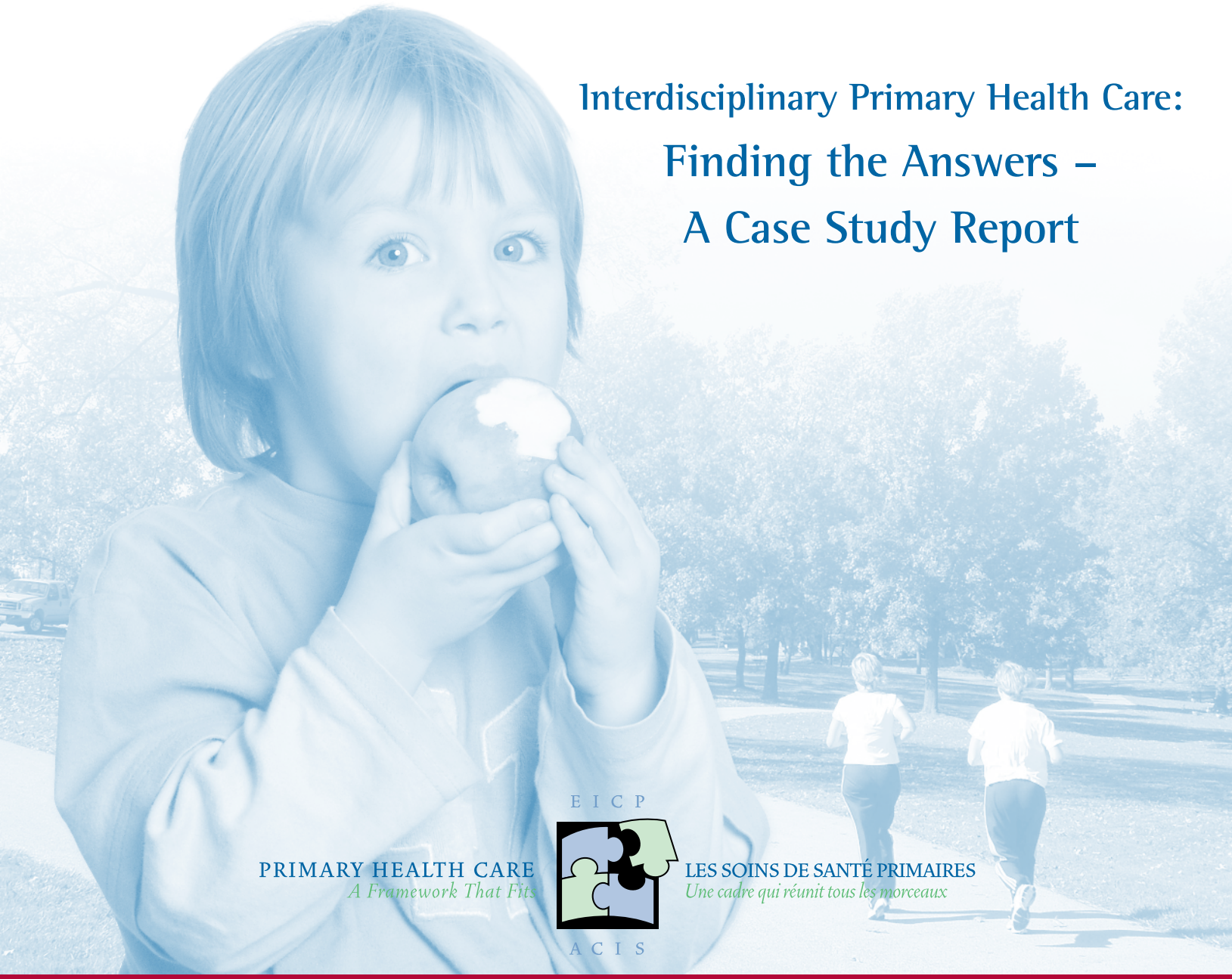
ENHANCING INTERDISCIPLINARY COLLABORATION IN PRIMARY HEALTH CARE

AMÉLIORATION DE LA COLLABORATION INTERDISCIPLINAIRE DANS LES SOINS DE SANTÉ PRIMAIRES

Interdisciplinary Primary Health Care:

Finding the Answers – A Case Study Report



EICP

PRIMARY HEALTH CARE
A Framework That Fits

ACIS

LES SOINS DE SANTÉ PRIMAIRES
Une cadre qui réunit tous les morceaux

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Acknowledgements

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) team would very much like to thank all who helped make this project—and this publication—possible.

We were overwhelmed by the response of health professionals working collaboratively across the country. Many of you took the time to fill out questionnaires giving us information about how your team works. Those of you who work at the primary health care organizations we visited faced additional work on our behalf. You planned for our arrival, scheduled staff and even arranged to have patients meet with us, and, on top of that, you took time out of your busy schedules to answer our questions.

You did all of this with tremendous generosity. At every site from Newfoundland and Labrador to British Columbia, you made us feel most welcome. You answered our questions openly and honestly, and shared with us your impressions of the challenges and rewards of collaborative interdisciplinary care.

We were particularly gratified to learn of the many innovative ways in which you have managed to overcome any obstacles in your path.

We thank you, and hope you enjoy the report.

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EXECUTIVE SUMMARY

Interdisciplinary collaboration is currently much discussed, even though it is certainly not a new way of delivering health care. In some areas of the country, it has been practiced for decades. It has been in the news lately because governments are recommending it to health professionals as a possible way of delivering primary health care more effectively and efficiently.

But what precisely is interdisciplinary collaboration? How do health care professionals practice it, and why? What challenges have they encountered, and how have they overcome them? Do they think working collaboratively is worthwhile, and if so, why? What do their patients/clients think?

This report answers these questions. It is the final report produced by the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative, which focuses on how to create the conditions for health care providers everywhere in Canada to work together in the most effective and efficient way so they produce the best health outcomes for their patients and clients. *Finding the Answers* explores the current reality of interdisciplinary collaboration in Canada through selected organizations across the country. These are (in alphabetical order):

- Dr. Charles L. LeGrow Health Care Centre in Port aux Basques, Newfoundland;
- Mid-Main Community Health Centre in Vancouver, British Columbia;
- Nor'West Co-op Community Health Centre in Winnipeg, Manitoba;
- Rosedale Medical Group in Hamilton, Ontario;
- Taber Associate Medical Centre in Taber, Alberta. While visiting Taber, the researchers also examined two other organizations that form part of the same network (the Chinook Primary Care Network) to which the Taber Medical Centre belongs.

Together, they represent a mix of rural and urban, large and small, new and old interdisciplinary organizations. In this report, they are examined through the lens of the EICP's Principles and Framework. The principles are considered to be the values shared by stakeholders that are critical to establishing and maintaining collaboration. They include patient/client engagement; population health approach; best possible care and services; access; trust and respect; and effective communication. The framework builds upon these principles and is composed of the structural and process elements required to support interdisciplinary collaboration. Its elements are health human resources; funding; liability; regulation; information and communications technology; management and leadership; and planning and evaluation.

Our key finding is that interdisciplinary collaboration is a flexible, multi-faceted and effective method of delivering health care. There is no single right way to practice interdisciplinary collaboration. No two organizations are alike, yet they have certain elements in common. In terms of patient/client engagement, all the primary health care organizations stress the importance of engaging patients and clients in their own care and teaching them the importance of taking responsibility for their own health. Some are making extra efforts to bring health services to people where they live, work or are educated. The more rural or mixed rural/urban organizations in particular certainly take the needs of the surrounding population into account in designing and delivering health care services.

Providing the best possible care and services to their clients is a goal shared by all the organizations. This desire has driven them to undertake many initiatives, including using care maps; adopting and designing clinical guidelines based on evidence; developing comprehensive quality improvement programs; and participating in monitoring and evaluating clinical programs. All are eager to improve their service delivery, including minimizing wait times.

At all organizations, the health professionals have earned high levels of trust and respect from their colleagues, patients and clients. However, most of the organizations experience some difficulties when new staff members are introduced, particularly in a new role, such as that of a nurse practitioner. Generally, the more inclusive the organization, the faster the new health care professional fits in and feels comfortable. But it can take some time for professional trust and respect to be earned and developed to a point where individuals are totally comfortable working with each other.

In terms of effective communication, staff at the organizations tend to be open and honest, and they pursue consensus wherever possible. Communication is made easier when individuals work closely together and hold regular meetings. The layout of the workspace is also a key consideration for communication; it can do much to either enhance or deter it.

The structure and composition of the selected organizations' teams differ, depending on the needs of the population, the choices of the professionals involved, and the availability of regional support teams. Some teams are made up of nurses and physicians, while other teams include various health professionals, such as dietitians and diabetes educators. At Nor'West, social workers dominate the team, and it is the only visited site to include a lawyer. Lethbridge includes a part-time newly graduated psychologist, while Charles LeGrow integrates an occupational therapist and a speech-language pathologist into its team. Pharmacists, while not always official team members, play an important role at Mid-Main and Rosedale. Four sites—Rosedale, the LeGrow Centre, Mid-Main and Taber—employ nurse practitioners, although the scope of the role varies among the organizations. Physiotherapists are present in Lethbridge and Charles LeGrow.

All the organizations offer some training and development, but overall there is little, and much of what exists is informal (e.g., lunch and learns). However, Charles LeGrow is pursuing formal team training through the "Building a Better Tomorrow" initiative. In terms of hiring practices, organizations follow their well-honed instincts as to who will be a good hire. Overall, there is not much evidence of performance management. That said, the organizations seem to have no trouble finding individuals who fit in with their culture, and there is little staff turnover. Health professionals speak highly of interdisciplinary collaboration, pointing out that it promotes efficiency and is a more effective way of delivering care. They also believe that it gives them a better work-life balance.

Funding differs quite markedly across the organizations. Regardless of the method of funding—fee-for-service, salary, capitation, or a variation thereof—interdisciplinary collaboration can occur and be sustainable in the long term only if health professionals are remunerated for meetings, planning, consultations or any other sort of interdisciplinary activity.

Liability and regulation do not appear to be obstacles to interdisciplinary collaboration. And while electronic medical records facilitate interdisciplinary care, they are not critical. Telehealth equipment, which has the capacity to bring urban services to a rural setting, is not widely available, and when it is, it is not used to its potential. This is mainly as a result of inappropriate funding models to compensate for these services.

Leadership—both clinical and administrative—is key to the success of collaborative care. The organizations examined have one of two styles: top-down or very flat; either works. The experience of the organizations shows that it does not really matter who assumes leadership, as long as it exists. Furthermore, these organizations are leaders. They demonstrate leadership in many ways: they are continually seeking new partnerships and adopting innovative approaches to better serve their clients/patients; they are eager to measure and evaluate; and they are constantly learning from other health professionals and organizations and sharing their successes with others.

Their collective experience is evidence that interdisciplinary care is thriving in some parts of Canada. Despite some challenges, this style of health care delivery offers real advantages. Health professionals would do well to carefully consider the merits of interdisciplinary care when choosing a practice style that will work for them.

INTRODUCTION

This paper is part of the Collaboration Toolkit, which represents the final stage of the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative. EICP began two years ago with funding from Health Canada. It has focused on how to create the conditions for health professionals everywhere in Canada to work together in the most effective and efficient way, so they can produce the best health outcomes for their patients and clients.

Ten national health professional associations and one coalition have led EICP: Canadian Association of Occupational Therapists, Canadian Association of Social Workers, Canadian Association of Speech-Language Pathologists and Audiologists, Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association, Canadian Physiotherapy Association, Canadian Psychological Association, Canadian Coalition on Enhancing Preventative Practices of Health Professionals, Dietitians of Canada and the College of Family Physicians of Canada.

EICP, through an extensive consultation process, created a workable blueprint for collaboration. The initiative held more than 30 consultations across the country and developed over 40 research reports, three DVDs and a website with an online toolkit.

The EICP toolkit consists of one report and one web-based inventory. This report, a critical component of the toolkit, aims to meet the information needs of health professionals. It should also be useful to other audiences, such as professional associations, governments, the general public and other stakeholders. An extensive inventory of tools, processes and practices to support health professionals in their interdisciplinary efforts has been undertaken and is available on our website: www.eicp.ca.

This report bridges the research with the "how to" by describing the current successful experiences of organizations with collaborative practice in primary health care. The purpose of this report is to spotlight real-life practices and examples showing that collaboration is "value-added" for our health care system. Between November 2005 and January 2006, EICP staff visited five selected interdisciplinary health care organizations—Dr. Charles L. LeGrow Health Care Centre; Mid-Main Community Health Centre; Nor'West Co-op Community Health Centre; Rosedale Medical Group; and Taber Associate Medical Centre—across the country to see first-hand what they are doing. The Methodology section outlines why these centres were chosen and how information was gathered on each of them.

This report also examines two other organizations that round out our examination of team-based care: Lethbridge Family Medical Centre and Pincher Creek Associate Medical Clinic. Like Taber, they are part of the Chinook Primary Care Network in southern Alberta. In addition, an interview with a psychologist involved in a primary health care pilot project at the Westend Clinic in Ottawa was conducted to complete the picture.

Each of the primary health care organizations visited pursues interdisciplinary care in its own unique way, bringing home the point that there is no single right way, no step-by-step prescription for how best to practice interdisciplinary care.

This report describes the organizations through case studies, which relate the following information:

- The nature of the site;
- The development history of the site's interdisciplinary practice;
- The population it serves;
- The type of health professionals it employs and how they are paid;
- How the centre is funded; and
- How the health professionals work together.

It then explores what was learned from the sites, based on the EICP's Principles and Framework, which have been agreed to by all the EICP's founders associations. The principles include: patient/client engagement; population health approach; best possible care and services; access; trust and respect; and effective communication. The framework elements are: health human resources; funding; liability; regulation; information and communications technology; management and leadership; and planning and evaluation.

The report finds that interdisciplinary collaboration is alive and well in many communities, and is benefiting both patients/clients and health professionals. The collective experience of all the primary health care organizations studied provides answers to some long-held questions about interdisciplinary collaboration, and gives a much clearer picture of the challenges of providing care in this way—and more importantly—how they can be overcome.

METHODOLOGY

The final stage of the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative comprises the development of a toolkit. The EICP Toolkit—including this report—has four specific objectives:

- To showcase real-life practices of interdisciplinary collaboration across Canada;
- To make available resources to guide health professionals who want to participate in interdisciplinary practice;
- To maintain the interest and momentum of other stakeholders in the adoption of interdisciplinary practices by providing information; and
- To influence values and behaviour, and activate change.

Case study research is the main source of information for this report. The research team wanted to study five primary health care organizations across the country to learn about their success in setting up interdisciplinary care (IDC) practices. The researchers asked stakeholders from the country's primary health care community (represented by individuals who had participated in EICP consultations) to nominate primary health care organizations with strong interdisciplinary practices. They received 120 nominations.

All nominated organizations were sent a brief questionnaire to find out more about them and to determine if they were interested in being chosen as a case study site. Responses were received from 38 potential candidates. To narrow the number to five sites, points were awarded, based on compliance with the determined primary and secondary selection criteria. The scoring formula was as follows:

Y + P + E + C + S = final score

Y = years of operation. Organizations must have been in operation for at least two years. (Change management theory suggests that this is the minimum time required to build a cohesive team.)

- Less than 2 years: 0 point
- More than 2 years: 1 point

P = number of professionals. In order to be eligible, the team had to include at least five professionals.

- 5 professionals: 1 point
- 6–8 professionals: 2 points
- More than 8 professionals: 3 points

E = percentage of professionals from associations represented on the EICP Steering Committee.

Less than 30 per cent: 0 points
- 30–49 per cent: 1 point
- 50–74 per cent: 2 points
- More than 75 per cent: 3 points

C = formalized collaborative arrangements. Organizations were scored according to the strength of their collaborative structure. Points were awarded as follows:

- Informal communication within the team: 0.5 points
- Established collaborative services (e.g., birth control, diabetes education): 0.5 points
- Formalized interdisciplinary meetings (e.g., regular on-site or virtual staff and program meetings): 1 point
- Interdisciplinary training: 1 point
- Formalized interdisciplinary procedures (e.g., referral forms, integrated triage, integrated client record, case conferencing, peer review, time blocked out for consultation): 2 points for up to 2 procedures in place, and 3 points for 3 or more rocedures in place
- Interdisciplinary policies (e.g., formal agreements and policies): 3 points
- Joint strategic planning process: 3 points

S = satisfaction surveys (patients and staff) are in place.

- Yes, satisfaction surveys are tracked: 1 point
- No, satisfaction surveys are not tracked: 0 points

Special consideration was given to organizations using methods other than satisfaction surveys to evaluate outcomes or processes.

Candidate organizations were then assessed according to secondary selection criteria, which addressed the balance of the following factors:

- Rural and urban client/patient populations;
- Pan-Canadian representation (western, central and eastern regions);
- Co-location, virtual collaboration, or a mix;
- Funding type: public versus mixed;
- Population type: general versus specific; and
- Information and communications technology use: high versus low technology.

Based on their scores, the following five organizations were chosen (in alphabetical order):

- Dr. Charles L. LeGrow Health Care Centre in Port aux Basques, Newfoundland;
- Mid-Main Community Health Centre in Vancouver, British Columbia;
- Nor'West Co-op Community Health Centre in Winnipeg, Manitoba;
- Rosedale Medical Group in Hamilton, Ontario; and
- Taber Associate Medical Centre in Taber, Alberta.

Representatives of the Taber Associate Medical Centre suggested we visit two other organizations (Lethbridge Family Medical Practice in Lethbridge and Pincher Creek Medical Clinic in Pincher Creek) that were part of their primary care network. Both were considered innovators in primary health care, and visiting their premises added depth to our research.

Two- or three-day visits were conducted at every selected organization. Researchers interviewed clinical and management teams, conducted focus groups with a cross-section of patients invited by the organizations, and reviewed on-site documentation. Staff were asked to anonymously complete a team effectiveness survey (n=96). The survey was a slightly modified version of one used by Saskatchewan Health to evaluate its primary health care sites. Using a four-point scale, ranging from 1 ("strongly disagree") to 4 ("strongly agree"), with no neutral mid-point, the survey measured key elements of teams, including: purpose and vision, roles, communication, service delivery, team support, partnerships and quality of care. Data were aggregated by site and as a whole. Highlights of these results can be found in the individual case study descriptions and in the key learnings.

Lastly, because the selected case studies did not allow us to explore collaboration between psychologists and other health professionals in primary health care, a pilot project to study the impact of including a psychologist in a medical group was added. This project took place at two clinical sites, including the "Westend Clinic," a family health team in Ottawa. Researchers interviewed the psychologist and a nurse who had been working with this team for the past year to learn about their challenges and their views of interdisciplinary collaboration.

The information collected through this process is discussed in this report. Several tools (forms, policies and procedures, job description, clinical pathways, etc.) that support collaboration at these organizations were collected and added to our on-line toolkit.

DESCRIPTION OF CASE STUDY SITES

This section presents a brief description of the main characteristics of the organizations visited. The information has been standardized for all the case studies. Each section portrays various aspects of the organization: how it developed an interdisciplinary practice; the population it serves; the type of health professionals it employs and how they are paid; how the centre is funded and financed; and how its health professionals work together.

The organizations are presented in alphabetical order. The appendices, found at the end of the report, provide a list of interviewees at each organization and some of the key tools used at each site. To access these tools that support indertdisciplinary collaboration, please visit the collaboration toolkit on the EICP website at www.eicp.ca.

Dr. Charles L. LeGrow Health Care Centre

The Dr. Charles L. LeGrow Health Care Centre is a multi-functional district health centre located in the town of Port aux Basques on Newfoundland's southwest coast. It is a 44-bed, fully accredited, non-denominational centre that provides inpatient and outpatient acute care and community services.

There are 14 acute care beds, a palliative care suite, a chemotherapy unit and a long-term care (LTC) wing. The 30-bed LTC wing has two slow-paced rehabilitation beds and two respite beds. The centre is also responsible for a 21-apartment seniors' building and 20 seniors' cottages. The LeGrow Centre admits approximately 1,000 patients per year and has about 14,000 emergency visits and 12,000 outpatient visits per year.

Specialty care is referred to neighbouring facilities and regional programs, and support is provided for certain clients through phone and teleconferencing. As with all the sites studied, staff at the LeGrow Centre do not hesitate to refer their clients and patients to other service providers in the community.

Keys to Success: What We Heard

- Very strong management that supports interdisciplinary care practices
- Integration of health and community services, including social and mental health services
- Collegial culture that invites open dialogue and conflict resolution
- Effective primary health care coordinator
- Population health approach

HOW DID IT DEVELOP AN INTERDISCIPLINARY PRACTICE?

The LeGrow Centre was built in 1984 to replace the former "cottage" hospital in the area. It is the only medical facility within a 170-kilometre radius, and as such, the health care demands upon it are large and complex.

In light of this, right from its inception, the centre was intended to accommodate a range of disciplines and to address the broad determinants of health. Community services staff—those involved with public health, home care, diabetes education, speech-language pathology and mental health—are housed at the centre. The rural nature of the centre means that most staff in health and community services know each other quite well.

In 1996, the LeGrow Centre united with eight other health facilities in the western region of Newfoundland to form the Western Health Care Corporation (WHCC), with a board of trustees appointed by the government. In 1997, the centre was chosen for a pilot program designed for rural communities. The aim was to promote primary health care by providing training positions, using advanced technology and introducing nurse practitioners. This was the impetus for intersectoral collaboration between the centre and community/social services. In addition, LeGrow received provincial funding for a Primary Health Care Enhancement Coordinator—a role designed to implement strategies to strengthen the delivery of primary health care services to community residents. In the spring of 2005, WHCC was dissolved and the Western Integrated Health Authority was created. This reorganization solidified the existing collaborative working arrangements.

WHAT POPULATION DOES IT SERVE?

The LeGrow Centre serves the population of the southwest coast of Newfoundland. Its catchment area has approximately 10,000 people living in communities bounded by the triangular areas between Coal Brook, Anguille and La Poile. Within this area, several communities have distinct needs and resources. During the tourist season, as many as 40,000 people visit the area. The centre also services several remote outlying communities accessible only by helicopter.

The centre is responsible for the medical clinics in the communities of Doyles, La Poile and Rose Blanche. These clinics are staffed by LeGrow's nurse practitioners. The centre's approach is to "provide service close to where people live."

WHO ARE THE HEALTH PROFESSIONALS AND HOW ARE THEY PAID?

The LeGrow Centre employs 130 staff, including the health professionals referenced in Table 1.

Table 1: Compensation and Source of Funding for Health Professionals—Dr. Charles L. LeGrow Health Care Centre

Position	Compensation Method	Source of Funding for These Positions
1 Recreational Therapist	Salary	Government
2 Nurse Practitioners	Salary	Government
1 Physiotherapist	Salary	Government
1 Social Worker	Salary	Government
5 Public Health Nurses	Salary	Government
1 Dietitian	Salary	Government
0.5 Diabetes Nurse Educator	Salary	Government
2.5 Physicians	Salary	Government
1 Speech-Language Pathologist	Salary	Government
1 Mental Health Counsellor (social worker)	Salary	Government
21 Registered Nurses	Salary	Government
4 Lab Technicians	Salary	Government
1 Pharmacist	Salary	Government
3 X-Ray Technicians	Salary	Government
1 Occupational Therapist	Salary	Government

Source: EICP Secretariat.

The centre also offers audiology services. A regional service visits clients approximately four times a year. It focuses on children referred by public health nurses and physicians, but will also see clients from the long-term care unit if they are referred. It has a very long wait list. As well, two private audiologists travel to the Port aux Basques area. One holds clinics at the hospital once a month (through a contract that addresses liability issues and includes a minimal charge for rent).

There are also four independent, fee-for-service physicians in the community who have links to the LeGrow Centre. Two of the community physicians are integral to the interdisciplinary service and teaching unit at the centre, participating in interdisciplinary care and planning teams (even though they receive no financial compensation for interdisciplinary work not related to teaching).

HOW IS THE CENTRE FUNDED?

The centre is a government-financed, fully accredited, non-profit health care centre.

In light of the serious shortage of physicians, in 1997, through the Primary Health Care Expansion Program (PHCEP), the provincial and federal governments provided pilot project funding to the LeGrow Centre. This allowed it to hire three nurse practitioners and gave the centre a designation as a teaching centre with Memorial University. In 2001, PHCEP funding ceased, but the centre continued to receive provincial initiative funding for the PHCEP coordinator role. This individual facilitates the collaborative work at the centre and in the community. An implementation committee, composed of management and the PHCE coordinator, was formed to provide direction and vision to the project.

Currently, two nurse practitioners remain on staff, and their positions have been absorbed into the overall operating costs of the organization.

HOW DO THE HEALTH PROFESSIONALS WORK TOGETHER?

The founding administration had a broad vision of health—a vision that extended beyond acute care treatment and management of existing disease to health promotion and disease prevention. "We have been in the 'business of collaboration' for a long time—long before it was *in vogue*," one staff member commented. Teams collaborate to provide client services and carry out intersectoral work related to population health projects. Trust and respect are palpable, which stems in part from the community familiarity that exists. But staff also believe it is due to the long-standing effect of being a PHCEP site.

Collaboration is second nature to staff. Both informal and formal meetings occur frequently. Grand rounds are an excellent setting for interdisciplinary communication. On the team effectiveness survey, staff indicated that they find meetings and between-meeting communications highly effective. They are satisfied that teams have the professional representation they need to function well. LeGrow has a rehabilitation team, a diabetes education team, a dysphasia team and a long-term care team, among others.

The Southwest Coast Interdisciplinary Working Groups (SIDS) is an interdisciplinary group composed of health and community/social service representatives. The PHCE coordinator chairs this group, which meets monthly at lunch hour. One of the community fee-for-service physicians also participates in this group. The group takes on interdisciplinary and intersectoral issues that arise, and collectively works towards the development of creative solutions. One of its initiatives is the "Gateway to Health" program, which targets individuals to improve their level of physical fitness. The group has also developed a web-based "Health Systems Database" that catalogues existing services at the centre and in the surrounding community.

The health professionals here believe that co-location is very important to collaboration. Through the day-to-day experiences of working together, they have developed a synchrony with their practice approach. The regular meetings associated with the SIDS group provide a mechanism for meeting with those in other sectors who are off-site. Regional programs and support are important to certain clients of the LeGrow Centre. Staff contact their regional colleagues by phone, in person or through teleconferencing.

Intersectoral collaboration is also a significant part of the work at the centre. Partnerships between the LeGrow Centre and other groups and organizations target health promotion and illness prevention programs and activities. Survey data support the view that the team sees the community as integral to the planning and delivery of programs and services.

Videoconferencing is available and is used to discuss cases with regional support teams or specialists, but there is no financial support for off-site physicians to participate.

The role of the PHCE coordinator is vital to collaboration in this organization. Although there has been turnover in this role over the years, each individual has brought fresh insights and has added to the dynamic nature of the role. Most of the PHCE initiatives on the southwest coast are dependent on the coordinator and require an ongoing commitment. A PHCE newsletter is a tool for sharing and communicating updates on current projects and initiatives occurring between professionals and across sectors. The coordinator continues to take training related to interdisciplinary collaboration. She has taken courses through the "Building a Better Tomorrow" initiative and is preparing to deliver the courses to staff at the centre.

The centre's culture includes a willingness to confront issues as they arise. For example, when the nurse practitioners (NPs) first arrived, they were welcomed by other disciplines and the community, but their role was undefined, and this created some confusion among the physicians, nurse practitioners and public health nurses as to who would be responsible for delivering which services, especially when there was overlap in scopes of practice. A weekend retreat, in which everyone agreed they had a problem and worked together openly and honestly, brought a resolution. As a result of that retreat, guidelines were developed for roles and responsibilities (i.e., who would do what).

The nurse practitioner works with long-term care patients, travelling to all the outlying clinics, doing assessments for patients on chemotherapy, seeing her own client roster, and covering the emergency department, depending on what the physician complement is for the week. They typically see 10–15 patients for half-hour appointments. In the outlying clinics, they will see up to 25 clients per day.

Another issue that arose was how to sustain the momentum in providing primary health care to the

community once project funding ceased. To resolve this, the centre turned to the community. In 2001, as the end of PHCEP funding approached, a weekend retreat took place in Port aux Basques. It was intended to explore with the community how primary health care could facilitate improved health and health care in the area. Attendees developed an action plan that included strategies such as holding interdisciplinary clinics on subjects like diabetes care, asthma and well women; engaging the community through enhanced information; and improving education and the use of existing resources in the community.

The LeGrow Centre continues to work closely with the community and has forged many partnerships, such as the ones with Peaceful Communities, the Gateway Women's Centre, various school and youth organizations, family resource centres, the Chamber of Commerce and service groups. The LeGrow Centre is not only a vital part of the Port aux Basques community, but also a key provider of health services to the people who live in the outlying communities of southwestern Newfoundland.

For a complete list of participants in this case study and some relevant documents (e.g., description of the PHCE Coordinator position, nurse practioner clinical role planning day, SID terms of reference) to support interdisciplinary collaboration used at this centre, please refer to Appendix A.

Hours of Operation

- Outpatient consultations are provided Monday to Friday, from 9 a.m. to 5 p.m.
- The emergency room operates 24/7 to cover after-hour services

Programs and Services

- Services provided on-site
- Emergency and outpatient clinics
- Limited operation room (no anaesthesia services)
- Chemotherapy
- Pharmacy
- Diagnostic services (lab and radiology)
- Physiotherapy
- Social work
- Occupational therapy
- Adult day camp
- Speech-language pathology
- Mental health counselling

Mid-Main Community Health Centre

The Mid-Main Community Health Centre is a non-profit community health centre located in central Vancouver. It is a registered charity governed by an independent board of directors. The centre has both a medical and a dental clinic.

Keys to Success: What We Heard

- Deep commitment from staff to community-based interdisciplinary health care, to the point of volunteering their services
- No turf protection, valuing the unique skills of each team member
- Recognition and respect for the power of the team as a unit
- Highly capable staff who are not afraid of presenting and introducing new ideas
- Organizational culture that embraces change and innovation
- Strong focus on—and commitment to—quality improvement processes

HOW DID IT DEVELOP AN INTERDISCIPLINARY PRACTICE?

Mid-Main started in 1986 with a group of people working in community health who envisioned a collection of community health centres on the Lower Mainland. These health centres would share resources by offering multidisciplinary health services under one roof, and in doing so, provide an alternative to private practice in medical and dental care. The Mid-Main area was chosen because of the need for increased health services and the availability of the building located at 3998 Main Street. In 1987, development of the new community health centre began with gathering a volunteer board of directors and hiring staff. Mid-Main Community Health Centre officially opened on June 22, 1988, with professionals, staff and a board who were committed to community health care. The mission of the Mid-Main Community Health Centre is "to improve the health of our clients by delivering comprehensive, accessible and high-quality health services according to individual and family needs."

From the outset, physicians and staff of the medical clinic also believed that interdisciplinary care was the best way to meet the needs of Mid-Main's patients. They recognized that physicians cannot "deliver it all" and that good health practice also includes health education and illness prevention. As funding permitted, diverse health professionals were hired at the medical clinic.

WHAT POPULATION DOES IT SERVE?

The medical clinic at Mid-Main serves members of the community who reside between Cambie Street and Knight Street, and between Broadway and Marine Drive—a very diverse urban population in the central area of Vancouver. To meet patients' needs and minimize patient use of emergency services and walk-in clinics, physicians do house calls and provide on-call services 24/7 for all their patients.

The client base of the medical clinic is 70 per cent female. It also has a large number of elderly clients and patients who are coping with mental health issues. In recent years, there has been a rise in the number of young families with children aged 0–5 using the clinic and in the number of patients who are new to Canada.

WHO ARE THE HEALTH PROFESSIONALS AND HOW ARE THEY PAID?

The community health centre's staff includes the health professionals referenced in Table 2.

Table 2: Compensation and Source of Funding for Health Professionals—Mid-Main Community Health Centre

Position	Compensation Method	Source of Funding for These Positions
4 Full-ime Equivalent (FTE) Physicians, (6 Part-time Physicians)	Salary	Vancouver Coastal Health Authority (VCHA) through the British Columbia Medical Association—Alternative Payment Blend
1 FTE Primary Care Nurse Specialist	Salary	VCHA
0.5 FTE Clinical Pharmacist	Salary	Core Funding
1 FTE Chronic Disease Coordinator / Dietitian	Salary	Primary Health Care Transition Funding

Source: EICP Secretariat.

HOW IS THE CENTRE FUNDED?

Funding for the centre has been a challenge throughout its history and remains an ongoing issue.

At first, the physicians subsidized their commitment to community care by working elsewhere. It was not until 1998 that the centre negotiated a service contract for four part-time doctors. A pharmacist, who shared the physicians' commitment to collaboration, volunteered her services for one half-day a week. The physicians found her services to be so useful that they began to subsidize her out of their own pockets. Now, there is enough money in Mid-Main's global budget to pay for half of her time.

Vancouver Coastal Health Authority (VCHA) provides funding for Mid-Main's medical services. The centre approached the VCHA to fund the primary care nurse specialist, who joined the team in 2002 as Mid-Main's only nurse. Using Primary Health Care Transition funding in 2003, Mid-Main hired a chronic disease coordinator, who is also a dietitian. Mid-Main, like many other primary health care groups across the country, has taken advantage of the Primary Health Care Transition Fund to improve its infrastructure and expand its services (e.g., electronic health records, office renovation, expand the professional team). However, there are some uncertainties regarding the sustainability of this funding, as the provincial government has made no commitment to maintain the current level of financing.

The centre pursues the application of grants whenever the opportunity presents itself. Mid-Main also acts as a flow-through financial agent for a small home-visiting program called "Parents as Teachers," which has received small grants from United Way's "Success by Six" program and VCHA's "SMART" fund.

Mid-Main's dental clinic has been financially successful because it manages to maintain a mix of patients with and without dental insurance. This has enabled the clinic to provide affordable dental care to lower income and uninsured clients. This financial stability also helps to support the organization overall.

HOW DO THEY WORK TOGETHER?

At Mid-Main's medical clinic, interdisciplinary care (IDC) is a part of the organizational culture. One team member stated, "IDC is expected and encouraged by the leadership team." Mid-Main has a dedicated group of clinicians and medical office staff who share a common vision and have been working together in a collaborative fashion for a long time. The comfort level about interdisciplinary care is high and there is mutual respect and trust among all members of the team. "People do what needs to be done. It is all about people—the biggest factor driving collaboration," another staff member said.

The structure at the centre is very flat, or as one person said, "Nothing here is top-down." Both clinicians and staff participate in making decisions and undertake evaluations with a clear goal of having the best clinician for the task deal with the patient at any given time. To facilitate this, the centre has "transfer of function" agreements (included in Appendix B) to ensure that the clinicians at the centre comply with British Columbia's regulations governing professional practice.

Mid-Main has a relaxed, open culture that is accepting of new ideas and people. The team "is willing to try anything to give better care." There is "a total willingness to embrace new ideas." This openness has resulted in many innovative practices and a team of clinicians and staff who are very savvy at managing change.

There are no structured orientation sessions for new staff. They learn about what other staff do by working side-by-side with them. There is a strong emphasis on having the right person in the right position, and a solid commitment to interdisciplinary care is required in order for new employees to be successful in their jobs.

The clinical pharmacist is very important to the organization and has taken on tasks above and beyond those of a traditional pharmacist. For example, she manages the smoking cessation program, facilitates diabetic group visits, oversees asthma care, supervises the warfarine program, and monitors maintenance medications for some patients with chronic illness. So great was her commitment to community-based interdisciplinary care that she volunteered her time for the first six months at the centre.

It took the nurse practitioner more than a year to develop her role. Nurse practitioners are not licensed in British Columbia (they will be by August 2006), but she has a broad scope of practice, providing acute care (not emergency), as well as care for those with chronic illness (diabetes, asthma), hypertension, sexually transmitted diseases, acute bladder infections, wounds, and skin problems. She supports all the patients at the medical clinic, and that support is welcomed and embraced by the physicians and other clinicians.

Mid-Main's staff strongly pursue quality improvement. They track data—particularly in chronic diseases, where they are part of a province-wide program in congestive heart failure and diabetes—in order to measure the ongoing efficacy of their clinical programs. In the team effectiveness survey, the staff strongly agree that team members must clearly understand their purpose. The survey also reveals that team members are very likely to accept the insights, knowledge and perspectives of members of other professions—and that they strongly agree that team-based functions are shared across professional boundaries. It also shows that team members believe that they work as a cohesive group and that a high level of trust and confidence exists.

They also pursue quality improvement at the management level, with the aim of improving the efficiency of the medical clinic's operations. This began out of necessity: money was so tight that they were obliged to be as fiscally responsible as possible. They currently use PDSA (Plan-Do-Study-Act) cycles to introduce and improve clinical and management processes. All staff members are involved in the PDSA cycles, including the office administrators and medical office assistants.

In an effort to improve access to services, in July 2005, staff introduced the "Advanced Access" system (they call it "Open Access"). This process, which is promoted by the Institute for Healthcare Improvement in the United States, has a motto associated with it: "Do today's work today." All staff members know this expression and have worked very hard to make the transition to Open Access a successful one. Everyone in the clinic recognizes the value of Open Access in reducing wait times for patients and in ensuring continuity of care.

Mid-Main does not have many written policies and procedures. Until now, new staff have learned about the culture, procedures and processes of the clinic "by doing," not through formal methods. This is working at Mid-Main, as patient satisfaction is consistently high and preliminary health outcomes for specific disease categories are positive.

Interestingly, all staff members who were surveyed strongly agree that working as a team improves the quality of patient/client care that is delivered at Mid-Main. However, as team members and management change, and as the organization grows, staff have realized that it is necessary to transfer knowledge and culture through documentation, not just through hands-on experience.

A complete list of people who participated in this case study and some relevant forms and documents (e.g.,Transfer of Function Agreements, Pharmacist Prescriptive Authority) that support interdisciplinary work at Mid-Main can be found in Appendix B.

Hours of Operation

- The centre is open six days a week and Tuesday evenings:
  - Monday: 8:30 a.m. to 7:00 p.m.
  - Tuesday: 8:00 a.m. to 7:30 p.m.
  - Wednesday: 9:00 a.m. to 5:00 p.m.
  - Thursday: 9:00 a.m. to 6:00 p.m.
  - Friday: 8:00 a.m. to 5:00 p.m.
  - Saturday: 9:00 a.m. to 2:00 p.m.
- After-hours, on-call services are available 24-hours-a-day to reach physicians, and until 11:00 p.m. to reach a dentist.

Programs and Services

- Medical and dental care
- Chronic disease education, including Group Medical Visits and Diabetes Best Practices Groups
- Clinical pharmacist services, including smoking cessation, asthma care, patient teaching and monitoring, and medication maintenance
- Nurse practitioner services
- Well Woman groups
- Well Baby groups*
- Mid-Main Youth Clinic, including a youth counsellor*
- Psychological counselling, in partnership with a fee-for-service psychologist
- GP Partnership*—management of home care patients from Mid-Main

*In partnership with Raven Song Community Health Centre

Nor'West Co-op Community Health Centre

Nor'West Co-op Community Health Centre is a non-profit accredited health agency that has been in existence since 1972. It is located in north Winnipeg.

Keys to Success: What We Heard

- Health care organization with mature interdisciplinary processes and culture
- Rare, passionate commitment to the community and its residents (Nor'West Centre is deeply embedded in the community)
- Exceptional team spirit and approach
- Innovative, imaginative programs geared to identified community needs
- Strong joint management, vital for successful integration of different staffs
- Problem-solving, can-do approach
- Ongoing quality improvement process
- Ability to foster supportive external relationships

HOW DID IT DEVELOP AN INTERDISCIPLINARY PRACTICE?

The Nor'West centre was established in 1972 by community members, as part of a co-operative community health centre. The vision, which was inspired by Scandinavian models, was as follows: "At Nor'West Centre, preventative care will be a fact, not a concept; the physician will become a member of a health care team, not the leader; the patient will become an individual, not an illness; and health care will involve the dentist, the nurse, the nutritionist, the social worker, the pharmacist, the community worker and the community working together, not in isolation from each other."

The vision has kept growing. It has been refined to its current version: "We envision safe and healthy neighbourhoods in Inkster and beyond, where citizens have nutritional and income security, where children and their families live together in environments that foster growth, potential and well-being, where individual and family wellness is promoted through an accessible network of holistic health services of the highest quality, developed and delivered in partnership with the community."

WHAT POPULATION DOES IT SERVE?

The health centre provides services mainly to residents living in the Inkster community, including the north Winnipeg neighbourhoods of Weston, Brooklands, Gilbert Park, Shaughnessy Heights, Tyndall Park, Garden Grove and Meadows West. The area is under-serviced by physicians, with only 3.2 in total. The surrounding community includes co-operative housing, social housing and seniors' housing, and has a high demand for health services. In addition, the health centre also serves specific groups of population in the city of Winnipeg (immigrant and refugee population, seniors requiring nursing foot care, women who experience family violence and women who have consumed considerable alcohol or drugs during their pregnancy).

The population of 31,275 that the Nor'West centre serves is diverse. The major cultural groups are Filipino, Ukrainian, Aboriginal, British, South Asian and German. The population is at higher risk than that of the overall Winnipeg region, based on many health status indicators, such as personal health practices, personal resources, health conditions and functional status. In particular, the population of East Inkster has a lower median income ($32,475 versus $43,383 for Winnipeg), a higher teen pregnancy rate (138.2 versus 57.3 per 1,000 females, aged 15 to 19), a higher rate of diabetes (56.2 versus 48.6) and overall, Inkster has a higher proportion of vulnerable populations e.g., Aboriginal, children under 15 years, visible minorities, single-parent families, persons with disabilities).

WHO ARE THE HEALTH PROFESSIONALS AND HOW ARE THEY PAID?

Nor'West began with a team of eight staff, and now has approximately 55, referenced in Table 3.

Table 3: Compensation and Source of Funding for Health Professionals— Nor'West Co-op Community Health Centre

Position	Compensation Method	Source of Funding for These Positions
2 Physicians	Salary/Contract	Winnipeg Regional Health Authority (WRHA) Purchase Agreement
3 Primary Care Nurses	Salary	WRHA Purchase Agreement
1 Reproductive Health Educator	Salary	WRHA Purchase Agreement
1 Dietitian	Seconded/Contract	Contract
1 Health Promoter	Salary	WRHA Purchase Agreement
1 Family Violence Counsellor (Social Worker)	Salary	Family Services and Housing (FSH)—Family Violence Protection Branch
1 Aboriginal Social Worker/Outreach	Salary	WRHA Purchase Agreement
1 Mental Health Counsellor (Social Worker)	Salary	WRHA—Direct
1 Diabetes Educator (RN)	Volunteer/Contract	Contract
4 Families First Visitors/Outreach (Social Workers)	Salary	WRHA—Direct
7.5 Public Health Nurses	Salary	WRHA—Direct
3 Home-Care Case Coordinators	Salary	WRHA—Direct
4 Footcare Nurses	Salary	WRHA Purchase Agreement
7–9 Community Development Workers (includes 1 Coordinator)	Salary	Winnipeg Foundation, United Way, Manitoba Arts, Manitoba Justice
4 Fetal Alcohol Syndrome Mentors/Outreach Workers	Salary	Healthy Child Manitoba
5 Immigrant Women's Counselling Services (IWCS) (Social Workers/Counsellors)	Salary	FSH—Family Violence Protection Branch
2 A Woman's Place Support Worker	Salary	
1 A Woman's Place Volunteer Coordinator	Salary	
1 Lawyer	Contract	Winnipeg Foundation
6–7 Early Childhood Educators/Director	Salary/Occasional Contract for special needs grant	FSH

Source: EICP Secretariat.

HOW IS THE CENTRE FUNDED?

The team receives funding from different sources. Because Nor'West is a co-operative, it requires a $1 lifetime individual membership fee. However, most of its funding comes from public funds from the Winnipeg Regional Health Authority (through direct funding and purchase agreements) and Family Services and Housing. It also receives grant funding from the United Way, the Winnipeg Foundation, Manitoba Arts and Manitoba Justice.

HOW DO THEY WORK TOGETHER?

Nor'West is client-centred, client-driven, and completely connected to its communities. Staff members are so committed that they are willing to visit clients wherever they are in the community. Staff embrace interdisciplinary care and the collaboration it entails. "Collaboration is totally ingrained in us," was a phrase repeated again and again. They believe unequivocally that interdisciplinary care is not just the best, but the only way to provide good care to their patients and clients. As one physician said, "We have a complex clientele. We couldn't provide care to them any other way."

Staff members are constantly looking for new partnerships and put a great deal of effort into building new collaborative arrangements. Staff members ask themselves how they can make potential stakeholders in the community "love us" so that they can work together towards a common cause.

The interdisciplinary nature of the centre means that teams are a modus operandi at Nor'West. Every staff member is expected to be on a team. The Community Development Team is an integral part of the collaborative practice—bridging and facilitating integration. The Inkster in Action initiative is one example of collaborative practices at Nor'West. This initiative comprises nine cross-functional teams: Research, Restaurant Committee, Communications, Nutrition/Food Security, Healthy Schools, Inkster in Action Steering Team, Active Living, Volunteer, and Workplace Wellness. Interdisciplinary collaborative practice is the "heart and soul" of the Primary Health Care Program. All collaborative projects have a research component to ensure that their objectives are still valid, and to assess and strengthen their performance.

Nor'West staff members admit that they "have more meetings than anyone else." On the plus side, the team meetings bring people together, break down silos, and offer staff an opportunity to contribute ideas for improving the health centre's programs, to share ideas from training sessions (also shared through lunch and learn sessions), and to stay current on what is happening in the rest of the centre. The results from the team effectiveness survey support this positive view. Respondents strongly agree that teams meet regularly for planning, that team members clearly understand their roles and that teams work very cohesively. Staff believe that meetings and between-meeting communications are very effective. On the other hand, our interviews also reveal that the number of meetings creates challenges, in terms of time commitment and scheduling.

The team has had two obstacles to overcome in working together cooperatively. First, the team is somewhat dispersed. While most individuals are at one location (61 Tyndall Ave.), a home-care team is located in a sister neighbourhood due to a lack of space. Some programs are located at two satellite locations. The programs that operate at satellite locations are integrated through two different intranets, a phone system and e-mail.

Second, the centre has had to integrate a block of new non-Nor'West staff. In 1999, Nor'West signed a joint agreement with Winnipeg Regional Health Authority (WRHA) and Family Services and Housing (FSH) with respect to the *Personal Health Information Act,* and began to work collaboratively with them. The public health nursing team and mental health worker moved to Nor'West's location. To ensure that all employees work together as smoothly as possible, staff participate in joint strategic planning sessions, joint program planning meetings, joint case meetings and a joint initiative (Inkster in Action), and all attend an annual staff retreat. As well, an integrated social work intake process has been implemented between the community mental health worker, Aboriginal coordinator and the family violence counsellor to better address clients in the community who need counselling services.

Nor'West has two strong leaders in its executive director and its primary care coordinator. The executive director is also the team manager of the WRHA staff—which has been very successful in integrating both sets of staff and ensuring that they work together—and the primary care coordinator is the clinical leader in health care. They have taken steps to ensure that all staff members are on the same track. In 2004, Nor'West co-facilitated and participated in a joint strategic planning session with WRHA and FSH, in which visions were shared and goals and priorities identified for the Inkster community. The team effectiveness survey shows that staff members are indeed satisfied with their leadership, which they feel is shared and is very reasonably delegated in line with areas of competence. Staff members also believe that they

have the opportunity to develop their skills within the team.

All staff members have been trained in quality improvement. To determine how well the centre is meeting clients' needs, the centre surveys clients and staff regarding satisfaction. Over the years, more than 90 per cent of the centre's clients have expressed satisfaction with the services and care received throughout its many programs. Quality improvement is an ongoing initiative, and staff and management take it very seriously, as evidenced by the many quality improvement plans in place. In fact, they have voluntarily participated in accreditation.

As one staff person said, "The bottom line is that we all want the best for our clients. We are all emotionally connected to the community and to each other."

A complete list of people who participated in this case study and some relevant documents (e.g.,Human Resources Plan, Staff Satisfaction Survey, Quality Monitoring Plan, description of the integrated goal sheet) that support interdisciplinary collaboration at Nor'West can be found in Appendix C.

Hours of Operation

- Monday to Friday, 8:30 a.m. to 6:00 p.m.
- Clinic is sometimes open on Saturdays and there are specialty clinics and other special events.
- Nor'West participates in an after-hours physician call schedule with other community health centres. There are also centralized after-hours information lines, such as Health Links and the Breastfeeding Hotline.

Programs and Services

- Primary Health Care Program (family medical care, treatment of minor emergencies, dietitian services, diabetes education and support, lifestyle counselling, fitness appraisal, pregnancy testing and counselling, well-baby clinic, teen clinic, flu shots, advocacy, referrals)
- Community education and health promotion on senior nutrition and active living, smoking cessation, weight management, parenting support, diabetes support and reproductive health
- Counselling programs (Family Violence Counselling Program, Immigrant Women's Counselling Program, Aboriginal Counselling Program and A Woman's Place)
- Early Learning and Childcare Centre (an on-site daycare facility, which started 30 years ago, offering many part-time spaces; there are also spaces for children with disabilities)
- Community Development Program, an ongoing program where community facilitators work with and for the Inkster community, as a resource and to assist in implementing community projects (which has led to Inkster in Action)
- Fetal Alcohol Syndrome (FAS) Mentor Program (counsellors work intensively for three years with women who are pregnant or have had a baby in the past two months and have used alcohol or drugs heavily during their pregnancy)
- Foot Care Program (began in 1984, funded by WRHA)
- Inkster in Action: a new joint (Nor'West, WRHA and FSH) initiative aimed at promoting physical activity and improving the nutrition of community residents, including kids in school; one project involves residents and service professionals working together to start a restaurant that serves healthy and delicious food
- Therapy for children and youth who have witnessed violence
- WRHA/Inkster Public and Mental Health Team (offers services and support from public health nurses, Families First home visitors, community nutritionist, and community mental health worker)
- Inkster Parent–Child Coalition (to provide programs and support in the areas of nutrition, safety, parenting, literacy and community capacity building)
- Legal aid available through services of a part-time lawyer

Nor'West is also involved in:

- Diabetes Care Mapping Project
- Gilbert Park Resource Centre, a multi-partner opportunity between Manitoba Housing, Family Services and Nor'West (the service professionals will work with this high-needs community to ensure that appropriate programs and services are available)
- Inkster Neighbourhood Network, which consists of community organizations that operate within the Inkster community to promote community wellness
- Healthy Start for Mom and Me—a provincial outreach program for pregnant young moms and new moms

Rosedale Medical Group

Rosedale MedicalGroup, a Family Health Team, is one of the oldest and most well-established interdisciplinary primary care practices in Ontario, having existed since the mid-1970s in the east end of Hamilton, Ontario.

Keys to Success: What We Heard

- Mature interdisciplinary and inclusive team
- Focus on efficiency
- Innovative ways to bring new members to the team
- Clear vision
- Excellent use of nurse practitioners
- Strong external partnerships
- Proactive pursuit of grants

HOW DID IT DEVELOP AN INTERDISCIPLINARY PRACTICE?

Two physicians, who were interested in finding better ways to fund and deliver care, started the practice in the mid-1970s. A third physician joined in 1984. In 1986, Rosedale was designated as a Health Service Organization, an early model for capitation funding in Ontario. In the same year, a fourth physician joined the practice. Capitation funding models have evolved in Ontario since then, and in 2005, Rosedale Medical Group became a Family Health Team with six practicing family physicians.

Rosedale physicians have a history of being early adopters of new thinking in care delivery. For example, they hired some of the earliest nurse practitioner graduates and have expanded their services to include other health professionals. They have maintained a strong working relationship with the Ministry of Health and Long-Term Care (MoHLTC), and Rosedale has often been chosen as a pilot site for new programs. Staff members continue to pursue opportunities for additional program funding.

In Ontario, Hamilton is known as a city unique for its adoption of the capitation funding model, which has not been widely adopted in the rest of Ontario. Rosedale is a member of the Hamilton Escarpment Primary Care Network Group, which encompasses eight additional physician groups and has worked in partnership with some of them.

WHAT POPULATION DOES IT SERVE?

Rosedale Medical Group currently serves approximately 14,500 patients. Although the group is located in the east end of Hamilton, patients come from a 400-square-kilometre area that spans Burlington to Dunnville, and Grimsby to Brantford. The patient population encompasses a wide cross-section of people from low- to middle-income streams, including specific populations, such as single-parent families and children, a significant elderly population (aged 50+), and a geriatric population (aged 65+). Rosedale physicians assume medical responsibility at three Children's Aid homes and several group homes for young offenders. Three physicians act as medical directors at four large long-term care facilities in Hamilton.

The ethnicity of the patient population is quite diverse, and becoming more so with recent immigrants and refugees from Kosovo, El Salvador, Eastern Europe and the Middle East.

WHO ARE THE HEALTH PROFESSIONALS AND HOW ARE THEY PAID?

The Group's staff includes the health professionals referenced in Table 4.

Table 4: Compensation and Source of Funding for Health Professionals—Rosedale Medical Group

Position	Compensation Method	Source of Funding for These Positions
6 Family Physicians	Capitation and Fee-for-Service	Ontario Ministry of Health, insurance companies (for things such as physical reports, vehicle accidents) and private patients
2 Nurse Practitioners	Hourly	Privately, by family physicians, and through special program funding from Ministry
1 Breastfeeding and Parenting Nurse Specialist	Hourly	Privately, by family physicians, and through special program funding from Ministry
1 Diabetes Nurse Educator	Hourly	Pharmaceutical company
2.2 Mental Health Counsellors (1 Social Worker, 1 Psychiatric Nurse)	Salary	Mental Health and Nutrition Program (provincial program)
0.5 Dietitian	Salary	Mental Health and Nutrition Program (provincial program)
2 Chiropractors	Capitation and Fee-for-Service	Pilot funding (from Primary Health Care Transition Fund, Ontario Ministry of Health), Work Safety Insurance Board, insurance companies and patients
0.20 (Combined) Massage Therapist/Acupuncturist	Fee-for-Service	Insurance companies and patients
7 Registered Nurses	Hourly	Privately, by family physicians
11 Medical Secretaries	Hourly	Privately, by family physicians
0.62 Nurses Assistant	Hourly	Privately, by family physicians
2 Homecare Coordinators (informal members of the team—assigned by CCAC)	N/A	Community Care Access Centre
2 Physiotherapists (informal members of the team—leasing space)	N/A	Renting
1 Pharmacist (informal member of the team—leasing space)	N/A	Renting

Source: EICP Secretariat.

HOW IS THE CENTRE FUNDED?

Rosedale Medical Group is a cost-sharing partnership. The major source of funding for the practice is through capitation, although some patients live outside the practice's geographic boundaries and are billed on a fee-for-service basis. The additional health professionals at Rosedale have enabled the practice to carry a larger patient enrolment than the provincial average.

Rosedale has enthusiastically pursued additional sources of funding. For example, the Ontario government offers incentives to reach and exceed targets in prevention activities, such as immunization and screenings. Rosedale has also solicited alternative funding from both government and private sources, such as drug companies, for special projects and to fund new positions, even if on a temporary basis. For example, Rosedale has been chosen as a pilot site for a project to incorporate chiropractors into a primary health care practice. Chiropractors usually bill on a fee-for-service basis, but as part of this project, they are instead remunerated through a blended model (capitation plus fee-for-service). The study is ongoing, so no recommendations for future funding have been made, as yet.

The MoHLTC has provided additional capital funding for information technology (IT), often as part of an incentive package to participate in primary care reform initiatives, along with the capitation funding. Rosedale Medical Group uses an electronic medical record (EMR) system to link all professionals in the practice. This investment allows the health professionals to access a patient's complete electronic medical record instantly.

HOW DO THEY WORK TOGETHER?

The Rosedale Medical Group is a pioneer in interdisciplinary care. The Rosedale Group's practice designation has changed over the years, but its interdisciplinary, collaborative philosophy has not. It hired some of the first nurse practitioners coming to Ontario from the United Kingdom, and also some of the first graduates from the new provincial education program for nurse practitioners. Since then, Rosedale has added diverse health professionals. The physicians believe that interdisciplinary care addresses three major problems:

1. The increasing complexity of medicine. They believe that it is necessary to include other services in order to provide excellent care.
2. The need to boost efficiency. They believe that, in order to treat large numbers of patients, which physicians will have to do as the baby-boom generation ages, it is best to delegate routine care, thereby giving the physician the time s/he needs to deal with the more complex cases.
3. Professional dissatisfaction (particularly overwork) among health care workers.

The physicians at Rosedale Medical Group are clearly the team leaders, but they recognize the strengths of other professionals and build on these strengths when providing care. And, according to the team effectiveness survey, staff understand their role within the team, strongly agree that their abilities, knowledge and experience are being fully used, and strongly believe that working together brings about more integrated and coordinated service delivery.

Each of the six family physicians works closely with an administrative support person and a registered nurse, who play an important role in the team by providing nursing support to the physicians and acting as case managers. They offer phone triage advice to patients, taking between 20 and 30 patient calls daily. Nurses may see patients independently for routine care, such as immunizations and allergy injections, disease prevention, and screening for breast and cervical cancers. The variety of health professionals at Rosedale means that the right provider can meet the patient's needs.

The nurse practitioners see a wide range of patients with both chronic and acute conditions. They provide routine services, such as annual health exams and well-baby care; and take some "emergency" calls from patients who need same-day service.

There is a clinic manager, whose role is vital to the group's interdisciplinary approach. She works with a lead physician (the physicians rotate this role) regarding day-to-day management in areas of human resources, finance, information technology and facility management, and acts as the main liaison with the MoHLTC. She also engages in strategic activities, such as developing accountability plans and performance measures in health systems planning and evaluation, and in community engagement. As a leader in the practice, she also sets standards for interdisciplinary team functions.

As one physician at the centre said, interdisciplinary care is essentially "all about communication." The office space has been designed in such a way as to facilitate this crucial aspect of the practice. Nurses and medical secretaries work in close proximity, and the physicians all share one large space and are easily accessible by other staff. A shared EMR also makes communication and record-keeping easier.

One of the chiropractors on-site pointed out that co-location is a key to his success. Ninety per cent of his

patients are referrals from Rosedale physicians, allowing the chiropractor to "focus on what I am good at," rather than on marketing and administration. Through discussions, the physicians and chiropractor agreed on the chiropractic services to be provided on-site.

At Rosedale, collaboration is so well integrated with daily activities that the staff do it without being completely aware of it; it is simply part of their style. Staff members learn most about each other's strengths by working together. Rosedale also has "lunch and learn" sessions and other educational activities that focus on a particular health issue, such as chronic pain or migraines, where discussion about how the different disciplines can help leads to a fuller understanding of roles. They have found this to be especially useful when bringing new staff on board.

At one time, the three original physicians owned the building and made decisions about other tenants based on the other services they wanted to have on-site. They have since decided to sell the building but maintain a good relationship with the present owners, and they have input into decisions about new tenants. This is vital because their decisions profoundly affect the range of care/services that is readily available on-site to patients. Physicians refer patients to the other professionals located in their building, such as physiotherapists, physician specialists and a pharmacist. Physiotherapy and clinical pharmacy are not directly a part of Rosedale Medical Group but, because of their proximity, and the fact that Rosedale practitioners communicate with these professionals regularly, they are considered part of the care delivery group.

The on-site pharmacist has an excellent relationship with Rosedale and often provides staff with drug information. The pharmacist follows up with patients to ensure medication is being taken properly, to address concerns and to evaluate side effects. If the patient identifies problems, the physician is advised. There is no financial incentive for the pharmacist to provide this service and no direct connection to the Rosedale medical practice. The pharmacist takes on this work because she believes that "this is what pharmacists should be doing." The pharmacist believes that this service improves the quality of care and that being in the same building enables close communication. Patients are given the "Passport to Health," which is an up-to-date booklet of patients' specific goals, medications and measures such as diet and exercise that support patients in their efforts to live healthier lives. This booklet was developed by the pharmacist and another family physician in the Hamilton area.

There is also a physiotherapy service in the building, and the physiotherapist and Rosedale health professionals often confer regarding patient care.

The Rosedale Medical Group also excels at creating external partnerships. Rosedale is the only medical practice in Hamilton with assigned Community Care Access Centre (CCAC) case managers, in recognition of the excellent relationships that the CCAC case managers and staff at Rosedale have developed and the efficacy of their working processes. There is daily communication between the CCAC case managers and nurses. In addition, they have monthly team meetings with the physicians, and everyone knows about changing patient needs.

Rosedale Medical Group's integration of diverse services has worked to increase accessibility and efficiency and provide high patient and staff satisfaction. It tracks employee satisfaction levels through annual performance reviews. The organization is benchmarked against past performances and also against other organizations through recent practice management evaluations and consultants' reports.

The upshot: Rosedale is offering comprehensive health services that meet its patients' diverse needs. It is also strongly encouraging its patients to use its services instead of the hospital emergency department. With respect to administrative decisions, the non-physician staff members perhaps do not have as much influence at Rosedale as they do in other interdisciplinary settings, but they recognize that the collaborative approach to care works well—as do Rosedale's many satisfied patients.

Please refer to Appendix D for a complete list of people who participated in this case study and some relevant documents (e.g., Confidentiality Agreement, Leasing Agreement, Performance Appraisal and Development Plan 2006) or forms that support interdisciplinary collaboration at Rosedale.

Hours of Operation

- Offers 24/7 care: The medical office is generally open weekdays for appointments. Occasionally, extra physician hours and appointments are added, as needed (for example, during flu shot season). Comprehensive care involving the diagnosis and management of acute and chronic disease is provided, as well as health promotion and prevention activities.

- After-hours and weekend coverage is provided by the Telephone Health Advisory Service and Hamilton Escarpment Primary Care Network group. Nurses triage calls and decide if the physician on call should be contacted. Patients are well educated regarding this service. Patient use of outside services, such as visits to walk-in clinics, is billed back to the Family Health Team. Rosedale patients' rate of use has been less than 3 per cent over the last five years.

Programs and Services

Comprehensive care, including:

- Diagnosis and management of acute and chronic disease
- Health promotion and disease prevention
- Primary reproductive care and pregnancy care
- Primary mental health care
- Primary palliative care
- Long-term care
- Chronic disease management programs
- Diabetes education

The Group plans to add addictions services and a pharmacist to the interdisciplinary collaborative team, although it already works very closely with the pharmacist on-site.

Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

These three primary health care groups are part of the Chinook Primary Care Network (CPCN), located in the mixed rural and urban area of southern Alberta, adjacent to British Columbia and the northern boundary of the United States. They each serve different communities with diverse ethnic, religious and cultural profiles. The specific needs and expectations of each community directly affect health service planning and delivery.

The **Taber Associate Medical Centre** is a partnership of eight physicians. It is a teaching site for students and residents from the University of Calgary's School of Medicine. **Pincher Creek Medical Clinic** is a partnership of eight family practice physicians. It is also a teaching site for medical students (urban and rural programs) from the University of Calgary. **Lethbridge Family Medical Practice** has six full-time and one part-time family practice physicians. In addition, the clinic has an internal medicine/gastrology specialist on-site. As the other two medical groups, Lethbridge Family Medical Practice is also a teaching site for medical students (residents) of the University of Calgary.

HOW DID THEY DEVELOP AN INTERDISCIPLINARY PRACTICE?

In the Chinook Region, the move towards enhanced interdisciplinary collaboration was initiated by a partnership between the Chinook Health Region (CHR) and approximately 80 family physicians, with the support of the provincial government, and funded by federal transfer funds. The trilateral relationship between Alberta Health and Wellness, the Alberta Medical Association and the Regional Health Authorities has facilitated primary care renewal efforts in the province of Alberta and has provided the basis for the CPCN. The primary care efforts in the region have focused mainly on physicians, with incentives and financial support that allow the physician groups to hire a variety of other health professionals.

The CPCN is providing support for program development and office practice redesign processes to the 15 participating primary care groups. One of the key strategies used to reinvigorate family practices is the formation of interdisciplinary family practice teams in physicians' offices. These teams are led by family physicians and involve a range of other health professionals, including registered nurses, nurse practitioners, social workers, diabetes nurse educators, required to meet the needs of the population they serve.

Keys to Success: What We Heard

- Physicians are represented on the regional Chinook Primary Care Network (CPCN) governance board. As well, Chinook Health Region (CHR) leaders and physicians are represented on many CHR working and management committees. The physicians and CHR leaders realize that it is financially advantageous to work together, and there is a high degree of mutual trust and confidence between the region and physicians. Among the provinces, this is unprecedented.
- The change management support made available by the CHR and facilitated through the CPCN support team to the physician groups has accelerated change.
- The targeted goals are the result of negotiation between the CHR and physician groups. No goals have been imposed.
- Physicians are paid through different methods (fee-for-service and alternate payment plan), but all agree on the benefits of interdisciplinary care and are committed to it.
- Electronic health records facilitate strong interdisciplinary care.
- The strong networking, partly facilitated by the Chinook Primary Care Network, has encouraged the dissemination of best practices among the primary health care groups.

There is a close relationship between many of the physicians in this region and the regional health authority. Physicians have always been invited to executive meetings and asked to voice their opinions on new directions. Consequently, there is a high level of trust between the region and local physicians, and primary health care is not regarded as something imposed from above. The region and the physicians have worked, and are working, together to achieve their mutually agreed-upon aims: to improve health services to a defined, fairly rural, population and to make physicians' workloads more manageable. Compared to medical networks in other provinces, the CPCN operates with a high degree of harmony, and this greatly facilitates the move to interdisciplinary care.

Taber began to work collaboratively in 1999, under the Taber Integrated Primary Care Project, a primary care demonstration project. This project successfully piloted an alternative payment mechanism for physician services that started in 2000. During this phase, a new alliance between the physician group and the CHR was established to jointly manage services traditionally provided independently. In order to increase comprehensiveness and service integration, the medical group is now hosting staff from the Chinook Health Region's chronic disease programs. The

integrated clinical group has expanded and now includes nurse practitioners, a dietitian, a diabetes health educator and a respiratory therapist. The Taber Associate Medical Centre shares a building with chiropractic, massage and counselling clinics.

Pincher Creek is also quite new to interdisciplinary care. Pincher Creek began to move towards collaboration in 2003 when it received three years of funding for the Pincher Creek Rural Primary Health Care Project, now known as the Good Health Initiative. The Good Health Initiative is physician-driven and clinic-based. The key components include chronic disease management, health promotion and screening, mental health and wellness, and a surgical expansion program. As part of this initiative, the clinical group has expanded and now comprises a nurse coordinator, a social worker, a registered dietitian and a clinical pharmacist.

In order to accommodate the physical needs of the expanded team, this clinical group recently changed location and is now adjoined to the Community Health Facility (formerly the Pincher Creek Hospital). As a result of this move, the clinic's quarters are expansive, newly renovated and freshly painted. The hospital and the clinic reinforce each other and stand as a bastion of health care for the area.

The Lethbridge Centre is the most recent of the three clinics to move towards collaborative care. It shares a building with a pharmacy and a dental clinic, which operate separately. The Medical Centre has been in existence for 32 years but adopted an interdisciplinary approach in the past 18 months, largely on the initiative of father-son physicians, Drs. Calvin and David Stewart, who believe that interdisciplinary care is best for the patient and beneficial for overworked physicians, too. They have retrained and expanded their team to include: a healthy lifestyle program coordinator; a nurse clinician in charge of prenatal assessment and screening, and managing cervical screening/breast health/women's health and well baby programs; more registered nurses to support individual clinicians; and a physiotherapist.

WHAT POPULATION DO THEY SERVE?

The **Taber Medical Centre** serves the 15,343 inhabitants of the municipality of Taber. The population in Taber is fairly homogeneous. Only about 5 per cent are visible minorities (mostly of Japanese descent), and Aboriginal populations represent less than 2 per cent. Kanadier Mennonites form the majority of Taber's rural population. In general, Taber has a younger population than the rest of the region, with slightly lower education levels, yet higher incomes. Approximately 65 per cent of families have children at home.

A high percentage of Taber Associate Medical Centre patients (approximately 60 per cent) have chronic disease/care issues including diabetes, hypertension, asthma, Chronic Obstructive Pulmonary Disease (COPD), depression and diseases of the musculoskeletal system.

The **Pincher Creek Clinic** provides services to Pincher Creek and the surrounding communities, including many residents of the nearby Piikani reserve—approximately 9,500 patients in all. It also operates a satellite clinic in Brockett.

There are many patients with chronic disease and chronic care issues, including diabetes, hypertension, asthma, COPD, cardiac-related problems, diseases of the musculoskeletal system, depression and anxiety. Many have risk factors for chronic diseases, including addictions, hyperlipidemia, obesity, inactivity and poor nutritional habits.

The **Lethbridge Family Medical Centre**'s 20,000 clients include Natives and Hutterites, along with the local Lethbridge population. Obesity is a major problem, as is diabetes. The clinic's popular Healthy Lifestyles program attracts patients from outside the clinic, who are welcome to attend. Lethbridge has a 400-member strong Marathon Runners Club, so it gives special consideration to sports injuries and sports-related conditions.

WHO ARE THE HEALTH PROFESSIONALS AND HOW ARE THEY PAID?

The Centres' staff include the health professionals referenced in Table 5.

Table 5: Compensation and Source of Funding for Health Professionals—Chinook Primary Care Network

Position	Compensation Method	Source of Funding for These Positions
8 Family Physicians	APP (Blend of Salary and Fee-for-Service)	Medical Services of Alberta Health
16 Family Physicians	Fee-for-Service	Medical Services of Alberta Health
2 Nurse Practitioners	Salary	Chinook Primary Care Network (CPCN)
9 Registered Nurses	Salary	CPCN
6 Licensed Practical Nurses	Salary	Clinics
3 Radiology Technicians	Salary	Clinics / Regional Health Authority
1 Respiratory Therapist (Co-located)	Salary	Chinook Health Region (CHR) Staff
3 RN Diabetes Educators (Co-located / Linked)	Salary	CHR Staff
3 Dietitians (Co-located / Linked)	Salary	CHR Staff
3 Laboratory Technicians	Salary	CHR
25 Assistants	Salary	Clinics

Source: EICP Secretariat.

HOW ARE THE CENTRES FUNDED?

Physician services are publicly funded through the physician services budget. Currently, the physician clinics engaged in interprofessional practice have hired other team members through their independent corporations. Prior to December 1, 2005, clinics that had clinical staff onsite compensated these team members from their practice and will continue to compensate them in this way. As of December 1, 2005, the CPCN distributes funds to a new entity, "the physician not-for-profit corporations," set up by each physician clinic, which now hires new clinical professionals to add to the existing teams. The Chinook Primary Care Network receives provincial funds that have been allocated from the Federal Primary Care Transition Fund to support enhancements to primary health care services.

Taber Associate Medical Centre adopted an alternative blended payment plan based on capitation and fee-for-services. Capitation is based on a provincial population cost formula, which is estimated based on the age and gender profile of the Taber population. The Medical Centre also receives fees for services and special bonuses for targeted health promotion and screening (such as the attainment of immunization rates). The physicians have hired the existing health professionals on the team (except the CHR co-located staff). New clinical team members will be funded through the CPCN partnership funding. The group's experience with this payment method was so positive that members adopted it formally after the pilot project ended. They report that this method allows them to focus more on community interventions, which are seen as key to improving the health of their population.

At **Pincher Creek**, the Good Health Initiative is funded through the Capacity Building Fund (CBF) and is supported by strong partnerships with the Chinook Health Region, Aakom-Kiyii Health Services and the Napi Friendship Centre. Physicians are reimbursed through a fee-for-service model. In order to maintain the interdisciplinary collaboration that characterizes this group, the physicians have been able to negotiate financial support for their involvement in interdisciplinary work (meetings, strategic planning, etc). The physician group currently receives financial support from the CBF to cover the salaries of the Good Health Team members, such as family practice nurses, the pharmacist, social worker, dietitian and nurse coordinator. The Good Health Team members will be sustained through CPCN funding. In addition, the Capacity Building Grant makes available special funding to support

communication, team development and education/training that will be sustained through CPCN funding. The CHR has designated resources to assist with the relocation and expansion of the clinic's surgical services.

The **Lethbridge Family Medical Clinic** is government-funded, and the physicians are paid on a fee-for-service basis. Prior to December 1, 2005, the clinic paid for the addition of clinical team members. Currently, this clinic receives funding from the CPCN to cover the salaries of some health professionals on the team (e.g., family practice nurses, physiotherapists) and to pay for the addition of new team members, as well as for the renovations required to accommodate a larger team. Certain provisions cover some IT-related expenses, marketing, communications, team development and training.

HOW DO THEY WORK TOGETHER?

All three centres have strong support from their regional health authority, and are fortunate, in that they have leadership from the Chinook Health Region's Vice-President of Medical Services, Dr. Vern Jubber, who is wholly committed to interdisciplinary care and to a population health approach. In his view, "Doctors have to be responsible for the health of the population, not just the patients who come to the door." This more holistic approach is made possible through a strong partnership with the physician group in the area, which has been involved in regional decision-making for some time.

Jubber believes that change requires the right leadership and the development of trusting relationships between physicians and the region. Once the team is complete and the collective vision established, it can start moving forward.

Clinical groups in the region receive very comprehensive population information from the regional health authority. This information is pivotal for health planning and programming. A number of structures are in place to promote interdisciplinary care:

- Regular clinical team meetings that occur at each site/program;
- Regular improvement meetings that occur at each site; and
- Regular improvement meetings, called "The Office Practice Redesign Initiative," which bring these groups together for regular learning sessions, followed by action periods that occur back at the local health sites.

This last initiative is helping the health professionals to build a common and solid foundation that encourages regular communication on-site, regionally and within their professional associations and bodies. The initiative is currently being guided by improvement advisors, Dr. Mike Davies and Dr. Mark Murray.

The team effectiveness survey shows that Chinook staff, like those at the other sites, strongly agree that working effectively as a team improves both the quality of care and the health status of the patients/clients. Staff also very much agree that the client is more involved in health care decisions.

Taber Associate Medical Centre

In Taber the team approach to health care is well established. Taber has several chronic disease management teams, including the Taber Asthma Program, which has had much success in reducing hospitalization rates and visits to emergency rooms. It has a co-located linkage with CHR Diabetes/Lipid Education Program, Building Healthy Lifestyles group education. A nurse practitioner and some physicians, along with a respiratory technician from the Taber Hospital, run the Taber Asthma Program. For a number of years, Taber also offered new methods of care delivery for infant care and women's care, in which public health nurses worked with physicians at well-baby clinics. The Taber group has a strong relationship with the RHA and enjoys its full support, and this has helped them.

The climate is open, both to communication and to change. "Change is our work. If we want to make a change, everyone needs to be completely honest. We expect everyone to speak up." At Taber, there is exceptionally strong clinical and management leadership, along with effective administration. This medical group has a cluster of national and provincial leaders: Dr. Robert Wedel is not only an inspiring leader for this group, but he was also the President of the College of Family Physicians of Canada in 2004–05. Mary Nugent, one nurse practitioner, was part of the executive team of the Nurse Practitioners Association of Alberta, and Michael Brand, the clinic manager, is part of the executive team of the Medical Group Management Association of Canada. Together, they provide leadership and vision to this medical group.

The group is still feeling its way, in terms of roles. When the first nurse practitioner arrived, she was given six months to examine community needs and define her role accordingly. She runs the Well Woman Clinic because so many women were leaving the community for Pap smears. A new nurse practitioner arrived a few months ago, and she is still

in the process of defining her role. Currently, she is supporting one of the physicians with a high number of more complex patients and, therefore, some work-life balance challenges. They are both learning as they go and are building the foundation for awareness of each other's skills and knowledge. The level of comfort, trust and respect is increasing week by week. The physician reports that the nurse practitioner is already saving him two hours a day.

Staff members at Taber are positive about the direction of primary health care renewal. They not only believe that the primary care system is improving, but also report that they are more satisfied with their professional practice, although, at times, they seem to be working harder. One of their challenges has been getting all personnel to buy into the change process. They recognized that CHR middle managers and clinic front-line administrative personnel play a key role in the success of the interdisciplinary model, and that they had to make extra efforts to bring them on board. Therefore, the group received support from an on-site coordinator, who enhanced communication and facilitated the change management processes during the pilot phase. Taber clinic's leaders claim that this position was vital to implementing the required changes.

This medical group has electronic medical records that are far more advanced than those in the rest of Canada. The group's EMR system not only allows the team to record and share patients' information, but also permits the physicians to access hospital information any time, anywhere. Physicians have a device that allows them to receive a password to access hospital patients' information from their homes. The ability to cross the boundaries of different organizations (medical group office, laboratory, diagnostic imaging and hospital) is the feature that makes this system a true electronic health record.

Pincher Creek Associate Medical Clinic

Better patient care is the common vision at Pincher Creek. The patient is the leader, and an interdisciplinary team of health professionals is there to support the patient in his/her choices.

The physicians and staff have been working as a team for 16 months. Among health professionals, "communication is the greatest challenge and the greatest strength." Primary health care "is a work in progress." Although the team "is still very green" and its members are still feeling their way, work processes are smooth and truly integrated.

A staff improvement committee meets once a week and, although members recognize they are new to team-based care, say that "it can work and it will work." No job descriptions exist, but staff members realize that one day they will need to be created, particularly if someone must be replaced. One physician likened the primary health care approach to building a house: "At Pincher Creek we are still working on the foundation, and are not yet at the stage of decorating the rooms."

There are many reasons to praise this team. They have created a positive and relaxed work environment and culture that embraces open communication, honest dialogue, innovation and creativity. Everyone recognizes the strengths of their colleagues and the benefits they bring to the team and to the patients. The physician group knew the nurse coordinator, social worker and the pharmacist before they joined the team, since they used to work together at the community's hospital. This may be one of the reasons this team has achieved so much in such a short time.

This medical clinic takes an interdisciplinary approach to patients' assessment, diagnosis and treatment. They hold care meetings with the patient to discuss and assess patients' options. As one of the physicians said, "Given our complex patients, I need the support of the team to ensure that the patients will receive adequate care." The recently added health professionals ensure that patients have access to resources available in the community for treatment or rehabilitation. They also play an important role in educating patients and providing information that makes sense within a cultural context.

Lethbridge Family Medical Clinic

Lethbridge is new to an interdisciplinary approach, and is still evolving. All but two of the physicians operating at the clinic embrace interdisciplinary primary health care, and they do so wholeheartedly. They report higher satisfaction from the team approach and relief that the needs of the patients they cannot address are being met by other health professionals.

Interdisciplinary care is largely physician-driven at this clinic. The physicians realized that they could not meet the needs of their patients alone, and that they are sometimes not the best ones to offer care. They recognized that obesity and chronic diseases, particularly diabetes, were major problems in their area, and that, as male doctors, they were not meeting the needs of their female patients. First, they turned to their staff for help and, later, to other professionals.

The clinic's popular Healthy Lifestyles program, which is run by a nurse who is also trained as a

fitness instructor, attracts outpatients, who are welcome to attend. Patients are offered the services of a nurse for such procedures as Pap smears and women's health screening. Lethbridge has a 400-member strong Marathon Runners Club, so the clinic gives special consideration to sports injuries and sports-related conditions, and hires physiotherapists to work on-site in a spare office, two days a week.

The Lethbridge physicians realized that there was a need for a psychologist, and came up with an innovative way to bring one into the clinic. They offer an office on Saturdays to an unchartered psychologist (the son of one of the physicians) and patients who are referred to him pay only what they can. The psychologist is working to become chartered, and his practice hours at the clinic will help him to reach this goal. The psychologist gets his requisite number of practice hours, and the patients get his help—a happy solution all around. Under a new model, patients will not be required to pay for psychological services, as CPCN funds will sustain the position.

There is a strong measure of equality and respect among all the health professionals and administrative staff working at the centre. Because Lethbridge is a small city and the medical community is even smaller, the doctors and nurses know each other and each other's strengths. This is vital to the success of collaboration.

No formalized team building has taken place, but all believe it would be useful to have. It would boost communication, an acknowledged weakness at the clinic. All agree that having access to patients' electronic health records facilitates the interdisciplinary approach tremendously.

Please refer to Appendix E for a complete list of people who participated in this case study and some relevant documents that support interdisciplinary collaboration (e.g., Office Improvement Pre-Work Packet, CPCN Communication Plan, CPCN Evaluation Workplan, CPCN Education/Support Menu) in the Chinook Primary Care Network.

Hours of Operation

Lethbridge

- Monday to Thursday, 8:00 a.m. to 7:00 p.m.
- Friday 8:00 a.m. to 5:00 p.m.
- Saturday 10:00 a.m. to 12:00 p.m.

Lethbridge's Walk-in Clinic

- Monday to Thursday 4:00 p.m. to 7:00 p.m.
- Friday 1:30 p.m. to 5:00 p.m.
- Saturday 10:00 a.m. to 12:00 p.m.

Pincher Creek

- Monday to Friday 8:45 a.m. to 4:30 p.m.
- Saturday and Sunday, closed

Taber

- Monday to Thursday 9:00 a.m. to 5:30 p.m.
- Friday 9:00 a.m. to 4.30 p.m.
- Saturday and Sunday, closed

Programs and Services

Lethbridge Family Medical Centre

- Healthy Lifestyle program
- Pre- and post-partum program (since 2005)
- Women's Health program
- Diabetes/Lipids Education (one part-time nurse and dietitian, who are CHR employees, have hours dedicated to the care of diabetic patients)
- Dementia screening program
- Physiotherapy services (two days a week)
- Dietitian services
- Obstetrics and gynecology
- Patient education sessions on hypertension and lifestyle choices

Pincher Creek

- Chronic disease management
- Health promotion and screening
- Mental health and wellness program
- Surgical expansion program

Taber

- Well Woman Clinic
- Well-Baby Clinic (2000–04)
- Diabetes/Lipid education
- Taber Asthma program
- International Normalized Ratio (INR) program
- Hypertension program

A Psychologist on the Team

THE EXPERIENCE OF THE WESTEND CLINIC

Only one of the sites visited, the Lethbridge Family Clinic, had a psychologist—and he was part-time, temporary and unchartered (he had graduated and was working on his practicum). All of the sites, however, noted the need for a psychologist, leading to a decision to examine the experience of the Westend Clinic, a family practice located in Ottawa.

In light of the number of consultations of a psychosocial nature, the Westend Clinic, a family practice office, was delighted to be given the opportunity to retain a psychologist on the premises for one year.

The Westend Clinic obtained the services of a psychologist as part of the Integration of Psychologists in Family Medicine Teams (IPEM) research project, funded by the Ontario Primary Health Care Transition Fund and coordinated by a psychologist and a family physician at Montfort Hospital in Ottawa. This project was piloted at two primary health care sites in Ontario. The anticipated benefits included continuity of care, ready and direct access (both for patients to a psychologist and for consultations between the physician and psychologist), higher satisfaction for patients and providers, and potentially, cost-effectiveness for the current health care system.

The physicians wanted to lighten their burden and also realized that they were not adequately trained to deal with the psychological problems of their patients.

Dr. Irwin Pencer, the psychologist assigned to the Westend Clinic, saw patients referred to him by the clinic's 11 physicians for short-term therapy (8 to 12 sessions, as specified in the research protocol for this project). The clinic has electronic medical records, and all health professionals, including the psychologist, share the charts. Patients were informed at the beginning of their consultations about this arrangement and were required to sign a form to grant consent to the psychologist to share the records with the physicians. Patients were advised not to disclose any personal information that they did not want to share with their physicians. This seemed to work well for patients and health professionals alike.

Preliminary evaluation results indicate that the project was very successful. The physicians were both relieved and delighted to have the psychologist on board, and gave him referrals as soon as he arrived. Dr. Pencer had no shortage of clients to fill his 8:30 to 4:30 day.

The psychologist regarded this chance to work in an interdisciplinary family clinic as "a great opportunity to be involved at the cutting edge of a revolution, or perhaps an evolution." Pencer noted that many psychologists worry that they might lose control of their practice in an interdisciplinary setting, but this was not the case. He found collaboration with the physicians to be positive—as was his entire experience at the Westend Clinic. In fact, it was so positive that the physicians invited him to stay at the clinic on a part-time basis, after the project ended.

IPEM is conducting a final evaluation of this project, which should be available this summer. Given the prevalence of mental health issues, governments and health care organizations will no doubt be interested in the scope and findings of this innovative project.

KEY LEARNINGS

This section presents a discussion of EICP's findings. It is based on what the researchers saw and have learned from the visited organizations. To facilitate this discussion, all the elements of the EICP principles and the framework for collaboration will be followed. The discussion of issues related to the principles (patient/client engagement; population health approach; best possible care and services; access; trust and respect; and effective communication) will be presented first. Discussion of issues or observations related to framework elements (health human resources; funding; liability; regulation; information and communications technology; management and leadership; and planning and evaluation) follows. At the end of this section, questions that are frequently raised about interdisciplinary collaboration will be answered.

Principles

PATIENT/CLIENT ENGAGEMENT

What We Heard

- Patients are part of the health care team. They are encouraged to be involved in their own care and are supported in achieving their health goals.
- Patients perceive team-based care as high-quality care.
- Community participation in health care operations and decision-making ensures that health care organizations remain attuned to the shifting needs of the population.
- Hiring culturally diverse staff enables health care organizations to tailor their services to immigrant groups, so that all patients can receive care in their first language.

All the primary health care organizations studied stress the importance of engaging clients. This means getting them involved in their own health care, ensuring that the health centre meets patients' needs, and staying in close contact with the community and patients to ensure that the centre is in touch with their needs.

Perhaps the most outstanding example of this approach is Winnipeg's Nor'West Co-operative Community Health Centre. It is very much a part of the surrounding community and is highly attuned to the shifting needs of its population. As a co-operative community health centre, community members participate in the board of directors and make decisions about what direction the centre takes. The result is a health centre that focuses as much on the social needs of its patients as on their health needs. Nor'West is a daycare, a family service centre and a community development centre, as well as a primary health care facility.

Patients are, first and foremost, encouraged to take an active role. They are given forms and asked to develop goals for their own care. These goals are evaluated over time by the interdisciplinary teams, and the patients and their progress are assessed periodically. Patients are also involved in Nor'West's planning. They participate in many committees and act as volunteers.

At the LeGrow Centre, too, patients are actively involved in working with professionals to improve their health and wellness. Two concerns expressed by the local community is the high rate of cardiovascular disease and a pervasive lack of physical activity. A committee at LeGrow, including a physiotherapist, a nurse and a dietitian, responded to these needs by designing the "Gateway to Health" program. Its goal is to engage the local population, including interested staff members, in health promotion activities to reduce overall cardiovascular risks. The first session was extremely well received, with more than 40 people participating. This program aimed to build capacity in the community to make it sustainable in the long run. Other self-management programs run in the community delivered in partnership with the centre include arthritis self-management and a smoking cessation program.

With probably the most diverse populations to serve, both Mid-Main and Nor'West have hired a culturally diverse staff that is able to communicate with clients in different languages and be respectful of cultural differences.

Most of the organizations visited make an extra effort to bring care to people where they live, work or are educated. Pincher Creek reaches out to the surrounding community, particularly to those individuals living on the nearby Pikanii and Blood reserves who choose to use the clinic's services. Charles LeGrow has special programs to support children in the schools. Vancouver and Rosedale do home visits, as well as assess some patients in long-term care organizations, when required.

Patients and families involved in this model of care are overwhelmingly supportive of interdisciplinary care. "This is what health care should be," said one person. "Taking care of my weight problem has alleviated other health problems," said another. "It's what every patient wants: one-stop shopping." None that the researchers spoke to voiced any concern

about being seen by a nurse practitioner, or a pharmacist, or any other health professional, rather than a physician. All felt that they were receiving a high quality of health care and went even further, suggesting that this should be the only model for delivering primary health care services in Canada.

POPULATION HEALTH APPROACH

What We Heard

- A population health approach is common at interdisciplinary sites. This approach to health care is particularly needed in rural communities, where the resources for satisfying needs are usually scarce.
- Intersectoral teams support population health approaches. Participation in intersectoral teams allows health care organizations to stay in touch with their communities and to work with other groups to boost the overall health of residents.
- Joint strategic planning is a powerful vehicle to ensure that health and social service organizations are aligned with community needs.

A population health approach is a consistent and rational way to set priorities, establish strategies and make investments in action to improve the health of the population. Normally, health professionals, planners and leaders work with members of the community to assess their needs and health problems. This approach to health care is particularly needed in rural communities, which have a defined population and few health professionals. All the organizations studied adopted this approach to a greater or lesser degree. The more rural or mixed rural/urban health care sites, such as the LeGrow Centre in Newfoundland, and the Lethbridge, Pincher Creek and Taber clinics in Alberta, certainly took the needs of the surrounding population into account in the way they practice care. The population data provided to them by the Chinook Regional Health Authority clearly helped the southern Alberta sites, in particular.

The LeGrow Centre stays in touch with its community through its intersectoral teams, such as the Southwest Coast Interdisciplinary Working Group, which has members from different sectors, including social services (from the provincial welfare and social services program), public health, home care and the education system.

One of Nor'West's main targets is to improve the overall health of the Inkster population. Following a population health approach, staff have conducted joint strategic planning sessions with community members, the Winnipeg Regional Health Authority, and Family and Social Services.

Rosedale has focused on the needs of its patients rather than addressing the needs of the community at large. This is partly because there are other professionals in the area and also because they have a rostered population. The team at Rosedale, through observations and contact with patients, remains close to the needs of its clients and alters its practices to better meet its clients' needs.

BEST POSSIBLE CARE AND SERVICES

What We Heard

- Health professionals are very passionate and committed to achieving the best possible care. They aim high, keeping in mind the best interests of their patients.
- All work hard to expand and improve their services. Some of the strategies used include adoption of care maps, clinical guidelines, and quality improvement programs, including accreditation.
- Health care organizations are concerned about facilitating access to services. Some have implemented, or are in the process of implementing, "Advanced Access" (a same-day booking system), while others have focused on strong, integrated, triage systems.

All the organizations studied aim to provide the best possible care and services to their clients. They are very passionate about this objective; in fact, this passion is the force that glues them together. The desire to provide the best possible care and services has driven the adoption of many initiatives, including care maps (for example, Winnipeg does diabetes care mapping); the design and adoption of clinical guidelines (the LeGrow Centre is drawing up clinical guidelines based on evidence); the development of comprehensive quality improvement programs (examples are the Charles LeGrow Centre and Nor'West); and participation in monitoring and evaluation of clinical programs (Vancouver assesses the performance of its chronic disease programs). Respondents to the team effectiveness survey attest to a commitment to quality care. They very strongly agree that working effectively as a team improves both the quality of care and the health status of patients/clients. Team members believe that working as a team has brought about more integrated and coordinated service delivery.

All are eager to improve their service delivery. Some do this formally through accreditation (Charles LeGrow and Mid-Main are fully accredited by the Canadian Council on Health Services Accreditation), but other organizations have designed and implemented their own quality improvement processes. Improvement and the pursuit of new ways of doing things are part of these organizations' culture.

The majority have undertaken specific initiatives to minimize wait times. In western Canada, Advanced Access, in which wait times are reduced and sometimes obliterated, is being studied and tried. Mid-Main has adopted this system, while the medical groups in southern Alberta are currently preparing to implement it. Advanced Access—a system of booking patients that is promoted by the Institute for Health Care Improvement in the United States—has increasingly been shown to reduce wait times in primary care. Its core principle is that patients calling to schedule a physician visit are offered an appointment the same day. Organizations need to study their practices and know where their bottlenecks are before they introduce this method, since it does not work if patient demand is permanently greater than the capacity of health professionals to offer appointments. Six elements of Advanced Access are important to its application:

- Balancing supply and demand;
- Reducing backlog;
- Reducing the variety of appointment types;
- Developing contingency plans for unusual circumstances;
- Working to adjust demand profiles; and
- Increasing the availability of bottlenecked resources.

Although these principles are powerful, they run counter to deeply held beliefs and established practices in health care organizations. Mid-Main invested great resources in tracking and understanding its own practice before it implemented this system. Strong and continued leadership has been required to ensure that everyone buys into the process and supports it.

On the whole, wait times are reduced when patients realize that different professionals can treat their problem, and that they do not necessarily have to see the physician. Wait times partly depend on how patients are triaged. Nor'West's centralized phone line ensures an integrated triage system. A good triage system depends on peoples' judgement, particularly the judgement of the front desk staff.

Mid-Main's front office staff was exceptional in this regard. Because Mid-Main has a very flat organizational structure: all staff members are included in meetings, and they all know how the clinic works and who is capable of doing what. The front staff use this knowledge to triage patients and to effectively trim appointments, as the Advanced Access system requires. By directing patients to the clinical pharmacist, nurse practitioner or other staff, they free up physician time and make the clinic run more smoothly. Rosedale also monitors the wait to see a physician and ensures that its patients have timely access to services.

TRUST AND RESPECT

What We Heard

- Trust and respect are vital, not only between patients and providers, but among the members of the health care team, in order to ensure effective communication and better services.
- Interdisciplinary educational sessions can support the development of trust and professional respect.
- It can take as long as two years for team members to be truly comfortable with one another, but it often takes much less time.

In all cases, staff members have the trust and respect of the patients and clients they serve. Patient satisfaction levels were high in all the organizations that monitored this important indicator.

What is perhaps more problematic in an interdisciplinary environment is ensuring trust and respect among the various health professionals who work together.

Most of the sites had some hurdles to overcome with regard to building the required relationships, particularly when a new role was introduced, such as that of the nurse practitioner. Rosedale's physicians were uncertain whether or not to allow chiropractors to practice on-site. After many meetings and educational sessions, they made the decision to accept them on the team, as long as the chiropractors agreed to limit their practices. The chiropractors did so because they understood the need to compromise and show flexibility. "It is all about learning and negotiating," one chiropractor said. The physiotherapists at the Lethbridge Family Clinic also experienced a learning curve as new members of the health care team. In both cases, these professionals had worked with and consulted physicians, and their level of care earned them respect. Most respondents to the team effectiveness survey believe that there is a high degree of trust, confidence and cohesion among team members at all the visited organizations.

In general, business research indicates that it can take as long as two years for professional trust and respect to be earned and developed to a point where individuals are totally comfortable working with each other. In health care, this can happen much faster, and often does, particularly in small communities, where health care workers know each other. This is also the case in more inclusive environments, such as that of Mid-Main.

EFFECTIVE COMMUNICATION

What We Heard

- Working side-by-side promotes communication and confidence. Proximity accelerates the development of the high level of trust and professional respect that is characteristic of high-performing teams. The layout of the physical space can also help (or hinder) communication.
- Information and communication technologies are widely used as vehicles for effective communication within a team. The most common ways of communicating information are informal communications, formal team meetings, memos and e-mails.
- When necessary, facilitators can be useful to bring people together and manage conflict.

The team effectiveness survey tells us that staff at the visited organizations are open and pursue consensus whenever possible. Such informal methods as working side-by-side and "nabbing" other health care workers in the hallway contribute to effective communication. Meetings are also important, so it is critical that interdisciplinary care facilities have large enough rooms to accommodate the whole team. Managers at all the sites made sure that staff meet regularly and that members are apprised of what is going on. Most meetings have ground rules and meaningful agendas. In some cases, the meetings are more structured. Having a chairperson can help staff to manage processes and conflicts. When the LeGrow Centre decided to hold a retreat to deal with its roles and responsibilities issues, it hired an outside facilitator.

Sending memos and e-mail also ensures that people are informed. E-mail is used extensively at Rosedale and Nor'West. Some organizations put considerable effort into their home pages, too, to communicate better with their clients, patients and community members.

The layout of the physical space is an important factor in supporting and facilitating communication among health professionals. At Rosedale, all physicians share the same office, which enables information sharing, encourages brainstorming, and facilitates the sharing of thoughts and ideas. Physicians have an assigned workstation inside this office and are allowed to personalize their workstations.

Mid-Main has gone even further: it has created one office space for all its health professionals, which include physicians, the nurse practitioner, the dietitian and the pharmacist. The physician leader at this practice noted that this has allowed her to watch more closely how other health professionals on her team approach care, articulate options to patients and work with other colleagues. Working in close proximity has helped her to better appreciate other members of the clinical team, which has translated into an increased level of confidence in other team members' skills.

At Nor'West, staff reported on numerous ocassions that space was a problem. Nor'West may have cramped quarters, but having a common space where the different health professionals come together has been vital to enhanced communication. Rosedale has also seen an improvement in communication since it renovated its clinical space to allow the registered nurse and the administrative assistant to work beside each other. This arrangement makes it easier for them to follow patients and make bookings and referrals.

Framework Elements

HEALTH HUMAN RESOURCES

TEAM ORGANIZATION

What We Heard

- It is important to form a team that meets the needs of the organization and patients, and to add new members as the need arises.
- Roles tend to evolve and are therefore likely to change over time. If role clarity becomes a problem for the team, it is best to address the issue head on.
- New staff members must be proactive in demonstrating their skills and the ways they can benefit the team.

Interdisciplinary care is all about structuring practices and teams in order to deliver high-quality, effective care to patients. The structure of the team differs, depending on the needs of the population. But respondents to the team effectiveness survey indicate that, regardless of the structure, team members accept insights, knowledge and perspectives of other professionals and that team-based functions are shared across professional boundaries.

Indeed, the composition of teams was very different from site to site. Some teams were made up of physicians and nurses (Taber). Dietitians and diabetes educator nurses were frequently part of teams; this was the case in Pincher Creek, Charles LeGrow, Mid-Main, Lethbridge, Nor'West and Rosedale. Social workers dominated the team at Nor'West, outnumbering the 1.2 physicians the health centre employs. Nor'West was the only site to include a lawyer as part of the team. Psychologists are not frequently found in formal interdisciplinary groups. Lethbridge and the Westend Clinic in Ottawa were two organizations with psychologists on their teams.

Charles LeGrow employs health professionals not traditionally found in primary health care groups, including an occupational therapist and a speech-language pathologist. Pharmacists, while not always official team members, played an important role at Mid-Main and Rosedale, taking on responsibilities that go beyond the regular duties of pharmacists. Four sites—Rosedale, the LeGrow Centre, Mid-Main and Taber—employ nurse practitioners.

Defining a team means assigning roles and responsibilities, and determining scopes of practice, a process that can initially be a struggle for teams. Difficulties seem to arise most often in relation to the role of the nurse practitioner because that role is newer and less clear. The nurse practitioner's role appears to be determined by multiple elements, including personal interests, population needs (e.g., female practitioners for Pap smears), and the needs of the physicians (e.g., activities they prefer to pass on to someone else on the team). Furthermore, the source of funding for the nurse practitioners' salaries seems to have a major impact on how their role evolves. Overall, defining roles and responsibilities is a lengthy process, and it is generally affected by the ability of team members to negotiate what they want and balance it against what they should/could undertake.

Nurse practitioners at the four sites have had very different experiences, but all have evolved into their role, defining it along the way. In Newfoundland, nurse practitioners were hired by the LeGrow Centre. They had a say in their role right from the beginning. They examined the needs of the organization and the patients to determine what would work best. Nevertheless, staff there had a hard time defining how the role of nurse practitioners differed from those of the physicians and public health nurses. To overcome this problem, the team hired an outside facilitator and held a retreat, discussed their difficulties openly, and came up with a document outlining the roles and responsibilities of each.

At Rosedale, physicians have a big influence on the role of the nurse practitioners, and this approach appears to be appropriate for the clinical team, including the nurse practitioners. It is important to note that it is the physicians who pay the nurse practitioners' salaries, and therefore, they may have more control. In Vancouver, the nurse practitioner is paid by Mid-Main Community Health Centre and the whole team agrees on the extent of her role. Taber has two nurse practitioners. The first one was given six months to feel her way forward and come up with a role that suited the needs of both patients and physicians. A second nurse practitioner was recently hired, and she is seeking a larger scope of practice.

Defining the role of the nurse practitioner involves lots of negotiation, which can be painful—but there are many tools that can help. Some personalities may be more problematic than others, but the lesson from the organizations studied is that it all works out eventually. Some people believe that older physicians are more resistant to changing their practices and less likely to participate in interdisciplinary groups. Our case studies demonstrated that this cohort is facing real work-life balance issues, due to the complexity of patients' needs and the difficulty of attracting physicians to certain regions in Canada. They are ready to try different approaches if they lead to increased quality of patient care and a more balanced workload.

Vancouver's Mid-Main Centre has written a scope of practice for the clinical pharmacist, and the physicians and the pharmacist agree to abide by it when they sign on. This could serve as an example for physicians, nurse practitioners and pharmacists working in an interdisciplinary environment. Mid-Main outlines duties and even how much time is spent on them.

This study found that health professionals—particularly those in non-traditional health care roles—have to be proactive on an individual level about their strengths when they are first hired. They need to show other staff what they can do. The pharmacist at Mid-Main was very proactive. She approached the centre, wanted to work there as a volunteer, and educated the staff about what she could do. She progressively played a more important role in clinical programs. Similarly, diabetes educator nurses and the dietitian had to educate others about their roles at Taber.

TRAINING AND DEVELOPMENT

What We Heard

- Most organizations provide little training and development for staff.
- Lunch-and-learn sessions are used to educate staff about interdisciplinary care protocols, best practices, and professionals' competencies and scopes of practice.
- Training in team dynamics appears to be very useful in strengthening teams.

Training and development are part of human resource planning. The primary health care groups visited offered some training for their respective staffs, but overall, there was little. All the organizations studied hold all-staff lunch-and-learn sessions. These normally focus on interdisciplinary care protocols or approaches, best practices, or education on competencies and scopes of practice. Nurse practitioners have done all-staff presentations on their role in both Newfoundland and Hamilton. An

interdisciplinary educational session on the role of chiropractors, in which a chiropractor teamed up with a physician to demonstrate some of the manipulations they normally do, helped to change the perception of this profession among the physicians at the Rosedale Medical Group.

Education about team dynamics and the essentials of sustaining change management is less common. However, when it is present, it seems very useful to strengthening teams. The primary health care coordinator at the LeGrow Centre has attended two of five training workshops for facilitators through the Building a Better Tomorrow Initiative. She is in the process of completing the other workshops and will be facilitating staff sessions at the LeGrow Centre, based on this experience. The courses are Understanding Primary Health Care, Building Community Partnerships, Conflict Management, Facilitating Adult Learning, and Team Development. Similarly, the Chinook Primary Care Network is facilitating interdisciplinary training for the primary care groups in the region. Some of this training is focusing on change management (e.g., Team Development, Change Management Support, Role Negotiation, Conflict Resolution, Coaching).

RECRUITMENT AND RETENTION

What We Heard

- A team approach to health care decreases on-the-job frustration and increases efficiency.
- It boosts staff satisfaction and retention.
- Collaboration, although vital to how organizations function, is often not part of team members' performance evaluations.
- Succession planning is neglected but important.

The studied organizations had no special formulae for hiring the right persons. Managers simply have a good understanding of the culture of their organization and therefore sense whether or not a person will fit in with the group's culture. Mid-Main, Nor'West, LeGrow and Rosedale all have strong reputations, so new staff, by word-of-mouth, have a good idea of what they are getting into. Although there was no formal recruiting procedure, this informal method appears to work. Down the road, succession planning may be problematic and could require more defined human resource practices.

There was little evidence of performance management. All sites evaluate performance, but do not do so directly for interdisciplinary collaboration. There was little turnover of staff at all the sites; the health professionals the researchers spoke to have found that interdisciplinary care promotes a better work-life balance and higher staff satisfaction. This was true of all the physicians interviewed, regardless of whether they were compensated through salary, fee-for-services or capitation.

At Nor'West, some staff members are dedicated to promoting a healthy workplace. They support and recognize staff and organize extracurricular activities to support team building. Similarly, at Rosedale, the clinic closes twice a year, giving the whole team a break; some extracurricular and social events also take place throughout the year.

An interdisciplinary focus heightens job satisfaction. Almost all the health professionals the researchers spoke to had high praise for collaborative work. Physicians reported being able to give more attention to the patients who need them the most and being able to focus on preventative care. One physician at Pincher Creek mentioned that he was relieved to have help with his "heart sink" patients—those whose needs were so extensive that he alone could not address them. Many spoke of the satisfaction they felt in seeing their patients improve under a team approach to care. One physician at Lethbridge said that he knew he was not the right person to address weight issues with patients, but that a nurse, whom he encouraged to become the coordinator of the Healthy Lifestyles group, had much more success. A nurse practitioner in Taber expressed her satisfaction in seeing asthma patients improve under team-based care.

Many health professionals spoke of the efficiency of the interdisciplinary system. Working together avoids telephone tag, facilitates decision-making about care and appears to allow health care workers to carry a larger patient load. Rosedale's staff pointed out that the team nature of their clinic allows them to carry a higher caseload than they otherwise would be able to carry. The on-site dentist at Mid-Main loves working there because it "allows him to do what he does best"—care for his patients—and also removes the need for him to spend time on marketing and administration. The two physiotherapists who come in one day each to the Lethbridge clinic prefer working there to the private clinic where they work the rest of the week—even though they have more equipment at the private clinic—because they love having immediate access to other health professionals and enjoy being part of a team.

FUNDING AND FINANCING PRIMARY HEALTH CARE SERVICES

FUNDING

What We Heard

- Interdisciplinary care can work well, regardless of how health professionals are funded, as long as health professionals are remunerated for their participation in interdisciplinary activities.
- Allowing health professionals to participate in the planning of funding activities and to decide which payment method best suits their needs ensures buy-in into primary health care renewal.
- Many interdisciplinary health care organizations pursue innovative methods of funding to build the team they need.

The organizations visited were unanimous on one point: regardless of the way health professionals are funded (and this is especially true for those paid on a fee-for-service basis), interdisciplinary collaboration can occur only if someone—either government or an individual—pays for it to happen. Health professionals cannot be expected to volunteer for meetings, planning, consultations or any other type of interdisciplinary-related activities on an ongoing basis. They need to be remunerated for those services if these critical aspects of interdisciplinary collaboration are to occur on a long-term basis.

In Newfoundland's LeGrow Health Centre and Winnipeg's Nor'West, all health professionals, including the physicians, are paid a salary. This enables them to give patients the time that they feel they need and to attend meetings with other caregivers as they see fit, without loss of pay. There are some fee-for-service (FFS) physicians associated with the LeGrow Centre. These physicians provide services in the community to the patients, but they also participate in many interdisciplinary rounds and committees at the health centre. The fact that they are not compensated for meetings or any interdisciplinary work does not prevent them from participating. However, they are more strategic in the meetings in which they choose to participate.

The Chinook Primary Care Network has decided to support and provide incentives for interdisciplinary teams through physician groups. Physicians enter into negotiations with the region and are given financial assistance to hire other health professionals (e.g., dietitians, social workers, physiotherapists, nurse practitioners, pharmacists).

The Chinook Health Region recognized the need to bring physicians on board with its renewal strategy. First, it acknowledged the need for a non-prescriptive style to allow physicians to choose the remuneration method that best suits their needs. In 2000, the physicians at Taber Associate Medical Group decided upon an alternate blended payment method, in which they are paid through capitation, FFS and bonuses for their clinical work, and then are "topped up" for meetings and other collaborative expenses related to interdisciplinary care.

At Pincher Creek and Lethbridge, physicians are paid on a FFS basis, with some bonuses for the attainment of screening and health prevention goals. They said they liked the FFS payment method because "it is the devil we know." The physicians at Pincher Creek and Lethbridge have been able to negotiate with the regional health authority to receive extra funding to compensate for the meetings and additional time that interdisciplinary collaboration requires.

All other health professionals in these medical groups receive a salary and provide their services to all patients, regardless of their ability to pay. Patients normally do not need a referral to see dietitians, social workers, physiotherapists, nurse practitioners, or any other health professionals working for a medical group in the region.

At Hamilton's Rosedale Medical Group, physicians are compensated mainly through capitation (approximately 65 per cent of their income), but they also receive fees for certain services (e.g., home visits), lump sum payments (e.g., after-hours care) and special premiums for achieving screening and prevention targets. In turn, they pay their staff out of the funding they receive. Rosedale's practice is a sustainable one, but the relationships it has built with other health professionals, the provincial government and some private sector companies has helped to diversify the practice and bring additional services to patients. Funding for a diabetes nurse educator is provided by a pharmaceutical company, while salaries for mental health counsellors and a dietitian come directly from the Ministry of Health and Long-Term Care. Patients have public access to all health professionals working at Rosedale.

Rosedale has brought in other private professionals by renting space to them very strategically. Although not official members of the team, the pharmacist and physiotherapists have become integral members of the health care team. Rosedale's physicians had the vision of a broad base of care and could act upon it because until recently, the three founding physicians owned the building where the Rosedale Medical Group is housed. Even after selling it, they retained a say in who would be the building's tenants. Collectively, they cover overhead costs and provide diversified health care services to their clients and patients. Patients are required to pay a fee, either through insurance or out-of-pocket, to have access to

the physiotherapists. Patient fees to the pharmacist are paid with the medications acquired at the on-site pharmacy.

The majority of the studied organizations pursue funding objectives through pilot projects. Rosedale, for example, is part of a project in which the chiropractor is part of the health care team. With the help of partial government funding, the chiropractor reports patients' progress to physicians. Mid-Main obtained temporary funding for a chronic care coordinator (dietitian). Westend Clinic in Ottawa has made public psychological services available through a pilot project that covers the salary of a psychologist.

FINANCING PRIMARY HEALTH CARE SERVICES

What We Heard

- Searching for financing (e.g., application for pilot projects or special funds) can be tenuous, but determination pays off.
- The studied organizations have varied sources of financing, from governments and charitable organizations to for-profit, private organizations.
- Innovative financing models are allowing health professionals involved in typical for-profit private care to serve all patients, regardless of their ability to pay.

Financing involves raising revenues to fund primary health care services. The major source of financing for primary care groups—through fixed and sustainable funding or special grants—is provincial governments. However, through the Primary Health Care Transition Fund (PHCTF), the federal government has played an important role in the financing of primary health care renewal over the past few years. This fund, which is transferred to the provinces, enabled the introduction of new professional members to the clinical teams and ensured that they received the necessary training to contribute to the success of those teams.

There are some concerns about the sustainability of this funding, as some provinces have not committed themselves to keep paying the salaries of the professionals hired through the PHCTF (e.g., a psychologist at Westend, a Chronic Care Coordinator at Mid-Main). Foundations and charity organizations like the United Way also play an important role. Nor'West has been proactive in applying for—and successful in securing—grants from the United Way and the Winnipeg Foundation; these grants enabled the centre to carry out vital community projects.

Vancouver's Mid-Main Community Health Centre has adopted an interesting business model. Its dental clinic has been able to compete with private clinics for more affluent patients in its zone. This has resulted in aproximately 50 per cent of its patients carrying private insurance. The revenues received from these patients have allowed the clinic not only to facilitate access to dental services for people with few resources who might otherwise be unable to pay, but also to give financial support to the medical clinic at times.

The Vancouver example also shows the lengths to which the pioneers of primary health care had to go in order to create the kind of collaborative practice they envisioned. Their commitment to primary health care is so high that the founding physicians, who had a vision of providing better care at the community level, subsidized the clinic in the early years by doing work elsewhere. Even the pharmacist who is associated with the clinic worked on a voluntary basis for the first six months because she held an ideal of working alongside other health professionals to provide quality care to clients. This level of commitment is exceptional and should not be construed as an example of how to establish an interdisciplinary care practice. However, it does exemplify the commitment of health professionals to high-quality, interdisciplinary care.

LIABILITY

What We Heard

- Staff at the studied organizations took steps to ensure that liability would not be an issue.
- Liability issues might be overrated and do not seem to be considered as a major barrier to interdisciplinary care.
- There have been no liability problems with the organizations, some of which have been in existence since the 1970s.

Judging from the sites visited, liability does not appear to be a barrier to interdisciplinary care. This is not to suggest that health professionals and administrators disregard liability altogether. Instead, they adopted the following approach in order to take care of the issue.

They:

- Ensured that all health professionals at their organizations had the level of liability insurance required by professional associations;
- Made this level of liability insurance a mandatory requirement;
- Required annual proof of certification and compliance with the respective regulatory colleges;
- Reinforced the need for certification and insurance during annual performance reviews or appraisals; and

- Ensured that the organization had basic malpractice liability insurance.

Once they had completed these steps, they could move on to doing what they do best—providing health care. The non-regulated staff are governed by tight accountability and reporting systems.

One site, Taber, was more proactive than the others in addressing the liability issue. The administrator of this medical group pays college registration fees and malpractice insurance out of the practice's funds. In doing so, not only is the administrator assured that health professionals are covered, but he also stays informed of professional issues that arise which could affect the group.

It also appears that insurance companies are willing to develop insurance packages that meet the needs of those working in interdisciplinary care.[1] Practitioners have been concerned mainly with getting appropriate individual insurance. If there is a more pressing need to acquire group insurance, insurance companies will no doubt develop new products to cover the needs of new arrangements.

What stands out is that, at all studied organizations, people said that it had never crossed their minds that liability was an issue. Some of the organizations, such as the Nor'West Co-op Community Health Centre and Vancouver's Mid-Main Community Health Centre, have been in existence for decades and have not had a problem with liability. The case examples would suggest that the importance of liability issues might be overrated and should not be considered a major barrier to interdisciplinary care.

REGULATION

What We Heard

- Regulatory colleges seem to support collaborative care.
- Regulation does not appear to deter interdisciplinary care.
- Overall, few health professionals seem to be familiar with the legislation that governs scope of practice.
- Provincial legislation stipulating the roles and responsibilities associated with various health professionals differs across the country. Health care organizations focusing on team-based care are designing their own solutions to ensure their interdisciplinary focus complies with provinicial legislation.

At all the studied organizations, regulatory colleges raised no objections to their professional members working in an interdisciplinary environment. In fact, many professionals seemed to be encouraged by their regulatory colleges to work with other professionals. The researchers saw no examples where there had been any complaints, and nothing suggested that regulatory colleges had any special concerns about interdisciplinary care.

That said, provincial legislation differs across the country, and certain provinces require more than others, in terms of stipulating the roles and responsibilities of various health professions.

In Winnipeg and Vancouver, physicians signed agreements allowing pharmacists (Mid-Main) and primary care nurses (Nor'West) to take over certain responsibilities in order to comply with provincial legislation. Vancouver's Mid-Main centre has "transfer of function" agreements to ensure that clinicians at the centre comply with British Columbia's regulations governing professional practice.

This research indicates that few people know about legislation governing scopes of practice. Nevertheless, researchers heard no complaints about the team nature of delivering care, and therefore, conclude that interdisciplinary care presents no implications for colleges, as yet.

INFORMATION AND COMMUNICATIONS TECHNOLOGY

What We Heard

- Information and communications technologies (ICTs) greatly facilitate interdisciplinary care.
- Electronic medical records are not indispensable to interdisciplinary care, but they do make interdisciplinary care much easier.
- So far, in Canada, information systems are provider-focused, not patient-focused.
- Telehealth is not being used to its full potential.

Information and communications technologies in health care involve phone systems, e-mail, electronic health records (EHRs), telehealth services, and other technologies to record, process and transfer data about patients and communities for health care planning, diagnosis and treatment.

Of the sites visited, five organizations—Rosedale, Mid-Main, Taber, Pincher Creek and Lethbridge — have electronic medical records (EMRs). The other two, Nor'West and the LeGrow Centre, maintain paper-based records. To keep everyone on the same page, Nor'West also has a front desk integrated phone/voicemail/triage system and a record-keeping system because it has more than one site and works jointly with Family Services and Housing and the

[1] This was the collective will expressed by various insurance companies that attended a meeting at The Conference Board of Canada, sponsored by Health Canada, to discuss liability issues in interdisciplinary collaboration.

Winnipeg Regional Health Authority. All EMRs were acquired with support from the respective provincial governments, which included, in some cases, transfer of funds from the Primary Health Care Transition Fund (e.g., Mid-Main).

EMRs are not indispensable to interdisciplinary care, but they do facilitate it. Many of the people interviewed at the sites that have EMRs sang their praises and remarked on how much time they save and how much easier they make interdisciplinary care. Patients, too, commented on the fact that EMRs save them the time, trouble and irritation of repeating their health histories to various health professionals.

Neither staff nor patients appeared to be too concerned about privacy issues. Patients at the Lethbridge Family Clinic permitted their health professionals to share information, and this facilitated care between, for example, the on-site physiotherapist and a physician.

At the Westend Clinic in Ottawa, all the professionals in that practice, including the psychologist, had access to the EMR. Patients were asked to sign a consent form allowing information to be shared between the physicians and the psychologist.

Of all the sites with EMRs, Taber appeared to be the most connected in that the system not only connects the physicians with the rest of the professionals in the team, but also allows them to access and exchange information with the laboratory and the community hospital. Physicians can access these records even from remote locations, like their own homes. The Taber example is the closest one to a truly electronic health information system.

Telehealth systems are available in Pincher Creek, Taber and the Charles LeGrow Centre. The latter uses a variety of telehealth services, when needed, for activities such as patient consultations, grand rounds and education sessions. It has recently connected with the regional teleoncology and telepsychiatry projects, which are part of the provincial telehealth strategy with the office of primary health care.

Telehealth equipment is not widely available, and when it is, is not used to its potential, mainly as a result of inappropriate funding models to compensate for these services. Telehealth has the capacity to bring urban services to a rural setting, making it a potentially attractive option for health professionals in small communities like Port aux Basques. However, although the technology is available there, patients in Port aux Basques are still traveling long distances to access specialized care.

ICTs in Canada are still provider-focused, rather than patient-focused. The majority of patients in Canada, especially in primary health care, are still unable to access their personal health records from home, access their lab results, send e-mails to other health professionals, or book their appointments on-line. It has been possible to do all this at leading international health care organizations like Kaiser Permanente in the United States.

Almost all the case studies have websites, which include such useful information as schedules, history, health education, health promotion and hours of operation. The LeGrow Centre even posts healthy recipes on its site.

MANAGEMENT AND LEADERSHIP

What We Heard

- Interdisciplinary care requires both clinical and administrative leadership.
- The clinical leader does not have to be a physician.
- Organizations can be “flat” or “top-down.” Either way works.
- It is absolutely vital that health care organizations keep in touch with the community and respond to patients’ changing needs.

Management and leadership are key to interdisciplinary care. Both clinical and administrative leadership are needed, and leaders of both groups need to be strong and visionary, and to be on the same page. Collaboration requires a clear vision, which often comes from one or two leaders who have an unwavering commitment and drive, and who are able to communicate their vision and transform it into reality.

Hamilton’s Rosedale clinic has committed leaders. In this case, it is the physicians who are the leaders. They understand *what* and—perhaps even more importantly—*who* fits with the organization. They have the support of a manager who understands the organization’s directions and needs and who is able to keep efforts focused. Taber, Lethbridge and Pincher Creek are somewhat similar to Rosedale in that the physicians are the leaders who determine the groups’ overall direction and functioning. They also have administrators who understand how to pull all the strings in the organizations.

Nor’West is fortunate to have two powerful leaders in the executive director and the primary care coordinator. The executive director is also the team manager of the Winnipeg Regional Health Authority staff, who work with Nor’West staff, which is key to ensuring that staff work together. She is very supportive of joint collaborative meetings and joint case conferences. The primary care coordinator, a

registered nurse, is the clinical leader in this group. She provides direction to the team and makes great efforts to keep everyone involved, even the staff at the satellite locations, in order to make sure a strong team spirit is always present. Although having a nurse as clinical leader is different from other centres where the physicians are the leaders, both arrangements work well.

Leadership does not necessarily mean top-down leadership. Vancouver's Mid-Main is a "flat" organization that is collegial and inclusive in its decision-making. Although the clinical leader is one of the physicians, she facilitates the involvement of the rest of the team and supports shared decision-making. All staff members, not just the clinical staff members, are involved. They are encouraged to bring their ideas to the table and to voice their opinions when new procedures are put into place. They meet on a regular basis to discuss issues, and they form committees from a mix of clinical and administrative staff members to address ongoing or larger issues.

At LeGrow, the physicians are at the core of the health care centre, but the administrative personnel, including the primary health care coordinator, are the ones who keep the team together. Perhaps this is the best approach for this organization, given the diversity of health professionals who comprise this team.

Clearly, no matter how these particular organizations choose to deliver care, or who is in charge, all are leaders in the health care field and are recognized for their leadership and innovations by provincial governments, regional health authorities, their respective communities, and other health professionals and organizations.

Each of the facilities in these case studies was chosen by the Ministry of Health as a test site for pilot projects. All are innovators; all are willing to consider new ideas and try new ways of delivering care, whether the ideas are their own or the Ministry's.

For example, Rosedale is among the first health care organizations to have chiropractors and other health care workers working together. It has some government funding, as part of an Ontario Ministry of Health pilot project. At Lethbridge, physicians had long recognized that their patients needed more psychological services. They came up with the idea of having an unchartered psychologist work on the premises, alongside a physician. In light of the fact that they were seeing a large number of sports-related injuries, they invited two physiotherapists to use their office space for one day each per week. The Vancouver Coastal Regional Health Authority often calls Mid-Main when it wants to pilot a new arrangement. The same holds true for Nor'West.

It is mostly the health centres themselves that lead the charge in terms of innovation, but sometimes it is the regional health authority that shows leadership. The Chinook Health Region has adopted an innovative philosophy that is accelerating primary care renewal in the region. As Dr. Vern Jubber, the Vice-President of Medical Services in the region said, "We are here to support the physicians and help them succeed." For example, the region is encouraging and supporting its family health groups to adopt Advanced Access and other Office Practice Redesign concepts, mostly borrowed from the Institute for Healthcare Improvement in the United States, which has some influence in western Canada.

Part of leadership in health care involves staying in close touch with the changing needs of patients, as well as with the larger community. Almost all of these interdisciplinary health centres have been in existence since the 1970s. Their surrounding communities have changed over that time; new people, new immigrant groups have moved in, and people have aged, bringing different health care challenges. When health centres have a board of directors, it is to their advantage to make sure that they use the board effectively. There is wisdom in making sure that it reflects the composition of the community, includes a variety of professionals and community leaders, and that board members are encouraged to share their expertise and knowledge. When this is the case, the health centre can address the true needs of the community and keep in touch with its ever-changing nature.

Nor'West has the benefit of a very committed, strategically chosen board of directors that offers the perfect balance of hands-on and hands-off support and direction. Because Nor'West focuses on social work—and social needs change faster than clinical needs—it is particularly important that its staff keep in close touch with the community.

When health centres do not have a board of directors, they must find other ways to gain information about the community. Regional health authorities can help these organizations by sharing health population data, and this is happening, for example, in Alberta's Chinook Health Region.

PLANNING AND EVALUATION

What We Heard

- Interdisciplinary health care organizations are planners. Staff members evaluate patients' needs and think proactively.
- The majority of organizations track clinical processes and pursue quality improvement, including accreditation.
- Planning, implementing, measuring and evaluating the outcomes empower staff and give them the momentum to continue to try to do better.

Leading interdisciplinary health care organizations embrace change. The staff's minds are open and they exhibit a never-ending eagerness to introduce new processes. At Pincher Creek, which is still new to interdisciplinary care, researchers heard, "We are change addictive, not change fearful." At Mid-Main, which has been offering interdisciplinary care since the 1970s, staff have Plan-Do-Study-Act (PDSA) cycles constantly. Planning, implementing, measuring and seeing the outcomes empower staff and give them the momentum to keep on trying to do better. Rosedale and Nor'West frequently examine their processes, identify needs, suggest programming and go into the community to forge partnerships and procure funding.

The majority of sites track clinical processes and have quality improvement processes that often are quite well developed. Mid-Main, Nor'West and Charles LeGrow are examples of this. They see the value in measuring process and outcomes, in identifying who is responsible for certain programs, and in deciding what indicators they should be tracking to improve care. Furthermore, Charles LeGrow and Nor'West voluntarily participate in accreditation processes and have more developed quality improvement structures and processes.

All of these organizations measure client satisfaction. Some, such as Nor'West, survey staff satisfaction. The LeGrow Centre was the only organization that measures team effectiveness.

The Chinook Primary Care Network has adopted outcome indicators based on SF-36s, a health survey that measures functional health and well-being. Mid-Main reports its success in managing chronic diseases, such as asthma, diabetes and congestive heart failure, to a province-wide chronic disease information system in British Columbia. Alberta was the province that went furthest in using population information for health planning purposes.

The Nor'West Co-op Community Health Centre has adopted a population health approach that crosses different sectors. This Winnipeg centre has information from the Winnipeg Regional Health Authority and uses it to make joint staffing and programming decisions with Family Services, public health and home care.

This also happens in Newfoundland. Six years ago, the LeGrow Centre used population health data to build a case to hire more health resources, particularly a nurse practitioner. Population data can build a case for, and help to determine, the size and the shape of the interdisciplinary and intersectoral care team.

All the sites in Alberta employed experts in change management and organizational effectiveness. The change managers realized that interdisciplinary care could not be pursued in a top-down manner, and that they had to get into the clinics to see what the workflow was like, how the clinics were operating, and what the needs were. Only then could they fully understand the challenges of the health professionals and make intelligent suggestions as to how to move forward. At Taber, staff quickly realized that middle managers had to be in agreement with the proposed changes; otherwise, it would not happen. The key to implementation was to get everyone on board.

The Nor'West Co-op Community Health Centre also recognized the importance of moving forward in a cohesive way. When new staff joined from the Winnipeg Regional Health Authority (WRHA) and Family Services and Housing (FSH), Nor'West staff invested time and energy in showing them the Nor'West way of providing care. It went out of its way to include them, to work with them, to manage them. Now, WRHA and FSH often look for Nor'West's leadership when they face an interdisciplinary challenge or activity.

FREQUENTLY ASKED QUESTIONS ABOUT INTERDISCIPLINARY CARE

1. Does interdisciplinary collaboration work?

There was an unwavering commitment to interdisciplinary collaboration at all of the organizations visited. This commitment stemmed from the belief that this is the most effective approach to care and service delivery.

2. Are patients reluctant to see professionals other than a physician?

Patients across the country welcomed the opportunity to have access to other professionals. In some cases, patients were very satisfied to have a nurse practitioner as their primary care provider, and were even more comfortable when they knew that these professionals worked closely with their physicians. What patients said they valued most was the feeling that they are part of the health care team.

3. Does interdisciplinary care undermine the physician's role?

Physicians overwhelmingly reported that they feel supported and able to provide better care when they work in interdisciplinary teams, and this in turn translates into better work-life balance and higher job satisfaction.

4. Is the physician always the best person to address a patient's health concerns?

Not always. It could be a dietitian, a nurse, a physiotherapist, a mental health worker or a host of other health professionals. Physicians were often the first ones to recognize the benefits of involving a team of professionals.

5. Is there only one way to deliver interdisciplinary care?

Approaches vary widely, depending on the culture of the organization, the preferences of those delivering the service and the nature of the needs it is addressing. The chosen approach seems to work best when it is willingly chosen, developed from the bottom up, and organized to meet the specific needs of professionals and patients.

6. Is liability more of an issue in interdisciplinary care?

In the organizations visited, professional staff did not consider liability to be a greater issue in an interdisciplinary care setting than in any other.

7. Does interdisciplinary care take more time?

The people who participated in this study were working smarter, not harder. Careful thought had been given to who should do what, and when to deliver the most effective care. The end result: a more efficient use of time by all involved.

8. Are health professionals highly resistant to change?

The health professionals across the country were willing to hear new ideas and try new arrangements. They embraced change rather than fearing it. Some called themselves "changeoholics."

CONCLUSION

The perspective gained on interdisciplinary collaboration from visiting these selected organizations is an overall positive one.

The health care sector as a whole has long been searching for new options and fresh ways to use its resources well and wisely. Provincial and territorial health officials are finding that interdisciplinary collaboration helps to:

- ensure the effective use of precious health care resources—both funds and people:
- facilitate access to health services, and
- provide more efficient and integrated primary health care services to Canadians in their own communities.

It is therefore no surprise that the provinces and territories are promoting the benefits of interdisciplinary collaboration and providing incentives to health care professionals to move towards it. Yet, despite this, some health care professionals are holding back, perhaps because they lack knowledge of how to proceed. Or they may hesitate because of concerns about finances, liability, professional autonomy, role clarity and coordination of care.

In some cases, their concerns may be legitimate. Certainly, the seven organizations featured in this report have faced challenges in terms of role definition, funding, lack of awareness of various health professionals' competencies, and lack of strong information technology systems that facilitate interdisciplinary collaboration. But they have managed to overcome the challenges and continue to choose to work together.

Interdisciplinary collaboration might not be for everyone. But, as our research and that of others suggests, it is a very viable option for many.

Across the country, at rural sites and urban ones, health professionals are creating formal and informal partnerships that make sense to them. At the same time, they are pioneering new ways of working together—many of them very successful.

Canadian health professionals are making real progress in defining the challenges associated with interdisciplinary collaboration and identifying how they can be overcome. The challenge now is to continue to build on the solid footing that already exists—to disseminate best practices and ground them in health care organizations.

Health care professionals and staff at the seven organizations profiled in this report have found that interdisciplinary collaboration works very well for them and their patients/clients. Their answers to the questions about interdisciplinary collaboration are therefore worth hearing—and heeding.

Appendix A
Dr. Charles L. LeGrow Health Care Centre
List of Interviewees and Key Tools

Appendix A.1 – Dr. Charles L. LeGrow Health Care Centre

1.0 List of Interviewees

Table 1: Dr. Charles L. LeGrow Health Care Centre List of Interviewees

	Name	Profession/Title	Team
1.	Dr. Wendy Graham	Physician, Community	Leadership Team
2.	Dr. Taor	Physician, Chief of Staff	Leadership Team
3.	Michelle House	Western Health Care Corporation	Leadership Team
4.	Sandra Moss	Western Health Care Corporation	Leadership Team, Management Team
5.	Susan Ford	Western Health Care Corporation	Leadership Team
6.	Sylvia Savory	Site Manager	Leadership Team, Management Team, Rehab Team
7.	Kelly Hatcher	Nursing Continuing Care	Patient Services Team I
8.	Cindy Butt	Nursing Public Health	Patient Services Team I
9.	Donna Parsons	Nurse practitioner	Patient Services Team I
10.	Mona Clarke	Nurse practitioner	Patient Services Team I
11.	Erica Parsons	Primary Health Care Coordinator	Patient Services Team I, Leadership Team
12.	Dr. Tabarmanaf	Physician on site	Patient Services Team I
14.	Sherry Croucher	Lab	Patient Services Team III
15.	Barbara Francis	X-Ray	Patient Services Team III
16.	Marina Parsons	Nursing Acute Care	Patient Services Team III, Rehab Team
17.	Faye Keeping	Nursing Outpatient/Emergency	Patient Services Team III
18.	Beatrice Osmond	Nursing LTC	Patient Services Team III, Rehab Team
19.	Tom Tobin	Social Work	Patient Services Team II, Rehab Team
20.	Doreen Noseworthy	Mental Health Counselor (Social Worker)	Patient Services Team II
21.	Gurang Shulka	Social Work off site	Patient Services Team II
22.	Melanie Parsons	Social Work off site	Patient Services Team II
23.	Patty Slaney	Dietitian	Patient Services Team IV
24.	Cathy Organ	Diabetic Education	Patient Services Team IV
25.	Tony Leamon	Speech/Language Pathology	Patient Services Team IV, Rehab Team
26.	Mary Snow	Physiotherapist	Rehab Team
27.	Amanda Penney	Occupational therapist	Rehab Team
28.	Shelley Nichols	Recreation	Rehab Team
29.	Anne Lawrence	Nurse Educator	Information/Education Team
30.	Lisa Brown	Medical Records	Information/Education Team
31	Shawn Vautier	Pharmacy	Patient Services Team I and III

Source: EICP Secretariat.

Appendix A.2 – Dr. Charles L. LeGrow Health Care Centre

2.0 Primary Health Care Enhancement (PHCE) Coordinator Position Description

Department: Primary Health Care Enhancement

Location: Dr. Charles L. LeGrow Health Centre, Port aux Basques

Date: February 12, 2004

GENERAL ACCOUNTABILITY

The specific responsibility of the PHCE Coordinator is to facilitate team building and collaborative working relationships among Western Health Care Corporation, Health and Community Services Western Region and the community of Port aux Basques through the Southwest Coast Primary Health Care Enhancement Implementation Committee (SIC).

The PHCE Coordinator achieves this task through projects aimed at enhancing Primary Health Care on the Southwest Coast. To this end, the position is accountable for researching potential projects; working with stakeholders to prioritize projects; gaining consensus and commitment on approved projects; and subsequent planning, implementing, monitoring, evaluating, managing and reporting on the success or shortcomings of such initiatives. (i.e., project management).

SIC is made up of the Chief of Staff, a MUN Family Medicine faculty member and local management across both health boards. SIC reports to the Joint Senior Team – Primary Health Care Subcommittee. The PHCE Coordinator provides verbal updates of ongoing projects to this subcommittee on behalf of SIC at each regular meeting. Additionally, the PHCE Coordinator provides a written report, reviewed and approved by SIC, to the Joint Senior Team – Primary Health Care Subcommittee on a six month basis. The reports are due September 30th and March 31st.

The PHCE Coordinator also brings forward any new projects endorsed by SIC to the Joint Senior Team – Primary Health Care Subcommittee for approval under Primary Health Care Funding. Possible primary health care enhancement strategies may originate with front line staff, an interdisciplinary working group, local management, the community, or the PHCE Coordinator. New prospects come to the SIC table for discussion and resolution. The PHCE Coordinator submits those project plans that are successful to the Joint Senior Team - Primary Health Care Sub-Committee for review.

The interdisciplinary working group is composed of representatives from disciplines across both health boards operating out of the Dr. Charles L. LeGrow Health Centre. The purpose and responsibilities of this group are to facilitate and promote interdisciplinary collaboration among professionals providing care to patients/clients in the LeGrow Health Centre and in the Community; to develop and/or implement tools/processes that enhance the progress of interdisciplinary teamwork; and to monitor current collaborative practices among health professionals and identify opportunities for improvement. The PHCE Coordinator is responsible for chairing this working group.

Funding for the PHCE Coordinator position is provided to one health organization for administrative purposes (i.e., Western Health Care Corporation), however, the position is a division of both health organizations (i.e., also Health and Community Services Western Region). For Regional administrative purposes, the PHCE Coordinator reports directly to the Vice President, Medical Services who sits on the Joint Senior Team - Primary Health Care Sub-Committee. Examples include job description, performance appraisal, and progress reports. For local administrative purposes, the PHCE Coordinator reports to the Director of Nursing/Site Coordinator who sits on SIC. Examples include such things as vacation, sick, and education leaves as well as travel reimbursements. The SIC is also responsible for overseeing the budget for Primary Health Care Enhancement on the Southwest Coast.

The Primary Health Care Enhancement Administrative Assistant reports to the Primary Health Care Enhancement Coordinator.

Appendix A.2 – Charles L. LeGrow Health Care Centre

NATURE AND SCOPE

This position is responsible for a wide range of activities that are consistent with the following framework document provided by the Provincial Primary Health Care Advisory Committee:

> "Moving Forward Together: Mobilizing Primary Health Care – A Framework for Primary Health Care Renewal in Newfoundland and Labrador (September 2003)."

The PHCE Coordinator researches possible primary health care enhancement initiatives by surveying the literature both nationally and internationally. The PHCE Coordinator manages projects from their initial selection and approval through to their termination and integration into everyday practice on the Southwest Coast. Ensuring that projects are completed according to agreed upon cost, schedule, and performance criteria is an ongoing challenge.

The greatest challenge in the position is communication across two health organizations as well as up and down the hierarchy within each health organization. Projects often require staff participation. It is imperative that managers/clinical leaders are aware of their staff's involvement in PHCE initiatives (via senior management as well as front-line staff) and too, that they fully support their staff's participation. A regular communication link between the PHCE Coordinator and functional managers is essential to the success of PHCE projects.

The PHCE Coordinator requires a sound knowledge of other quality improvement initiatives underway across both health organizations. A database of quality improvement initiatives between the two health organizations could identify duplication of efforts across sites and ensure that existing best practices are utilized. Such a database is currently under development by the Community, Hospital, University Research Group (CHURG). Ideally, the Coordinator would work closely with the quality improvement department in each health organization as well as with CHURG to seek out collaborative opportunities.

Liaison with Regional Risk Management may be necessary when addressing projects aimed at reducing liability, decreasing hospital readmissions and improving the quality of care.

An integral linkage needs to exist between the Primary Health Care Enhancement Coordinator and parties in Information Technology. Of particular importance are those groups working on Meditech and CRMS. For Western Health Care Corporation, this would involve a liaison with the IT Steering Committee and the Information Management Performance Improvement Team. For Health and Community Services Western, this would involve a connection to the CRMS Steering Committee and the Information Management Quality Improvement Team. Provincially, the Newfoundland and Labrador Centre for Health Information will be a key linkage.

Electronic interdisciplinary interaction (i.e., referral and documentation) is the building block upon which most Primary Health Care initiatives are established. Current primary health care enhancement efforts are focusing on the necessary background work needed to ensure the success of electronic communication. This includes interdisciplinary team building and the development of protocols and forms for Interdisciplinary communication. The IT platforms will provide an opportunity to monitor referral and interdisciplinary care. However, this assumes that such systems have been designed to provide such information.

The Coordinator also requires the cooperation of the Communications Director in each health board to ensure that Primary Health Care Enhancement efforts are communicated regularly to all health staff throughout the Western Region. Both Communications Directors will also be intricately involved in media strategies to frequently inform the community of Primary Health Care Enhancement plans and progress.

Various initiatives may require the negotiation of partnerships with outside agencies (e.g., Arthritis Society; Lung Association; Regional and Provincial Wellness Committees; Department of Psychiatry, Janeway Children's Hospital; Gateway Women's Centre). A positive image with the community is essential. The coordinator must be fully integrated into the community through committee work in order to achieve the rapport necessary for establishing effective partnerships.

The Coordinator participates on the following internal and external committees/meetings.

Internal:

- Southwest Coast Primary Health Care Enhancement Implementation Committee
- Regional Interdisciplinary Steering Committee
- Southwest Coast Interdisciplinary Working Group
- Site Performance Improvement Team

Appendix A.2 – Dr. Charles L. LeGrow Health Care Centre

Emergency Regional Performance Improvement Team - Telehealth Working Group

External:
District Advisory Council
Community, Hospital and University Research Group
Peaceful Communities (i.e., mental health and violence)
Zone Board (occasional e.g., Broadband Initiative, community planning days)
Understanding the Early Years
Community Education Network
Western Regional Wellness Coalition
Tobacco Free Network

DIMENSIONS

Number of Staff: 1 Administrative Assistant
Annual Operating Expenses: $110,000.00

SPECIFIC ACCOUNTABILITIES

1. Facilitate team building and collaborative working relationships among Western Health Care Corporation, Health and Community Services Western Region and the community of Port aux Basques
2. Research and bring forward leading edge Primary Health Care practices to the Southwest Coast Primary Health Care Enhancement Implementation Committee for consideration
3. Manage Primary Health Care Enhancement initiatives from start to finish (i.e., ultimate integration into everyday practices)
4. Maintain communications throughout Western Health Care Corporation and Health and Community Services Western Region as well as with the community and external partners
5. Provide verbal updates and Interim and Year-End Reports as required by the Joint Senior Team - Primary Health Care Sub-Committee
6. Assist the exchange of information with other Primary HealthCare Enhancement sites throughout the region.

Appendix A.3 – Charles L. LeGrow Health Care Centre

3.0 Nurse Practitioner Clinical Role Planning Day

BACKGROUND

The Nurse Practitioner role was introduced as a new profession at the LeGrow Health Centre in 1997. The nurse practitioner's role was not fixed, and there were several changes in direction and focus. Generally, individuals felt there was a lack of clarity of who should be doing what, particularly among the nurse practitioner role, physician role and the public health nurse role.

WHAT?

In the winter of 2001, a nurse practitioner planning day was held to examine the role for the southwest coast and how this role impacted and overlapped with other professions, specifically the public health nurses and physicians at the Centre and in the community.

WHY?

It was decided by all involved that it would be beneficial to come together and have an open discussion and planning session so that all individuals would have an understanding of roles and responsibilities. This would allow everyone to deliver the most appropriate, high quality services, in the most efficient manner. Everyone agreed that it would be best to deal with these issues openly and directly as a team.

WHO ATTENDED?

Nurse practitioners, public health nurses, physicians (Centre and community), management of the LeGrow Centre, management of community health services, the primary health care coordinator, a recorder and a facilitator all attended the session.

HOW WAS THE DAY ORGANIZED?

The day was a combination of team exercises and discussion sessions. The day began with a discussion of the basic principles that the group felt was important to their working relationships and operation as an effective team. The principles they adopted were:

1. Focus on the situation, issue or behaviour, not the person.
2. Maintain the self-confidence and self-esteem of others.
3. Maintain constructive relationships with your employees, peers and managers.
4. Take the initiative to make things better.
5. Lead by example.

Participants set the ground rules for behaviour and interaction for the session at the outset of the day.

Ground Rules
1. Respect for each other.
2. Stay focused.
3. Treat all questions as important.
4. Promptness (start and end on time).
5. Decision-making will be by consensus.

The agenda for the day was as follows:

Morning:
- Catch me if you can 15 minutes
- Review basic principles 5 minutes
- Choose ground rules 10 minutes
- Presentation on the nurse practitioner meeting 20 minutes
- Breakdown of areas of overlap with public health 30 minutes
- Break 15 minutes
- Discussion of overlap with public health 70 minutes
- Lunch 90 minutes

Afternoon:
- Human knot 15 minutes
- Breakdown of areas of overlap with physicians 35 minutes
- Discussion of overlap with physicians 50 minutes
- Break 15 minutes
- Identification of nurse practitioner priority areas 30 minutes
- Organizational structure/reporting relationships 30 minutes
- Allocation of identified nurse practitioner role
- and staffing levels 25 minutes
- Wrap-up and next steps

Appendix A.3 – Dr. Charles L. LeGrow Health Care Centre

WHAT KIND OF QUESTIONS DID THEY FOCUS ON IN THEIR DISCUSSIONS ABOUT ROLES?

Nurse Practitioners and Public Health:

- What is your clinical role?
- What does your advanced practice role look like in each of your areas of work?
- What are the areas of overlap in service delivery between nurse practitioners and public health nurses?
- Within those areas, what does the overlap look like in terms of roles?
- From this, what are the areas where advanced practice is required?
- What are the opportunities for working together in these areas and where are the roles distinct?

Nurse Practitioners and Physicians:

- What are the areas of overlap in role?
- What should the role of the nurse practitioner be in the areas of overlap?
- Are there opportunities to work together in these areas?

Other areas of exploration included:

- What are the priority areas that should be identified for the nurse practitioners on the southwest coast?
- Are there other areas that should be developed as advanced practice roles?
- Are there areas that should be restructured by the nurse practitioners as their primary responsibility?
- What should the reporting relationship look like in the organization?
- Do we need to set up an ad hoc committee to review this role yearly?
- Who would evaluate the nurse practitioner clinical role?

At the end of these discussions there was a final question:

- After looking at what the nurse practitioner role will now encompass, how should that service be allocated?
- Can these services be provided with the current nurse practitioner resources or should there be further recruitment?

The terms of agreement on roles and responsibilities that developed out of this planning day are still being used at the LeGrow Centre. The nurse practitioners held education sessions with staff and the public shortly after the planning day to explain their role.

WHAT CAN BE LEARNED FROM THIS EXAMPLE?

Current and future models of primary health care with an interdisciplinary composition must address the area of roles and responsibilities. Often this involves sensitive and highly charged discussions, and are therefore frequently avoided.

This exemplar from the Le Grow Centre shows how a diverse team of providers and managers collectively acknowledged the need to directly face the issue, and how they acted on this need through the Nurse Practitioner planning day.

The 2004–2005 Year End Report for the Primary Health Care Enhancement Initiative at the Le Grow Centre ends with a quote that in many ways reflects the collective will and action demonstrated through this Planning Day:

> ***"People acknowledge that when they are involved in making decisions affecting their future, they develop a sense of ownership and commitment to carrying out those decisions."***
>
> **John Burbridge,**
> ***Beyond Prince and Merchant***

Appendix A.4 – Dr. Charles L. LeGrow Health Care Centre

4.0 Southwest Coast Interdisciplinary Working Group (SID) Terms of Reference

PREAMBLE

SID will build on previous work of the now defunct Working Group Sub-Committee of the Primary Health Care Enhancement Implementation Committee. Regional Performance Improvement had suggested incorporating such work in an Interdisciplinary Grand Rounds format. However, a new forum was seen as both necessary and distinct from Grand Rounds.

PURPOSE & RESPONSIBILITIES

1. To facilitate and promote interdisciplinary collaboration among health professionals providing care to patients/clients in the LeGrow Health Center and in the Community
2. To develop and/or implement tools/processes that smooth the progress of interdisciplinary teamwork
3. To assimilate the tools/processes being developed by the Regional Interdisciplinary Steering Committee into everyday practice on the Southwest Coast
4. To monitor current collaborative practices among health professionals and identify opportunities for improvement

ACCOUNTABILITY

SID is accountable to the Southwest Coast Primary Health Care Enhancement Implementation Committee (SIC) (i.e., Susan Ford, Dr. Wendy Graham, Sandra Moss, Graham Payne, Sylvia Savory, Dr. Richard Taor & Robert Turnbull). The work accomplished by SID will be shared with the Regional Interdisciplinary Steering Committee via the Primary Health Care Enhancement Coordinator.

COMPOSITION

- PHCE Coordinator (Chair)
- PHCE Administrative Assistant (Recorder)
- Physician Rep.
- Nurse Practitioner Rep.
- Patient Care Coordinator
- Speech Language Pathologist
- Community Health Nurse Rep. (Public Health)
- Community Health Nurse Rep. (Continuing Care)
- Diabetes Nurse Educator
- Dietitian
- Occupational Therapist
- Physiotherapist
- Child Behavior/ Management Specialist
- Public Health Inspector
- Pharmacist
- Social Worker Rep.
- Mental Health Social Worker
- Recreational Therapist
- Others by invitation for education

MEETINGS

In general, SID will meet the second Friday of every month from 11:30 – 1:00 p.m. in the Boardroom of the Dr. Charles L. LeGrow Health Centre. The Primary Health Care Enhancement Coordinator will chair meetings. The Administrative Assistant for Primary Health Care Enhancement will record minutes and distribute them to SID and SIC members.

Appendix B
Mid-Main Community Health Centre
List of Interviewees and Key Tools

Appendix B.1 - Mid-Main Community Health Centre

1.0 List of Interviewees

Table 1: Mid-Main Health Centre List of Interviewees

	Name	Profession/Title
1.	Dr. Sue Turgeon	Physician
2.	Dr. Lise Loubert	Physician
3.	Dr. Anita Lee	Physician
4.	Cristina Sutter	Chronic Disease Coordinator (dietitian)
5.	Susan Troesch	Clinical Pharmacist
6.	Diane Middagh	Primary Care Nurse Clinician
7.	Maureen McMillan	Medical Office Administrator
8.	Amrit Kang	Medical Office Assistants
9.	France Trono	Medical Office Assistants
10.	Vesna Blagoicevic	Physician's Assistant
11.	Richelle Ibarrola	Receptionist
12.	Cindy Weeds	Administrative Coordinator
14.	Irene Clarence	Executive Director (current)
15.	Colleen Ming	Executive Director (past)
16.	Sherry Wasserman	Counselor
17.	Dr. Sandy Ko	Dentist
18.	Donna Lee	Dental Hygienist

Source: EICP Secretariat.

Appendix B.2 - Mid-Main Community Health Centre

2.0 Transfer of Function from One Discipline to Another (May 2003)

POLICY

Functions that are legally or by convention considered to be within the scope of practice of Physicians providing care to a patient at Mid-Main Community Health Centre may be transferred to the advanced practice Clinical Nurse under the following conditions:

1. It is deemed to be in the best interest of the patient.
2. The professions involved agree to the transfer of the function.
3. The transfer of the function does not contravene existing legislation (including scope of practice legislation or the hospital act) or relevant standards for practice, or current community standards for health care delivery.
4. The mechanism for transferring the function from one profession to another, including a description of the function to be transferred, is clearly documented.
5. The clinical Nurse specialist accepting the transferred function has acquired the necessary (knowledge, skills and judgement) to perform it to the same standard as the profession transferring the function.
6. A mechanism for certifying and monitoring ongoing competence for the Nurse performing the transferred function is in place.
7. The Nurse accepting the transferred function has the resources to perform the function to the same standard as the profession transferring it, including access to immediate support for the profession which transferred the function.
8. A mechanism for regularly monitoring and reviewing outcomes is in place.

PROCEDURE FOR DEVELOPING A TRANSFER OF FUNCTION AGREEMENT

1. The Mid-Main Community Health Centre physicians and the advanced practice nurse jointly assess whether patient care could be facilitated if one professional group performed a specific function currently carried out by another (for example, would care be facilitated if an advanced practice nurse performed a function normally carried out by physicians).
2. Records of the advance practice nurse qualified to perform the transferred function will be maintained by the department or the program. These records will be made available to the person(s) certified to perform the function, Physicians at Mid-Main.
3. A list of the approved delegated medical acts will be kept for quality of care review.

REFERENCES

Registered Nurses Association of British Columbia. 1992. Guidelines for Specialized Nursing Skills and Delegated Medical Functions. Pub. No. 51. Vancouver: Author. C&W Transfer of Function Policy. 1999.

TRANSFER OF FUNCTION AGREEMENT

The role of the advanced practice clinical Nurse at Mid-Main Community Health Centre is to provide primary care to patients in collaboration with Mid-Main Physicians. The Nurse will maintain a current registration with the Registered Nurses Association of British Columbia. Procedures and functions will be performed as outlined in: *Women's Health Nurse Practitioners Manual UCLA Harbor General, Planned Parenthood BC Medical Standards and Guidelines; the Graham & Uphold 2nd Edition Clinical Guidelines in Child Health; Adult Health and 3rd Edition Family Practice (with appropriate Canadian adaptations; and First Nations and Inuit Practice Guidelines for Nurses in Primary Care.*

Appendix B.2 Mid-Main Community Health Centre

ADVANCED PRACTICE NURSE ACCEPTING DELEGATION

Signature_____ Date_____

	Delegating Physician	Date of Authorization
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Appendix B.3 - Mid-Main Community Health Centre

3.0 Pharmacist Prescriptive Authority

The undersigned physicians delegate the designated pharmacist, licensed to practice under the Pharmacy Act of B.C., the authority to authorize prescription refills under the conditions outlined in the following protocol.

In exercising this authority, the pharmacist will use professional judgement, taking into consideration:

- The patient's health problems
- The previous rate of use
- The duration of use of the drug

The quantity authorized shall be limited to the usual quantity supplied, but no more than three months usage.

When refill decisions are made, they will be documented on the patient's chart, indicating the drug name and quantity authorized, physician name, the date of authorization, name of the pharmacy phoned and authorizing pharmacist's signature. The pharmacist will leave chart with physician to review refill after it is completed.

A meeting with physicians will be held annually to review this agreement.

Narcotic and Control Drugs are not included in the protocol.

The pharmacist will have the authority to refill maintenance medication for patients on the continuous therapy under the prescribed indication(s) as follows:

1. Hypertension Medication
2. Congestive Heart Failure Medications
3. Anginal Medications
4. Arrhythmia Medications
5. Antiplatelet & Stroke Medication
6. Arthritis/Hyperuricemia/Gout Medications
7. Thyroid & Antithyroid Medication
8. Glaucoma Medications
9. Contraceptive Medications
10. Asthma and COPD Medications
11. Allergy Medications
12. Hyperlipidemia Medications
13. Diabetic Medications
14. Acne Medications
15. Osteoporosis/Osteomalacia Medications
16. Hormone Replacement Medications
17. Dermatologic Medications
18. Zyban/Nicotine Replacement
19. GI/Ulcer Medications
20. Antidepressant Medications
21. Mood Stabilizing Medications
22. Neuroleptics
23. Antianxiety/Hypnotic Medication
24. Antiseizure Medications

In addition, under this protocol, the pharmacist may make dosage form adjustments.

Authorization is limited to the Mid-Main Community Health Centre patient population seen within the last year.

PHARMACIST ACCEPTING DELEGATION

Signature_____ Date_____

Appendix B.3 Mid-Main Community Health Centre

	Delegating Physician	Date of Authorization
1.		
2.		
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Appendix C
Nor'West Co-op Community Health Centre: List of Interviewees and Key Tools

Appendix C.1 - Nor'West Co-op Community Health Centre

1.0 List of Interviewees

Table 1: Nor'West Co-op Community Health Centre List of Interviewees

	Name	Profession/Title	Team
1.	Nancy Heinrichs	Executive Director	Management Team, Inkster in Action Team, Administration Team
2.	Renata Cook	Primary Care Coordinator	Management Team, Primary Health Care Team, Clinical Coordinators, Joint Case Meeting Team, Inkster in Action Team, Joint Program Planning Team, Administration Team
3.	Michelle Kirkbride	Community Development Coordinator	Management Team, Clinical Coordinators, Inkster in Action Team, Joint Program Planning Team
4.	Kim Storeshaw	Director, Domestic Violence Services	Management Team, Joint Case Meeting Team
5.	Gerry Loewen	Footcare Coordinator	Management Team
6.	Tammy Fredericksen	FAS Mentor Program Coordinator/Clinical Specialist	Management Team, Primary Health Care Team, Clinical Coordinators, Joint Case Meeting Team
7.	Terry Rogowsky	Nor'West Early Learning and Child Care Centre Director	Management Team, Joint Case Meeting Team, Joint Program Planning Team
8.	Trina McQueen	HR Officer	Management Team, Inkster in Action Team, Administration Team
9.	Dr. Lucie Hlas	Physician	Primary Health Care Team, Joint Case Meeting Team
10.	Dr. Julian Ospina	Physician	Primary Health Care Team, Joint Case Meeting Team, Inkster in Action Team
11.	Cindy Peters	PC Nurse	Primary Health Care Team, Joint Case Meeting Team, Joint Program Planning Team
12.	Dvora Braunstein	Community Mental Health Worker	Primary Health Care Team, Joint Case Meeting Team, Inkster in Action Team, Joint Program Planning Team
14.	Linda Fadden	Family Violence Counsellor	Primary Health Care Team, Joint Case Meeting Team, Joint Program Planning Team
15.	Eileen Sanderson	Aboriginal Health Outreach Worker	Primary Health Care Team, Joint Case Meeting Team, Inkster in Action Team, Joint Program Planning Team
16.	Lisa Zapitelli	Health Promoter	Primary Health Care Team, Joint Case Meeting Team, Inkster in Action Team, Joint Program Planning Team
17.	Michelle Chornoby	PC Nurse	Primary Health Care Team, Joint Case Meeting Team
18.	Susan Roe-Finlay	Diabetic Educator	Primary Health Care Team
19.	Lori Bohn	Dietitian	Primary Health Care Team
20.	Jacquie Sarna	Public Health Nurse	Primary Health Care Team, Joint Program Planning Team
21.	Barb Kirk	Homecare Coordinator	Primary Health Care Team
22.	Kim Storeshaw	Director, Domestic Violence Services	Clinical Coordinators
23.	Marla Johal	Public Health Nurse	Joint Case Meeting Team

(cont'd on next page)

Appendix C.1 - Nor'West Co-op Community Health Centre

Table 1 *(cont'd)*: Nor'West Co-op Community Health Centre Site Visit List

	Name	Profession/Title	Team
24.	Timmalee Thompson	Homecare Coordinator	Joint Case Meeting Team, Inkster in Action Team
25.	Cheryl Starr	Community Member, Volunteer	Inkster in Action Team
26.	Lisa Janke	Community Consultant (Inkster Parent Child Coalition)	Inkster in Action Team, Joint Program Planning Team
27.	Caprice Kehler	Community Programmer (Inkster Parent Child Coalition)	Inkster in Action Team, Joint Program Planning Team
28.	Pam Zorn	Community Facilitator	Inkster in Action Team
29.	Jason Orchyk	Employment & Income Assistance Case Worker	Inkster in Action Team
30.	Ruth Lindsey-Armstrong	Children's Special Services Child Care Coordinator	Inkster in Action Team
31.	Brian Gutnik	Vocational Rehabilitation Counselor	Inkster in Action Team
32.	Agnes Deveaux	Public Health Nurse	Inkster in Action Team
33.	Val Koop	Community Facilitator	Inkster in Action Team, Joint Program Planning Team
34.	Charlene Lipka	Community Facilitator	Inkster in Action Team, Joint Program Planning Team
35.	Kate Wood	Administration Manager (WRHA)	Administration Team
36.	Shashi Sharma	Public Health Clerk	Administration Team
37.	Michelle Chartrand	Public Health Clerk	Administration Team
38.	Susan Benoit	Administrative Assistant	Administration Team
39.	Sherry Allard	Medical Receptionist	Administration Team
40.	Sonia Thiessen	Medical Receptionist	Administration Team
41.	Karolina Grajewski	Medical Receptionist	Administration Team
42.	Ivan Sabesky	Chair	Board Members
43.	Dan Skwarchuk		Board Members
44.	Anne Llsoway		Board Members
45.	Chris McCarville		Board Members

Source: EICP Secretariat.

Appendix C.2 - Nor'West Co-op Community Health Centre

2.0 Human Resources Plan 2006-2009

PREAMBLE

The Human Resources Plan for Nor'West is part of a larger picture, which incorporates the changing needs in the community, as well as changes and innovation in the provision of community health services. It will allow Nor'West to be proactive in its management and development of human resources. This plan will be evaluated and reassessed yearly in conjunction with quality planning by the Human Resource Committee, as well as the standards outlined in the Accreditation.

OBJECTIVES OF THE HUMAN RESOURCE PLAN

- Provide a high quality, responsive service to all staff in the centre
- Identify future staffing needs by examining past trends and future needs
- Identify the demographic and systemic changes that will affect Nor'West and program delivery in the future
- Identify staff training and development needs within programs as well as in relation to the Strategic Plan for Nor'West
- Identify an action plan and time frame for following through on the objectives (Quality Plan)
- Identify Human Resource requirements to fulfill the objectives of the Strategic Plan

HUMAN RESOURCE PLANNING PROCESS

- Examine staff turnover during the last three years
- Examine growth patterns and other challenges in the organization -past and future- as it relates to staffing needs
- Examine and respond to the objectives of the Strategic Plan
- Forecast the demand for human resources and develop a recruitment strategy
- Examine training and development needs of staff based on an inventory and evaluations. Identify gaps in training and a plan to address the needs.
- Obtain staff feedback on Human Resource issues and needs with centre wide staff survey, working groups and committees as well as other informal communication

TOOLS

- Human Resource Planning guide - Corporate Needs, External Factors, Internal Analysis, Management Implications, Staffing Requirements Table (see attached)
- Staff Survey
- Strategic Plan
- Accreditation Report

WHO IS INVOLVED?

- The Management Team will lead the process and be responsible to carry out the action plan in a timely manner
- The Executive Director will have a lead role in creating and approving the Human Resource Plan, and obtaining resources to carry out this plan
- The Safety & Health Committee will be involved in reviewing the HR Plan and making recommendations as they relate to health and safety
- The overall staff will have input into the development of the plan through staff satisfaction surveys and other feedback

HUMAN RESOURCE PLANNING GUIDE

- Corporate needs
- External factors
- Internal analysis
- Management implications
- Projections - staffing
- Staff training and development - yearly
- Quality Plan – yearly
- Staff Survey Results – yearly

Appendix C.2 - Nor'West Co-op Community Health Centre

CONCLUSION

Staffing Needs Assessment

In examining staffing needs of Nor'West Co-op Community Health Centre, a summary of current staff and staff separations for the last 3 years was prepared **(See Human Resource Planning Guide, Staffing Levels & Projections, Staffing Separations.)** The projected needs for 2006-2009 are based on past separations as well as projected growth for the Centre.

As Nor'West is expected to become ACCESS Inkster by 2008, there is little to no projected growth for most programs for the next 3 years leading up to the creation of this centre. However, Nor'West is actively pursuing options for space and is working with WRHA on the expansion of Primary Care, which has been identified by community residents as being a main concern.

Past separations indicate some programs have higher turnover rates than others. In particular, the Nor'West Early Learning & Child Care Centre has doubled its rate of turnover during 2003 from 3 separations in 2002 to 6 separations in 2003. This number remained constant in 2004. This can be attributed to a few factors: first, a new director was hired during 2003, so it is not unusual to witness increased turnover as adjusting to a major change such as this one is difficult for staff members. Second, 2 long-time employees of the daycare retired during 2003.

Due to the nature of these factors, it is unlikely that this unusually high turnover rate will continue to be a problem in the Day Nursery. Nor'West can anticipate recruiting and staffing needs to return to normal levels **(See Human Resource Planning Guide, Staffing Levels & Projections, Staffing Separations.)** for childcare workers. However, Nor'West will continue to monitor the situation through turnover rates, staff satisfaction surveys, absenteeism, and performance appraisal.

Nor'West will continue to use current recruiting tools and methods for 2006 – 2009. Individual programs (in conjunction with the Executive Director) are responsible for determining qualifications required and job descriptions for any new positions created. Directors/Coordinators are responsible for reviewing current job descriptions and updating as necessary, through performance appraisal and when filling a vacated position. Individual programs may choose to advertise in specific publications or locations, and most positions are advertised in the Winnipeg Free Press and the HRDC Job Bank On-Line.

Nor'West will also continue to monitor demographic trends and changes occurring in the community serviced

by the centre. Additionally, Nor'West will continue to examine systemic changes as they occur at Nor'West and in the Health Care System.

As information is provided to Nor'West regarding the upcoming ACCESS Inkster project, the Executive Director, Board of Directors, and Management Team will all have roles to play in the planning process.

Training and Development Needs

In response to comments from staff surveys as well as informal discussions, the Human Resources Committee is currently working on an Educational Framework which will allow for more sharing of information across departments and/or specialties. In the past, there has been a demand for information presented by one Program Team to another or to members of several different teams. For example, Community Development presented on Gang Awareness, a topic that is of interest to Primary Care, Mental Health, Public Health, FAS, etc. FAS has presented information to Primary Care, Community Development, and the Daycare. The Educational Framework will formalize this process.
Staff members will be surveyed to determine what sort of educational or training topics they are interested in learning more about. This list of topics will then be distributed and teams or individuals can pick topics they are comfortable in presenting. Sessions will take place every few months that any employee of the centre will be free to attend if their schedules allow.
This will allow for more information sharing as Nor'West tries to become more integrated.

Strategic Plan

Nor'West took part in an integrated Strategic Planning session in Spring 2004. The Integrated Project is a result of this Strategic Plan, whereby Nor'West, WRHA, and Family Services & Housing will be working together to promote physical activity and nutrition within the Inkster community. Human Resources will continue to support staff in an administrative role in order to help all Nor'West employees perform to the best of their abilities while working toward this

project goal by providing policies and procedures for essential HR functions such as recruitment, selection, performance appraisal, and training and development.

Nor'West Co-op Community Health Centre Inc.
Human Resource Planning Guide

A) CORPORATE NEEDS

	What is in process?	What specific actions are planned?
Expansion of existing program/ services	- primary care expansion	-working with WRHA for additional funding
Addition of new facilities	- Nor'West on Alexander - new space for 61 Tyndall site	- still working with City of Winnipeg - working with WRHA & MB Health to secure funding
De-emphasis or discontinuance of any programs/services	- nothing planned as long as current funding levels can be maintained (or increased)	-
New services/programs	- A Woman's Place opened in fall of 2004	- securing funding for future years
New technologies or applications	-	-
Changes in operating methods or productivity improvements	-	-
Changes in administrative, information, or control systems	- updating of computers continues	- Internet policy
Changes in management or organizational structure	-	-

B) EXTERNAL FACTORS

	What is in process?	What specific actions are planned?
Are qualified (competent) recruits available in the labour market?	- shortages of ECEs, Physicians in labour market	- continue to make salaries as competitive/attractive as possible within funding limits/union requirements
Are there changes in the personnel relations climate?	- staff survey, feedback in performance appraisals, etc.	- activities such as staff retreat, social outings, more organization ir. Vacation schedules, performance appraisals

C) INTERNAL ANALYSIS

	What is in process?	What specific actions are planned?
Do we have excessive turnover in any group?	- turnover is high in Daycare due to some unusual circumstances; turnover is expected to return to a lower level	- continue hiring as needed
Is there too little turnover or mobility in any group?	-	- monitor turnover/lack of turnover for signs of problems, investigate the possibility of making changes (i.e. lateral movement, restructuring, etc.) if a problem is identified
Are there any age patterns that may be imbalanced in any group?	-	- monitor to be prepared in cases of high numbers of retirement, etc.
Is there a proper balance (employee mix) for each department?	- good representation of different cultures in IWCS staff, Aboriginal Outreach	- keep needs of clients in mind when making hiring decisions
Are there specific performance problems in any group?	- Daycare sometimes has trouble hiring qualified workers	- keep up to date records of any performance problems through accurate performance appraisals, documentation in personnel files
Are there potential shortcomings in levels of technical competency?	- new phone/email system	- training will be provided
Are there any internal HR processes that need changed?	- participated in HR Benchmarking Survey in 2005	- will examine results of survey and determine what if any processes need change

Appendix C.2 - Nor'West Co-op Community Health Centre

D) MANAGEMENT IMPLICATIONS

	What is in process?	What specific actions are planned?
Are there enough employees who could become managers?	- there are several well qualified, experienced employees throughout the centre	- keep encouraging continuing education in relevant fields
Do the present managers have adequate technical competence for the changing demands?	- training will be provided re: new technology; staff members and directors/coordinators identify gaps in performance i.e. technical competence	- keep encouraging continuing education in relevant fields
Do they have the appropriate managerial skills and experience to meet the changing demands?	- must meet qualifications set out in job descriptions when applying for positions	- keep performance appraisals up to date; use proper interviewing and hiring processes
Is the management structure and staffing appropriate for our objectives?	- monitored through staff satisfaction surveys, performance reviews with Executive Director	- continue to examine management structure and staffing, make changes where necessary

Appendix C.2 - Nor'West Co-op Community Health Centre

DEMOGRAPHIC AND SYSTEMIC CHANGES

A) Demographic changes

Demographic changes in the Inkster community are monitored by the WRHA and the Nor'West Community Development Team. Community Development uses this information when making decsions regarding programming needs and project goals, and also uses this information to keep the entire centre informed of community needs. Community need drives the programs at Nor'West.

B) Client's needs and expectations

Clients' needs and expectations are monitored through satisfaction surveys (each program), focus groups for projects such as accreditation, and community needs assessments completed by the Community Development Team and the WRHA. Clients also express their needs directly to Nor'West staff. For example, the Keewatin Community Resource Centre approached Nor'West for assistance with keeping the KCRC open and available to the community, and MB Housing approached Nor'West to oversee the development of a resource centre in Gilbert Park.

C) Methods used to deliver services

Nor'West is recognizing a need to make services more available to the community the centre serves. This includes research and planning for projects such as a Teen Clinic in Sisler High School, a satellite clinic in Weston/Brooklands, and programs in the community such as the Safe & Sound program.

D) Available resources

The KCRC will provide Nor'West with the opportunity to alleviate some of the concerns around space as it will allow some existing staff to move to a new location and provide areas for new programming i.e. youth drop-in, etc. Nor'West is also actively working with WRHA and MB Health to secure funding for a new facility.

E) Government policies and priorities

Nor'West is subject to government rules and regulations such as health and safety standards, Dacycare regulations, standards of licensing for physicians, etc. Furthermore, Nor'West is a partner with MB Justice and Family Violence in A Woman's Place, which opened in 2004.

F) Labour-management relations

There are several different bargaining units in place at Nor'West. The WRHA and other funders largely perform negotiations. Contracts will be re-opening over the next few years and this will require a lot of HR time as well as raise issues concerning funding.

G) Labour supply

ECEs and Physicians are in short supply all over Manitoba, causing recruitment and retention difficulties in these areas. Otherwise, there are typically very good response rates to employment opportunities even in times of low unemployment.

H) Integrated Project "Inkster In Action"

Nor'West, WRHA & Family Services & Housing participated in a joint Strategic Planning Process which has resulted in an integrated project between the 3 agencies. The project focuses on physical activity and nutrition.

Appendix C.2 - Nor'West Co-op Community Health Centre

Nor'West Co-op Community Health Centre Inc.				
Human Resources Plan Staffing Needs Assessment				
2006-2009				
POSITIONS	**STAFFING LEVELS**			
Primary Care	**2003**	**2004**	**2005**	**Projected 2006-2009**
Primary Care Coordinator	0.50	0.50	0.50	1.00
Primary Care Nurse	1.40	1.40	1.40	4.00
Advanced Practice Nurse	0.40	0.20	0.20	1.00
Physicians	1.20	1.20	1.20	4.00
Receptionist	2.20	2.20	2.20	4.20
Counselor (Family Violence)	1.00	1.00	1.00	1.00
Health Promoter	1.00	1.00	1.00	1.00
Aboriginal Health Outreach	1.00	1.00	1.00	1.00
Dietician (7Oaks)	0.05	0.05	0.05	0.05
Diabetic Educator (Volunteer)	0.05	0.05	0.05	0.05
Total Primary Care EFT	**8.80**	**8.60**	**8.60**	**17.30**

Community Development	**2003**	**2004**	**2005**	**Projected 2006-2009**
Community Development Coordinator	1.00	1.00	1.00	1.00
Community Development Facilitator	2.50	3.75	3.75	3.75
Youth Worker	0.32	0.32	0.25	0.25
Project Assistant	0.00	0.00	0.25	0.25
Total Community Development EFT	**3.82**	**5.07**	**5.25**	**5.25**

WRHA	**2003**	**2004**	**2005**	**Projected 2006-2009**
Team Manager	0.50	0.50	0.50	0.50
Admin	2.00	2.00	2.00	2.00
Public Health Nurse	6.50	6.50	9.00	9.00
Families First	2.00	2.00	4.00	4.00
Shared Care	0.50	0.50	0.20	0.20
Community Nutritionist	0.05	0.05	0.05	0.05
Community Mental Health	1.00	1.00	1.00	1.00
Total WRHA EFT	**12.05**	**12.05**	**16.25**	**16.25**

Footcare	**2003**	**2004**	**2005**	**Projected 2006-2009**
Coordinator	0.80	0.80	0.80	0.80
Nurses	2.40	2.40	2.40	2.40
Total Footcare EFT	**3.20**	**3.20**	**3.20**	**3.20**

FAS Program	**2003**	**2004**	**2005**	**Projected 2006-2009**
Coordinator	1.00	1.00	1	1.00
Mentors	3.00	3.00	3	3.00
Total FAS EFT	**4.00**	**4.00**	**4.00**	**4.00**

Appendix C.2 - Nor'West Co-op Community Health Centre

POSITIONS	STAFFING LEVELS			
Early Learning & Child Care Centre	**2003**	**2004**	**2005**	**Projected 2006-2009**
Director	1.00	1.00	1.00	1.00
Supervisor	0.00	1.00	1.00	1.00
Early Childhood Educators II	4.00	3.00	2.00	2.00
ECE Assistants	1.00	1.50	1.50	1.50
Inclusion Worker	0.80	1.50	1.00	1.00
Total Early Learning EFT	**6.80**	**8.00**	**6.50**	**6.50**

Administration	**2003**	**2004**	**2005**	**Projected 2006-2009**
Executive Director	0.50	0.50	0.50	0.50
Accountant	0.40	0.40	0.50	0.50
Administrative Assistant	1.00	1.00	1.00	1.00
Human Resources Officer	0.50	0.50	0.50	0.50
Total Administration EFT	**2.40**	**2.40**	**2.40**	**2.50**

Immigrant Women's Counselling Service	**2003**	**2004**	**2005**	**Projected 2006-2009**
Director	1.00	1.00	1.00	1.00
Counselors	4.00	4.00	4.00	4.00
Volunteer Coordinator	0.00	0.00	0.50	0.50
Admin	1.00	0.50	0.50	0.50
Outreach	0.00	0.50	0.50	0.50
Total IWCS	**6.00**	**5.00**	**6.50**	**6.50**

Woman's Place	**2003**	**2004**	**2005**	**Projected 2006-2009**
Admin	0.00	1.00	1.00	1.00
Intake	0.00	2.00	2.00	2.00
Lawyer	0.00	0.40	0.40	0.40
Total IWCS	**0.00**	**3.40**	**3.40**	**3.40**

TOTAL NOR'WEST EFT	**47.07**	**51.72**	**56.10**	**64.90**

STAFF SEPARATIONS						
Position	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Executive Director			1			
Physicians		1			2	
Outreach Workers	2	3	2	1	2	1
Daycare Workers	1	3		3	6	6
Primary Care Nurse	1	1				
Footcare			1			
Accountant			1			
Volunteer Coordinator			1			
FAS Coordinator						1
FAS Mentor						1
Medical Receptionist						1
Nurse Practitioner						1
IWCS				3	2	
Total Per Year	4	8	6	7	12	11

Appendix C.2 - Nor'West Co-op Community Health Centre

STAFF TRAINING & DEVELOPMENT

Mandatory Training & Development for staff at Nor'West currently includes CPR/1st Aid training/re-certification and Aboriginal Cultural Awareness (through WRHA.) All Staff Members are also required to attend the Staff Retreat, which will be held in Spring 2006.

Some staff members have expressed an interest in topics that have previously been offered on a centre-wide basis, specifically Vicarious Trauma and Non-Violent Crisis Intervention. The Executive Director and Management Team will determine which trainings will be offered on a centre-wide basis.

Each program area has a separate budget to be used by staff members attending non-mandatory trainings. Individual employees and their Director/Coordinator identify non-mandatory Training & Development Needs during the employee's yearly performance appraisal. The employee or their Director/Coordinator may also make suggestions for training the employee may benefit from as they become aware of opportunities throughout the year. The Director/Coordinator must authorize all trainings attended and will make decisions based on the cost of the training, the benefits of attending the training, previous training attended by that employee, and the overall training budget for that program.

Staff members are encouraged to take advantage of training opportunities offered through WRHA or identified in the binders in the staff room.

Staff members who wish to attend training other than centre-wide trainings must fill out the Application for Training form and have it authorized by their Director/Coordinator. The form is then submitted to Finance for payment and passed to the HR Officer.

Appendix C.2 - Nor'West Co-op Community Health Centre

Quality Monitoring Plan 2005-2006
Program Name: HUMAN RESOURCES

Objective/Method	Quality Dimension	Indicator	Standard / Target	Data Source	Quarter
To provide staff retreat and team development within Nor'West, WRHA & FS&H	Availability Equity Communication Work life Learning environment	All staff are given the opportunity to participate in staff retreat/development day	Staff Retreat/Development day held for all staff 80% of staff will indicate satisfaction with the day	Evaluation forms from event held on June 10, 2005	April - June 2005
Participate in Human Resources Benchmarking Survey through WRHA	Efficiency Effectiveness Learning environment Work life	Results of survey will compare Nor'West with WRHA and other health agencies in Canada		HRB Survey based on personnel files, payroll files, current practices	July - September 2005
Update Pesonnel Policies for non-unionized staff	Communication Effectiveness Work life	Personnel Policies will be reviewed and updated.	A complete set of personnel policies.	Existing policies Collective Agreements	October – December 2005
Develop new HR processes based on results of Human Resources Benchmarking Survey or areas of concern identified through staff surveys, performance issues, management team, etc.	Work life Competence Communication Effectiveness			Staff Survey Performance Appraisals Time sheets Management Team	October 2005 - March 2006
Survey staff Satisfaction re: Human Resources, Info Management	Communication Competency Effectiveness Learning environment	# of staff who indicate satisfaction on yearly survey,	85% of staff will indicate satisfaction with workplace	Staff responses	January – March 2006

Appendix C.3 - Nor'West Co-op Community Health Centre

3.0 Nor'West/WRHA Staff Satisfaction Survey 2005

Human Resources

1) Nor'West Co-op Community Health Centre/WRHA provides fair and equitable compensation(ie salaries/benefits) relative to other community health centres/daycares

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

2) Personnel policies at Nor'West are applied in a fair and consistent way

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

3) Feedback provided to staff on individual performance is objective, interactive, positive and constructive

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

4) I can have open discussions about work-related issues with my manager or supervisor

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

5) In the last month, my manager or supervisor has acknowledged when I've done a good job

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

6) Co-workers tell me when I've done a good job

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

7) Staff input is encouraged and used in planning and decision making

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

8) The organization actively consults with staff on workplace issues

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

9) Staff creativity, innovation and initiative is encouraged

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

10) Nor'West/WRHA makes effective use of my skills and abilities

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

11) I trust the management in my organization

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

12) I am able to make decisions to do my job effectively

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

13) The organization provides a safe, healthy space to work

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

14) My safety concerns are addressed promptly in my workplace.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

15) I have encountered discrimination in my workplace

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

16) In the past year, I have personally experienced discrimination at work

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

17) My daily work has low risk for harassment

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

18) My daily work has low risk for violence

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

19) I am treated with respect in my work environment.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

20) There are people at work I can talk to if I need help in resolving conflict.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

21) I have adequate time available to plan and carry out my work

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

22) Overall, my workload is manageable

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

23) *Nor'West staff only:* I am aware of the Nor'West Human Resources Plan

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

24) I tell my friends that this is a good place to work

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

25) I feel I am part of a team

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

26) Overall, my well being and feelings of satisfaction relative to this workplace are:

Very Good	Good	Neutral	Poor	Very Poor

Comments:

Things that would help to improve this workplace for me as a staff person are:

Information Technology

27) The organization has processes or systems in place to foster regular, effective internal communication

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

28) How would you rate the email system?

Very Good	Good	Neutral	Poor	Very Poor

Comments:

29) How would you rate the phone and voicemail system?

Very Good	Good	Neutral	Poor	Very Poor

Comments:

30) How would you rate your computer access?

Very Good	Good	Neutral	Poor	Very Poor

Comments:

31) I have the equipment I need to do my job.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

32) ***Nor'West staff only:*** **I am aware of the Nor'West Information Management Plan**

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

33) Did you take part in a computer training session provided by Anna?

Yes **No**

Why or Why not?

34) Did you take part in an email training session provided by Kelly?

Yes **No**

Why or Why not?

35) Monthly Staff and Board Minutes are accessible, timely and clear

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

36) All program quarterly reports and statistics are accessible, clear and useful

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

37) I have timely access to basic information for day-to-day work and decision-making

Strongly Agree	Agree	Neither Agree or	Disagree	Strongly Disagree

Disagree

Comments:

38) Please list any software programs that would better meet your computer needs:

39) In the last year, did you need assistance from the IT support person?

Frequently | Fairly Often | Occasionally | Rarely | Never

Comments:

40) How would you rate this assistance?

Very Good | Good | Neutral | Poor | Very Poor

Comments:

Education and Training

41) The organization encourages, supports and provides ongoing education, training and development

Strongly Agree | Agree | Neither Agree or Disagree | Disagree | Strongly Disagree

Comments:

42) Did you attend any on-site or off-site training in the past year?

Yes | No

Why or Why not?

Appendix C.3 - Nor'West Co-op Community Health Centre

43) *Nor'West staff only:* **The "Application to Attend Training" process is easy to use**

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

44) I attended the Best Practices Lunch 'n' Learn session

Yes **No**

Why or Why not?

---

45) I know where to find Best Practices information for my position.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

46) I use Best Practices information to do my job.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

---

47) Do you have any suggestions that would improve our awareness or use of Best Practices at work?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

Appendix C.3 - Nor'West Co-op Community Health Centre

48)I find the monthly all-team staff meetings to be informative and useful.

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Comments:

Please identify your team:

Primary Care	Admin	FAS	Nor'West on Portage
Community Development	Footcare	Daycare	WRHA

Appendix C.4 - Nor'West Co-op Community Health Centre

4.0 Quality Monitoring Plan 2005/2006

Program Name: PRIMARY CARE

Objective / Method	Quality Dimension	Indicator	Standard / Target	Data Source	Quarter
To evaluate charting practices within the primary care team Chart Audit – joint with WRHA	**System Competency**- appropriateness, competence, safety **Responsiveness –** Availability, timeliness, continuity	Total # of the charts audited • per indicators developed by the QI WRHA Team	• per WRHA indicators	Chart Audit - WRHA	April – June'05 2005
To offer a primary care service that generates high level of satisfaction and meets clients' needs.	**System Competency** – effectiveness, appropriateness, **Responsiveness –** availability, accessibility, timeliness, continuity, **Client/Community Focus** –respect and caring, communication	• Total # of responses • satisfaction with the physician services • satisfaction with the nursing services • satisfaction with the front desk • timeliness of the appointment • indictors as per survey • any recommendations	• 85% of clients will be satisfied • indicators as per survey	Client survey	July – Sept., 2005
To offer a dietitian service that meets clients' needs and has positive outcomes. To provide primary care service to clients with Diabetes per Manitoba Standards - part of the Diabetes Care Map Pilot project with WRHA	**System Competency** – appropriateness, effectiveness, legitimacy, **Client/Community Focus** - communication, respect and caring **Responsiveness –** Accessibility, timeliness **System Competency** – appropriateness, effectiveness, legitimacy, safety	• Total # of responses • Satisfaction with the information given • Resources given meeting clients' needs • Timeliness of appointment • # of clients who had at least one goal met • Overall satisfaction with the service • Total # of clients enrolled into the Diabetes care Map/Total # of clients with Diabetes • # of clients who had complete fasting blood work completed • # of clients who had A1cHb done q 3 months • # of clients who had ophthalmology exam (annual) • other indicators as per care map and the recommendations of the Diabetes Care Map Implementation Committee • reasons for the clients not being enrolled • reasons for the care map not being completed	85% of clients will be satisfied with the overall service • indicators as per survey 100% of clients with Diabetes seen at Nor'West for their care will be enrolled in the Care Map • as per indicators developed by the Implement ation committee	Client surveys Chart audit Diabetes care map review	Sept. 2005 – March 2006 Jan '05 – March 2006

Appendix C.5 - Nor'West Co-op Community Health Centre

5.0 Policy and Procedure Manual – Integrated Goal Sheet

Nor'West Co-op Community Health Centre

Policy: **Integrated Goal Sheet**

Category: Clinical Primary Care Program

Effective: January 1, 2005

Purpose: To ensure and facilitate:

- integrated approach to client care
- continuity of care
- client driven care.

Procedure: **Integrated Goal Sheet** – enclosed - will be placed by the medical receptionist team in the Integrated Client Record on the left hand side of the chart – 2nd page. The form will be used by the members of the Primary Health Care Team when setting goals with their clients.

Nurse – Physician team – will initiate and document goal setting with the following clients:

- all clients seen for CPX
- clients seen for life style changes i.e., weight loss, smoking cessation, stress management etc
- as identified by client and /or provider

Social Work / Counseling team (Primary Health Care)

- will initiate and document goal setting with all clients by the second meeting or as identified by the client or the provider

Goal Setting Process / Review

- goals should be recorded using client words and be specific
- target dates should be client driven and attainable
- goals should be initialed by the client whenever possible
- goals should be reviewed with clients by the primary provider as per target dates and at least once a year
- updates / progress on goals should be document / dated as per form
- all clients will be given the choice of having a copy of their goal sheet.

Approved by:
Clinical Director: _____

Executive Director: _____

Date: _____

Appendix D
Rosedale Medical Group: List of Interviewees and Key Tools

Appendix D.1 - Rosedale Medical Group

1.0 List of Interviewees

Table 1: Rosedale Medical Group List of Interviewees

	Name	Profession/Title	Team
1.	Jennifer Warrington	Clinic Manager	
2.	Sandy Billyard	Administration	
3.	Mary Goodacre	Nurse Practitioner	Nurse Practitioner & Dietitian Team
4.	Linda Rogers	Nurse Practitioner	Nurse Practitioner & Dietitian Team
5.	Amy Pender	Dietitian	Nurse Practitioner & Dietitian Team
6.	Dr. Adrian Hornich	Physician	Geriatric Team, Pharmacist Team, Physiotherapy team
7.	Delynne Riddell	Registered Nurse	Geriatric Team
8.	Angela DiCesare	Administration	Geriatric Team
9.	Li Yin	Massage Therapist / Acupuncturist	Massage Therapy / Acupuncture Team
10.	Leslie Henderson	Administration	Massage Therapy / Acupuncture Team, Chiropractor Team
11.	Iris Krawchenko	Pharmacist	Pharmacist Team
12.	Dr. Jason Aguanno	Physician	Mental Health Team, Chiropractor Team
14.	Gloria Muller	Counselor	Mental Health Team
15.	Suzanne Swanton	Counselor	Mental Health Team
16.	Tanya Delismunovic	Administration	Mental Health Team
17.	Dr. Tony Opie	Physician	Home Care Team
18.	Krista Van Hiel	Registered Nurse	Home Care Team
19.	Wendy Chrysler	CCAC	Home Care Team
20.	Grace Rogers	CCAC	Home Care Team
21.	Dana Quinn	Physiotherapist	Physiotherapy team
22.	Dr. Janice Koole	Physician	OB Team
23.	Dijana Manojlovich	Registered Nurse	OB Team
24.	Janet Fuller	Breast-feeding / Parenting	OB Team
25.	Dr. John Riva	Doctor of Chiropractic	Chiropractor Team

Source: EICP Secretariat.

Appendix D.2 - Rosedale Medical Group

2.0 Confidentiality agreement

It is the policy of the Practice that all employees agree to sign and adhere to a Confidentiality Agreement.

Procedures:

Each new employee will be presented with a Confidentiality Agreement to sign and be witnessed upon employment. Since all employees have free access to confidential clinic information and trade secrets, in whole or in part, ALL employees will be required to sign an Acknowledgment of Confidentiality Statement. This signed document of the employee's agreement to uphold the provisions of this policy will be kept on file in the employee's personnel file.

CONFIDENTIALITY AGREEMENT

ACKNOWLEDGMENT OF CONFIDENTIALITY STATEMENT

I have received a copy of, read, understand and agree to uphold the written policy on matters of confidential information and trade secrets. I also understand that in my daily job duties, I will have free access to confidential clinic operations and any violation of confidentiality, in whole or in part, could result in disciplinary action up to and including termination and/or legal action.

Confidential information is defined as any information found in a patient's medical record, personal information and work-related information (including salary information). All information relating to a patient's care, treatment or condition constitutes confidential information. This confidentiality policy also encompasses any trade secret, scientific or technical information developed by the Practice or its personnel.

Employees shall never discuss a patient's medical condition with any non-employee of the Practice, friends or family members. Confidential matters involving patients will not be discussed in areas where they might be overheard by other patients or other non-employees of the Practice. Staff members are to be aware at all times that conversations regarding patients are not to be overheard by others and take appropriate steps to ensure this confidentiality.

All salary information is confidential and may not be shared with others in the clinic or with patients. Only authorized individuals may relay salary information to employees or non-employees.
Any unauthorized disclosure of confidential information by employees could render the clinic liable for damages. Any employee who violates the confidentiality of clinic, medical- or employee-related information is subject to disciplinary action up to and including termination from employment.

Signed this _____ day of _____

Employee Name (please print):

_____

Appendix D.2 - Rosedale Medical Group

Signature:

_____

Witnessed by Practice representative:_____

Date:

_____

Appendix D.3 - Rosedale Medical Group

3.0 Leasing Agreement

ROSEDALE MEDICAL GROUP

1955 King Street East
Hamilton, Ontario
L8K 1W2
Telephone: (905) 547-0508
Fax: (905) 547-6865

<Date>

<To Whom It May Concern>

Dear <>,

Further to our recent conversations, the purpose of this letter is to confirm our mutual understanding of the terms on which you will be continuing to rent office space at Rosedale Medical Group.

1. The term of your association shall commence January 1, 2005 and continue until March 31, 2006.

2. The Rosedale Medical Group will provide you with reception, telephone and management administrative services.

3. The Rosedale Medical Group will provide you with access to the use of two exam rooms.

4. The Rosedale Medical Group will provide you with access to a full-time, administrative assistant (defined as 35.5 hours per week, based on Rosedale Medical normal administrative staff work week) at a rate of $<> per hour. If the assistant is required to work more than 35.5 hours per week due to your schedule or if you wish to pay her more than $<> per hour, you will be billed the assistant's hourly rate plus 20% for vacation time, sick time and applicable employer taxes.

5. You will be responsible for the expense of maintaining your own professional licenses and malpractice insurance.

6. You agree that you will not solicit Rosedale Medical Group patients and will see them only on site.

7. The Rosedale Medical Group will collect, administer and have full access to all billings and collections for services rendered by you through the Rosedale Medical Group, including without limitation Pilot Project, OHIP, WSB, medical-legal, insurance and miscellaneous cash, cheque and credit card billings.

8. The Clinic Manager will produce a revenue reconciliation report dated the month end on the 1st of the next month and you will be billed <>% of all fees collected as a rental fee due by the 10th of the month. An outstanding report dated the month end will also be produced by the Clinic Manager by the 10th of next month.

9. In the case of dispute resolution, the Clinic Manager of Rosedale Medical Group will be the mediator.

10. This agreement will be reviewed every three months and either party can terminate this agreement on six months notice.

11. This agreement will be subject to change if additional staff are required as your practice grows.

Please sign below as acceptance of the terms listed above. If you have any questions, please let me know.

Sincerely,

_____ _____

<Name> Date

Appendix D.4 - Rosedale Medical Group

4.0 Performance Appraisal and Development Plan 2006

Employee Name:	Date Completed:
Position:	
Team:	Supervisor:

PURPOSE:

The purpose of the Performance Appraisal and Development Plan is to promote the effective use of our staffing resources. The key requirement in this process is to review duties and performance levels, and identify any development needs.

OBJECTIVES:

The objectives of the Performance Appraisal Development Plan are to:

1. Encourage meaningful communication between the employee and supervisor;
2. Inform employee of their level of performance;
3. Identify skills and aptitudes for development;
4. Challenge the employee to continually improve performance and personal effectiveness.

INSTRUCTIONS:

Before completing the form, please:

1. Refer to the employee's job description to review the major duties and responsibilities;
2. Review the objectives/goals for the previous year;
3. Consider the following points:
   A. What results are expected from the employee?
   B. What has been the employee's contribution?
   C. Has this employee been working to full potential?
   D. How could this employee's performance be improved?
   E. What potential exists for growth?

The finalized copy is signed by the employee, and forwarded to the reviewing supervisor for signature. The completed Performance Appraisal form should be returned to Human Resources.

Appendix D.4 - Rosedale Medical Group

KEY ACTIVITIES	PERFORMANCE SUMMARY
Major responsibilities, primary duties, important functions as listed on the position description. Please list these in order of priority, with the most important at the top. Most jobs have 3-5 key objectives.	Review each activity. Record major contributions over the past 12 months including areas in which performance improvements are needed to increase effectiveness.

List special contributions made over the past 12 months:

Appendix D.4 - Rosedale Medical Group

SKILL APPRAISAL

SKILL	PERFORMANCE SUMMARY
JOB KNOWLEDGE: Consider the employee's ability to: • Demonstrate the knowledge and understanding required in the job • Achieve quality of results • Be thorough and accurate • Enhance productivity	
GETTING THINGS DONE: How effective is the employee in: • Planning activities and organizing resources • Determining and implementing appropriate courses of action • Setting priorities and meeting deadlines • Coordinating and controlling activities	
PROBLEM SOLVING: Consider the employee's ability to: • Recognize and anticipate changing events and conditions • Obtain information and analyze problems • Make quality decisions	
INTERPERSONAL SKILLS: How effectively does this employee: • Lead and/or participate in team activities • Achieve results through/with other employees • Persuade and consider others • Listen	
COMMUNICATION: How effectively does the employee: • Communicate verbally • Communicate in writing • Use appropriate methods or styles of communication • Recognize the importance of good communication • Provider feedback (confirm communication)	
PEOPLE MANAGEMENT: (if applicable) How well does the employee: • Motivate directly reporting employees • Develop the abilities of employees • Foster growth in individuals	

Appendix D.4 - Rosedale Medical Group

TRAINING AND DEVELOPMENT

1. What plans have you made and the employee agreed to address the necessary improvements?

2. Recommend developmental activities not directly associated with performance on the present job, if applicable:

OVERALL COMMENTS

Supervisor's comments, include the main points of the discussion in the space below:

Supervisor's Signature: **Date:**

Employee's Comments:

Employee's Signature: **Date:**

Your signature does not necessarily signify agreement; it simply indicates the appraisal has been discussed with you.

Reviewing Supervisor's Signature: **Date:**

Appendix E

Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

List of Interviewees and Key Tools

Appendix E.1 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

1.0 List of Interviewees

Table 1: Chinook Health Region / Chinook Primary Care Network List of Interviewees

	Name	Profession /Title	Team
1.	Dr. Robert Wedel	Physician, Taber Associate Medical Group Team; Co-Chair: CPCN	Leadership Team
2.	Dr. Calvin Stewart	Physician, Lethbridge Team	Leadership Team
3.	Janet Lapins	VP, CHR	Leadership Team
4.	Arvelle Balon-Lyon	Primary Care Planner: CPCN	Leadership Team
5.	Eileen Patterson	Coordination Consultant, Chinook Chronic Disease Network	Leadership Team
6.	Vern Jubber	VP: CHR, Co-Chair, CPCN	Leadership Team
7.	Mark Watt	Primary Care Facilitator, CPCN	Leadership Team
8.	Colin Zieber	Director, Palliative Care, CHR	Leadership Team
9.	Cheryl Andres	Director, Transitional Care, CHR	Leadership Team
10.	Dr. Catherine Scrimshaw	Physician	Associate Medical Clinic, Pincher Creek Team
11.	Dr. Karen Brunner	Physician	Associate Medical Clinic, Pincher Creek Team
12.	Dr. Robert Cameron	Physician	Associate Medical Clinic, Pincher Creek Team
14.	Dr. Steyn de Wet	Physician	Associate Medical Clinic, Pincher Creek Team
15.	Dr. Andrew Jackson	Physician	Associate Medical Clinic, Pincher Creek Team
16.	Dr. John Rottger	Physician	Associate Medical Clinic, Pincher Creek Team
17.	Della Osterlee	Administrator	Associate Medical Clinic, Pincher Creek Team
18.	Susan Gerber	Social Worker	Associate Medical Clinic, Pincher Creek Team
19.	Cheryl Dolan	Registered Nurse	Associate Medical Clinic, Pincher Creek Team
20.	Hannelore Hammoser	Registered Nurse	Associate Medical Clinic, Pincher Creek Team
21.	Cathy Mitchell	Dietitian	Associate Medical Clinic, Pincher Creek Team
22.	Florri MacDougall	Clinical Pharmacist	Associate Medical Clinic, Pincher Creek Team
23.	Dr. Bruce Christensen	Physician	Taber Associate Medical Group Team
24.	Dr. Jillian Demontigny	Physician	Taber Associate Medical Group Team
25.	Dr. Gerald Beckie	Physician	Taber Associate Medical Group Team
26.	Dr. Norman Chychota	Physician	Taber Associate Medical Group Team
27.	Dr. Wade Steed	Physician	Taber Associate Medical Group Team
28.	Dr. Wesley Steed	Physician	Taber Associate Medical Group Team
29.	Dr. Noordin Virani	Physician	Taber Associate Medical Group Team

(cont'd on next page)

Appednix E.1 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

Table 1 *(cont'd)*: Chinook Health Region / Chinook Primary Care Network Site Visit List

	Name	Profession /Title	Team
30.	Dr. David Yamabe	Physician	Taber Associate Medical Group Team
31	Mary Nugent	Nurse Practitioner	Taber Associate Medical Group Team
32.	Nicole Kinniburgh	Nurse Practitioner	Taber Associate Medical Group Team
33.	Michael Brand	Manager	Taber Associate Medical Group Team
34.	Janine MacMurchy	Receptionist	Taber Associate Medical Group Team
35.	Marion Parkinsen-Howg	Dietitian, DLE Program	Taber Associate Medical Group Team
36.	Lori Sincennes	Diabetes Nurse Educator, DLE	Taber Associate Medical Group Team
37.	Dr. C. Stewart	Physician	Lethbridge Family Medical Team
38.	Sherry Leavitt	Nurse, Healthy Lifestyles Program	Lethbridge Family Medical Team
39.	Bruce Stavant	Physiotherapist	Lethbridge Family Medical Team
40.	Diane Smith	Physiotherapist	Lethbridge Family Medical Team
41.	Lynette Nilloughly	Reception	Lethbridge Family Medical Team
42.	Mary Krams	Nurse, Diabetes Education	Lethbridge Family Medical Team
43.	Evelyn McCormack-Wong	Dietitian	Lethbridge Family Medical Team
44.	Liz Demare	Nurse, Women's Health Care	Lethbridge Family Medical Team
45.	Conrad Boehme	Psychologist Candidate	Lethbridge Family Medical Team
46.	Carol Inglis	Registered Nurse	Lethbridge Family Medical Team

Source: EICP Secretariat.

Appendix E.2 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

2.0 Office Improvement - Pre-work Packet, Oct 11, 2005 by Mark Murray & Associates

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Appendix E.2 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

General Information

Overall Structure of the Project

The Office Improvement Project will involve a number of primary care teams, along with priority Regional Health Authority programs and services linked to primary care, working intensively together for approximately one year, to test and refine new models of office-based practice. During that time, teams will participate in Learning Sessions and maintain continual contact with each other and faculty members through email and conference calls.

Project Learning Sessions

Learning Sessions are the major integrative events of the project. Through plenary sessions, small group discussions and team meeting attendees have the opportunity to learn about various aspects of improving office based care. The Learning Sessions will be working and learning sessions. During these sessions, the attendees will have the opportunity to:

1. Learn from faculty and colleagues
2. Receive individual coaching from faculty
3. Gather new information on the subject matter and process improvement
4. Share information and collaborate on improvement plans
5. Develop action plans to improve access and office efficiency.

Schedule for the Learning Sessions

Office Practice Redesign Learning Sessions dates:

October 27th and 28th, 2005 (The Ramada Inn)

January 19 and 20th, 2006 (Lethbridge Lodge)

March 16th and 17th, 2006 (Lethbridge Lodge)

June 13th and 14th, 2006 (Lethbridge Lodge)

September 12 and 13, 2006 (Lethbridge Lodge)

November 14th and 15th, 2006 (Lethbridge Lodge)

* The sessions run from 9:00 am – 5:00 pm each day.

* Lunch and snacks will be provided.

Appendix E.2 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

Between Learning Sessions: Action Periods

The time between Learning Sessions is called an **Action Period**. During Action Periods, participants will work within their offices to test and refine improvements in their systems of care.

Although participants focus on their own offices, they remain in continuous contact with other participants and faculty. This communication takes the form of conference calls and email. In addition, teams share the results of their improvement efforts in monthly reports.

Action Period activities are not limited to those who attend the Learning Sessions (see below), but are open for anyone within the primary care office/organization who wants to participate. We encourage participation from other office personnel and others from the organization. This is a vital component to begin the deployment of innovations.

Conference Calls

Conference calls will be scheduled monthly throughout the course of the collaborative. These calls will be topic-specific, dealing with a particular aspect of access or office improvement, but customized to the needs of the teams. A general call-in number will be published for teams to call in and participate. These calls offer a great opportunity for additional site team members to participate in the work of the project.

Monthly calls:
(all to be held on the last Wednesday of the month,
from 12:00 – 1:00 pm)

Monthly Reports

Each participating team will be expected to submit a monthly practice report, which will include the status of their aims, measures, and changes tested and implemented. The details of these reports will be discussed at Learning Session 1, and a format will be provided for the teams' use. Teams will receive written feedback from the faculty every month (except months of Learning Sessions). The reports are due on the first day of each month.

Communication

Electronic communication will be a major mode of communication among faculty and participants during the course of the project. Electronic mail will be used to disseminate information to participants, ask questions of, and receive replies from faculty and participants, and conduct ongoing discussions of content. For now, a contact list with all participants' names will be distributed to you however; a lit serve/bulletin board will be set up on the Primary Care Network web-site early in November. The web-site address is (www.chinookprimarycarenetwork.ab.ca) Note: the web-site is currently under development.

Appendix E.2 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

Project Timeline (See attached Calendars)

Pre-work and Month 1 – Project begins

- Receive pre-work packet and begin activities and preparations for first learning session (LS).
- Select the local improvement team
- Complete the pre-work conference phone calls
  - One conference call for prework-overall view of Project: Wednesday, October 12th from 12:00 pm to 1:30 pm.
  - One conference call for instructions in process mapping
  - One conference call for data collection and management: Friday, October 14th from 12:30 – 1:30 pm.
- October 27-28, 2006 - Attend Learning Session #1 at the Ramada Inn

Month 2

- November 1, 2005 - Monthly Practice Report due
- November 30, 2005 - Participate in monthly team conference call with faculty
- Faculty will provide written feedback in response to the monthly report.

Month 3

- December 1, 2005 – Monthly Practice Report due.
- December 28, 2005 - Participate in monthly team conference call with faculty
- Faculty will provide written feedback in response to the monthly report.

Month 4

- January 1, 2006 – Monthly Practice Report due.
- January 19-20, 2006 – Participate in Learning Session #2 at the Lodge

Month 5

- February 1, 2006 – Monthly Practice Report due.
- February 22nd,2006 - Participate in monthly team conference call
- Faculty will provide written feedback in response to the monthly report.

Month 6

- March 1, 2006 - Monthly Practice Report due.
- March 16 and 17th, 2006 - Participate in Learning Session #3 at the Lodge

Month 7

- April 01, 2006 - Monthly Practice Report due
- April 26, 2006 - Participate in monthly team conference call
- Faculty will provide written feedback in response to the monthly report.

Appendix E.2 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

Month 8

- May 1, 2006 - Monthly Practice Report due.
- May 31, 2006 - Participate in monthly team conference call with faculty
- Faculty will provide written feedback in response to the monthly report.

Month 9

- June 1, 2006 – Monthly Practice Report due.
- June 13-14, 2006 – Participate in Learning Session #4 at the Lodge

Month 10

- July 1, 2006 – Monthly Practice Report due
- July 26, 2006 - Participate in monthly team conference call
- Faculty will provide written feedback in response to the monthly report.

Month 11

- August 1, 2006 - Monthly Practice Report due
- August 30, 2006 - Participate in monthly team conference call
- Faculty will provide written feedback in response to the monthly report.

Month 12

- September 1, 2006 - Monthly Practice Report due
- September 12-13, 2006 – Participate in Learning Session #5 at the Lodge

Monty 13

- October 1, 2006 - Monthly Practice Report due
- October 25, 2006 - Participate in monthly team conference call
- Faculty will provide written feedback in response to the monthly report.

Month 14

- November 1, 2006 - Monthly Practice Report due
- November 14-15, 2006 – Participate in Learning Session #6 at the Lodge

Appendix E.2 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

Problem Statement

Our health care system is plagued by delays to get an appointment with a primary care physician or a specialist, extended telephone waits when placed on hold; repeated phone calls to obtain a test result or to have a question answered by a provider.

These delays adversely affect clinical outcomes, patient satisfaction, and cost. People often assume that reducing delays and increasing access will increase cost. In fact, the opposite is true; delays and restricted access are properties of poorly designed, costly systems. Using system design principles and queuing methods, organizations can develop and implement changes that reduce delays at the same or lower cost and position themselves for revenue enhancement.

There is a proven process and a set of principles that can help providers and practices rid themselves of unnecessary waits for their patients. Reduction of waits can be achieved, without adding costly resources, by predicting and managing patient demands.

We can never discover the right way to deliver care or determine the right team or group of people to deliver the right care if we are delayed. So prior to building the correct team we have to eliminate the waits and delays in order to optimize system performance. Then we can successfully build the right care team.

Collaborative Vision

The Primary Care Office Improvement Project teams will work together for 14 months to design, test, and deploy new models of clinic practice and practice management that will lead to fundamentally improved performance levels including: improved access; improved office flow and efficiency; increased patient, provider and staff satisfaction; improved clinical outcomes, lower costs and better interdisciplinary care teams. Our mission is to demonstrate that clinical office practices, with appropriate redesign, can achieve significant improvements in performance relevant to today's urgent need for more accessible, higher-value health care, increased capacity, and improved financial outcomes.

By working collaboratively with experts and practitioners, sharing ideas and knowledge, learning a new methodology of change, and measuring progress, we will build upon existing innovations and generate new innovations to create office practices that offer customers the best possible solutions to their healthcare needs.

The Learning Model and Model for Improvement, used in the Institute for Healthcare Improvement Breakthrough Series, will serve as the frameworks for the Project. We will strive to meet our goals in 14 months by sharing ideas and knowledge, and learning and applying methodologies for reduction of delay. Methodologies for spreading organizational change across primary and specialty care systems will be stressed as well.

Appendix E.2 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

Collaborative Goals:

Reduce delay for an appointment to an offer of same day.
Reduce delays at an appointment (cycle time) by 30%.
Reduce no-shows by 30-33% of current no-show rate.
Reduce cost/visit by 20%. (or improve net revenue)
Increase continuity of care to 90%.
Increase panel size by 10%.
Improve clinical outcomes (measure needs to be determined)
Improve staff including provider satisfaction
Improve patient satisfaction
Increase utilization of selected protocols and guidelines (operational and clinical)
Improve interdisciplinary team utilization and function

Project Expectations

Local Improvement Leadership Steering Team and faculty will:

- Build on the performance improvement efforts already in place.
- Offer coaching to organizations.
- Provide communication strategies to keep the site teams connected to the ST faculty during the Project.
- Provide resources to support team travel and participation in the Learning Sessions
- Provide information on subject matter, application of that subject matter and methods for process improvement, both during and between Learning Sessions
- Provide access and exposure to nationally recognized healthcare experts.

Participating site teams are expected to:

- Perform pre-work activities to prepare for the first Learning Session.
- Focus organizational intention to actively test and deploy new processes in office-based care by connecting the goals of the Project to a strategic plan for the practice.
- Identify Primary Care Improvement Senior Leaders/Team : (Clinic Manager, Medical Director/Leads, Nursing Director/Clinical Care Coordinator, and Support Staff Coordinator must participate in all of the Learning Sessions. They must be actively involved in communication and planning, and they need to set expectations with management, providers, and staff that the philosophy of waits and delays is not longer tolerated. Senior leader support is necessary for success and senior leaders serve as champions for the spread of changes in practice within the practice
- Provide resources to support their improvement team; including resources necessary for the Learning Sessions and time to devote to testing and implementing changes in the practice.

- Make well-defined measurements that relate to their aims at least monthly and plot these measures over time for the duration of the collaborative. (Key changes will be annotated on these graphs of the measures).
- Share information with other clinic participants, including details of changes made and data to support these changes, both during and between the Learning Sessions.
- Utilize the monthly team report format (narrative and data).
- Test changes using rapid change cycles (PDSA tests).
- Be open to changing actions and systems in order to improve clinical management and office efficiency.
- Provide a lead physician who will champion the testing and spread of changes in the practice environment, and will attend all Learning Sessions.
- Provide their team time to devote to testing and implementing changes in the practice.
- Participate in conference calls between sessions.
- Utilize the listserv to communicate with faculty and other teams.
- Establish 'the minimal data set' of measures to improve access and office efficiency.

Pre-Work Activities for Learning Session One (October 27/28)

To prepare for the first learning session, teams will work with the planning group to complete the following tasks:

I. Create their local improvement/leadership team.
II. Define the aims.
III. Define the measures and collect and graph baseline measures
IV. Complete process flow mapping, and role task determination.

I. Create the Team

Having an appropriate and effective team is a key component of successful improvement efforts. Choose your team members based on their knowledge of and involvement in the aim and the processes that will be affected by working towards the aim.

Your improvement team will consist of two components, **the system team members** (local improvement leadership team) and **additional local team members**. The system team members will include the Clinic Manager, the Medical Director/lead, and the Nursing Director/Clinical Care Coordinator and Support Team coordinator. The system team members (Leadership Team) are expected to attend all of the Learning Sessions. The active participation of system team members is essential to the success of this collaborative because the changes affect all of the providers, all of the clinical staff, and most of the departments that support clinical care. The local team members should include the local improvement leadership team as identified and, in addition, additional champion Physicians at the local site, Nurses and Medical Assistants at the local site, the Registration Manager, the Medical Records Manager, the Quality Improvement Manager, and any other team member whose department will be affected by the changes. Your local team will probably have 4 –5 team members that are intimately involved in the changes. In addition, it might also have a number of department managers/leads that are considered ad hoc, and only attend the meetings when changes relevant to their area of expertise or department are planned and discussed. Make sure the team is not so large that it is difficult to get work done. Five or six individuals is a good size for the local team, if your office practice can support that number of people on the team. The team should have representation from three different dimensions: clinic management, provider expertise

and day-to-day leadership. There may be one or more individuals on the team who fit each dimension– and one individual may fill more than one role–but each component should be represented to successfully drive change in your clinic..

System Team Members:
Clinic Manager
Medical Director/Physician Lead
Director of Nursing/Clinical Care Coordinator
Support Team coordinator

Local Team Members:
Primary Care Site Leader *(responsible for success of clinic team)*
A pilot site leader is the person with enough clout in the clinic site to institute change and has the authority to allocate the time and resources necessary to achieve the team's aim. It is important that this person have authority over all areas that are affected by the change. Examples of an appropriate pilot site leader include a clinic manager, or practicing physician/provider and/or clinical care coordinator

Clinical/Technical Expertise *(responsible for understanding provider practice and processes of care)*
The physician/provider is considered the clinical/technical expert in this case, because the physician knows the subject matter (practice management) intimately and understands the processes of care. Because the clinical office setting and its processes can be quite varied and complex, there need be a variety of clinical/technical expertise represented on the team. For example, the physician has the best knowledge of what occurs in the exam room, nurses often know most about the office flow, and schedulers have an intimate knowledge of the clerical office processes. For these reasons, it is important to have all these areas of expertise represented on the team.

It is critical to have at least one physician champion on the team. This champion should have a good working relationship with colleagues and with the day-to-day leader described below, and be interested in driving change in the system. The physician champion is an opinion leader in the office practice (individuals sought out for advice who are not afraid to test change).

Day-to-Day Leadership *(Key contact for your team, responsible for coordinating communications with the Collaborative faculty.)*
The day-to-day leader will be the critical driving component of the project, assuring that tests of change are implemented and overseeing data collection. This is frequently an experienced Director of Nursing or Clinic supervisor/Manager. It is important that this person understand not only the details of the system, but also the various effects of making changes in the system. This individual also needs to be able to work effectively with the physician champion. The day-to-day leader is frequently responsible for generation of the Monthly Practice Report.

Additional Team Members: Round out your site teams with staff members from the clinic who can be helpful toward achieving your aims. Possibilities include front office staff, case managers, and information system staff.

Suggestions for Support team members:
- Finance and reimbursement.
- Information systems.
- Registration

- Medical Records
- Medical and Clinical Affairs.
- Other centralized services.

Team Members that should attend the Learning Session:
The Senior Leaders are required, along with the Champion Physician, to attend the Learning Sessions. Their participation is critical to the success of the team. They need to learn the methodology, and plan for action when returning to your institution. The senior leaders and the Champion Physician should attend every meeting. This is particularly critical due to the length of the collaborative – only 14 months. In order to achieve the outcomes we desire, we have to have the senior leadership focusing consistently on this collaborative and the access and redesign changes. If additional team members wish to come, that would be great as well. We have developed the following guidelines from past Collaboratives to help you determine who should attend the learning sessions.

- The Clinic Manager
- The Nursing Director (usually the day-to-day leader).
- The Medical Director/Physician Lead
- Additional Physician Champions
- Support Team coordinator

II. Define the Aims

The improvement model is based on three fundamental questions:
(1) What are we trying to accomplish?
(2) How will we know that a change is an improvement?
(3) Of the changes we can make, which ones will cause an improvement?

The first question is meant to establish an aim for improvement that focuses group effort on using data and information about patients and what other customers, such as payers, believe are important to help define an aim. Aims should be as concise as possible. Sometimes a team must test an aim before it becomes truly focused. Following are some tips for writing an aim:

State the aim clearly
Achieving agreement on the aim of a project is critical for maintaining progress, but agreement is not easily achieved unless the aim is very clearly stated. Teams make better progress when they are very specific about their aims. Be brief; a single sentence is best.

Base your aim on data
Examine data that your site has on waiting times for appointments; office wait time and patient satisfaction. Focus on issues that matter to your patients and you.

Include numerical goals
For example; setting an aim such as "reduce delays in patients obtaining a routine primary care appointment" is not as effective as "All patients requesting a routine appointment will be able to get an appointment within 1 day." Numerical goals clarify the aim, direct the measures of improvement, and focus initial changes.

Set stretch goals
Setting stretch goals – for example, "assure superior satisfaction for > 95% patients" – immediately tells people that the status quo is not an option. The role of leadership is to make it clear that the goal cannot be met by simply tweaking the existing system. Once this is clear, people begin to see how barriers to achieving the stretch goals can be overcome.

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Set an AIM
An aim is an explicit statement summarizing what your team hopes to achieve during the project. Both senior leaders and front line personnel must participate in the establishment of the aims. Senior leaders should assure that the aims are aggressive and aligned with the strategic goals of the organization. Front line personnel will feel challenged by the aims statements. It is essential that both senior leaders and staff agree on the aims in order to achieve optimal results.

Each Team will need to develop two primary aims around the two categories of office performance – Access and Office Efficiency. *Each group should develop at least one aim in each of these categories before Learning Session 1. During Session 1, we will work together to refine these aims.* Below are sample aims consistent with the goals of this Collaborative:

Access Aim:
"Offer any patient an appointment today for any problem with their Primary Care Provider by August 1, 2004."

Office Efficiency Aim
"Decrease cycle time by xx % by August 1, 2004."

Use the space below to begin to draft your Access and Office Efficiency Aims statements. Bring this page with you to the first Learning Session, where you will refine these aims.

Access

Office Efficiency

Other Aims

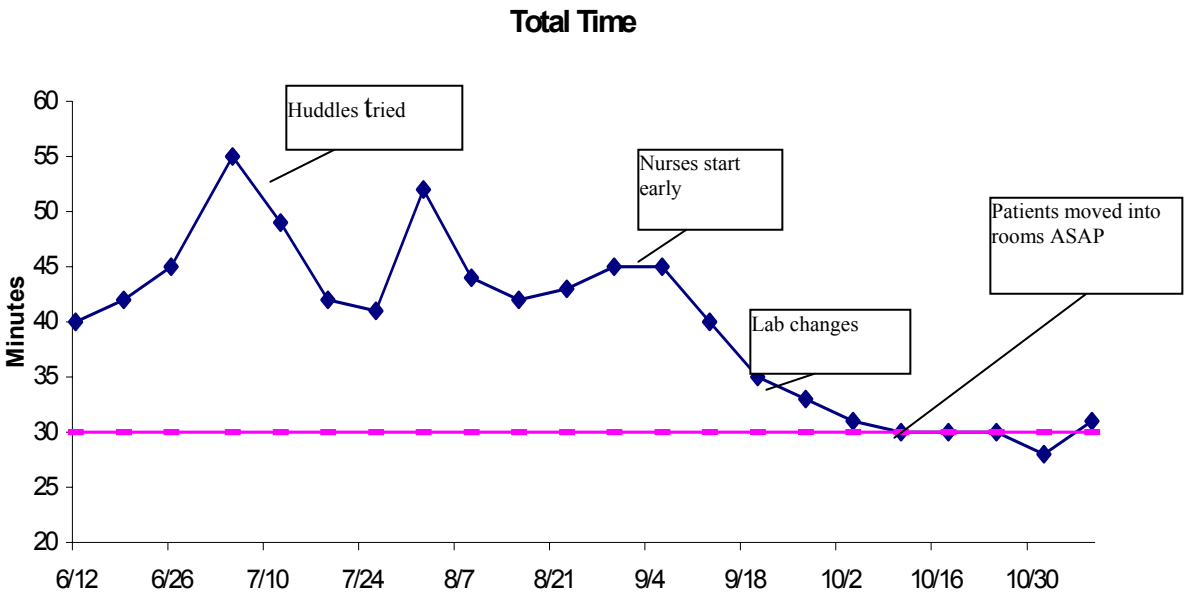
III. Define the measures and collect and graph baseline measures:

This project is focused on improving access and the clinic office practice, not measurement. Measurement will, however, play a central role in the project. The most important measures required during this Collaborative are measures that directly relate to your aim. The measures will provide the means to assess progress toward your aim. Faculty will be working with departments to create office-based measurement systems that are meaningful to performance and practical to maintain. We seek usefulness in our measures, not perfection. Participants will be encouraged to use existing organizational

metrics and resources for measurement when appropriate. Each department will be expected to continuously monitor a core set of measures around access and office efficiency. These measures are intended to accelerate improvement, not slow it down.

The annotated time series (pictured below) is a helpful tool in monitoring progress. A team from a previous Access Project developed the annotated time series below. The graph depicts the performance of the system over time and identifies the occurrence of key events. The key events include both the changes made and any other circumstances that could impact performance.

Cycle Time Run Chart



Items to consider that make measurements simpler and more effective:

1. Plot data over time. Improvement requires change and change is a temporal phenomenon. Much information about a system and how to improve it can be obtained by plotting data over time—delays, demand, and patient satisfaction—and observing trends and other patterns. That is why an annotated series or run chart is the minimum standard for displaying data.
2. Focus on the measures that are directly related to your aim. If the aim is to reduce length of time the patient spends in the clinic on the day of appointment, collect data on that measure and plot the data on the annotated time series.
3. Use sampling. Sampling is a simple, efficient way to understand how a system is performing. When large system changes are desired, the variety of conditions included in the sample rather than its size is the primary concern. Sampling is especially important if your organization does not have an electronic data collection system. To save resources, rather than obtaining data for each patient, try obtaining data for every 20th patient or for patients entering the department at set times during the day (such as 10am, 4pm, 10pm, and 4am). During the Project, these data can be collected daily and summarized weekly using a median
4. Integrate measurement into daily routine. Useful data are often easy to obtain without relying on the information system. Develop a simple data collection form and make collecting data part of someone's job.

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What to Measure

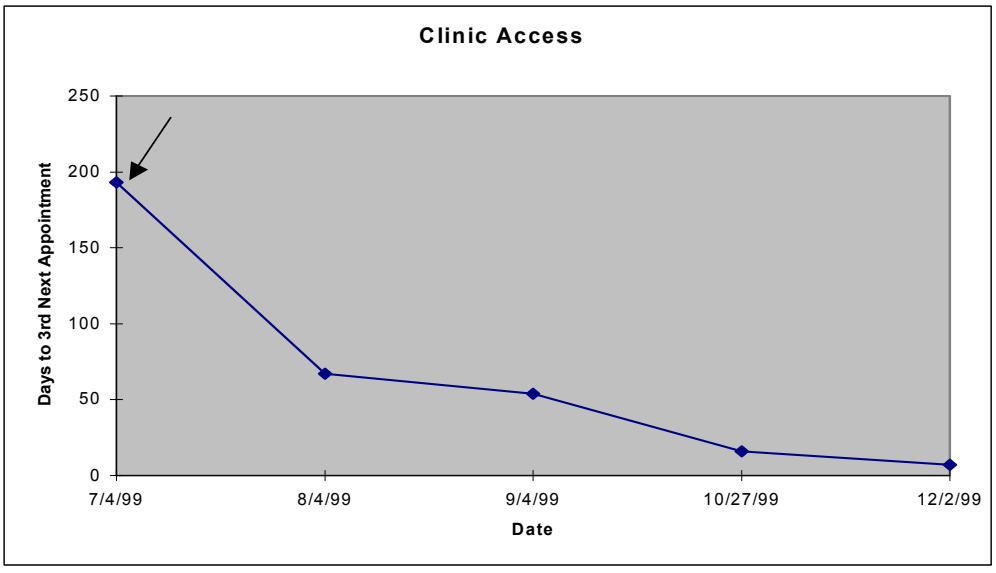
It is important to begin data collection before Learning Session 1. This will give you insight into your department's current performance and will serve as baseline data for your project. At a minimum, we ask that you seek complete the following measures for Learning Session 1 with special attention to the Third Next Available and Cycle Time Measures. If there are additional measures that will help to track the progress on your aims, you may also collect and present that information at Session 1.

1. Third Next Available Appointment (Access to Care)

Access to care is a key determinant of patient satisfaction. The recommended measure of access is the number of *calendar* days to the third next available appointment. The delay for the third available appointment is used (rather than the first or second) because it is a better reflection of your system availability. The first or second appointment may be available due to a cancellation or some other event.

To understand current access to your office, select one specific appointment type to begin with, such as a request for a routine appointment, or a physical exam. Use your scheduling system (whether it is computerized or manual) to count the number of days from a selected reference day to the day when the third next appointment of that type is available.

Do this exercise same day and time each week, and plot the number of calendar days to the third next available appointment for as many weeks as possible prior to Learning Session 1. An example plot is shown below.



2. Patient Flow and Cycle Time

The recommended measure of patient flow is cycle time (time from check in to check out). All offices can easily collect this information on a sample of patients three to four times a day, several days a week. Since 10 AM and 3 PM tend to be the busiest, they are useful times to assess our cycle times. Have the receptionist record (either on the patient's chart or a simple data collection sheet) the time each patient

with appointment times between 10-11 AM and 3-4 PM actually enters the office. Using the time that the patient actually enters the office instead of their appointment time is a more accurate reflection of the time that truly matters to the patient.

At the end of the visit, the last staff person to interact with the patient (whether it is the billing person or the receptionist who schedules a return appointment) should record the time the patient leaves the office. Calculate the average weekly cycle time on a graph. Additional details will be provided at the Learning Sessions about calculating the percent of "value-added" time vs. "non-value added" time. For now a simple measure of total cycle time is sufficient**.**

3. Continuity or Match

This refers to a measure of the likelihood that patients will see their own Primary Care Provider when requesting care. It is based on retrospective data. It does not refer to the number of patients on a given provider's schedule that are that provider's patients, but rather, from the patients' perspective.

Primary Care:

"Of our patients visits to primary care, what percentage were to their PCP?"

Specialty Care:

"Of all patients visits to our specialty, what percentage were with the specialist of record?"

4. A Measure of Your Demand

The focus of this Collaborative is to reduce patient delays for an appointment. The wait time for an appointment reflects the gap or time lapse between when the demand for that appointment is declared and when the resource or the supply at the practice is applied. Therefore, in order to understand the dynamics of the appointing system we need to measure the delay for appointments, the demand for appointments and the supply of appointments..

Demand for appointments comes from two sources; external sources, for example patients calling in or walking in or being referred into the practice for an appointment, and internal sources, that is, return appointments generated by the practice itself.

Demand is defined as the number of requests for appointments. It is not the number of visits made or appointments completed.

Demand = requests for appointments

Visits = activity or supply of appointments

Practices will often confuse activity with demand and confuse activity measures with demand measures. When we look retrospectively at the work completed, we are looking at activity, which more accurately reflects supply of resources, not demand for resources. For example, if we saw 500 visits last month in the practice, the 500 visits represents activity or supply, not the demand. There could have been more demand that was pushed out to the future, or less demand that was masked by a full schedule. Therefore, we need to measure demand prospectively. Initially, this can be a somewhat awkward measure. Daily demand, measured in this way, is calculated in the following way:

Daily demand = A1+A2+A3+D=Total demand

A1* = Total of appointment requests (and appointments made) called in to your office on any given day (regardless of the day to which the appointment is actually assigned).

A2* = Total number of individuals walking in to be seen (walk-ins) on a given day, whether seen than or given a future appointment.

A3* = Total number of patients requesting an appointment through other methods/venues (Central Appointment Unit, "add-ons", etc.)

D = Total number of follow-up appointments or returns generated today

A1+A2+A3+A4+A5 = *externally generated demand

****D = internally generated demand***

Most teams report they find it best to capture the demand during the appointment booking process. Many appointment requests are passed from hand to hand prior to the actual booking. In this way, the booking of the appointment is the defining moment and it is at that point that the demand is captured.

All teams should collect the demand data. It can be collected by hand at the reception desk and wherever appointments are made. The data should be collected daily for **a period of at least two weeks initially** and periodically thereafter. We would suggest measuring demand at the clinic level and at the individual provider level and reporting this measure by the day of the week. In this way, we can start to see the variation by provider and by day of week.

5. Supply Measure(s)

Supply is the measure of provider capacity or availability. All systems rely on adequate and flexible capacity. It is helpful to think of supply in three dimensions:

- Macro Supply—the number of providers and how many hours they work
- Deployment of supply—the way that the macro supply is spread throughout the day, week, month and year
- Process of supply—defining the work and who should do it to optimize supply

Provider Full Time Equivalents (FTEs)

The number of providers available, expressed as FTEs, is the most basic measure of supply.

This data is often surprising and offers insight into demand and capacity management. For example, the chart may show four provider FTEs available on a Monday, traditionally the highest demand day. Alternatively, the data may reveal seven provider FTEs on Thursday, one of the lower demand days. This indicates a need to manage provider days off in a different way to better match supply and demand.

Expected productivity/appointments per session

After determining the number of FTE providers available in a given period, it becomes important to measure and know how many patient visits per specific period each provider is capable of seeing in the present system. This is the next finer cut at macro capacity. It is a rough calculation of approximately how many appointment slots (or hours of availability) each provider, or a system of providers, has available. Stop at any point in the calculation to determine the expected daily, weekly, monthly, or yearly capacity of each provider. Add all the providers' data together to arrive at system capacity. The calculation is a simple multiplication exercise:

- Slots per hour X hours per day = appointments per day
- Appointments per day X days per week= appointments per week
- Appointments per week X weeks per year = appointments per year

6. Fail to Keep and Cancellations

Tabulate the number of failed appointments (no shows) by day or week and convert this to a percentage to establish the No-Show and Cancellation rates. This measure is important since failed appointments are wasted capacity, which cannot be assigned to another patient.

7. Patient and Provider/Staff Satisfaction

Please bring with you to Learning Session 1, any data you may currently be collecting on patient, staff, and provider satisfaction.

8. Visit Utilization Rates

This refers to the visits per patient per year to your system. It can be reviewed by department, by organization, and by individual provider.

9. Panel Size

This refers to the number of unique or individual patients per provider. Care should be taken to avoid double counting patients who have seen more than one provider. If this number is not readily available to you via your information systems, consider calculating the number of individual patients seen in the last 18 months. This is generally a good reflection of your active patient panels.

If patients do not have a specific PCP or specialist, the cumulative panel size of the department, divided by the Clinical Provider FTE's will give you a theoretical panel size for your team. This will be discussed at the first Learning Session.

IV. Prework Observations/Assignments

In addition to the baseline measurement data that you will collect before Learning Session 1, please complete the following observational exercises. These exercises will give you important insights into how your current system works and how patients perceive their care within your system.

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Clinic Walkthrough

This exercise asks you to walk through what a patient and family member would experience during a typical visit to your office. You may want to do the walk through at your own office, or at another office in your health system (if applicable). Here is how to do it.

Inform staff you are likely to meet, in advance, that you will be doing this.

They might be on their best behavior, but we have found that it is far better to have them be a part of the process than to surprise them. Ask them not to give you special treatment. Choose to be an individual with a particular problem such as an elderly person with congestive heart failure or the parent of a child who has a fever.

Go through the experience just as the patient and family would.

Call in for an appointment (try to select a day of the week and time of day when you would expect delays to be the longest), drive to the office, find a place to park, and check in. Try to act as if you have never been there before. Follow the signs. Tell the clerk that you are simulating a patient experience and that you want to go through what they do during (e.g. the check in process). Actually fill out forms if there are ones to fill out. Find out about how long they wait and sit in the waiting room that long; wait your turn. Do the same in the examining room. If the patient undresses, you should undress. If the patient does a peak flow meter, you should too. Ask each health care provider to treat you as if you were a real patient. Experience it all.

As you go through the process, try to put yourself in the patient's (or family member's) position.

Look around as they might. What are they thinking? How do they feel at this moment?

1. *When you called for an appointment, did you get a recording? Were you put on hold at any point during the conversation? How long were you waiting to talk to someone? Did you have to call back? How long did the entire process take? How many days did you have to wait before the day of your appointment?*
2. *When you arrive at the site, does anyone greet you? How do you know what to do?*
3. *How long do you wait at each stage of the process (e.g., registration, waiting room, exam room, diagnostic testing, check-out, pharmacy)?*
4. *Are there any points in the process where staff seem to be waiting for patients, for other staff, for equipment?*
5. *Are there any points in the process where the waits seem especially annoying (e.g., when you are in the exam room waiting for the physician, or in the waiting room if it is crowded and noisy)?*
6. *Are there any points in the process where the waits seem to pass more quickly (e.g., are there videos in the waiting room or educational material in the exam room)?*
7. *How do other patients respond to their interactions with your system?*
8. *At the end of the visit, do you feel that you were well taken care of/? Would you come back? Would you tell your friends to come to this clinic?*
9. *What ideas come to mind as you pass through the system for how the process can be streamlined or made more efficient for patients and staff?*

Below is a sample data collection form for your walk-through. This data should be included in your storyboard poster for Learning Session 1.

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What NEEDS did you find during the walk through?	What IMPROVEMENTS could be made to address these needs?

V. Prepare A Storyboard

Each Learning Session is designed to create an environment conducive to sharing and learning from each other's experiences. To facilitate this at the first Learning Session, each team will construct a storyboard stating their aims, the team members, and data on office practice measures within the organization. At the first learning session, each organization will receive a 30-in. by 40-in. foam core board, pushpins, tape, an easel, and other supplies on-site so that your team can present what you have accomplished and learned so far.

There will be time to refine your work at the learning session and time during the year to complete work on the aims. Your audience consists of other office/clinic teams, and collaborative faculty and observers who are not familiar with your aims and your work. Therefore, the storyboard should be as clear and concise as possible

Your storyboard need not be fancy. We simply want to be able to be able to learn about each of the teams and share information. Following are some guidelines to plan for your storyboard.

Storyboard Content:

Introduce Your Team

- Name
- Brief Description
- Members

Your Team's Aims

Baseline Measures Plotted Over Time

Summary of Walk-Through

Accessing the Collaborative's Communication System

Electronic communication will be a major mode of communicating among the planning group and participants during the course of the Collaborative. Electronic mail will be used to disseminate information to participants, ask questions of, receive replies from faculty and participants, and conduct ongoing discussions of content. The web site for the collaborative will be: www.chinookprimarycarenetwork.ab.ca. Please note: the website is currently under construction, and won't be functional until the end of November.

Monthly conference calls with faculty will be held every month when we do not have a Learning Session (please look at the schedule on pages 6 -7 or refer to the attached calendar).

Monthly practice reports will be due on the 1st of each month, starting on November 01, 2005. Faculty will be sending feedback to teams regarding the monthly practice report every month we do not have a Learning Session (refer to the schedule on pages 6-7 or to the attached calendar).

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Advanced Access Checklist (High Leverage Changes)

Choose a system / True demand/Capacity analysis

- ❑ Can we do today's work today?
- ❑ Develop communication plan
- ❑ Collect true demand
- ❑ Identify the number of providers needed per day to meet demand
- ❑ Compare true demand to current staffing pattern
- ❑ Readjust provider staffing days/hours to match pattern of demand
- ❑ Identify plan to periodically check true demand/supply

Work down backlog

- ❑ Develop communication plan
- ❑ Collect first third available appointment for any appointment type
- ❑ Develop backlog reduction plan: identify when capacity will be added
- ❑ Identify who is on what team
- ❑ Develop backlog reduction plan: smart strategies
- ❑ Set beginning and end dates
- ❑ Plan staffing to support backlog reduction plans
- ❑ Monitor and measure give feedback as to progress on reducing backlog
- ❑ Celebrate when provider reaches same day access for both urgent and routine appt

Reduce appointment types and lengths

- ❑ Develop communication plan
- ❑ Identify who is on what team
- ❑ Educate staff about P, T and U appointments and any exceptions
- ❑ Identify appointment types that are tied to a room
- ❑ Decide on standard appointment length
- ❑ Choose implementation date
- ❑ Educate reception staff on their new role in panel management rather than appointment triage

Continuity

- ❑ Review current continuity
- ❑ Develop process to have each patient designate a PCP
- ❑ Develop expectation/procedure among staff that each provider will see all their patients that have designated them as a PCP on the days when they are working
- ❑ Collect patient/ PCP continuity data monthly from the patients perspective to monitor progress and to identify areas for improvement

Develop contingency plans

- ❑ Define what is "today" and develop a plan for those patients who are seen past that cut-off
- ❑ Develop time off policy based on demand
- ❑ Implement procedure to implement a post vacation scheduling process
- ❑ Identify plan for when provider is sick
- ❑ Identify how the Family Practice Nurse(s)/ other interdisciplinary team members)will be used within the team

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- ❑ Identify how the team appointments are distributed – who and how
- ❑ Identify how the unassigned appointments are distributed – who and how
- ❑ Identify plan for short staffing days
- ❑ Identify plan for communicating with panel patients and reassigning them when a provider leaves
- ❑ Develop plans for predicted variances e.g. flu season, school and sport physicals, admissions to the hospital, trauma, laceration, excision, procedure, longer visit than expected, mother that brings three children instead of one, etc.
- ❑ Scripting for common occurrences e.g. getting reason for visit at the end of the scheduling process instead of at the beginning, when a provider is absent, when the patient doesn't have a PCP, etc.

Reduce demand

- ❑ Improve continuity
- ❑ Change provider incentive to doing all of today's work today
- ❑ Look ahead at patient's future appointments and see if any of those patients can be managed in a different manner
- ❑ Use acute visits as opportunities to look ahead and do necessary screening as part of preventive care or to add future chronic care visits to today's work (max pack)
- ❑ Review current standards for visit intervals and lengthen if appropriate or manage patient in different ways (telephone or email follow-up or RN visit, etc)
- ❑ Use other team members during a visit to help make visit more efficient
- ❑ Try other strategies for providing care – telephone, email or group visits
- ❑ Use guidelines or other protocols to manage patients over the phone (i.e. UTI, sinusitis and VURI)

Work on clinic efficiencies

- ❑ Collect data on in office wait times and identify opportunities for improvement
- ❑ Flow map the office process using a flow map process
- ❑ Measure the office demand and match to capacity
- ❑ Synchronize patient, provider and information
- ❑ Predict and anticipate needs
- ❑ Optimize rooms, equipment and staff
- ❑ Identify and manage the constraint
- ❑ Look for associated processes that effect the office flow (chart room, billing, lab, etc) and develop associated and connected processes

Monitor/Measure outcomes

- ❑ Monitor true demand periodically
- ❑ Monitor first third available appointment (delay) as needed
- ❑ When Advanced Access is implemented monitor future open capacity
- ❑ Monitor continuity
- ❑ Monitor patient, provider and staff satisfaction
- ❑ Monitor urgent care visits
- ❑ Monitor office cycle times

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Office Efficiency Checklist: High Leverage Changes

Balance Capacity and Demand

- ☐ Predict Daily Demand (Encounters)
- ☐ Predict Hourly Demand (Telephone Calls, Advice Calls, Encounters)
- ☐ Understand Clinician Supply
- ☐ Understand Support Staff Supply
- ☐ Predict Demand for Visits with Special Resource Needs (Procedures, Well-Woman, etc.)
- ☐ Match Staff Availability to Demand

Synchronize Patient, Provider, and Information

- ☐ Start AM and PM appointment on time
- ☐ Register patients by telephone
- ☐ Check charts before patient visit
- ☐ Refine rooming criteria and process to speed up patient flow/reduce delays
- ☐ Document and do all work in real time
- ☐ Adopt truth in scheduling

Predict and Anticipate Patient Needs at Time of Appointment

- ☐ Align expertise to patient needs
- ☐ Capture additional information during appointing to alert care team to needs
- ☐ Anticipate patient needs during daily team huddles
- ☐ Implement communication short-cuts (flags, bulletin board, quick messages, e-mail)

Optimize Rooms and Equipment

- ☐ Open rooming
- ☐ Two exam rooms per physician
- ☐ Standardized supplies
- ☐ Ensure fully stocked rooms
- ☐ Discuss rooming approach for day at morning huddle

Optimize the Care Team

- ☐ Identify rate-limiting steps and resources
- ☐ Reallocate work to appropriate level of skill, expertise, and licensure
- ☐ Implement pre-approved protocols to delegate care tasks (immunizations, selected refills, chronic disease protocols etc.)
- ☐ Separate phone flow, patient flow, and paper flow
- ☐ Reassess forms for ease of completion (check-off boxes, etc.)

Minimize Constraints for Providers

- ☐ Interruptions and distractions (telephones, messages, etc.)
- ☐ Non-value-added work (work that others could perform)
- ☐ Waiting: medical records, rooms, support staff, equipment
- ☐ Searching for supplies, materials, information
- ☐ Inadequate pre-printed aids/forms for patient care

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Eliminate Waste

☐	Eliminate multiple entry
☐	Eliminate overkill
☐	Sample
☐	Remove Intermediaries

Improve the Flow of Work

☐	Minimize hand-offs
☐	Move steps closer together
☐	Remove bottlenecks
☐	Automate
☐	Do tasks in parallel
☐	Consider people in same system

Optimize the Work Environment

☐	Access to information
☐	Training
☐	Cross-training
☐	Reduce set-up time

Manage Variation

☐	Standardize as much as possible (forms, equipment, rooms)
☐	Implement contingency plans to manage variation
☐	Manage peak demand (season)
☐	Manage peak demand (day-of-week)
☐	Manage peak demand (time of day)

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Sample Monthly Report for Team

Facility: _____ **Team Name:** _____

Contact Person: _____ **Date of Report:** _____

OVERALL AIMS:

Access: *(Example: Our aim is to offer an appointment today for any problem urgent or routine by July 1, 2006)*

Office Efficiency: *(Example: Our aim is to decrease the lead time by 20% by July 1, 2006)*

Clinical Teams: *(Example: Our aim is to implement, measure and improve at least 5 prevention or chronic disease protocols by March 1, 2006)*

MEASURES RELATED TO THE AIMS:

Measure	Baseline Data	Frequency of Measurement	Goal
Third next available appointment			
Cycle Time			
Demand/Supply Analysis			
Panel Size			
No-show rate			
Continuity			
Cost per patient visit			
# Clinical Protocols Implemented			
Team Summary Score			

**Attach run charts (Excel portion of report) for each measure, including annotations to show actions taken.*

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BRIEF DESCRIPTION OF ACTIONS TAKEN ***(Be sure to indicate the month that the changes were tested)***

ACCESS	DESCRIBE ACTIONS/CHANGES TESTED OR IMPLEMENTED
Balance Daily Capacity and Demand	
Reduce Backlog	
Reduce Appt. Types and Times	
Develop Contingency Plans	
Reduce Demand for Visits	
Increase Capacity	

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BRIEF DESCRIPTION OF ACTIONS TAKEN ***(Be sure to indicate the month that the changes were tested)***

OFFICE EFFICIENCY	DESCRIBE ACTIONS/CHANGES TESTED OR IMPLEMENTED
Balance Capacity and Demand for non-appt. work)	
Synchronize Patient, Provider, Information	
Predict and Anticipate Needs	
Optimize Rooms, Equipment and Staff	
Manage Constraints	

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BRIEF DESCRIPTION OF EXPERIENCE ***(Be sure to indicate the month that the changes were tested)***

CLINICAL TEAM	MONTH	# TIMES TEAM MET	MEETING LENGTH
	OCT		
	NOV		
	DEC		
	JAN		
	FEB		
	MAR		
	APR		
	MAY		
	JUN		
	JUL		
	AUG		
	SEP		
	OCT		
	NOV		
DESCRIBE WHAT WENT WELL			
DESCRIBE WHAT SHOULD BE BETTER			
DESCRIBE CHANGES YOU ARE CONSIDERING			

Summary Comments:
Please include summary comments below about teamwork progress, noteworthy and successful actions, analysis of the data, newly discovered barriers, and/or rationale for changes in strategy.

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Collaborative Glossary

Action Period

The period of time between Learning Sessions when teams work on improvement in their home organizations. They are supported by the faculty and WCC Staff, and they are connected to other Collaborative team members.

Aim

A written, measurable, and time-sensitive statement of the expected results of an improvement process.

Annotated Time Series

A line chart showing results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur. This allows the viewer to connect changes made with specific results.

Assessment Scale

A numerical scale used to assess the progress of participating teams toward reaching their aim. (1= forming and 5 = outstanding, sustainable improvement.) In each Collaborative, teams are assessed monthly and the expected level of attainment is a 4 (significant progress). Teams are asked to assess their own progress using this indicator as well.

Chair

The leader of the Collaborative, usually a nationally known expert in the topic.

Champion

An individual in the organization who believes strongly in the improvements and is willing to try them and work with others to learn them. Teams need at least one physician champion on their team. Champions in other disciplines who work on the process are important as well.

Change Concept

A general principle for changing a process. Change concepts are usually at a high level of abstraction, but evoke multiple, specific ideas for how to change processes. "Team roles are defined and tasks delegated," "Regular follow-up is assured," are examples of change concepts.

Clinical Information System

Data required to deliver good chronic illness care. This information is arranged in ways that enable the team to examine the status of key aspects of care across their patient population or panel. This is displayed as a patient registry. Sophistication ranges from color-coded index cards to fully integrated computerized systems.

Collaborative

A time-limited effort (usually six to 12 months) of multiple organizations, which come together with faculty to learn about and to create improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other, thus: "Everyone learns, everyone teaches."

Collaborative Team

Involves all participants from all clinics and/or health plan/clinic teams.

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Cycle or PDSA Cycle

A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes:
Plan: a specific planning phase;
Do: a time to try the change and observe what happens;
Study: an analysis of the results of the trial; and
Act: devising next steps based on the analysis.

This PDSA cycle will naturally lead to the plan component of a subsequent cycle.

Day-to-Day Leader

The person on the organization team who is responsible for driving the improvement process every day. This person manages the team, arranges meetings, assures tests are being completed and data are collected. Usually requires 0.25 FTEs or more to complete this role.

Early Adopter

In the improvement process, the opinion leader within the organization who brings in new ideas from the outside, tries them and uses experiences with positive results to persuade others in the organization to adopt the successful changes.

Early Majority/Late Majority

The individuals in the organization who will adopt a change only after it is tested by an early adopter (early majority) or after the majority of the organization is already using the change (late majority).

Implementation

Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

Key Changes

The list of essential process changes that will help lead to breakthrough improvement, usually created by the leadership team and chair based on literature and their experiences.

Key Contact

The individual on the organization team who takes responsibility for communication between the team and [sponsor], including reporting monthly and disseminating information to team members from the Institute. The Key Contact is often the day-to-day leader on the team.

Learning Session

A two-day meeting during which participating organization teams meet with faculty and collaborate to learn key changes in the topic area, including how to implement them, an approach for accelerating improvement and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills and materials that prepare them to make immediate changes.

Measure

Key measures should be focused, clarify your team's aim and be reportable. A measure guides the ability to track patients for delivery of proven interventions and to monitor their progress over time.

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Model for Improvement

An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

PDSA

Another name for a cycle (structured trial) of a change, which includes four phases: Plan, Do, Study, and Act. See Cycle above. Sometimes known as Plan, Do, Check and Act (PDCA).

Physician Practice Manager/Owner Senior Leader

The physician manager or owner of the practice/clinic serves as the executive who supports the team and controls all the resources employed in the processes to be changed. This person is the senior leader of the office/clinic, and works to connect the team's aim with the organization's mission, provides resources for the team and promotes the spread of work of the team to others.

Pilot Site

The office/clinic location for focused changes. After implementation and refinement the process will be spread to additional locations.

Practice Report

The practice report is the physician's report of how well clinic is doing regarding improved access and office efficiency. It will also be the standard reporting format for monthly progress updates in the Collaborative. This concise two-page report includes an aim statement, measures to be used, a sampling plan, a listing of the changes made and the results displayed graphically on annotated run charts.

Pre-work Packet

A book containing a complete description of the Collaborative, along with expectations and activities to complete prior to the first meeting of the Collaborative.

Pre-work Period

The time prior to the first learning session when teams prepare for their work in the Collaborative, including selecting team members, scheduling initial meetings, consulting with senior leaders, preparing their aim, and initiating data collection.

Process Change

A specific change in a process in the organization. More focused and detailed than a change concept, a process change describes what specific changes should occur.

Run Chart

A graphic representation of data over time, also known as a "time series graph" or "line graph." This type of data display is particularly effective for process improvement activities.

Sampling Plan

A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. This is included on all Senior Leader reports. It emphasizes the importance of gathering samples of data to obtain "just enough" information.

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Spread

The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on Diffusion of Innovation (Everett Rogers, 1995).

Team

The group of individuals, usually from multiple disciplines, that drive and participate in the improvement process. A core team of three to four individuals attend the learning sessions, but a larger team of six to eight people participate in the improvement process in the organization.

Technical Expert

The technical expert is also the clinical expert, the physician, within the office who has a strong understanding of the clinical processes to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis and team function.

Test

A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

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3.0 Chinook Primary Care Network – Communications Plan

COMMUNICATIONS PLAN:

Chinook Primary Care Network

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BACKGROUND:

The Chinook Primary Care Network (CPCN) is committed to primary care improvement.

Primary Care is defined as the entry point or the front door to the health care system. Most frequently, that is when the patient sees their family physician but it could be a visit to the Emergency Room.

Primary care is considered comprehensive when the primary provider enters into a sustained partnership with the patient to share responsibility for the overall coordination and care of the patient's health problems; biological, behavioral, or social. Physicians have traditionally provided the care, but, increasingly, the move to Primary Care Networks has created the opportunity for teams of health care professionals to support the physicians including nurses, dietitians, pharmacists and mental health workers to provide primary care to a defined panel of patients.

Through collaboration with participating physicians and Chinook Health, CPCN has adopted carefully planned strategies and principles to meet the primary care objectives outlined by the Alberta Trilateral Master Agreement.

The CPCN is committed *"to work collaboratively with key stakeholders to develop, implement and evaluate evidence-based primary care delivery models aimed at improving access, quality of care and satisfaction for both patients and health care providers."*

CPCN represents nine rural communities: Coaldale, Cardston, Crowsnest Pass, Fort Macleod, Magrath, Milk River, Taber, Picture Butte and Pincher Creek. The partnership also includes six city of Lethbridge clinics: Campbell, Haig, Lacidem, Family Medical and Northside Medical.

More than 100 physicians are participating in the CPCN and providing care to over 157,000 regional residents.

CPCN PROGRAM AND PROVINCIAL OBJECTIVES:

1. Utilize existing evidence-based data and research to create a collaborative plan and approach.
2. To support family practice physicians in the provision of comprehensive, accessible and coordinated primary health care services to a defined population.
3. Form interdisciplinary family practice teams.
4. Enhance linkages between family practice teams and RHA services, medical specialists' care and community resources.
5. Continue development of clinic electronic medical record and links with regional RHA information systems.
6. Participate in community population health initiatives and health education programs.
7. Participate in a Redesign of the Clinical Office Practice initiative.

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COMMUNICATION OBJECTIVES:

1. The Chinook Primary Care Network is committed to effective, two-way communication with its internal and external stakeholders. Timely, accurate and coordinated communication is essential for meeting this commitment.
2. All communication will be complementary to and will reflect the language and spirit of the provincial communication direction.
3. Local communication components will be complementary to the regional and provincial direction but will be tailored to meet local needs.
4. CPCN "spokespeople," regional and local, will be designated responsibility for CPCN communications and will act in conjunction with the Chinook Primary Care Network leadership committee delivering agreed-upon key messages. If a member of the CPCN other than the spokesperson is approached by media, they will work with a spokesperson to respond appropriately.
5. Spokespeople will make the CPCN leadership committee aware of media interviews and other communication opportunities.
6. Where appropriate, Chinook Health Corporate Communications can assist with delivering key messages and communication tools in conjunction with the leadership committee.

TARGET AUDIENCES:

Internal audiences:

- All staff
- Chinook Health Board of Directors
- Regional Executive Council
- Chinook Leaders Council
- Participating Physicians and Clinic staff
- Community Health Councils
- Chinook Primary Care Network Leadership Committee
- Chronic Disease Network Leadership Team

External audiences:

- Physicians who are not participating in the Network
- General public
- Media
- Elected officials: Mayors, Reeves, MPs, MLAs, etc.

MESSAGE/S:

1. Primary Care is the entry point or the front door to the health care system. Most

frequently, primary care is delivered when a patient sees their family physician but it could be a visit to the Emergency Room.

2. Primary Care Networks have created the opportunity for teams of health care professionals comprised of registered nurses, nurse practitioners, social workers, pharmacists, dietitians and a range of other healthcare professionals to provide primary care alongside family physicians.
3. Family practice teams will link with Chinook Health Region programs and services. In some instances, services will be co-located to enhance service delivery. In other instances, more formal links will be formed.
4. Healthy living and prevention of chronic disease will become a primary focus.
5. Prevention of chronic disease can happen at multiple levels; in the physician's office, community or home.
6. Physicians have an important role to play in the promotion of self-care intervention and self-management of chronic disease. Statistics indicate people are 60 per cent more likely to adopt a healthier lifestyle if they receive instruction or direction from a physician.
7. Primary care equates to a shift in thinking from a system driven to support acute and episodic treatment to one of chronic disease prevention and management. Evidence suggests about 95 per cent of care relates to chronic disease management.
8. Primary care is built around the patient – client centred.

ISSUES:

Positives:

1. There is already significant support from physicians.
2. Lots of success stories to report

Challenges:

1. Members of communities may not be aware of the Chinook Primary Care Network.
2. Keep messages simple and build on messages appropriately.
3. Getting the public and health care providers (physicians, nurses, etc) to recognize the value in doing things differently.
4. Making sure everyone is aware, has a good understanding of CPCN and supports the key messages.

COMMUNICATION STRATEGY:

Communication will focus on the value of working with your identified physicians and family practice teams to coordinate all aspects of health care. Statistics indicate that people are 60 per cent more likely to adopt a healthier lifestyle and a self-management program if they receive that advice and information from a physician.

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Communication to health care providers and the general public will also highlight the determinants of health: income and social status, social support networks, education, employment and working conditions, social environment, physical environment, biology and genetic endowments, personal health practices and coping skills, health child development, health services, gender and culture.

It will also relate the benefits of CPCN to local communities. Residents will be particularly interested in hearing how it will enhance their own experiences when they visit or need to visit with their family physician. It will educate the public on the appropriate use of health care services (you may have 24 hour access to an Emergency department but should use it only when it's appropriate to do so).

Communications will begin to educate residents and staff about how partnerships between Chinook Health and local family practice teams aim at creating a more efficient system.

The undercurrent of all communication will be to encourage Chinook Health residents to work with their family physicians and their teams to support them in their health care needs.

COMMUNICATIONS ACTIVITIES:

1. **Regional Health Authority monthly staff newsletter**
2. **Regional Health Authority internal website**
3. **Chinook Primary Care Network website**
4. **E-newsletter**
5. **Local Board and Regional Health Authority Leaders**
6. **Media Briefing –** To serve as relationship building and education exercise with local media. The intent would be to invite media to learn more about the Network.
7. **News release**
8. **Face-to-face meetings –** CPCN participants, physicians, Chinook Health and allied health providers could make face-to-face presentations to groups who want or need to gain an understanding of the Chinook Primary Care Network.
9. **Physician Newsletter**
10. **Chinook Physician's Association Presentation**

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11. Brochures, Handouts, Posters/Signage

12. Ongoing media relations

BUDGET/RESOURCES:

EVALUATION:

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4.0 Chinook Primary Care Network Evaluation Workplan

Objective 1: Access:
Increase the proportion of residents with ready access to primary care.

Dimension	Key Success Factors/Outcomes	Indicators	Potential Evaluation Questions	Tool
▪ Patients and families can identify a primary health care provider/team ▪ Patients and families that identify a primary health care provider/team that can see them in a reasonable amount of time ▪ Health providers who are satisfied will stay in the PCN	▪ xx% can identify a primary health care provider ▪ xx% can identify they can see the appropriate health provider in a reasonable time (e.g. 3rd next available appointment) ▪ Clients will be satisfied with their access to primary health care providers ▪ Stable workforce within the PCN	▪ increase in # who can identify primary care provider ▪ increased satisfaction of clients with their ability to access their primary care provider ▪ increase in percentage of primary care physicians who align themselves with the PCN ▪ increase of other health care professionals involved in the PCN ▪ Primary health care providers working in the PCN report an increased level of satisfaction ▪ 3rd next available appointment ▪ Number of new primary care options available ▪ Decrease in the number of low acuity ER visits ▪ Hospitalization rates for selected diagnosis	▪ Are patients and families able to identify a primary health care provider/team? ▪ How long do patients need to wait to obtain an appointment with their provider? ▪ Are patients satisfied with their access to providers in the PCN? ▪ What are the turnover rates for health care providers in the PCN? ▪ Has access to primary care services increased?	Provider satisfaction surveys (pre & post measures): ▪ *Assessment of Chronic Illness* Care (ACIC) – Delivery System Design section Source: Improving Chronic Illness Care (ICIC) ▪ *American Medical Group Association* (AMGA) survey Source: Mike Davies Patient satisfaction surveys regarding access (pre, mid-point & post measures): ▪ "Greenbook" – *Assessing your Primary Care Practice* Source: Clinical Microsystems Operational measures (initial & yearly measures): ▪ *Assessing your Primary Care Practice* Greenbook Source: Clinical Microsystems

Objective 2: Coordination of 24/7 Care:
Provide coordinated 24-hour, 7-day-per-week management of access to appropriate primary care services.

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Dimension	Key Success Factors/Outcomes	Indicators	Potential Evaluation Questions	Tool
▪ Appropriate 24/7 care coordinated by the PCN	▪ The PCNs have a pivotal role in coordinating 24/7 care ▪ Appropriate utilization of 24/7 care	▪ Increase in number of contacts after hours care options coordinated by the PCN ▪ Track 24/7 care options (i.e., # of hrs calls to physicians, ER, UCC)	▪ What are the processes that support coordination and the sharing of health information for 24/7 care and what impact does this have on patient utilization of services? ▪ What is the utilization of the different 24/7 care options for patients and how do they influence coordination of services from a systems perspective? ▪ What % of patients are aware of the role of PCNs in after 24/7 care? ▪ Are patients & providers satisfied with the coordination of 24/7 care?	Provider satisfaction surveys (pre & post measures): ▪ *Assessment of Chronic Illness Care* (ACIC) – Delivery System Design section Source: Improving Chronic Illness Care ▪ *American Medical Group Association* (AMGA) survey Source: Mike Davies Patient satisfaction surveys (pre, mid-point & post measures): ▪ *Patient Assessment of Chronic Illness Care* (PACIC) Source: Improving Chronic Illness Care

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Objective 3: Health Promotion and Disease/Injury Prevention:
Increase the emphasis on health promotion, disease and injury prevention/care of the medically complex patient and care of patients with chronic diseases.

Dimension	Key Success Factors/Outcomes	Indicators	Potential Evaluation Questions	Tool
▪ Shift from individual episodic levels of care to include a more population-based approach	▪ Improvement in population health indicators ▪ Greater alignment between public health and primary care sectors ▪ Programs and services are based on population health needs	▪ Improved population health indicators (to be determined) ▪ Coordinated and integrated strategies between public health and PCN to address the needs of the population ▪ Increase in # of primary care practices who have developed automated patient registries	▪ How have public health/population health strategies been incorporated into PCNs and what impact do they have on the creation of new primary care public health models of service delivery? ▪ What is the improvement in population health indicators? ▪ How have public health and primary care programs been aligned?	Operational measures (initial & yearly measures): ▪ *Assessing your Primary Care Practice* Greenbook Source: Clinical Microsystems Provider survey (pre & post measures): ▪ *Assessment of Chronic Illness Care* (ACIC) –Evidence section Source: Improving Chronic Illness Care

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Objective 3: Health Promotion and Disease/Injury Prevention:
Increase the emphasis on health promotion, disease and injury prevention/care of the medically complex patient and care of patients with chronic diseases.

Dimension	Key Success Factors/Outcomes	Indicators	Potential Evaluation Questions	Tool
Care Management / Chronic Disease Management: ▪ Comprehensive care through whole person care approach to service delivery	▪ Improved whole person care for patients with complex diseases ▪ Utilization of care pathways/protocols for chronic disease ▪ Integrated registry for chronic complex disease ▪ Self care optimized for patients affected by chronic complex disease	▪ Increase of patients participating in education, wellness and self care initiatives ▪ Improved clinical indicators (to be determined) ▪ Number of patients registered ▪ Improvement in utilization of clinical practice guidelines in selected areas	▪ What is the improvement in clinical indicators for patients with chronic disease? ▪ Is the PCN using a chronic disease registry? ▪ How has coordination and follow-up improved for complex chronic disease patients? ▪ What self care options are available to patients with chronic disease through or linked to the PCN? ▪ What new partnerships have been formed related to community action and/or strategies? ▪ Have these community group referrals increased? ▪ In there evidence of consistent health messages through partnerships? ▪ To what extent have infrastructure changes been made to allow sharing of CDN resources within the CHR? ▪ How have perceptions of primary care level integration changed? ▪ Has continuity of care increased and clinical duplication decreased? ▪ Has there been an impact on	Provider survey (pre & post): ▪ *Assessment of Chronic Illness Care* (ACIC) –Evidence section Source: Improving Chronic Illness Care Patient Satisfaction Survey (pre & post): ▪ Leatt, Pink & Guerriere Source: Healthcare Papers Patient Self-care Surveys (pre, mid-point and post): ▪ *Patient Assessment of Chronic Illness Care* (PACIC) Source: Improving Chronic Illness Care ▪ Stanford participant evaluation forms (pre & post workshop) Source: Stanford Patient Education Research Center Clinical data collection from CHR Meditech Laboratory and other clinic-based sources

			patient's perceived quality of life in relation to team care? ▪ Has there been an increase in physician use of BHL services? ▪ Is there evidence of health status improvement? ▪ Has there been a decrease in CD ER/Acute services? ▪ Has CPG compliance increased in prioritized areas? ▪ Has information been developed to support physician clinic chronic disease registry? ▪ Does BHL registration system include components that would allow it to be used as a regional CD registry? ▪ Are there reminder systems in place for one aspect of CD care within physician clinics and/or BHL system? ▪ Have new processes and infrastructure been developed to support new program inclusion into BHL Infrastructure for referrals? For common assessments? ▪ Is there an increase in access to self-care resources?	

Appendix E.4 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

Objective 4: Coordination and Integration:
Improve coordination and integration with other health care services including secondary, tertiary and long-term care through specialty care linkages to primary care.

Dimension	Key Success Factors/Outcomes	Indicators	Potential Evaluation Questions	Tool
▪ Improves health status and quality of life of clients being seen within a PCN ▪ Collaborative approach between physicians and regions resulting in integrated, optimized service delivery across the continuum (primary, secondary, tertiary)	▪ Formal relationships between primary care physicians and health regions results in aligned services ▪ Enhanced processes in the shared responsibility between specialty services* and the PCN for common client outcomes ▪ Shared health information between health care providers/services ▪ Information technology used to facilitate the shared of information ▪ Reduced duplication and fragmentation	▪ Maintain or increase RHA and physician participation in PCNs ▪ Decrease in duplication of services ▪ Appropriate referrals to specialists ▪ Reduced wait times for specialist services ▪ Evidence of service integration across the continuum (primary, secondary, tertiary) ▪ Appropriate information shared between providers ▪ Tracking referrals to CHR specialty services/clinics ▪ Increased patient and provider satisfaction with continuity of care	▪ How has coordination and integration been enhanced? ▪ How have linkages between primary care providers and acute, tertiary, and long-term care been improved? Rate linkages. ▪ Has coordination & integration through the PCN improved health outcomes for patients? ▪ What is the satisfaction of patients with coordination of care of primary care? ▪ What is the satisfaction of health providers in all levels of care (primary, acute, tertiary and long-term care) with the coordination of care through PCNs? ▪ Is appropriate health information being shared between providers and services? ▪ What improvements have been made to integrate with other health care services, including secondary, tertiary and long-term care through specialty linkages to primary care?	Provider satisfaction surveys (pre & post): ▪ *Assessment of Chronic Illness* Care (ACIC) – Delivery System Design section Source: Improving Chronic Illness Care ▪ *American Medical Group Association* (AMGA) survey Source: Mike Davies Patient satisfaction surveys (pre, mid-point & post): ▪ *Patient Assessment of Chronic Illness Care* (PACIC) Source: Improving Chronic Illness Care

Appendix E.4 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

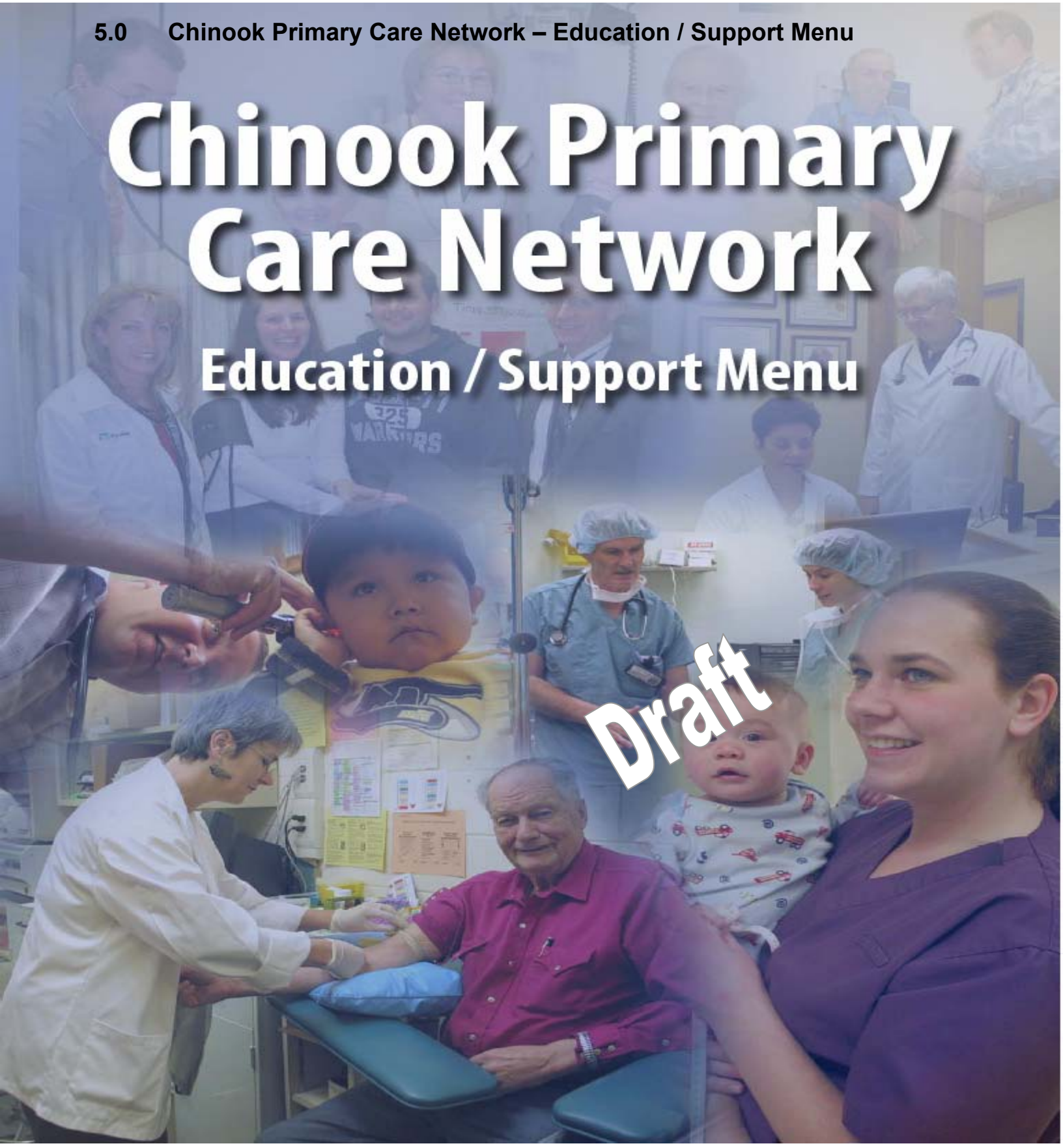
Objective 5: Multi-disciplinary Teams:
Facilitate the greater use of multidisciplinary teams to provide comprehensive care.

Dimension	Key Success Factors/Outcomes	Indicators	Potential Evaluation Questions	Tool
▪ Improved quality of care to clients through utilization of multidisciplinary teams	▪ Patient safety is enhanced ▪ Adherence to practice guidelines ▪ Client is seen at the right time, right place and right person ▪ Clients will be satisfied ▪ Enhanced provider satisfaction ▪ Providers understand the scope of practice of others and work diligently to maximize to appropriate scope of practice within the PCN	▪ Decreased adverse medical events (to be defined) ▪ Increased use of practice guidelines ▪ Increased levels of satisfaction of clients ▪ Increased satisfaction in health providers ▪ Increase number of health care providers working to optimized scope of practice ▪ Improved lead time ▪ Improved cycle time ▪ Over-under chart (Increase activity compared to supply – time provider spends with patient vs. total time in the office)	▪ To what extent have PCNs been able to implement multidisciplinary teams? ▪ Does the use of multidisciplinary teams increase access for patients in the PCN? ▪ How have issues of staff mix, scope of practice been addressed? ▪ Can multidisciplinary teams increase the uptake of CPGs? ▪ How have multidisciplinary teams impacted health outcomes for patients in the PCN? ▪ Are patients and providers satisfied with care provided by multidisciplinary teams?	Provider satisfaction surveys (pre & post): ▪ *Assessment of Chronic Illness* Care (ACIC) – Delivery System Design section Source: Improving Chronic Illness Care ▪ *American Medical Group Association* (AMGA) survey Source: Mike Davies Patient satisfaction surveys (pre, mid-point & post): ▪ *Patient Assessment of Chronic Illness Care* (PACIC) Source: Improving Chronic Illness Care Staff satisfaction (pre, mid & post): ▪ Greenbook *Primary Care Staff Satisfaction Survey* Source: Clinical Microsystems Teamwork (monthly) Source: Mike Davies Operational measures (initial & yearly): ▪ *Assessing your Primary Care Practice*

				Greenbook Source: Clinical Microsystems Ongoing measures: ▪ Lead time ▪ Cycle time ▪ Over-under chart (Supply compared to Activity) ▪ Measures of % completion of the chronic disease and prevention measures agreed upon during the course of the project. Source: Mike Davies

Appendix E.5 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

5.0 Chinook Primary Care Network – Education / Support Menu



Appendix E.5 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

Welcome

This menu has been developed to guide orientation and training as well as to assist your clinic to access available educational resources and supports. These resources are available to family practice team members, as well as physicians and existing office staff.

Supports are offered through a variety of sources, including physician leads, clinical care coordinators, provincial government, the Chinook Health Region, the Chinook Primary Care Network (CPCN) office and contracted outside sources.

Identify the areas of interest to you and your group by placing a check mark in the box next to the topic areas and contact the Chinook Primary Care Network or the specific contact provided to book these education opportunities.

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1. Family Practice Team Development

This series is intended to develop and strengthen team cohesiveness and individual excellence. The strength of a team is based on the sum of its parts. A solid foundation is essential to a strong team.

a. Team Development / Communication

☐ *This series will facilitate teams through the steps to becoming a championship team. Having an appropriate and effective team is a key component of successful improvement efforts.*

- ☐ ***Introduction and Conceptual Overview (The ABC's of Championship Teams)***
- ☐ ***Diagnosing the Team's "State of Health"***
- ☐ ***Creating an Operational Performance Plan***
- ☐ ***Who Does What around Here***
- ☐ ***Role Negotiations: Who Does What around Here***
- ☐ ***Decision Making: How Things Get Done Around Here***
- ☐ ***What it feels Like to Work around Here***
- ☐ ***Conflict Resolution***

b. Having Fun at Work (The Fish Philosophy)

☐ TBA

c. Coaching Workshop *est. time: 1-2 days*

☐ *This workshop introduces professionals to a "coaching" role rather than the traditional role of "expert". Understanding and adopting a coaching role encourages clients in wise decision making with respect to daily behaviour changes that work for them.*

2. Office Practice Improvement

☐ *The Chinook Primary Care Net work has engaged in a 2 year collaborative initiative with Dr. Mark Murray and Dr. Mike Davies regarding access improvement, optimizing interdisciplinary family practice teams and implementation of decision support tools for teams. The initiative is based on the International Healthcare Institute (IHI) improvement process and principles. A series of learning sessions will be offered followed by action periods to implement clinic specific improvements with the guidance of the improvement advisors.*

1. *Access Improvement*
2. *Analyzing Workload and Workflow Testing*
3. *Design and Implementation of Operational Teams*
4. *Design and Implementation of Interdisciplinary Teams*
5. *Championship Teams Workbook*
6. *Optimizing Teams*
7. *Utilization / Implementation of Decision support tools (protocols and guidelines)*
8. *Developing and Recording Measures to Sustain and Spread Success*
9. *Local Improvement Teams*
10. *Group Emails and Telephone Calls*

Dr. Mark Murray and Consultants
Phase I groups: Oct 27, 2005 through Nov 16, 2006
Phase II - May 2006

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3. Practice Management Support

☐ *The Practice Management Program (PMP) was established in the 2003 Trilateral Master Agreement to assist physicians interested in working with their respective health regions to develop a Primary Care Network. PMP works with physicians to support them throughout the provision of information and guidance on business issues, including, but not limited to, group formation, practice governance, taxation, liability, etc., so that physicians are in a position to make informed decisions throughout the process. PMP also acts as the primary contact for facilitation of communication and information sharing between the physicians and their PCN and the Alberta Medical Association. The Practice Management Program has been involved with supporting the development of the Chinook PCN from the start of the business planning process. Ongoing PMP support into implementation will include coordinating service needs around business management and operation issues that arise within the PCN. Such support will occur in physician clinics or though email or telephone consultations as applicable.*

**AMA Practice Management Program*

Consultant: Sean

Contact info:

Navigating the Health Care System

Optimizing Physician Office Management

Providing Legal, Business & Financial Knowledge

Strategic Planning

Opening Lines of Communication & Assisting in Exchanging Ideas & Information

Preparing Physicians to be Active Participants in their PCN

Identifying Budget, Resources & Service Gaps

Human Resource Challenges & Planning

Understanding Information Management & Technology Needs

4. Clinical Process Support

The Alberta Toward Optimized Practice (TOP) program succeeds the former Alberta Clinical Practice Guidelines program and maintains and distributes Alberta Clinical Practice Guidelines. TOP is a health quality improvement initiative that fits within the broader health system focus on quality and complements other strategies such as Primary Care Initiative and the Physician Office System Program. The Toward Optimized Practice Program is participating as part of the Chinook Improvement Initiative and has been working closely with the local teams to support both clinical and operational flow mapping.

These sessions are booked on-site, include a number of team members and a consultant, the entire clinical process taking place over a period of time.

☐ **a. Clinical Work Flow Mapping**

☐ **b. Clinical Work Flow Mapping Workshop – dates TBA**

☐ **c. Clinical Measure Support**

☐ **d. Process Improvement**

5. Accessing / Referring to CHR Programs and Services

The intent of these presentations is to increase awareness of available services, support resources and appropriate referral processes for the following CHR programs:

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a. Building Healthy Lifestyles (Chronic Disease Prevention and Management)

☐ **Diabetes / Lipid Education Program**

Educational sessions for individuals with Diabetes or IFG/EGT who would benefit from lifestyle / disease management information.

The services provided include:

- Individual counselling and follow-up sessions
- Group classes
- Insulin initiation/adjustment
- Pediatric diabetes education services
- Pregnancy clinic
- Learning centre and resource library
- Health professional education and in-services
- Community education
- Aboriginal Diabetes Prevention and Management Program
- Inpatient support

☐ **Cardiac Rehabilitation Program**

Providing cardiac clients and their families with information, direction and support to maximize their recovery, rehabilitation and long term management of heart disease. The aim is to improve quality of life through improved cardiovascular functioning, life styles modification to control risk factors through an enhanced support system of professionals and peers.

☐ **Heart Function Clinic**

Providing consultation, management and supportive care for individuals who have been diagnosed by a physician, as having chronic heart failure.

The program offers:

- Comprehensive client centered education specific to chronic heart failure management (pathophysiology of heart failure, nutrition, activity, medications and healthy lifestyle choices).
- Individualized follow up (nurse clinic or nurse/physician clinics) tailored to individual client and family needs
- Telephone follow-up with nurse clinician as required

☐ **COPD Program**

A rehabilitation program for those with respiratory disease. Any person who has been diagnosed, by a physician, as having asthma, emphysema, chronic bronchitis, or any of the other chronic lung diseases and is physically capable of doing the exercises in the clinic will qualify for the program.

☐ **Asthma Program**

*The overall goal of the **asthma clinic** is to help asthmatics better manage their condition. The clinic achieves this by providing education on asthma and then discussing ways the disease can be controlled.*

The clinic runs monthly with the following outline:

- Session One: *Nurse Assessment and History*
  Assessment of medications and spirometry by a respiratory technician
  Physician visit
- Session Two: *Evening Group Meeting*
  Discusses risks, triggers, medications, devices and goals
- Session Three: One Month Follow-up
  Review medications, changes and develop an Action Plan

☐ **Nutrition Services**

Assessment and education to individuals with a variety of health and nutrition concerns. The services provided include:

- Group education classes specific to nutrition and disease and general healthy eating.
- One on one assessment (and follow-up) for any nutrition related concerns.

- Implement and monitor enteral and parenteral nutrition support. Prepare client/family for post-discharge nutrition support.
- Organize client referrals for the Southern Alberta Home Enteral Program.
- Provide nutrition education to staff, clients, and community members as required.

b. Rehab

The Chinook Rehabilitation Medicine Department provides a variety of rehabilitation services that support people in achieving and maintaining independent and productive lifestyles. The Chinook Rehabilitation Program provides rehabilitation services to all CHR facilities and in all CHR communities and consists of the following disciplines:

- ☐ **Occupational Therapy** - *Assess, diagnose, treat and help prevent impairments to a client's ability to function in their everyday environment*
- ☐ **Physical Therapy** - *Assess, diagnose, treat and help prevent disorders of human movement*
- ☐ **Speech Language Pathology** - *Assess, diagnose, treat and help prevent disorders in language, speech, voice, fluency, cognition and other related communication disorders as well as swallowing disorders*
- ☐ **Therapeutic Recreation** - *Uses recreation and leisure pursuits as a modality to treat clients with physical, cognitive, social, emotional and/or environmental limitations*

c. Laboratory

☐ *The Laboratory currently operates on 20 sites across the region.*
A complete Laboratory "Guide to Services" is available both in print copy and on the CHR Intranet under Departments => Diagnostic and Therapeutic => Laboratory. To order this manual, see print resources on page 19. The information summarized below is in the guide.

- For general inquiries call the Client Service Center at 388-6067
- We offer a dedicated physician office line for "results only" at 394-1627
- The LRH site operates on a 24/7 basis.
- *Rural Hospital sites offer services Monday-Friday. Weekend hours are primarily intended for in-patient and emergency room work. Call back services are available after routine hours. 24/7 courier is available to transport specimens for testing in Lethbridge if not performed on site. Collection Site locations are available in Taber and Cardston.*
- *Urgent Care sites, Picture Butte and Coaldale operate Monday to Friday and do not have call back services.*
- *Lethbridge currently has several Collection Site locations that operate Monday to Friday. Lethbridge Community Lab, located in the auxiliary on the LRH site offers extended service hours 7:00 am to 9:00 pm Monday to Friday and 8:00 to 4:00 on Saturday. Special instances for Sunday collection can be accommodated.*
- *Transport/Courier: Specimens are transported twice daily from all CHR Lab and Collection Site locations.*

d. Family Health

- ☐ **Women's Health** - *Prenatal Education; in Preparation of Delivery; Healthy Infants; Breast Health; Cervical Health*
- ☐ **Children's Health** - *Genetics; Baby Specialty Services; ACH Outreach Clinics; Child & Adolescent Mental Health Program (CAMP)*

e. Seniors' Health

☐ **Acute Geriatrics**

Encompass both the Geriatric Assessment and Rehabilitation Unit (GARU), and the Post Acute Rehabilitation Program.

GARU *– 25 bed inpatient program located on 5A-LRH, specializing in interdisciplinary diagnosis and short term treatment of the elderly. Referrals are accepted from all hospitals, LTC facilities or community within the CHR. Referrals must be physician approved. All referrals enter through the Community Transition Team (CTT) – contact 388-6601 for details or use referral form #101862-05/04.*

ACE *– Acute Care of the Elderly provided by the GARU program for seniors with an acute illness that contributes to a functional decline and has potential for reversible components. Must have sufficient cognitive function to participate and needs physician approval.* ***Referrals from LRH ER and all acute care units at LRH.***

PARP *– 20 bed inpatient program for persons >18 years of age who have recently undergone an acute illness currently on 5B-LRH (with anticipated move to St. Michael's Health Care Facility in the fall of 2006) specializing in a team approach for short term intensive rehabilitation services. Referrals are accepted from within Southern Alberta. Must be physician approved. Make referrals through the CTT – contact 388-6601 or use Referral Form #101862-05/04.*

☐ **Geriatric Physicians**

☐ **Community Care**

The Seniors' Health Program provides an array of services in the Continuing Care system for seniors and clients with disabilities who have non-acute needs.

☐ **Continuing Care**

Continuing Care Facilities, formally known as nursing home, auxiliary hospital or long term care, provide care for individuals with complex medical conditions. Continuing Care Facilities provide services through an interdisciplinary care team which includes a Registered Nurse on-site 24 hours a day.

Care Services Provided:

- Professional Nursing Service
- Personal Care Service
- Life Enrichment Services
- Specialized Therapy Services
- Medication and Medical/Surgical Supplies

☐ **Palliative Care Program**

The Regional Palliative Care Program helps people and families when there is no known cure for an illness that threatens life.

The goal of palliative care is to relieve pain and other symptoms, and to improve the quality of each day in the person's life.

Palliative care...

- Values life and accepts death as a normal process.
- Does not speed up or slow down death.
- Offers support to help the person live as actively as possible.
  Palliative care offers support to help families cope from the start of the person's illness until after the person has died. The program centers the care on the person, family and loved ones.

f. Mental Health

☐ *The CHR Mental Health Program works in collaboration with related agencies and supports, to provide a high standard of accessible mental health services in order to promote, maintain, and improve the mental health of individuals of all ages, and their communities. The Mental Health Program strives to be client/family focused and community-based, and to develop a continuum of mental health services in keeping with the Provincial Mental Health Plan's scope of mental health services.*

g. Others (as identified by family practice clinic)

☐

h. Population Health

In addition to working with community health groups and agencies to address the Social Determinants of Health, Population Health offers the following:

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☐ **Herbal Remedies – Get the Facts!**

Explore the myths and mysteries of herbal supplements, vitamins and minerals. This class will:

- Provide the facts, benefits and potential dangers of herbal supplements
- Discuss whether vitamin / mineral supplements are required
- Provide safe guidelines for their use

☐ **Vegetarian Eating**

Vegetarian eating can reduce the risk of heart disease, diabetes, cancer and obesity. But does it provide enough nutrients such as Iron, Calcium, Vitamin D, Vitamin B-12 and Protein? This class provides:

- Information on preparing healthy, vegetarian meals
- Ideas for getting the required nutrients
- Recipes and resources for vegetarian eating

☐ **Hugs – You count, Calories Don't!**

This ten-week course will help break the diet cycle and rebuild a confident new lifestyle. Fee: $80 includes 2 textbooks and a workbook. Each week you will meet in a small group led by a fitness instructor and a registered dietitian to discuss:

- Eliminating the diet mentality
- Changing the way you look at food and weight
- Feeling good about yourself and your size
- Healthy physical activity
- Building a non-diet lifestyle for better health because you count; calories don't!

Contact Info: 388-6654

☐ **Cooking Club**

This class provides information on:

- How to prepare nutritious meals on a budget
- Meal planning and cooking
- How to cook with a variety of new recipes

Contact Info: 388-6666, extension 3571

☐ **Making Baby Food**

This class is great for parents and caregivers who would like to provide their babies with nutritious and delicious baby food while saving money. Better Beginnings clients may receive a cookbook for free when attending the Making Baby Food class. Non-Better Beginnings clients can purchase a grinder or cook book. Contact Info: 388-6668

☐ **Stop Dieting, Lose Weight**

A 10 week program that helps people make healthier decision and rebuild lifelong patterns through practical, gradual steps is offered twice a year. The concept is "Live a life without diets, enjoy physical activity and improve self-confidence".

☐ **Interfaith Community Kitchens**

Daily cooking sessions designed to assist participants learn how to prepare healthy, tasty, budget conscious recipes are held at the Interfaith Chinook Country Community Kitchen. There is no cost and Children's programs are held during the cooking sessions.

☐ **Think Think Again**

Car seat education session for drivers ticketed for child car safety seat non-compliance. 4th Tuesday/month. Call 327-2847 to register.

☐ **Expectant Parent Child Car Safety Seat Education Class**

Expectant Parent Child Car Safety Seat Education Class. Offered 2 evenings/month. Call 388-6677 to register.

☐ **Nitsitapii Wellness Program**

Comprehensive Wellness program based on traditional cultural values. 10-week session delivered once / year – January – March. Holistic Program based on Mental, Emotional, Physical and Spiritual perspectives. Contact 388-6694.

- ☐ **Aboriginal Women's Wellness Day**
  The one day session, normally held in August, focuses on women's wellness issues and various health related topics. Provide methods Aboriginal Women can use to achieve a balanced lifestyle using concepts of the Medicine Wheel and other holistic approaches. Contact 388-6694.
- ☐ **Wellness Presentations and Workshops**
  Provide individual presentations or workshops on various topics. Delivered to agencies on site. ½ day to full day sessions. Offered on an 'as needed' basis. Contact 388-6694.
- ☐ **Aboriginal Youth Wellness Project**
  Aboriginal Youth identify what they want to learn about health and wellness and making better health choices. Project offered during the summer and fall. Contact 388-6694.

h. Community Transition Team

- ☐ **Care Planning Consultants**
  Assist in complex discharge planning, provide linkages and communication with community services, screen ER patients and assess needs for community resources , acute admission, Acute Care of the Elderly (ACE), GARU and PARP services.
- ☐ **Psychogeriatric Consultants (PGC)**
  Have an expertise in geriatric mental health, i.e. dementia, depression, behavioural concerns and are available to facilities and the community of the CHR.
- ☐ **Geriatric Consultant**
  Possesses knowledge and expertise regarding clinical geriatrics and gerontology, conduct comprehensive geriatric and rehabilitation assessments for GARU and PARP referral region wide.
- ☐ **Rural Transitions**
  Community care coordinators assist in complex discharge planning in rural acute care sites. All referrals must be physician approved and can be sent by faxed or mailed using Geriatric/PGC/PARP Referral form #101862-05/04 or via Meditech.

6. Specific Clinical Training for Physicians & Interdisciplines

Specialty programs and areas will offer support around the following:

a. Mental Health

- ☐ *Community level mental health screening, assessment, management & maintenance education & skill development through shared care.*

b. Cognitive Screening

- ☐ *Offered by one of the Geriatricians or Clinical Nurse Specialist (Acute Geriatrics), this session will review the common screening tests used in clinical practice. Both the purpose of the tests as well as the administration of the tests will be reviewed. Some clinics may arrange with the Geriatricians to hold in-house Cognitive Screening Clinics.*

c. Palliative Care Management

- ☐ *Taught by the Palliative Care Physicians and / or Palliative Nurse Consultants, a series of 12 modules are available covering the various aspects of the art and science of providing quality Palliative Care to your patients. Examples of sessions are GI issues, Communication, Pain Assessment and Management, Palliative Sedation, Respiratory Issues, and many more.*

d. Pap Smear Training

☐ *Community level screening, assessment and management education through a self-directed learning manual; preceptorship technical skill development and assessment / certification – under development*

e. Health Screening and Maintenance

☐ *Community level health screening, assessment and maintenance education. Provide team orientation to develop protocols & pathways.*

f. Medication Management

☐ *Under development*

g. Generalist vs. Specialist Care

☐ *Under development*

Chronic Disease Training and Clinical Template / Protocol Implementation

h. General Chronic Disease Management

☐ *This workshop provides an overview of the principles and rationale for chronic disease management and the use of an integrated approach to chronic disease. Also reviews common risk factors and co-morbidity via a self-study / interactive group presentation. Access to the new chronic disease tools and training support will be provided.*

i. Vascular Protection

☐ *An overview of vascular protection evidence of best practice, availability of tools and resources for providers and patients. This workshop provides a service delivery model and clinical care flow. Relevant technical skill development is provided through self-directed learning and technical training based on team needs.*

j. Heart Failure

☐ *An overview of chronic heart failure evidence of best practice, availability of tools and resources for providers and patients. This workshop provides a service delivery model and clinical care flow. Relevant technical skill development is provided based on team needs.*

k. Chronic Respiratory

☐ *An overview of chronic respiratory evidence of best practice, available tools and resources for providers and patients. This workshop provides a service delivery model and clinical care flow. Relevant technical skill development is provided based on team needs.*

l. Chronic Disease Preceptorship with Medical Specialist

☐ *This is an opportunity to learn through shared care of complex patients with a medical specialist. A follow-up case review with the Primary Care interdisciplinary team is included.*

m. Other

☐

7. Formal Linkages with CHR Programs and Services

The CHR has experienced the value and success of formally linking appropriate CHR programs and services to support family practice. Formal linkages may include relocating or redesigning

appropriate clinical services to link team members, as required by local population needs, to specific family practice teams. For example: Chronic disease specialty teams being linked around a common patient population and providing their services on / off site collaboratively with family practice teams and patients; Mental health / social work services being aligned to provide some on-site shared care services. An important role of the specialty teams will be to provide ongoing support and education, as required, to enhance the development of the family practice team's capacity to manage specific patients' issues.

a. Linking with RHA Programs and Services in a New Way

☐ *Initiate a team based dialogue with individual team members involved in service co-location*

8. Linking with Community Resources

a. Addiction / Detox

☐ TBA

b. Personal Directives

☐ *A Personal Directive is a legal document that allows Albertans over the age of 18 to provide written instructions for future health decisions, as well as choose who will make important personal and health related decisions in the event they lose capacity. A 1-hour education session at your clinic will bring you the most accurate and up-to-date information on this important topic. For questions, resources, or educational seminars on Personal Directives or Guardianship contact:*
Bill Alles, BCR, BSW, RSW, Med (Cand.)
Public Guardian Representative and Personal Directives Specialist
Office of the Public Guardian, Lethbridge
Alberta Seniors and Community Supports
Ph: 382-4195
Bill.Alles@gov.ab.ca

d. Health Link

☐

9. General Computer Training

Specific software applications support and training

☐ **a. Excel Level 1**

☐ **b. Excel Level 2**

☐ **c. Excel Level 3**

☐ **d. Outlook Level 1**

☐ **e. PowerPoint Level 1**

☐ **f. PowerPoint Level 2**

☐ **g. Word Level 1**

☐ **h. Word Level 2**

10. Information Systems Support

The work of the family practice teams will be facilitated by expanding opportunities to link physician office systems with regional information systems (Meditech). This will provide family practice

teams' timely access to CHR test results and other important data. A primary care information systems working group and a Physicians' Informatics Educator has been established to support the above strategies and identify other key strategies that will support participating physicians.

a. Information Management

- ☐ *Single point of inquiry for Primary Care Clinics for the purposes of data management, clinical informatics support, and general IM/IT issues.*

b. Meditech Access for Physicians and Teams

- ☐ *An orientation to the MEDITECH system geared towards increased awareness of the capabilities of this system.*
  MEDITECH linkages for physicians using remote access fobs.
  MEDITECH linkages to Physician Office Systems through automatic downloads.

c. Meditech Linkages to Physician Office Systems

- ☐ *Facilitating requests for improvement of functionality of Physician Office Systems. For example, integration of clinical practice guidelines, electronic collection of information for the measurement of clinical indicators, panel size and composition, patient registries etc.*

d. Introduction of the New Meditech Client / Server Platform

- ☐ *An orientation to the Enterprise Medical Record.*
  Point of entry for suggestions from physicians re: development and implementation of the Provider Order Management (POM) and Patient Care Manager (PCM) modules of the new platform.

e. Privacy and Confidentiality

- ☐ *Presentations and on-line support for information regarding the Health Information Act (HIA) and the Freedom of Information and Protection of Privacy Act (FOIP) in relation to the collecting, using and sharing of personal health information.*

11. Clinical Skills Development

a. CPR / Emergency Response

- ☐ *First responder education for initial management of life threatening conditions through skills based group learning, (Basic Cardiac Life Support). Under development.*

b. Wound Management / Protocols

- ☐ *The CHR Wound & Skin Care Committee is pleased to invite all PCN physicians and staff to attend a 1-day workshop entitled "The ABC's of Wound Care". These sessions are co-sponsored by Convatec and provide education in assessment, prevention, and management of vascular, arterial, and diabetic ulcers according to evidence-based wound healing principles. These sessions will be offered periodically throughout the calendar year at various locations in the region. Invitations to register will be sent directly to all clinics prior to these events. A minimal fee will apply.*

c. Blood Pressure Measurement

- ☐ *Standardized & evidence based training on the skill of accurate Blood Pressure measurement.*

d. Neonatal Resuscitation Program

☐ *Designed for health care professionals whose responsibilities may require them to participate in neonatal resuscitation, this program lays the foundation of knowledge and skills required for development of specialized skills. Provider and Recertification Courses available.*

e. Other

☐

12. Operational Support – Human Resources and Office Administration

CPCN will be posting templates of these resources on the website. For further information contact: www.chinookprimarycarenetwork.ab.ca

a. Introduction to Clinic Environment *est. time: 1.5 h*

☐ *This important first step will introduce new employees to the clinic environment, including: physical layout, daily routines, reporting structure, etc.*
**Book through: Primary Care Office physician lead / clinical care coordinator / clinic managers*

b. Personal Development Plans for Clinical Care Coordinators, Physician Leads, Clinic Managers *est. time: 1.5 h*

☐ *During the introductory phase, a member of CPCN will provide orientation to this tool. This tool offers an opportunity for staff to sit down and plan orientation and professional development on a one-on-one basis. It will help staff members identify priority areas of learning and excellence and then assist in the process.*

c. Job Descriptions

☐ TBA

d. Wage / Benefit Information

☐ TBA

e. Interview Tools

☐ TBA

f. Performance Review

☐ TBA

g. Understanding Scope of Practice of Interdisciplines

☐ TBA

h. NPC Financial Reporting

☐ TBA

i. "In and Outs" of Not-for-Profit Corporations est. time: 2h

☐ *Facilitated by accountants available to answer questions regarding* Not for Profit Corporations

13. New Physician Orientation to CHR; Medical Staff Positions; Secondary and Tertiary Programs and Facilities

Under development.
**(Jodi Tamayose*
Ph# (403) 388-6135)
jtamayose@chr.ab.ca

Appendix E.5 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

**Soon to be available through CD ROM

- ☐ **a. Privileges**
- ☐ **b. Photo ID and Emergency Pass**
- ☐ **c. LRH Paging System**
- ☐ **d. Health Records**
- ☐ **e. Central Information Services**
- ☐ **f. LRH Surgical Suite**
- ☐ **g. Medical Directors / Department Directors**
- ☐ **h. Locum Consents**

14. Other

- ☐ **a. Presentations from Other Innovative Practices**
- ☐ **b. Pharmaceutical Training and Support**
  **(Local Pharmaceutical Representatives)*
- ☐ **c. Pharmaceutical Company Vendor Training and Support**

15. Chinook Health Region Print Resources

These resources are available free of charge to physician's offices. We anticipate that this list will expand over time as CHR Programs encourage the use of other sponsored print resources. CHR Programs will advise you of such additions as they become available.
*To access these materials, please complete a "**Physician Office Print Resource Requisition**" and fax it to CHR Materiel Management Central Stores at 388-6129.*
Please ensure that all fields are completed before submission. CHR Stock and Form numbers are provided on the list of print resources. Orders will be filled and delivered to your office/clinic within a few days. Please order resources for your clinic rather than individually for Physicians within clinics.

We trust that these resources will be of value to you.

CHR Print Resources for Distribution to Physicians

CHR Stock #	Form #	Description	Packaging
		CLINIC FORMS	
053540	HS0001-125	Alberta Prenatal Record	PKG/50
058728	1654	BHL Program Referral	EA
056086	532	Asthma Action Plan	EA
056078	1532	Asthma Admit Orders	EA
052369	101207	Consent/Surgical Operation	EA
063910	n/a	Diabetes Care Flowsheet	PAD/50
051816	301	Req. for Treatment - DTC-Psych.	EA
052448	101847	Pain Relief in Labour	EA
052415	101567	Physician Order - Surgical/Procedure	EA
052483	101069	Surgical/Procedure Booking Request	PKG/100

Appendix E.5 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

		SURGICAL PATIENT INFORMATION	
052409	101563	About Anesthesia	EA
053708	1095	Breast Reduction Patient Information	EA
052958	1016	Cataract Day Surgery Patient	EA
053009	1016E	Eye Day Surgery Patient Information	EA
053432	1093	Gall Bladder Removal	EA
053429	1094	Hemovac Drains	EA
053430	1097	Hernia Repair	EA
052410	101564	Pain & Pain Relief after Surgery	EA
051872	370	Pediatric Day Surgery	EA
051871	369	Pediatric Pre-Op Assessment	EA
051874	372	Preparing Your Child for a Hospital Stay	EA
052394	101357	Pre-operative Assessment	EA
053431	1096	Rotator Cuff Repair	EA
058849	1728	Admit Day of Surgery Passport	EA
058852	1727	Day Surgery Passport	EA
		ASTHMA / COPD	
056087	1505	Asthma Diary	EA
056096	1545	Winning with Asthma Booklet	EA
061603	1782	Winning with Asthma Card	PKG/100
062033	562	COPD Program Brochure - Respiratory	EA
		BUILDING HEALTHY LIFESTYLES	
057339	1625	BHL Class Calendar	EA
057715	1755	BHL Healthy U Brochure	EA
		DIABETES	
059649	1751	Hypoglycemia Treatment - Adult	EA
063911	n/a	Diabetes Calendar	PKG/25
		FAMILY HEALTH	
062621	128E-0	Give and Take - Pregnant Women: Facts about Alcohol and Other Drugs	EA
		NUTRITION	
060024	1762	Be True to Your Heart	PKG/25
AANT04	AANT04	Canadian Food Guide Tear Sheets	PAD/100
060025	1763	Eating for a Healthy U	PKG/25
052842	868	A Guide to Feeding Your Baby	EA
059899	1567	Guidelines for Healthy Eating - Diabetes	PKG/25
061463	101923	Guidelines for Healthy Eating - Aboriginal	EA
052854	897	No Added Salt - Adult	EA
062622	NT0022	Nutrition for a Healthy Pregnancy	EA

Appendix E.5 – Taber Associate Medical Centre, Pincher Creek Medical Clinic and Lethbridge Family Medical Practice

		PHYSICAL ACTIVITY	
062316	NT0040	Canada Activity Guide Tear Sheet - Adult	PAD/100
062623	HG0012	Prenatal / Postnatal Fitness	EA
		SENIORS' HEALTH	
	101868	Palliative Care Program Client and Family Information	
		SMOKING CESSATION	
062503	527A-O	For Smokers Who Want to Quit	EA
		LAB	
		Lab Guide to Services	EA

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EICP Steering Committee

- Canadian Association of Occupational Therapists
- Canadian Association of Social Workers
- Canadian Association of Speech-Language Pathologists and Audiologists
- Canadian Medical Association
- Canadian Nurses Association
- Canadian Pharmacists Association
- Canadian Physiotherapy Association
- Canadian Psychological Association
- Canadian Coalition on Enhancing Preventative Practices of Health Professionals
- Dietitians of Canada
- The College of Family Physicians of Canada