A CALL TO ACTION: A PLAN FOR CHANGE

Primary Care Networks
Spring Into Action
April 13, 2011

ONE ISLAND COMMUNITY ONE ISLAND FUTURE

Provincial Health Structure

In accordance with the ***PEI Health Services Act***, which came into effect in 2009, our health system is comprised of:

- **Department of Health and Wellness**, the Ministry responsible for policy development and administration of publicly funded health services on PEI.

- **Health PEI** is a Crown Corporation responsible for the day-to-day operational delivery of health services in PEI in accordance with policies set out by the Department.

Department of Health and Wellness

Take the go! pei Healthy Living Pledge!
it's good for us all

Minister: Honorable Carolyn Bertram

Deputy Minister: Tracey Cutcliffe

Portfolio:

- Aboriginal Affairs Secretariat
- Chief Health Office
- Finance and Corporate Management
- Health System Planning and Development
- Sport, Recreation and Healthy Living

Health PEI: Governance

Board of Directors - Overview

- Responsible for the operation and delivery of health services
- Appointed by the Minister
- 10 members
- 1 employee: Health PEI President and CEO

- 2 sub-committees: Compliance and Monitoring, Quality and Safety

- Task Group: Public Engagement Task Group

Strategic Direction: Four Main Goals

- **Goal 1: Quality** – Above all else we must ensure that our health system has the capacity to provide safe, dependable, quality care which promotes good health outcomes.

- **Goal 2: Equity** – We will provide fair allocation and timely access to services based on need so that Islanders get the services they need, and need the services they get.

- **Goal 3: Efficiency** – We will use health care resources and information as efficiently as possible, ensure value for money, and make best use of workforce skills.

- **Goal 4: Sustainability** – We will ensure that the health system is stable to meet the needs of current and future generations.

Why Change???

- 32% of Islanders have at least one chronic disease
- 33% of this group use approx 51% of GP visits, 55% of specialist visits and 72% of nights spent in hospital
- Patients with 3 + chronic conditions use 3 times as many hospital or nursing home days, more than 2X as many GP visits, and 1.5X as many specialist consultations than people with no chronic condition
- Only 30% of people with diabetes were being referred to the Prov. Diabetes Education Program.

Why Change???

- In 2006, Islanders with diabetes stayed 3 times longer in hospital, had 2X as many visits to family physicians and specialists than Islanders without diabetes.

- Hypertension has been the leading cause for a visit to health centres

- In a sample of 98 COPD patients at Harbourside HC, 15% were overweight and 55% were obese. Co-morbidity rates were high for cardiac (44%) and hypertension (36%) issues.

Opportunities for Impact

- Provide timely access to key services in targeted areas
- Reduce hospital admissions for people with ambulatory care
- sensitive conditions (national measure of public access to PHC)
- Appropriate length of stay for bed based services (i.e. length of stay for chronic diseases)
- Reduce emergency department utilization
- Improve patient outcomes and satisfaction

Community Hospitals and Primary Health Care

Strategies to Improve Health:

- Primary Health Care Networks
- Integrated Chronic Disease Prevention and Management
- Mental Health Services Strategy
- PEI Organized Stroke Care Model
- Cancer Control Coordination

Primary Care Networks

- Integration of services, accountability, sustainability
- Builds on current delivery sites and augments where necessary to ensure 30 kilometer radius from a Primary Care site for all Islanders - access
- Five Networks are geographically established:

  West Prince, East Prince, Queens West, Queens East and Kings
- Distribution ensures similar population sizes, equitable staff/ resource allocation

Network Elements

- Staffing: Team based model, co-location where possible
- Physician engagement
- Enhanced Access:
  - Smooth transition between programs and services
  - Outreach – capacity to respond to areas of highest need outside a centre, based on criteria
  - Extended hours of service
- Information Technology – capacity to ensure continuity of patient care and increase collaboration
- Management/ Accountability – Provincial management structure to ensure consistent model application, province-wide protocols, standards, etc.

Programs/Services:

Networks:

- Clinical/Medical Based Services
- Health Promotion and Prevention
- Chronic Disease Prevention and Management (e.g Diabetes Education)
- Targeted Screening Programs
- Services to Special Needs Populations

Provincial:

- Community Mental Health, and Community Nutrition
- Future - Public Health Programs

A Typical Network/Centre

- ✓ Integrated Health Providers on Site: Diabetes Educators, Community Dietitians, others based on need
- ✓ Highly Collaborative Model – Patient sees the Right Person at the Right Time, patient-centered care
- ✓ Well-developed chronic disease prevention and management protocols which maximize the scope of all professionals; targeted screening (initial focus on COPD and hypertension)
- ✓ Capacity to respond to patient need on an urgent basis

A Typical Network/Centre

Manager and Administrative Clerical Support

Medical Director

Nursing Clinical Lead

Network Admin Supervisor & Sec/Clerk

Core Team:

- Family Physicians (group of 4 to 8 Family Physicians)
- Nurse Practitioners
- Registered Nurses
- LPNs
- Diabetes Educators
- Administrative and Clerical Staff

Challenges with Implementation

- Time
- Role changes and role clarity
- Communication – consistent messaging
- Educating the public
- Funding – allocation, equity and standardization

Integrated Chronic Disease Prevention and Management (ICDP&M)

- High rates of risk factors and chronic disease in PEI
- Based on the Expanded Chronic Care Model (Wagner)
- Work aligned with the components of the model e.g.

  a) Standardizing patient education materials to increase awareness of risk factors and promote personal responsibility for health (passport to health)

  b) Identifying trainer needs to enhance skills in providing self-management support, promoting optional use of resources
- Testing patient-centred, evidence based care pathways for chronic disease using inter-disciplinary collaborative approach.

ICDP&M

- ABOUT - Increased integration of services within the health system and between the health system and the community
- ABOUT - reducing the utilization of acute care services
- ABOUT – Quality care and quality of life

- Demonstration projects implemented for COPD and Hypertension
- Year one – planning, implementation and evaluation (2011)
- Year two – roll out across networks; commence diabetes pilot project
- Work closely with Department of Health & Wellness and with community based organizations

“Living a Healthy Life”

- Stanford’s Self-Management Program

- A self-management program for people with ongoing health problems, their caregivers and loved ones
- Topics include healthy eating and physical activity, managing symptoms, better communication and how to make daily tasks easier
- Offered in French and English through Department of Health and Wellness
- At various sites across the Island
- 74% retention through 5 pilots and 20 programs

Mental Health Services Strategy & the Networks

- Mental Health Services Strategy was developed to reduce fragmentation and enhance service delivery through a continuum of mental health care, and improved access to mental health care. Networks are part of that continuum.

- Mandate includes providing services through the Networks where primary care is delivered
- Training for Network clinical staff to support patients with mild to moderate and transient anxiety and depression

- Pilot for Collaborative Mental Health, which includes rapid access is being piloted in O'Leary Health Centre.

Mental Health Services Strategy & the Networks

- Defined operational model/ new structure
- Reviewed and revised Crisis Response Protocols (Strategy)
- Completed design for centralized model for childrens' intake
- Reviewed and standardized adult intake for community mental health
- Design for complex case processes nearing completion

- Transition Planning
- strategies to be developed for three priority populations – child/youth, seniors, concurrent disorders
- Human resource strategy for mental health staff

Impacts to Date – Demonstration Projects

COPD : **(Harbourside Clients)**

- Reductions in ED use (30%) and reduced repeat visits to ED (50%)
- Accuracy in diagnosis (39% did not have COPD)

Diabetes: Early results demonstrate that with regular A1C monitoring 15% of diabetic patients can achieve an A1C <7.0%, and 71% can improve their A1C levels

- Provincial diabetes educators integrated into 17 family practices across province.
- Previous diabetes PRIISME project resulted in significant lower rates of blood glucose levels, blood cholesterol and blood pressure.

Impacts to Date

Physician engagement: Physicians collaborating at Parkdale; Physicians at Kensington, Sherwood, Polyclinic, Boardwalk have expressed interest in exploring collaborative initiatives.

Extended hours - Summerside Experience (Harbourside HC)

Reduction at PCH ED: 1000 fewer ER visits for Harbourside patients over a year

Triage levels to PCH ED by Harbourside Clients

- Triage level 4 reduction

  09/10 (1,073) 10/11 (806) - 33.1% reduction

Next Steps:

- Team development in Networks
- Physician and staff engagement continues
- Enhanced staffing as funding allows
- Staff training re: working to scope, sharing the vision
- Health service assessment process underway
- Communication strategy
- Technology and EMR planning with Canada Health Info-way