satisfaction rose to 80%.
- EPIC supports this by giving us one health record for the patient and everyone uses the same software.
 - One of the two hospitals use the same system, which supports continuity of care.
 - Helps support chronic care coordination
 - Allows an easy signal to the team that they need to follow-up
 - Facilitates e-consults with specialists such as endocrinology
 - They see the history, they see the labs, and can make a recommendation e.g. get the MRI and labs
 - Supports patient self-management
 - Gives patient a record of the diagnoses, patient instructions, etc. before they leave the office after a visit and is also available online
 - Patients go to KP.org where they can check their information such as their allergies, immunization records
 - Chronic diagnoses linked to HealthWise encyclopedia with information
 - They can e-mail the doctor that they have seen and get a reply with link that they log into for security reasons
 - All diagnosis and labs are online – at first the caregivers were concerned, but KP asked whose health is it? Patients should see the information.
- Automated medical record is not a magic bullet, but has tremendous potential: OO + NT = COO (Old organization plus new technology = Costly old organization)
- This is not an IT project. It's a business project and a cultural transition in care delivery with a heavy IT overlay. You need a strong clinician/IT partnership

Managing Organizational Change, Patient Registries and Patient Portals: The Capital Health Experience

Dr. Allan Ausford, Medical Lead, Capital Health Epic EMR Project

Donna Strating, Vice President, Information Systems and Equipment and Chief Information Officer, Capital Health

- Through smart IT, we can drive better access to the right and useful information
- Capital Health supports more than one kind of primary care
 - PCNs
 - Non-aligned physicians
- To support care to complex patients, information from many sources is brought together.
- There are many things competing for the time of the provider so it's critical that their time is used as efficiently as possible.
- In 2004 Capital Health released Net CARE – secure electronic collection of a person's health information.
 - This tool is available to all authorized health providers – public health, physician, surgeon, etc.
 - Are rolling out this solution across the province by 2008 and to the NWT
 - Send lab and reports electronically
- Infoway CDM Innovation Project is bringing all the diabetes information together.
 - Key to improved care for patients
- Another project is Capital Health Link
 - Take some of the burden off of clinicians
 - Looking at taking on-call information
- Have chosen EPIC as the single data base with shared patient information
 - Very different from the way information is gathered in a paper based system
 - Solution has scheduling and charting components, also are looking at patient portals in the future
 - If not email, then at least information on immunizations, etc.

Allen Ausford

Dr. Ausford used the example of a patient with complex care needs to demonstrate the power of the electronic health record:

- What happens from the patient's perspective
 - 62 year old female
 - History of diabetes with complications
 - Dialysis
 - High lipids
 - Lower back cellulitis
 - On the list for a renal transplant
- If Vioxx was pulled off the market seven years ago, there would have been no easy way of knowing who was on Vioxx. Now with the HER could find out who is, and in another seven years will be able to see who had cardiac issues and was on Vioxx.
- Chronic disease management was paper based seven years ago. The patient would have had limited support. Now, the practice is able to create a roster of diabetic patients and have a nurse coordinate care. Seven years from now, the diabetes education centre and nurse, etc. will all be able to work together.
- In seven years, if acute care is on the system, the primary care network will check on the patient every day she is in hospital.

- Now the physician gets alerts for screening where seven years ago, they would have to look through the paper documentation. In the future, they could configure the alerts so they only get useful alerts, etc.
- NetCARE makes a huge difference in continuity of care, allowing the practice to see who's in emergency, who's been admitted, etc.

A New Technology for Chronic Disease Management

Magdalena Naylor, Associate Professor, Department of Psychiatry, MD, PhD., University of Vermont www.med.uvm.edu/mbmc

Dr. Naylor's clinic wanted to improve the maintenance of coping skills in patients after completing group cognitive behavioral therapy for chronic pain, alcohol dependence and weight control.

- They decided to use interactive voice response telephone technology to maintain the changes in behavior and amplify the impact of human intervention treatment.
 - Used the touch tone keypad of the telephone to key in responses to a series of questions following a branching logic model
 - Patient answers questions, fed into a computer, analyzed once a month by a therapist who then gave the person feedback to help them understand what is working for them to manage pain, etc.
- The project is seeing improvements in pain management, people decreasing their alcohol use and use of the technology increased weight loss and its maintenance.

SESSION FOUR

Primary Care Research Discussion Group

Dr. Thomas Feasby, Vice-President of Academic Affairs, Capital Health, and Associate Dean, Clinical Affairs, Faculty of Medicine and Dentistry, University of Alberta chaired the deliberations of the Research Discussion Group. The group met to identify new research opportunities and practical ways in which current research and evaluations can be applied.

Takeaways

- Work needs to be done to develop a framework (definitions) and indicators that have broad agreement for research. Work done by the Primary Care Initiative Committee needs to be implemented, and coupled with the EMR and other IT solutions to allow for consistent data collection.
- The necessary data isn't always available (i.e. patient satisfaction, cleanliness, etc.)
- The opportunity exists to incorporate research into the operational side of PCNs.
- Need to develop expertise in:
 - Knowledge transfer - partner with experienced researchers, across jurisdictions
 - Accessing targeted funding
 - Training in doing research
 - Providing PCNs with people, data, statisticians, evaluations, etc.
- The U of A's Primary Care Research Chair can become a catalyst.
- Electronic health records can facilitate research by making it easier to share data.
- Need to look at a new funding envelope (i.e. ISIS), develop a Canadian Centre for Primary Care Research and learn to better leverage funding.

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