Alberta College of Family Physicians

ACFP | Medical Home Leadership Forum
Synopsis : December 3, 2011

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Executive Summary

The Alberta College of Family Physicians (ACFP) supports the College of Family Physicians of Canada's (CFPC's) vision of the Patient's Medical Home (PMH), which, as described by CFPC past president Dr. Robert Boulay, "aims to meet the needs of Canadians for a family practice which will serve as the hub, or home base, to provide or arrange and coordinate the range of medical and health care services needed by its patients."

MEDICAL HOME LEADERSHIP FORUM

On December 3, 2011, the ACFP hosted a Medical Home Leadership Forum that brought together a group of Alberta family physician leaders to discuss and explore the PMH concept—its fundamental principles, structure, and potential to improve the quality and delivery of medical care in Alberta.

The one-day forum was held in Edmonton, and 39 participants from across the province were in attendance.

PROGRAM OVERVIEW

The forum consisted of two keynote presentations, followed by group discussions and a conclusion.

Dr. Calvin Gutkin, CEO of the CFPC, presented *The Wonder of the Medical Home – Its Vision and Principles!*, which explained the core elements of the PMH, and suggested potential mechanisms for implementation of the model.

Dr. Susan Lieff, professor and vice-chair of education in the Department of Psychiatry at the University of Toronto, presented *Leadership Primer for the Medical Home*, which sought to inspire critical thinking about different types and techniques of leadership that could co-exist in the PMH, and to challenge the notion of traditional leadership.

In the second half of the forum, attendees broke into small groups to share their personal experiences within their practices and communities, elements of the PMH that already exist in their practices, and ways that others could be incorporated.

RESULTS

Due to the broad range of the practice types represented, many different scenarios of team-based care were discussed.

Throughout the discussions, overarching themes of a shared vision, adaptive leadership, evolution from traditional silos into integrated teams, role clarity, infrastructure support, and adequate time and resources for team building emerged.

IMPLICATIONS FOR PRACTICE OR POLICY

The Medical Home Leadership Forum encouraged dynamic discussion that identified successes, challenges, and potential strategies for incorporating components of the PMH into different practice models throughout Alberta. The results of these discussions will be used to inform policy and practice through education, research, and advocacy by the ACFP. Continued discussions and initiatives to further promote the PMH concept will be supported by the rich dialogue at this event.

FUTURE DIRECTIONS

Forum participants valued the opportunity to learn more about and discuss the PMH concept, exchange ideas and experiences with their colleagues, and explore how the PMH could work in their practices and in Alberta's health care system.

The implementation and use of the PMH will continue to evolve; much like the health care system itself, the PMH model calls for constant critical adaptation and adjustment. The PMH is a pivotal component in the journey toward true patient-centred, adaptive health care services.

Some family physicians' practices already resemble a PMH; they have been working in team capacities to deliver care for years.

Synopsis

FORUM PURPOSE

There is an increasing demand for patient-centred primary health care, delivered by multidisciplinary teams with family physicians practising comprehensive care and by those with focused practices working in collaborative teams—e.g., Primary Care Networks (PCNs), Family Care Clinics, and Clinical Networks.

The purpose of the Medical Home Leadership Forum was to provide a backdrop for Alberta family physician leaders to explore the many facets of the PMH and how it correlates to their own practices, as well as how the PMH model could meet current demand and ultimately improve the delivery and quality of health care in Alberta.

Overall, the interactive forum was an important step toward improving patient care and strengthening relationships among health care providers, as well as between providers and patients. The forum initiated educational dialogue, challenged beliefs and values, instilled ideas, and identified potential actions necessary to build on the success of existing PMH models in Alberta.

FORUM OBJECTIVES

- Explore the PMH model and discuss the role of family physicians practising within this model in various clinical settings in Alberta.
- Network with a diverse group of family physician leaders to share experiences with the PMH model and its existence in various practices and settings in Alberta.
- Identify barriers and challenges in various practices and settings, and strategies for improving communication and collaboration among team members.
- Highlight successes, proven methods and practices of collaboration, and ways these can be built upon.
- Explore the broad competencies of family physicians and their relationships with other health care professionals to determine whether these can be applied in a wide variety of clinical practice settings.
- Strengthen participant knowledge of PMH to enable the sharing of key messages and findings from the Medical Home Leadership Forum with colleagues and stakeholders in communities throughout the province.

PARTICIPANTS

To collect a useful cross-section of ideas and experiences, the ACFP invited family physicians from across the province to attend the forum, representing rural and urban communities including Grande Prairie, Red Deer, Rimbey, Taber, Lethbridge, Sundre, Pincher Creek, Spruce Grove, Calahoo, St. Paul, Vulcan, Olds, Peace River, Edmonton, and Calgary.

Physician practice settings, backgrounds, and roles included community-based family medicine, teaching clinic, maternity, satellite clinic, First Nations health care, hospitalist, emergency, and palliative care. (Appendix 1 includes a list of physicians who attended the event, including a description of their background and their unique practice.)

FORUM CONTENT AND PROCESS

ACFP president Dr. Paul Humphries welcomed participants and challenged his colleagues to:

- Question and explore values
- Consider, embrace, and build on others' ideas
- Learn from and share with one another

Two keynote sessions were then presented by Dr. Calvin Gutkin and Dr. Susan Lieff. The afternoon consisted of small group breakout discussions and concluded with a discussion of next steps.

KEYNOTE PRESENTATIONS

To set the stage for the forum, and to generate ideas and questions for the small group discussion segment of the program, two keynote sessions were presented.

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

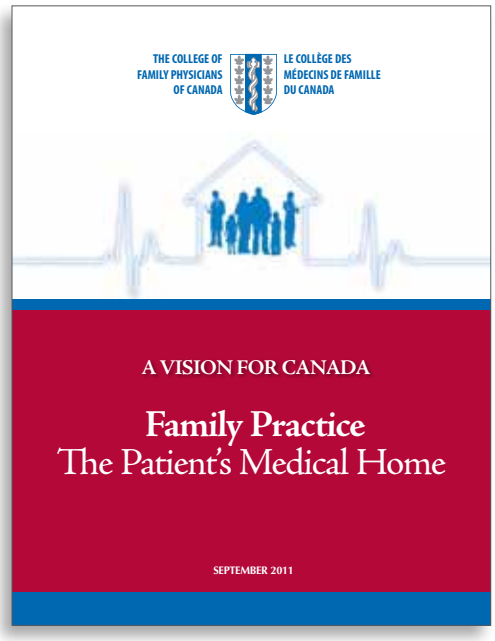
The Wonder of the Medical Home – Its Vision and Principles!
Dr. Calvin Gutkin, MD, CCFP, FCFP, CEO – CFPC (Mississauga, ON)

Dr. Gutkin described the foundation of the PMH.

PMH Definition
The CFPC defines the PMH as follows:

- A family practice defined by its patients as the place they feel most comfortable—most at home—to present and discuss their personal and family health and medical concerns
- The central hub for the timely provision and coordination of a comprehensive menu of health and medical services patients need

- A place where patients, their families, and their personal caregivers are listened to and respected as active participants in both decision making and the provision of their ongoing care
- The home base for the continuous interaction between patients and their personal family physicians, who are the most responsible providers of their medical care
- A place where a team or network of caregivers including nurses, physician assistants, and other health professionals—located at the same physical site or linked virtually from different practice sites throughout the local or extended community—work together with the patient's personal family physician to provide and coordinate a comprehensive range of medical and health care services



- A place where patient–doctor, patient–nurse, and other therapeutic relationships are developed and strengthened over time, enabling the best possible health outcomes for each person, the practice population, and the community being served

PMH Objectives

1. Every person in Canada will have the opportunity to be part of a family practice that serves as a PMH for themselves and their families.
2. PMHs will produce the best possible health outcomes for the patients, the practice populations, and the communities they serve.
3. PMHs will reinforce the importance of the Four Principles of Family Medicine for both family physicians and their patients.

Figure 1: The Pillars of the PMH

PMH Goals

1. A PMH will be patient centred.
2. A PMH will ensure that every patient has a personal family physician who will be the most responsible provider of his or her medical care.
3. A PMH will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician working together with peer physicians, nurses, and others.
4. A PMH will ensure i) timely access to appointments in the practice, and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice.
5. A PMH will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.
6. A PMH will provide continuity of care, relationships, and information for its patients.
7. A PMH will maintain electronic medical records (EMRs) for its patients.
8. PMHs will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research.
9. A PMH will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI).
10. PMHs will be strongly supported i) internally, through governance and management structures defined by each practice, and ii) externally by all stakeholders, including governments, the public, and other medical and health professions and their organizations across Canada.

Figure 2: The PMH in the Community

Dr. Gutkin also provided insight into incorporating these elements into any practice regardless of team composition and size, practice setting, or location.

A Leadership Primer for the Medical Home

Dr. Susan Lieff, MD, MEd, FRCPC (Toronto, ON)

Dr. Lieff's presentation inspired critical thinking about leadership types and techniques, challenged the traditional notion of leadership, and prompted participants to examine different leadership styles that could be successful and applied in the PMH.

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Participants evaluated the relevance of mental models of leadership for working in a health care network. Dr. Lieff challenged hidden assumptions and beliefs about leaders and the work of leaders, pointing out that leadership thinking has evolved in order to cope with complexity.

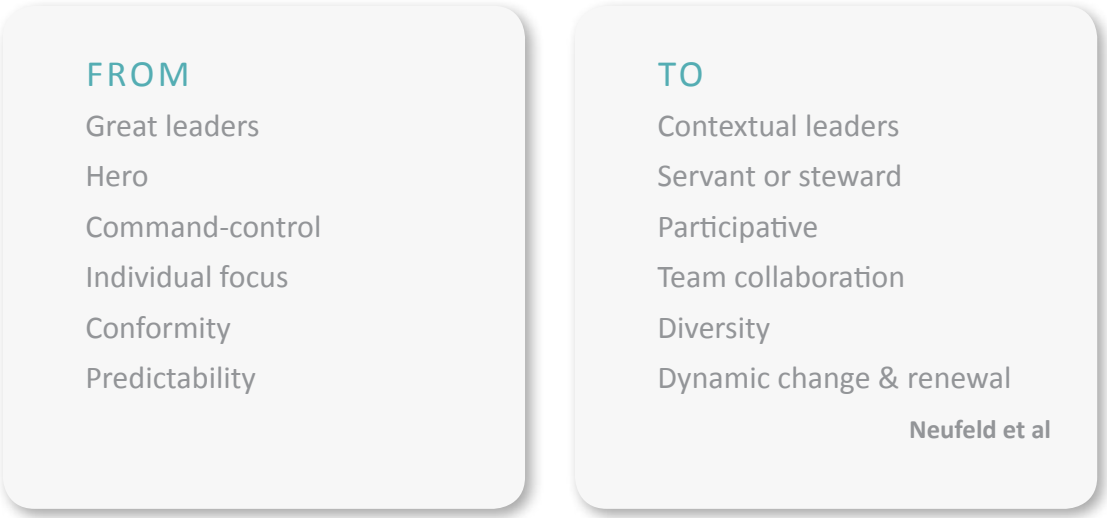


Figure 3: The Evolution of Leadership (Neufeld et al)

Participants were encouraged to reflect on why networks and teams are needed to manage the health care of our communities. Dr. Lieff hypothesized that the intensive work of family physicians involves patients and communities with complicated and complex health care needs. She compared the agreement on process and certainty of outcomes for three levels of issues: simple or known, complicated or knowable, and complex or unknowable (Stacey, 1966).

Participants considered the following paradigms of leadership for simple, complicated, and complex issues:

- **Community-ship and Engaged Leadership** (Mintzberg, 2009) is a modest, distributed construct within an engaged community in which everyone can exercise initiative.
- **Adaptive Leadership** (Heifetz, 2003) is based on the idea that leadership is not about expertise, providing solutions, and taking problems off others' shoulders but about being improvisational and experimental. This paradigm works when issues can't be resolved by expert knowledge and routine; it is adaptive. The role of the adaptive leader is to enable, learn "their way," shift the focus of responsibility to people at all levels, "get on the balcony," and have confidence in the group.
- **Leaderful Practice** (Boston Consortium, 2005) is democratic and humanistic. Leadership is not centred on any one individual; more than one leader operates at one time. This practice derives from people working together to a common purpose, and anyone can rise to serve the group need. In this collaborative and compassionate paradigm, every member is valued.

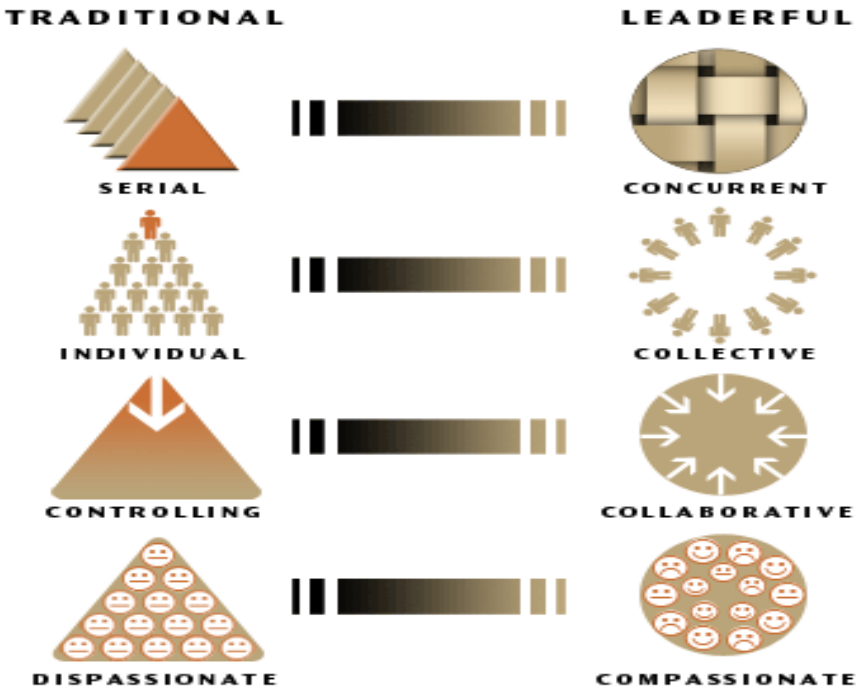


Figure 4: The Tenets of Leaderful Practice vs. the Traditional Model (the Boston Consortium, 2005)

Dr. Leiff asked participants, "Could any of these paradigms relate to your practice? How?" and gave the table groups an opportunity to briefly discuss and reflect on the questions. This facilitated session acted as a warm-up for the reflective and energetic dialogue to follow.

Common Themes and Overarching Threads

Participants separated into small groups to share personal experiences in their practices and communities. A facilitator and recorder were present in each group to lead discussions and record comments. During discussions, a series of thought-provoking questions were posed to participants to generate stories of successes and challenges, as well as possible strategies for where and how the PMH could be implemented in practice.

COMMON VISION, GOALS, AND VALUES

Participants expressed a common need for a shared vision, mission statement, and goals that would help shape their teams and practices. Individuals must understand how they fit into the big picture and contribute to the vision; it is much easier to motivate people who are inspired and recognize their purpose.

Participants spoke of current medical cultures and acknowledged the need for a paradigm shift that embraces teamwork, accepts change, and supports innovation. For a PMH model to work effectively, environments must be respectful and encourage knowledge sharing and open communication.

In view of the complexity of the health care system and the changing environments in which the participants operate, strategic plans must be continuously reviewed to meet the changing needs of the patient, the team, and the practice.

Many teams are very focused on the team—organizing the work so it works for the team, not the patient.

Putting the patient first and having the team work around patient needs makes much more sense.

PRACTICE AND TEAM SIZES

Many participants felt that small practice teams were easier to implement and worked as a more flexible and efficient unit than large teams. The consensus is that it is easier to allocate funds and resources to small teams than to large teams, which are more time consuming and therefore more expensive.

In comparison to large teams, small teams were perceived by many to be better at communicating, as well as including and appreciating each health care professional and minimizing role ambiguity. Team members must feel that their opinions are heard and valued, and that they are acknowledged for their role in patient care.

Participants stressed that small teams positively impact their practice and patients. With small teams, patients are more actively involved in their own care, patient and clinical satisfaction improve, and relationships between patients and health service providers and among health service providers improve.

MULTIDISCIPLINARY TEAMS

Composition

Given participants' varied backgrounds, their teams, communities, and practice settings also varied. Some teams included an individual family physician and nurse, while others were composed of several health care service providers (e.g., family and other physicians, licensed practical nurses, registered nurses, nurse practitioners, physician assistants, dieticians, occupational therapists, and social workers).

Professional Silos and Integrated Teams

Participants recognized a need for integrated teams to improve patient care and outcomes. Team members can take the following measures to support and strengthen working relationships and team cohesiveness:

- Understand each team member's contribution to patient care.
- Appreciate the individual expertise of each health professional on the team.
- Improve relationships between patients and the team.
- Discard stereotypes and negative attitudes toward other professional groups.
- Develop distinct roles for each team member based on professional skills.
- Develop and proactively employ team protocols for various patients and clinical issues.
- Use member skills and abilities to facilitate care of specific types of patients to ensure the right care is provided at the right time, in the right setting, and by the right professional.

Collaboration

Many success stories were shared about collaborative teams improving access, efficiency, and patient care.

Nurses are valuable members of the team. In one clinic, the development and implementation of nurse protocols has led to a more streamlined process, improved patient access and care, and increased average visit times with the physician.

Other examples:

- A licensed practical nurse has patients complete a series of initial tests (e.g., blood work or blood pressure) prior to seeing the physician, resulting in more efficient care, and ensuring they receive the required screening for their needs.
- Nurses perform diabetes management, encouraging and counselling patients on any difficulties they may encounter, which can decrease hospital visits.
- In a clinic with a large elderly population, two nursing assistants complement two registered nurses. The nursing assistants perform the time-consuming task of creating complex care plans for the patient, allowing physicians more time with patients.
- Physicians also noted that some patients prefer to see a nurse and their doctor in the same clinic, in one clinic visit.

In addition to nurses, other medical professionals also ease the demand for physician attention. Physicians spoke of strong collegial support and team members covering for each other in team-based practice settings/clinics, leading to improvement in team members' work-life balance.

Patient and Team Relationships

Patients must recognize and respect all health care professionals as part of the team responsible for their health care. The following are participant suggestions for improving rapport between patients and team members:

- Educate the patient on clinical processes and delivery of care.
- Introduce the patient to team members involved in their care and explain the vital role each health care professional plays in the overall care plan.

Supporting Multidisciplinary Teams

Adequate time, resources, and support are required to build, implement, and strengthen the PMH. This allows teams to:

- Collaboratively develop time management strategies to foster a more accessible and efficient practice
- Define roles and responsibilities
- Continually develop, review, and revise plans and strategies as needed

Participants discussed team-building initiatives that have benefited their practice. For example, some physicians have participated in and highly recommend the Access Improvement Measures (AIM) Program.* Alberta AIM assists physicians and their teams to focus on access, efficiency, and clinical care improvements.

The chart below describes factors that foster a team environment, those that impede successful teamwork, and some strategies that are useful in building successful teams.

Factors supporting multidisciplinary teamwork	Factors impeding multidisciplinary teamwork	Strategies to support multidisciplinary teamwork
• Committed members who play a key role in team development • Staff with a common purpose or vision, who work together to achieve it • Clearly defined team roles and responsibilities • Explicit support for such development at the organizational level	• Lack of appropriate space and resources • Lack of knowledge about other health care professionals, scope of practice, roles, and professional training • Attitudes that reinforce stereotypes and archaic professional hierarchies	• Integrate procedures and perspectives to improve patient-centred care • Take the opportunity to learn from and about one other • Reflect critically on one's own knowledge base • Surrender certain aspects of professional role where reasonable • Share knowledge and insight with the team to develop a common understanding • Train staff initially and in service to prepare for working in and leading teams • Encourage interdisciplinary training in schools

**** The AIM Program is an initiative of Alberta Health and Wellness, the Alberta Medical Association, Health Regions, and Primary Care Networks.***

Alternative Models of Delivery

Participants recognized that traditional models of delivery may not be feasible or optimal, and that new models of care are always emerging. Some shared examples of success that other clinics could build upon.

Population-focused care is care delivered to groups with similar conditions. Delivering care in this way allows resources to be better allocated and access improved. Participants cited cases in which group education and care led by the appropriate health professional are helpful for those with chronic care.

When patients are the focus, care must be available and accessible to all. Some patients may not be able to access the health care system in the traditional manner due to age or health status, for example. In these cases, health care professionals should consider these unique patient needs and develop innovative solutions. Patients should be provided with care in the most appropriate place (e.g., homes, institutions, senior care facilities).

Specific examples:

- One team examined ways to improve primary care access for Aboriginal women on a reserve. They achieved success by providing patients with access to services at night, and by having a female physician visit patients door-to-door.
- In another community, physicians began visiting the Supported Living (SL) 2 and SL3 senior homes to facilitate access for seniors. As a result, more patients had access to clinic time, so patient satisfaction increased.
- A team offered an STI clinic for a half-day each week at a lodge, where a major shift occurred once the clinic came to the patient, rather than the opposite.

ACCOUNTABILITY AND MEASURES

Data quality and access to patient information are essential. Limited access to information can affect assessment outcomes, planning changes, testing solutions, and informed decision making. Indicators and data should be designed and based on the team's needs and goals. Data collection could include patient and team member satisfaction, access, demographics, and other proactive measures of needs that link directly to the common goals of effective teams and high-quality care. For example, patient feedback can be used to assess a team's effectiveness.

Timely access to accurate data has the potential to enhance and encourage evidence-based decision making and allow for standardization and linkage of data sets. Finally, timely access can enhance the capacity for valid comparison and trending.

ADEQUATE RESOURCES AND SUPPORT

Family physicians are typically the first line of contact for patients in need of health advice or care; they are the professionals responsible for coordinating access to other areas of the health care system. With limited access to physicians or primary care teams, often patients have no choice but to enter the health care system through the emergency room (ER). Improving access to physicians, nurses, and other health care providers can reduce the pressure on ERs. For example, by using a team-based approach (a respiratory technologist, a nurse, and a physician) that specifically targets asthma patients, one clinic has experienced a drop in emergency care required by asthma patients.

Forum participants felt that adequate funding must be made available for physicians, teams, and infrastructure. This includes funding for physical space, technical equipment (e.g., EMRs and computers), and adequate compensation to cover all contributing team members' time. It is not realistic for physicians to personally provide this funding unless they are reasonably compensated.

Participants believed that sufficient and adequate physical space is required for service delivery, as well as for meetings to share knowledge and best practices. The needs of the community, patients, and team must be considered when determining an appropriate location and site design (e.g., access to high-risk groups, mobility issues, bus routes, safe parking, easy accessibility).

Resources must also be allocated to support electronic technology. All team members require access to up-to-date, comprehensive patient information in order to make informed decisions and deliver high-quality patient care. EMRs should be easily accessible to all staff, along with electronic information and telecommunication technology to support long-distance clinical health care, professional health-related education, public health, and administration.

Participants also identified the need for more effective resource allocation, suggesting that it is possible to share staff and resources among practices/clinics in a more efficient manner (e.g., a dietitian working at several clinics streamlined the processes).

Forum participants recognized that the development and implementation of successful teams will not occur overnight. Long-term, predictable, and sufficient investment in primary care and health care teams is required.

PMH FLEXIBILITY

Participants expressed a need for the PMH to complement their individual practice needs. The PMH is not a one-size-fits-all model. Team members must be flexible in their approach; the delivery of care may vary with each patient and clinic location. The network and team must be flexible enough to meet solo practice needs, while also bearing broader goals in mind.

Despite this variation, the universal goal of the PMH is to ensure patients have accessible, high-quality, individualized care, delivered in the most efficient manner by the appropriate health care professional.

COMMUNICATION STRATEGIES

Effective communication requires a common vision, role clarity, and a trusting environment. The quality of care depends to a large extent upon the quality of information shared. Forum participants discussed communication methods used in their practices; these varied depending on patient needs, team, and location.

Patient-Physician Communication

Communication between patients and health care providers empowers patients with the knowledge and information they require to actively participate in their care. Common forms of communication include sharing and discussing pertinent information, using websites (managed by a clinic manager) that provide general health information to the community, and using computer programs that inform patients of new health issues or programs (e.g., eight-week smoking cessation programs).

Physician Communication with Locums and New Learners

Participants stressed the need for a mechanism to keep new and part-time practitioners regularly informed and updated to ensure they can practise at full capacity. For example, one team uses a communal notebook that describes the practice, available resources, and contacts to help integrate individuals into the practice.

> *"Information" and "communication" are often used interchangeably, but they signify quite different things. Information is giving out; communication is getting through.*
>
> **Sydney J. Harris**

Communicating with Other Health Care Professionals

Communication is essential to sharing knowledge and best practices. Participants discussed the following forms of communication:

Staff/Team Meetings

- Meetings range from a five-minute briefing to a half-day meeting—weekly, monthly, and/or annually.
- They involve all staff/team members.
- Meeting participants discuss patients; share best practices; and evaluate practice management issues, staffing issues, and practice redesigns.

Skype, Tele-Health, Video Conferencing

- These technologies allow off-site, rural, and remote physicians the opportunity to attend meetings and sessions and interact with other physicians in different communities and clinics.
- Some physicians and health care professionals hold monthly tele-health sessions on rheumatology.

Electronic Communication

- Electronic communications tools promote better communication and are crucial to efficiency and clarity. Common electronic tools that are being used to improve patient care include email, electronic newsletters, and EMRs.
- One clinic uses EMRs and has added other physicians (e.g., surgeons, obstetricians, orthopaedics, psychiatrists) as clients to the server, resulting in paperless communication between health care professionals.

Evaluations/Process Updates

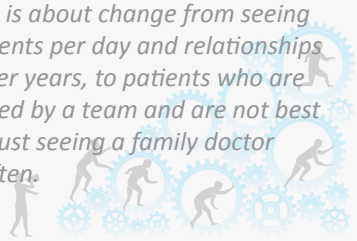
- Process updates can help notify the team of the next available appointment times.
- Updates keep all physicians current on what their colleagues are doing so they can collaborate and complement one another's work as needed.
- Staff evaluations are an opportunity for staff to candidly discuss successes and challenges, identify issues early on, and make adjustments as a team.

Communication with the Greater Health Care Community

- One common practice is to hold meetings with PCNs to discuss and gain insight into different processes used at different sites.
- Physicians from a number of small towns gather on the first Tuesday of every month to discuss common issues and concerns.
- Many practices use peer review processes for charts (especially deaths) and sharing of interesting cases.

Communication takes time and resources. Participants were concerned that although reviewing files, coordinating care, and attending meetings are valuable activities that improve their ability to provide care and maintain strong interdisciplinary teams, they can be time consuming, often lead to more administrative duties, and may cause delays in meeting clinic demands. It was suggested that additional time could be better spent with patients. It is important for physicians and teams to recognize that effective communication will streamline processes, improve interaction between teams, and ultimately improve care delivery.

Leadership is about change from seeing 30–35 patients per day and relationships built up over years, to patients who are better served by a team and are not best served by just seeing a family doctor every so often.



Small Group Discussions

A series of thought-provoking questions were posed to participants during discussions as prompts to describe scenarios of team-based care in current practices, successes, challenges, and ways these could be applied to the PMH model.

LEADERSHIP ROLE

What do you see as the role of the physician with regard to leadership in the PMH?

Although a physician may not necessarily be leading the team at any given moment, he or she ultimately bears full responsibility for the patient's care.

Participants agreed that the main focus of the PMH is the patient; leadership goals should be shaped by patient needs. The family physician guides the tone, goals, and culture of the team by coordinating care, collaborating with other health care professionals and building and strengthening working relationships.

One discussion group described the "flower model," which uses a sunflower to represent the traditional delivery of physician care. The large centre represents the physician as the core leader and decision maker. The group noted that, in fact, the ideal flower model for the PMH would be the daisy—with a small centre and large petals. Using this analogy, the physician is at the centre of patient care and the large petals represent the team, who perform duties that match their competencies and skill sets. Participants acknowledged that in order for the "daisy model" to flourish there must be an environment of trust, respect, commitment, effective communication, and confidence in other health care providers. Everyone must be on the same page so the patient does not receive mixed messages.

The importance of adaptive leadership and roles and how they vary depending on the team setting, practice, and unique patient needs were also discussed. For example, a mental health professional may lead a session on cognitive behavioural therapy, a palliative care nurse with extensive knowledge and expertise relating to a specific patient may take the lead on that team, a physician may lead and coordinate care of a complex medical patient, and a health care administrator may lead office and finance issues.

Participants agreed that there must be adequate information and knowledge transfer between team members to ensure effective continuity of care. For example, physicians must have complete and accurate patient information to confidently approve or make decisions. This requires the use of communications tools such as EMRs and regular team meetings. Ideally, in a patient-centred model, patients would be provided with all the available information and

options, allowing them to make an informed decision. However, some patients will instead ask the physician to decide which option is acceptable, as long as the physician has complete and accurate patient information.

Colleges and associations representing health care professionals must collaboratively define roles and responsibilities and assess which roles can be delegated to or shared with others.

PHYSICIAN AS GATEKEEPER

Where can we find, or how can we create, opportunities to remove the physician as gatekeeper to allow multiple points of access to other members of the collaborative team without specific approval from the family physician?

Patients access health care services in different ways depending on the clinic, setting, patient needs, and physician or team. With this in mind, participants discussed various modes of referral:

Self-Referral

Some participants found it important to allow patients to directly access another health care professional (e.g., mental health, dietician, social worker) but recognized that family physicians must have access to information from these consultations. In certain rural areas, patients can book appointments with other health care professionals without first visiting their family physician. In this case, the family physician receives a follow-up email informing him or her of the patient's visit, and must follow up on visit notes. Again, this requires additional time and resources, which must be reflected in funding models and resource allocation. Participants expressed concerns that patients would overuse or misuse services if they were left to self-referral. This issue could be addressed by educating patients and providing them with the knowledge and resources to accurately refer themselves.

Referral through Family Physician

Many participants felt that the role of the family physician as gatekeeper was a positive mechanism; however, there were concerns about practising in a system in which patients do not have a family doctor. Participant consensus was that all patients should have a regular physician and that physicians cannot care for a large number of patients without the assistance of other health care professionals. Undiagnosed patients require the expertise of a physician, and the gatekeeper role is therefore pivotal in generating a diagnosis. Once the patient is diagnosed, other team members can become involved. In one example, the first appointment with another health care professional is made by a family physician, but subsequent visits are made by the patient.

Participants viewed the family physician as the "quarterback" who educates patients on available resources (not all resources are available to everyone—based on location, needs, age). The family physician/clinic must maintain up-to-date information on these resources in order to lead the patient in the right direction.

Some participants have found success in introducing patients to the entire health care

team on their first visit. This practice builds rapport and trust between the patient, the physician, and other health care professionals on the team. The patient must understand the role of each team member to feel fully confident in the care plan

Referral by Other Health Care Professionals

Participants described situations in which health care providers refer patients to other health care professionals. For example, in one town, mental health personnel refer patients to a psychiatrist if deemed necessary, without the family physician's approval. However, the family physician is informed of the referral to ensure continuity of care.

Participants discussed a concern about the need for physicians to better prepare their patients to see other health care professionals. One clinic uses EMRs to make charts readily accessible. This practice also enables nurses or other team members to refer patients.

PMH

Is it just a fad?

Current models of care require critical examination and adjustment to ensure the effective delivery of care, and to meet the demands of an ever-evolving environment. The PMH is a viable solution that can increase patient access and satisfaction, has the potential to alleviate constraints on the health care system, and offers the shared benefits of teamwork to help reduce the burnout rate of health care professionals.

The strength of the PMH model is the team foundation. Implementation will require the support of all health care professionals, organizations, and stakeholders, but has the potential to succeed with commitment, perseverance, and action. Examples of PMH are beginning to emerge more rapidly throughout Alberta.

Conclusion

NEXT STEPS

The ACFP and its members will need to engage and collaborate with colleagues, other health care professionals, and stakeholders, and continue to further explore the concept of the PMH in Alberta.

The most effective way to promote positive change is to have an army of ambassadors who can demonstrate the successes of the PMH in everyday practice. Participants were encouraged to take what they learned at the forum back to their communities, build on the successes, address challenges, and embrace opportunities.

Physicians in attendance were asked to identify what they personally would do to advance the PMH upon returning to their communities. The following were some of the responses:

- Commit to continue building a local medical home in my clinic
- Will look at a proposal to pursue a government-funded medical home project in my community
- I will come next year if we move towards operations
- Expand patient's medical home
- Increase committee with Primary Care Network (PCN) partners
- Lobby for medical home model
- Build on relationships that continue to build effective teams
- Gather fresh ideas to resolve various challenges
- Discuss this concept with the physicians in my area
- Introduce this concept to my MLA and AHS administration at zone level
- Commit to continue to be involved in the conversation about advancing this topic
- Increase measurement to evaluate programs
- Session helped clarify concepts of medical home and will allow me to be a better advocate for this (model)
- Commit to debriefing colleagues and try to expand or utilize better the CDM nurse
- To investigate AIM access
- I will try to increase my investment of energy into the PCN model in my community to foster intra and inter professional collaboration
- Ensuring co-administration benefit medical home program during PCN development
- Format was good, small group sessions could have been a little longer (more time)

- It seems that many if not all the topics/issues discussed today are very similar if not the same as topics discussed at several AHS/PCN meetings over the past 2 years. I wonder how aware AHS is about the Medical Home?
- Key Action: to discuss the ideas of this vision with colleagues
- Emphasize medical home model with PCNs in Alberta
- Continue to evaluate the idea of teams and what they mean in primary care
- I would do this again. Would like to expand who attends
- Feedback on process are fun discussions, but participants are already on board ("preaching to the converted")
- Give more thought/explore appropriate funding models
- Continue to expand collaborative care within our PCN
- Restart regular clinic meeting
- Great day; Dr. Lieff's comments about difficulty in recognising our own mental constricts

THE ACFP'S COMMITMENT

Promoting the PMH will continue to be a priority of the ACFP. The board is committed to continuing to build awareness and understanding of the vision and merits of the PMH with members, peers, and the public. The ACFP will continue to provide a forum to discuss, network, and disseminate resources on current successes and PMH models in Alberta.

Appendix

PARTICIPANT LIST

ELEANOR ANDREWS

Eleanor Andrews, B.Sc., MD, CCFP, FCFP
Grande Prairie, Alberta

I am a family physician and have had my practice since 1981. I treat all ages but have a special interest in geriatrics. Because I am a member of a PCN, my patients have access to a care coordination team for complex medical and social issues. Brief counselling (6–8 sessions) is available on an emergency basis on the same or next day. My practice includes a licensed practical nurse for nursing functions, including medication reconciliations and injections.

KATHERINE ATCHISON

Katherine Atchison, MD, CCFP
Red Deer, Alberta

I am a family physician with a wide practice population, including in-patient hospital care, nursing home care, obstetrics, hospitalist rotation, and a member of the sexual assault assessment team. I am a preceptor for family practice residents. I try to provide care from the cradle to the grave and see multiple generations and extended families in my practice to get the whole picture of the individual. The PMH is essential for providing concise, complete, and comprehensive care to the patient.

BRAD BAHLER

Brad Bahler, MD, CCFP
Sylvan Family Health Centre.
Sylvan Lake, Alberta

I am a full-spectrum family physician, president of the Wolf Creek PCN, and a faculty member of Alberta AIM. My current practice includes office-based primary care, obstetrics, hospital work, geriatrics, palliative care, and medical examiner responsibilities. Our clinic is heavily involved in physician training both at the medical student and resident levels. Our staff complement is a mixture of PCN-supported staff and privately employed staff deployed according to a team health concept. We are constantly looking for ways to expand our PMH and enrich the services provided to our patients. We continue to work with Alberta Heath Services on service integration with primary care physicians and as a group are very enthusiastic about the principles behind the PMH.

ALLAN BAILEY

Allan Bailey, MD, CCFP
Associate Clinical Professor, Department of Family Medicine, Faculty of Medicine, University of Alberta; Co-Chair, Provincial PCN; Physician Leads Executive, Alberta Medical Association; Site Director, Westview Physician Collaborative Community Teaching Site, Department of Family Medicine, Faculty of Medicine, University of Alberta; Westgrove Clinic, Spruce Grove, Alberta

Westgrove Clinic is a group practice of 10 fee-for-service family physicians who are members of the Westview Physician Collaborative (WPC) and the Westview PCN. The WPC is the non-profit corporation of approximately 70 physicians in our community that formed the WPCN in 2005. It is predominantly a distributed primary care delivery model that co-locates collaborative multidisciplinary team members in the clinics under contract or employment of the clinic owners. Comprehensive family medicine is provided by these physician-led teams within each clinic PMH. Despite the limited budget provided by the Alberta government PCN funding model, the clinic has evolved roles and processes to provide panel management through the use of chronic disease

registries, proactive preventative health manoeuvres using proactive office encounter technicians, group medical appointments, and a robust EMR.

MICHAEL GEORGE BOORMAN

Michael George Boorman, MD
Rimbey, Alberta

I practise in a small rural community that is served by a 20-bed acute care hospital and an 85-bed long-term care hospital. I am involved with five other physicians in a group practice out of a modern clinic building that uses electronic billing and charting and has online access to Alberta Netcare. In addition to physician offices, the clinic provides office space for the other professionals (two registered nurses, two registered nursing assistants, a dietician, and a pharmacist) who are involved in our PCN. The PCN involves physicians from three other central Alberta towns (Ponoka, Lacombe, Sylvan Lake), which provide the critical mass to finance the necessary administrative staff. The focus of our PCN in Rimbey is management of chronic illness (e.g., diabetes, hypertension, COPD, asthma). Patients can book appointments with the professional of their choice by calling the clinic—their "Medical Home."

SERGIU CIUBOTARU

Sergiu Ciubotaru, MD, CCFP
Clinical Lecturer; Outgoing Unit Co-Director, Medicine Hat (June 30, 2012); Rural Alberta South (RAS), Family Medicine Residency Program, Department of Family Medicine, University of Calgary, Calgary, Alberta

I practise family medicine with four other partners at Crescent Heights Medical Clinic in Medicine Hat. My practice includes clinic patients; evening and weekend walk-in patients; one in five hospitalist rotations for the patients of the clinic, including community call; and low-risk obstetrics with the Family Medicine Maternity Clinic in Medicine Hat. I am also one of five physicians who do rounds for patients at old age homes. Our clinic provides an array of services with the help of PCN health care workers (nurses, pharmacist, social work counsellor, physiotherapist), as well as podiatry and audiology. We have an EMR and make extensive use of electronic communication from and to hospitals, old age homes, home care, pharmacies, etc. In our clinic, there are three family medicine preceptors who teach and mentor medical students, clerks, and residents.

CHRISTINE ELLIS

Christine Ellis, MD, CCFP
Rimbey Hospital and Care Centre, Rimbey Medical Clinic, Rimbey, Alberta

Within our PCN, we have been able to create PMHs by having registered nurses, licensed practical nurse panel managers, a dietician, and a pharmacist work in our clinic with us. Patients can see any one of these health care professionals, without necessarily starting with a physician visit.

TOBIAS GELBER

Tobias Gelber B.Sc., MD, CCFP (An)
Pincher Creek, Alberta

CATHY SCRIMSHAW

Cathy Scrimshaw MD, CCFP, FCFP
Pincher Creek, Alberta

The Associate Clinic has 11 physicians supported by about 28 staff members and cares for about 10,000 patients. We work in a previously empty wing of our hospital, which was renovated to suit our needs in 2006. We are the only clinic in town. Some of the physicians also run an outreach clinic in Brocket on the Peigan reserve. Our philosophy is to provide patients with the right care by the right person at the right time. Continuity of care is paramount to us, and each physician therefore has a well-defined panel of patients that he or she cares for. Patients see their physician exclusively except when that physician is unavailable due to absence from the clinic. Our co-located team of five licensed practical nurses, a registered nurse, a social worker, a dietician, a pharmacist, and two respiratory therapists provide exceptional population screening and chronic disease management to our patients. These health care providers are accessible to our patients by self-referral, and physicians also encourage patients to see them. In addition to clinic work, all physicians in the group do obstetrics, cover ER, and admit and manage in-patients. These are requirements for working in our clinic. We also have

physicians with additional training in endoscopy, cardiac stress-testing, GP surgery, GP anesthesia, and acupuncture.

LORRAINE MANN HOSFORD

Lorraine Mann Hosford, MD, CCFP, FCFP
Clinical Department Head, Family Health, Edmonton Zone; Medical Lead, Health First Strathcona Urgent Care Centre, Sherwood Park, Alberta; Executive member, Sherwood Park PCN

Our clinic of six physicians participated in an AIM initiative in 2010, and we have since improved timely access for our patients and opened up access for new patients. Each physician is aware of his or her panel and their availability. After completing AIM, we recruited a nurse to help with patient management, and this expanded team experience has been very positive. As a result, our PCN adopted a "Family Practice Nurse" program. The ACFP and CFPC vision of the PMH is consistent with my values and experience in providing patient care as a family physician in my community over the last 20 years.

PAUL W. HUMPHRIES

Paul W. Humphries, MD, CCFP, FCFP
Professor, Family Medicine, University of Alberta, Edmonton, Alberta

Though my current practice is home and hospice palliative care, I spent 30 years of my medical career in full-service regional (Northwestern Ontario) and city (Edmonton) family medicine in team environments with a high commitment to student and resident teaching. My base practice at the University of Alberta's Royal Alex Family Medicine Centre is closely modelled on the PMH style, as was the private clinic in Thunder Bay owned by my family and that of my nurse practitioner. I find it gratifying to work in the team delivering home palliative care in Edmonton. The Regional Palliative Care Program represents a PMH model with a functional floating team membership applied in keeping with "lead in your scope" care.

KAREN LUNDGARD

Karen Lundgard, B. Sc. (Med), MD, CCFP, FCFP
Associate Medical Clinic, Peace River, Alberta

I have been practising in Peace River for over 33 years and have a large panel of patients who consider me to be their family physician. I work in the only medical clinic in Peace River, and we offer a multidisciplinary team for medical care. My clinical assistant is a registered nurse, and she does blood pressure and diabetic patient follow-ups, prenatal visits and teaching, and lab and investigation follow-up. She is often the first point of contact for our patients. We are also part of a PCN. The nurse practitioner in our clinic assists us with the care of our patients and does dedicated STI and contraceptive clinics, as well as seniors' lodge and home care visits. We offer team-based care for all prenatal patients in the North Zone as well.

FRED H. JANKE

Fred H. Janke, B.Sc., M.Sc., MD, FCFP, FRRMS
Sylvan Lake, Alberta

I am a full-spectrum family physician, member of the Wolf Creek PCN, and full-time faculty member in the Department of Family Medicine, University of Alberta. My current practice includes office-based primary care, some obstetrics, hospital work, geriatrics, palliative care, and after-hours community call / urgent care responsibilities. Our clinic is heavily involved in physician training both at the medical student and resident levels. Our staff complement is a mixture of PCN-supported staff and privately employed staff deployed according to a team health concept. We are constantly looking for ways to expand our PMH and enrich the services provided to our patients.

RAEGAN KIJEWSKI

Raegan Kijewski, MD, CCFP
University of Alberta Family Medicine Centre, Royal Alexandra Hospital, Edmonton, Alberta

Our clinic is a full academic teaching clinic with a team-based approach to comprehensive care. We provide 24/7 on-call support for patients. The clinic is PCN supported, offering a full range of medical services. The family practice cares for all ages and currently has some families with four generations. We have a responsive EMR system and support, and are AIM trained and dedicated to access and practice management improvement.

CATHY MACLEAN

Cathy MacLean, MD, FCFP, M.Cl.Sc., MBA
Professor, Department of Family Medicine, University of Calgary, Calgary, Alberta

While Department Head at the University of Calgary, I led the introduction of intraprofessional teams and the reorganization of physicians to provide team-based care on Microsystems. Arranging new physical space was a fundamental step in facilitating team-based care. A new funding model was introduced in December 2010, which moved physicians away from fee-for-service. EMRs were optimized. Our PMH incorporates teaching not only for medical students and family medicine residents but also for pharmacy, nursing, and social work students. Research will be integrated in all we do, and the department is looking at quality measures that would be most relevant for tracking performance and improving patient care. A plan is in place for a future Patient Advisory Board. We already have a clinic management structure with policies to direct day-to-day operations. Further development of the PMH is a part of the department's strategic plan.

RICHARD MARTIN

Richard Martin, MD, CCFP, FCFP
Assistant Clinical Lecturer, Department of Family Medicine, University of Alberta, Grande Prairie, Alberta

I am a community- and hospital-based family physician. I play an active role in professional education for medical learners and peers, expanding the boundaries of current patient-centred collaborative models.

OWEN UKRAINETZ

Owen Ukrainetz, MD, CCFP
Bigelow Fowler Clinic, Lethbridge, Alberta

Our practice is in the early stages of redesign. In cooperation with PCN, we are developing teams to enhance screening and provide comprehensive delivery of medical services.

LEN WADE

Leonard Wade, MD, CCFP
Vulcan Community Health Centre, Vulcan, Alberta

Our clinic group practice, located within the Vulcan hospital, consists of four doctors—two full time, two part time, all male. We accept any patient as long as his or her address is within our county. Our patients are mainly elderly, but we see a full age range, with 7,000 active charts. Within the building are home care, community health, ER, eight acute care beds (one used for hospice/palliative care), 15 long-term care beds, physiotherapy, X-ray, lab, occupational therapy, and mental health. We cover the ER 24 hours a day, with the exception of two weekends per month (covered by AMA locum services). There are no obstetrics at our hospital, but we do prenatal care. The ER workload is 300–400 patients per month, all after hours (during the day most ER patients are triaged to our clinic). One per cent of ER visits are level 1 triage score. One nurse practitioner and one female doctor are each available one day per week.

ROBERT J. WEDEL

Robert J. Wedel, B.Th., B.Sc., MD, CCFP, FCFP Medical Director, Chinook PCN; Co-Chair, Alberta AIM; Associate Clinical Professor, Departments of Family Medicine, University of Calgary and University of Alberta; Past President; Fellow; Chair, Advisory Committee on Family Practice; Chair, History and Narrative Committee; Vice-Chair, PMH Implementation Committee, CFPC, Taber, Alberta

I have been a family physician in Taber, Alberta, for over 30 years. We began the Taber Project in 2000 as a demonstration project in Alberta, integrating an alternative remuneration model, an EMR, the governance model currently seen in PCNs, and a strong multidisciplinary team-based service delivery model. We have continued with enhanced access and chronic disease management enhancements. We have enabled our EMR to generate a broad spectrum of improvement measures, both process- and outcome-oriented. Our current ratio of other providers per family physician is 2.64, using primarily PCN funding.

Other family physicians in attendance:

WAYNE DAVIDUCK
Calahoo
KHURRAM JAHANGIR
Peace River
VANESSA MACLEAN
Lethbridge
J MYBURGH
Sylvan Lake
ANDRIES NIEMANN
Daysland
JANET REYNOLDS
Calgary
CAROL ROWNTREE
Sundre
STEVEN TURNER
Olds

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