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Facilitating Care Coordination between Primary care and Referral Consultants

Presented by: Mark Watt, MSc, RN, BN; Paula Hanarahan, BSN, MN, RN; Nancy Dillon, DNP, RN

MARK WATT
Good morning, everyone. I'm so glad that you were able to join us for our, our talk. I think we have a couple of session, a couple of talks in this session. So I'll try to keep this on time and, and Tiff will help me out here. So what I wanted to share with you today is a quality improvement story and yesterday, we heard a little bit about storytelling, the power of storytelling, but I'll leave it up to you to decide if this story is a happy story, a sad story, or something in between. With every good story, there are some protagonists. And so this is our team back home that was working with the myQ in family practice. We have Doctor Brad Bahler, our family physician. Arvelle Balon-Lyon, who is here at the conference. Our practice facilitator, Nancy Dillon and our program manager, Paula Hanrahan. This story takes place in Newfoundland, Canada. And if you've never been to Newfoundland, Canada, it is an absolutely gorgeous place. It is a relatively small population and geographically distributed in many small towns across the island. So we see we have about half a million population, we have about 630 family physicians and at the time that this story takes place, this province is going undergoing some significant change. There is a political agenda to redescribe what health care should look like. What are the health care priorities for this jurisdiction? And so they're undertaking a massive three year consultation and engagement process to draft this--to draft this new proposal. Concurrently, the regional health services which are predominantly responsible for acute care and community services, which had been previously had four jurisdictional boundaries are now coming together under one roof. So we have massive reorganization, political climate change. We've just been through COVID as we have lots of clinician burnout. And so we were looking at this story as like this has got to be a positive story facing all of these conditions. We have a few bright spots. We had a couple of new physician organization programs launched in the province. The first being the Family Practice Renewal Program, which is a quality improvement program to help support family physicians improve quality of care and family practice networks which helps organize family physicians in how they bring priorities to work with health authorities and delivery of care. Both of these are relatively new within a couple of years. So they're just getting their feet wet but definitely bright spots considering all of the change. So the MyQ program that I mentioned is a quality improvement program. Initially we launched to do access and efficiency improvements in practice and the quality of care, improvements in practice, and have seen some mild success. Despite the impact of the pandemic, there was still interest in participating in virtual learning collaboratives, but there's a desire to do more and the desire to do more really took shape in terms of how could family physicians, who are independent

contractors, work with the some health--health authority programs to redesign services. How could they work with referral consultants or specialists in terms of providing care to patients that they could no longer care for in primary care? As I said, well, can we put together a learning collaborative? Would they come? There's no organizing structure for bringing these people together formally as these other organizations are still relatively new. Would it be possible? We had lots of questions in our mind about whether given all of these factors, we would actually see an interest in continuing to do quality improvement in primary care and then more broadly with system partners. So like every good story, we're running on a very quick timeline. We had four weeks to engage individuals in the province around this opportunity. And you can see that, you know, we started with working with primary care physicians and asking them the question of where do you have opportunities to improve care coordination with a referral partner? And they were quick to come forward. They said yes, you know, we're experiencing lots of problems. We'd love to work with a referral coordinator to start to iron things out, but we don't know who they are. Many times in the Regional Health Authority, they didn't know the person that they actually were referring them to. They didn't know how to even contact them to say, hey, would you like to do this with me? So, while we had 14 primary care physicians, which, which represents one physician for a practice. So the practice size and influence about 3 to 4 physicians per practice. So, as we were engaging with family physicians and then starting to work through, you know, who would be the best referral agency or specialist provider to work with? It had lots of contacts which didn't actually result in many matches. So we might have met with the Regional Health Authority program. No, thanks. We're not interested, we have too much change going on, work with a specialist. So this is not something we can take on right now without, without more support. And speaking of support, the only support we were able to provide were honoraria for physician participation and some CME credits. So we didn't have a lot here. We had a lot of adversity and relatively low engagement. So we came to this challenging part of our story. We where we said, is this worth going forward? Should we continue this, is this something that really will be impactful for this jurisdiction or not? We did. We said, you know what we think that there are going to be other and intended improvements beyond just what would happen with improving care between these two organizations. So this is what our participation in our seven month learning collaborative looked like, which had 4 three- hour sessions with a one hour touch point in between. So relatively short duration and short contact. And what it was that those teams were trying to improve in this scenario? The teams were focused, as you can see here, were around improving referrals to gastroenterology, and to a regional health program for heart failure. So we got them together. We said, let's talk about the issues. What are the issues that you're facing that really we could work on together to make an improvement? And you know, I don't think there'd be any surprises here. I think these are the challenges that you face day to day when coordinating with partners. Information exchange is a problem, not knowing if referrals are accepted or, or how long those referrals will take. You know, what, what information is important for the specialist to receive? What information is important for primary care providers to have? How do we manage in the uncertainty when we're not sure that there's a diagnosis yet? Who's doing what in follow up? Those are the kinds of issues that the providers were speaking to and were hoping to make some progress

towards. We agreed that there were going to be, in this care coordination agreement, which was not going to be a negotiate. This wasn't a service contract that we were looking to explore. We were trying to use quality improvement principles. So we said, well, let's establish some groundwork of, you know, what are the principles that these groups would be agreeing to do in order to make the improvements in the problems that they were having? And really it boiled down to these five principles: sender, send the work right away right away. So meaning the right information is going so the receiver can do the right next step. The receiver does the work right away. So, trying to avoid triage and delay and access in finding that access for that patient. We agreed that it was important that both parties felt that their needs were met in, in any of the decisions that were moving forward, that we had a strong focus on eliminating a delay. And that was some of our biggest problems. We had sometimes wait times of up to a year to access some specialty care. And then lastly, we didn't want this to not have any meaningful impact long term. There was an agreement that we would monitor this quality movement agreement for a period of time. So, what did they do? So in this short period of time with these very small people, a small number of groups, we identified some of the most important things that they needed to work on, which were around creating guidelines for the management and assessment of referrals. So which of those needed to move quickly? Which of those actually didn't need to move to specialty at all? It could be better managed in primary care with some additional supports. We were able to remove delays by, in the heart failure clinic, by instead of requiring an echocardiogram as a definitive mechanism to access service, we were able to shift to using BNP, thereby cutting out, you know, an eight month delay in accessing care and potentially all the poor associated outcomes. So, we were really proud that these teams really came together with a gusto to make some significant improvements and really redesigned things that were without their control individually. These were things about how did they come together and decide together to make some important changes in how they were going to support patients in a new way. So I wanna talk a little bit about the role of the practice facilitator in this because that's really why we're here today. And the role of practice facilitator really helped them streamline their streamline documentation and information exchange. They started talking very quickly about their expectations. But in that talking, there was a lot of assumptions about what was meant. And so the practice facilitator because they're not a content expert, was able to pause and say, tell me more about this, what exactly about this is needed. And it was funny, it wasn't just the practice facilitator that didn't actually understand the assumption. It was also the other side and they were just too, they were not willing to state that they didn't understand that assumption. So by the fact that we were that neutral third party, we could ask all of the silly questions. It really did create a new level of understanding about what the expectations were on each side. An example would be close the communication. One party thought it was fine. It's in the system, somebody can look it up. Well, there was an assumption that the other party had access to that scheduling system to see it. And so they decided, you know, what, let's take some of the guesswork out of this and let's actually be proactive and send information. And so small changes like that really started to improve how the groups work together. Care coordination was messy. It was very, very complex in terms of who is doing what and a lot of assumptions about, oh, you're doing that? Oh, I was doing that or you don't do that?

Well, that's a mistake. Like we've got a gaffe. And so we spent a lot of time helping them clarify around the different roles and responsibilities across, you know, teams of like 8 or 12 people. So that was a really valued piece that the practice facilitator brought was around that clarifying expectations and defining processes. And of course, there was a lot of energy and a lot of agreement we were able to achieve. But at the end of the day, it really came down to who's gonna document this because, of course, as we have staff turnover, as we have, you know, shifts in our context, what are we going to do, that's going to keep us on track with what we said we were going to do? So we played a, a bit of a role in helping them document. I guess we had this idea when we started this program that, oh, there must be this kind of a template out there somewhere. We can just go and grab that and we'll be fine. And so today, we wanted to bring it here to say, not that we think that ours is perfect, but we know that you always appreciate something practical to take away. So this ended up being our template for the two groups to say, if you're looking to do something in a quality improvement way with care coordination, here's a starting point. So please make it better. Please share. So at the end of our story, we had small numbers, but there was a lot of assumptions, a lot of clarity, a lot of relationship building that was accomplished through our time working with these practices. They have told us that they feel much more confident now when they're back at committee, back at provincial tables to be advocating for the right things. So, again, here are some very specific things like the BNP test was not provincially available to all physicians. We had to get an exemption from this family physician to order it in order for them to access care. Now, they're advocating for family physicians to have broader access to laboratory testing that they need to fulfill referral requirements to keep close the communication again. So not assuming that just because you put things in the system that would be able to have access to it. So there's a lot of intangibles that will allow care coordination to scale, but we wouldn't have known them without taking the time to do these small tests of change. They work with small numbers. So I'll leave it to you to judge this story. If this was a happy story, was a sad story, or somewhere in between. And my take on the answer to that story: One day, a man was walking along the beach when he noticed a boy picking something up and gently throwing it into the ocean approaching the boy. He asked, what are you doing? The youth replied, throwing starfish back into the ocean. Surf is up, the tide is going out. If I don't throw them back, they'll die. Son, the man man said, don't you realize there are miles and miles of beach and hundreds of starfish? You can't possibly make a difference. After listening politely, the boy bent down, picked up another starfish and threw it back into the surf. Then smiling at the man, he said, "I made a difference for that one."

AUDIENCE MEMBER
Once you gathered all the information. were there any challenges to relaying that information back? Say if you're working with the primary care, getting that information back to them to kind of implement those changes.

MARK WATT
Yeah, the....there was a hope that we'd be able to use some electronic, secure electronic messaging. They weren't on the same systems. We thought we'd be able to do that. We

ended up not doing this. We defaulted to paper and facts, which again, it means a process that's gonna be fraught with change. The biggest improvement that we had there was around the clarity of when we're sending patients back to primary care here is generally the order in which we're going to make changes to their care moving forward. And that was their biggest improvement is, oh, ok. So now as a primary care physician, if I've tried the first line things, I can try the second line things without re-referring them back to you. So we started to decrease the the demand on specialty care to manage everything. So that was the biggest thing. But though the specialty care providers were very happy once they understood the gap to fulfill it. Yeah.

AUDIENCE MEMBER
Was it hard? I'm assuming that you were working with primary care practices. So, was it hard as a as a practice facilitator? Because I'm not sure how you're set up, you're working with primary care, but to even get in the door to the special, the specialty services and, you know, for them to be welcoming to you who is just you and they probably don't know you.

MARK WATT
So we probably had something as an advantage to us. So the advantage, though they didn't know us. You're right. So when we picked up the phone and called, they did answer, they let us come in and present to them the opportunity, they probably didn't realize that we were a family physician program support. And so we were able to leverage that. We're a neutral third party, which allowed us to build trust on both sides relatively quickly. So had, you know, so you get, yeah, whether that's an advantage or disadvantage we were able to get in and we were able to play that neutral party without necessarily, you know, kind of saying we're, our interests here are around improving primary care. Yeah.

AUDIENCE MEMBER
Are there any plans to disseminate some of these learnings to some of the practices that had expressed interest? But then didn't actually sign up?

MARK WATT
Yeah. So I mentioned the Family Practice Network. So coincidentally, like they wanted to improve coordinated care, but they just, you know, they were doing it in committees and there was just, there were lots of impasses. So what we were able to do is produce these as some, we have some good news stories that are, we should, should have shared about those as well to have the FPNs disseminate. So not just those who expressed interest but also to all of their membership. So we actually have plans to do that. And then that's why I think this is gonna be so important to say, what were the critical pieces that we learn and share them? So that way both constituents know that, oh, these guys are really talking practically about some of the issues that we face. So yeah, we do have plans. And so if that's us, then we'll turn it over to who's next. Thanks so much.