

**AN ACTION FRAMEWORK:
TO SUSTAIN AN EFFECTIVE HEALTH CARE MODEL
FOR
PRINCETON AND SURROUNDING AREAS**

July, 2013 – June, 2014

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CONTEXT:

The Background:

There is substantial literature regarding the challenges faced by smaller communities, such as Princeton, including:

- **Health Status**
 - People in predominantly rural regions have a lower life expectancy than the Canadian average
 - Disability rates are higher
 - There is increased prevalence of chronic disease
 - There is increased negative impact on the health of the elderly
- **Access to primary care services – continuity of health care from a family practitioner**
- **Access to surgical, obstetrical and specialist services**
- **Access to emergency and critical care**
- **Difficulties in recruiting, training and retaining staff**
- **Fewer available community supports**
- **Geographical dispersed populations, providers and facilities, leading to difficulties in achieving economies of scale**
- **Limited planning and operational capacity to develop networks and partnerships**

In 2011 the Inter-Divisional Strategic Council (ISC) was formed, composed of seven Divisions of Family Practice, representing over six hundred family physicians, Interior Health, Ministry of Health and the General Practice Services Committee (a collaborative committee empowered by the Physician Master Agreement between the Ministry of Health and the British Columbia Medical Association). One of the priorities of the ISC is to play a leadership role to break down the barriers and work across the health system to sustain successful recruitment and retention of family physicians, including for smaller communities in Interior Health region. The Lead of ISC, therefore, took on the responsibility of assisting Princeton with their process.

By 2012, precipitated by the need to reduce service in the Emergency Room at Princeton General Hospital, media reports in Princeton reflected the community's general feelings of frustration, hopelessness, with no sense of control over the complexities of a health system, where decisions are often made remotely and it is not clear or understood who is accountable for what and who can be called upon to make changes.

The AIM:

Develop and sustain an effective health care model for people living in and around Princeton.

Objectives:

The health care model in Princeton has to:

1. Provide security and confidence to the people of Princeton and surrounding areas that their health care needs will be met
2. Promote a healthy community
3. Provide effective and honourable transitioning for physicians i.e. retirement process
4. Offer a clear and compelling practice model to practitioners* that supports recruitment and retention of practitioners and health care staff, including medical students and residents
5. Implement a group, collaborative practice of physicians and nurse practitioner working together in one location
6. Outline accountabilities to and by patients
7. Pursue best practice, quality and innovation

**refers to current and future full service Family Physicians and Nurse Practitioners*

The Process:

The Vice-President of Community Integrated Services for Interior Health sponsored a process to develop an Action Framework to sustain an effective health care model for the population of Princeton. Key elements of the process included:

1. An urgent time frame: February – June 2013
2. A health care group with leaders from the Town of Princeton, the Regional District of Okanagan-Similkameen, the Interior Health Authority, and the local Division of Family Practice as well as the physicians and nurse practitioner
3. Lead of the Inter-Divisional Strategic Council assigned responsibility for the development and sign off of the Action Framework
4. Co-leadership between Community Integrated Health Services and Medicine and Quality portfolios of Interior Health

Success Factors of the Developmental Stage (January – June, 2013):

By Spring, 2013 the Media and involved leaders were reporting more hope, more energy and greater trust in the health care system in Princeton, noting specifically:

- Significant assets in Princeton and surrounds, including: committed and energetic leadership, responsible and interested media, community participation
- The response of Interior Health to set up a committee to look at sustaining services in the emergency room
- Princeton Community Consultation organized by Support our Health Care (SOHC) and facilitated by the University of British Columbia Okanagan (UBCO)
- A shared understanding of the complexity of the health system
- Shared Vision: a new future can be created through working collaboratively
- Commitment of local and IH leaders to work together for the people of Princeton
- The process to develop the Action Framework included over 25 people

- Practitioner Interviews providing deep input into not only the process but also including: group, collaborative, practice; advice to new physicians, successful components of long term practice in a rural community
- Commitment of IH to resource community engagement, public relations and communications
- Ministry of Health and British Columbia Medical Association's signing bonus to recruit family doctors to high need rural communities, including Princeton
- Current family physicians commitment to working with incoming family physicians to develop an effective and sustainable health care model for patients
- Increased number of volunteers in Princeton to services such as Palliative Care
- Princeton Arts Council willing to assist in developing a welcoming and comfortable environment starting with rotational art displays
- Agreement on a Tri-Lateral mechanism of town/regional district, Interior Health and the doctors and NP to build upon early successes, to continue the improvements and build a healthier Princeton in the years ahead
- Rural Emergency Enhancement Fund (REEF) from the Joint Standing Committee on Rural Issues (JSC), a joint committee between the Ministry of Health and British Columbia Medical Association
- Investment by Princeton and the Regional District for accommodation for locums replacing vacant Emergency Room positions
- Effective, collaborative physician recruitment tactics
- The linkage to the South Okanagan Similkameen Division of Family Practice and the Inter-Divisional Strategic Council
- Rural Physicians for BC (RPs4BC) program from the JSC

COMPONENTS OF THE ACTION FRAMEWORK:

The components of the Action Framework are consistent with the literature and were identified as most important to Princeton:

1. The community as a strong partner
2. A responsive health authority
3. Access to Primary Health Care
4. A group, collaborative practice
5. Access to specialist advice and care
6. Emergency care for patients
7. Integrated community health services
8. Measuring for improvement
9. Regular reporting to the public

The Action Framework has a time frame of one year. This promotes urgent attention and enables all partners to measure the effectiveness of the approach through the year and decide at the end of the year how to continue to build a Healthy Community in the Town of Princeton and surrounding area.

(a) THE COMMUNITY AS A STRONG PARTNER

To enable the community to be a strong partner in health and health care, a tri-lateral committee was identified as a critical component. This tri-lateral approach would build a sense of security for the population related to their health care needs and local health care issues; to influence, monitor and report upon Princeton issues with system implications and provide a consistent, welcoming environment to new physicians and staff. The Health Care Steering Committee fulfils this mechanism and evolves from a previous Health Care Sustainability Committee that has been meeting since July, 2012. The Initial Terms of Reference for the Steering Committee are appended. The tri-lateral approach respects the autonomy, roles and fiduciary responsibilities of Interior Health, the Town of Princeton and the Regional District, as well as the autonomy and professional and regulated accountabilities of the physicians and nurse practitioner.

The Steering Committee honours previous community priority processes.

(b) A RESPONSIVE HEALTH AUTHORITY

Effective health authority management in a rural community includes the review of its policies and practices so that rural communities can be administered effectively. To support local decision making and accountability, Interior Health reviewed its structures and acted upon two recommendations:

1. To align local administration leadership with leadership of programs not located in Princeton to streamline local decision making
2. To develop regular monthly meetings of off-site and on-site administration with monthly updates to the Steering Committee, covering issues and successes.

(c) ACCESS TO PRIMARY HEALTH CARE FOR THE POPULATION

International Health Researcher, Barbara Starfield's body of work related to the benefits of primary health care has been extensively published. She has shown evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death. The evidence also shows that primary care is associated with more equitable distribution of health in populations. In British Columbia, Hollander Analytical Services, an independent evaluator contracted by the General Practice Services Committee, has shown that higher levels of 'attachment' between a patient and a family practitioner lead to better outcomes and significant cost-avoidance savings among higher needs patients.

Access to primary health care is described in three parts in this section: Patient Population to be Served, Current Access and Opportunities to Improve Patient Access

- **Patient Population to be Served**

All patients in the community of Princeton and surrounding area will be offered care by the group practice, as well as patients from other communities such as Hedley or Merritt who choose to come to Princeton for services.

- **Current Access**

- Approximately 130 patients per day are currently seen between four practitioners. At present, there is a wait time of approximately one to two weeks to have a booked appointment to see a doctor or NP. All practitioners try to make time for urgent patients, but recognize that the inability to provide same day service is contributing to higher ER use. None of the practitioners have a capacity to take on new patients, but do so by default.
- Currently, providers care for patients primarily between the hours of 9 a.m. to 5 p.m. plus Saturday morning. Combined, the practitioners are accessible for approximately 139 hours per week for patient care in a clinic setting (not including ER coverage).
- Transportation for patients, if needed, to primary health care will be available through the community bus. If additional capacity is required, voluntary drivers and/or taxi vouchers could be added.

- **Opportunities to Improve Patient Access**

The practitioners and Steering Committee might identify opportunities to improve patient access to the benefits of Primary Health Care such as:

- Advanced Access patient booking.
- The General Practice Services Committee's a GP4ME initiative
- Extended clinic hours
- Group medical visits

(d) A GROUP, COLLABORATIVE PRACTICE of PHYSICIANS AND NURSE PRACTITIONER IN ONE LOCATION

The group, collaborative practice in one location to provide primary health care will include the following elements:

1. **Space:** ensuring there is a suitable space, ultimately, for up to four family physicians and one nurse practitioner to see their patients. In Princeton, this requires renovations to the Cascade Clinic to provide an adequate number of examination rooms and office space for the practitioners. The Princeton Arts Council is partnering with the Steering Committee to create a more welcoming and healing space for patients in the health care buildings. The space belongs to Interior Health and a **"Site Operational Agreement"** is appended to this document.
2. **Staffing:** IH employees currently staff the Cascade Clinic. In the future, the group, collaborative practice could take on the responsibility of employing Medical Office Assistants (MOAs) and staff support. Any agreement between Interior Health and the practitioners to be included in the **"Site Operational Agreement"**. An important part of this model is flexibility on staffing. The following key principles are agreed upon to guide staffing:

- a. Current clinic staff are included in any transition plans
 - b. Trained MOAs (or equivalent education and skills) are critical for the success of a group, collaborative practice. Recruitment of trained MOAs is one option and offering training to IH staff is another option
 - c. One of the MOAs (staff) would be in a managerial or supervisory role for the clinic
 - d. Staffing arrangements, costs and roles will be part of the “**Site Operational Agreement**”
 - e. Billing to be part of the “**Site Operational Agreement**”
3. **Group, Collaborative Practice Agreement:** Practice details will be agreed to and signed off by existing and incoming practitioners through a “**Group, Collaborative Practice Agreement**”, which is appended to this document. The Agreement includes, but is not limited to, the following elements:
- a. Services to be provided in the clinic
 - b. Emergency Room coverage
 - c. Hospital patient care
 - d. Residential client care
 - e. Patient allocation and access including wait list management
 - f. Documentation
 - g. Technology
 - h. Health and wellbeing of practitioners
 - i. Mentoring and practice experiences for medical students and residents

(e) ACCESS TO SPECIALIST CARE

Access to specialist care for patients in rural communities can be achieved through multiple strategies, including:

- Transporting patients from rural communities to urban communities where specialists practice
- Specialists travelling to rural communities
- Access to specialists through tele-health
- Access to specialist advice to family doctors through **Rapid Access to Consultative Expertise**
- Provision of adequate specialist space including for group medical visits
- Continuing medical education

Patient Transportation for specialty care

Health Connections (HC) is a low cost bus service to improve access to non-emergency medical appointments for patients residing in rural and remote communities. The objective of HC is to assist rural and remote citizens who may not otherwise have access to important medical appointments in urban communities. This can be achieved by streamlining existing routes with service enhancements along the Osoyoos-Penticton-Kelowna corridor. Interior Health, the Regional District and BC Transit are working together on this issue.

Specialists travelling to Rural Communities

The Northern Isolation Travel Assistance Outreach Program funds travel and travel time for specialists in eligible rural communities. (Princeton is an eligible community.) The maximum number of visits for each of the seventeen eligible specialties is 24 per year, for each eligible community. The health authority is required to provide the space for visiting specialists. The Ministry of Health also recommends that such visits should, where possible, be coordinated with Continuing Medical Education for Family Physicians.

Current and Approved Services: Princeton receives one day per month from the following specialties:

- Adult psychiatrist
- Geriatric psychiatrist
- Addictions specialist

In addition, Princeton receives intermittent specialist care from a paediatrician and cardiologist.

Needed care from other specialties has been identified as:

- Surgery: assessments (including orthopedic) referral process, pre-surgery preparation and post surgery care/supports
- Obstetrics/Gynecology
- Oncology
- Child and Youth Psychiatry
- Cardiology
- Respiriology
- Endocrinology

Access to Specialist Care through Tele-Health

Plans are underway to equip Princeton with tele-health equipment and to train and build staff expertise to use the equipment. Tele-health for specialist care is still in early stages and is most needed where the specialist needs a video as well as an audio link. Tele-ultrasound, tele-psychiatry and tele-dermatology are probably the best and earliest examples being pursued in B.C.

Rapid Access to Consultative Expertise (RACE)

RACE is a program of the Shared Care Committee, Providence Health Care in collaboration with Vancouver Coastal Health. It has three province-wide programs currently:

- Child and adolescent psychiatrist
- Chronic Pain specialist
- Treatment resistant psychosis specialist

However, there is an openness of RACE to explore expansion to other parts of the Province, by recruiting specialists from other regions to be part of the Program to offer local family physicians:

- timely guidance and advice regarding assessment, management and treatment of patients

- assistance with plan of care
- learning opportunity – educational and practical advice
- enhanced ability to manage the patient in the family doctor office
- calls returned within two hours and commonly within an hour

The South Okanagan Similkameen Division of Family Practice has agreed to work as part of the Princeton Health Care Steering Committee to understand the population need for specialist care; to identify how effectively specialty resources are used and explore new options such as tele-health and RACE.

(f) HOSPITAL AND RESIDENTIAL CARE

The hospital in a rural community is the dynamic centre of a health care network, both locally and regionally and includes the following roles:

- Oversight of valuable infrastructure and assets. The space is multi-purpose and can be used to meet other objectives.
- Collaboration between acute and primary health care providing seamless care for patients
- Outreach to community services and resources
- In-reach of specialist services
- Education of the public on how to most effectively and appropriately access health care
- Technological advances such as tele-health
- Facilitation of continuing medical and public education to build knowledge and community capacity
- Centre of patient self management supports and expertise
- Network with other hospitals to build a regional acute health care system, with explicit roles and expectations and measures

The hospital administration, with support from the Princeton Health Care Steering Committee, will be empowered to identify and recommend current and future acute care and hospital use, including:

- Provision of medical oversight for 37 people living in residential care, address gaps in care and understand family roles and experience (explicit protocols included in “***Practitioner Practice Agreement***”)
- Appropriate utilization of hospital beds
- Inpatient allied health services such as: physiotherapy, clinical nutrition, occupational therapy, respiratory therapy, speech pathology and social work
- Diagnostic services such as: laboratory, ECG and general radiography

(g) EMERGENCY CARE PROTOCOLS IN PLACE INCLUDING: ER COVERAGE, PATIENT TRANSPORTATION AND ROLES OF PARAMEDICS

Problems identified for rural Emergency Care across Canada, which may or may not be experienced in Princeton:

- Unscheduled ER closures
- Responsive community
- Data not collected, not understood who analyzes and uses
- Primary Health Care wait times increases the use of the ER
- Maintaining 24/7 staff for ERs
- Skill maintenance for ER staff and paramedics
- Sustainability (costs)
- Patient Transportation for critical care

Ensuring best practice critical care for residents of the Town of Princeton and surrounding communities

1. Sustainability of 24/7/365 Emergency Room coverage
2. The residents know where the de-fibrillator is housed in the community and ensure that many people are confident in its use.
3. Emergency management data is connected to Interior Health's emergency and trauma statistics with regular data provided to the Steering Committee
4. Pursue opportunities to increase patient access to the benefits of Primary Health Care
5. Plan and implement skill maintenance for physicians, NP, nurses and other health care providers
6. Transparency of actual costs by Interior Health
7. Early deployment of HART team (clinicians with high acuity credentials) from Penticton to support Princeton patients.
8. HARTs deployed to meet Princeton Basic Life Support (BLS) ambulance en route to Penticton Regional Hospital for the patients whose clinical needs exceed the scope of BLS attendants.
9. BCAS identifies a set of improvements and targets with the Princeton Health Care Steering Committee, including vehicle readiness to transport patients
10. Complete a Memorandum of Understanding between Provincial Health Services Authority (PHSA), Interior Health, British Columbia Ambulance Services (BCAS) and BC Bedline to:
 - Reinforce the coordination through BC Bedline for all Life Limb Threatened Organ transfers
 - Confirm Air Transport response protocols (Autolaunch of HART, Scene response and Hospital Intercepts)
 - Confirm deployment by BCAS Air and Regional Dispatch of most appropriate transportation based upon clinical needs of the patient in consideration with geographical and meteorological factors

- Enact the agreement to deploy HARTs to meet Princeton BLS en route to Penticton from a 911 call and by-pass the need to go to the hospital first to activate this service.

Building Capacity related to Emergency Paramedics and Patient Care

1. Improve retention and recruitment of BCAS paramedics in Princeton
2. Assist workload demands in rural facilities by utilizing paramedic skill set to assist nurses in the delivery of patient care – understanding in facility paramedic will always be supernumerary requiring immediate leave for emergency paramedic call out

OPTION FOR REVIEW: IH OFFERS ENHANCED TRAINING TO A PARAMEDIC FOR 3 YEAR RETURN OF SERVICE EMPLOYMENT AS AN ADVANCED CARE ATTENDANT

(h) COMMUNITY INTEGRATED HEALTH SERVICES

The intent for this model is to wrap and link community health services around patients and their family practitioners. Community health includes:

- Public Health Nursing
- Mental Health and Substance Use
- Aboriginal Health
- Early intervention (Dental and Speech)
- Home Health including short term, continuous and palliative care
- Chronic Disease Management

This model puts patient/family capacity to self manage and patient/family confidence as the priority. Self management refers to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical and emotional management. There is strong evidence that proactive interventions focusing on behaviour change and supporting self-efficacy are associated with greater change and more sustained levels of behavioural and clinical benefits. It is important to note that only specific patient self management techniques, such as the Stanford Model used by University of Victoria's Centre on Aging, have demonstrated these results.

Public Health Nursing and Home Health Nursing are based in Princeton and a shared service model out of Penticton provides for other community services. Therefore, models that provide the greatest access for patients to those resources and services are helpful. Community Hospice volunteers, coordinated by the Princeton General Hospital Social Worker, provide key services and supports to patients in the hospital and community. Models such as Group Medical Visits – supported by the Practice Support Program and peer-led patient self management training – offered by University of Victoria's Centre on Aging, group well-baby visits, and the cognitive behavioural therapy-based telephone coaching supports of Bounce Back are some examples.

Allied Health professionals practice in the hospital, community and residential care, providing the following valuable resources and services, including:

- Social Work

- Physiotherapy
- Dietician
- Occupational Therapy
- Respiratory Therapy

Princeton is part of the South Okanagan Similkameen Healthy Living Coalition Society. Linkage between the coalition and the Princeton Health Care Steering Committee is vital. For example, both bodies are using community demographic and health care utilization data to inform priorities, such as improved access and best practice for pre-natal care, prevention and management of Diabetes and Chronic Obstructive Pulmonary Disease. Focus areas include:

1. Community Engagement
2. Multi-Sectoral Collaboration
3. Political Commitment
4. Healthy Public Policy; and
5. Asset-based Community Development

(i) CONTINUOUS MEASURING FOR IMPROVEMENT

Until there are agreed upon success measures or indicators, the Steering Committee has only anecdotes to measure success. While stories are vital and should form 50% of showing success, measures and targets should form the other 50%. The Steering Committee will confirm its short term and long term measures or indicators, but might consider the following:

Short Term Measures or Indicators: July 1st to October 31st, 2013

- Recruitment and retention of four family physicians and one nurse practitioner
- Fully functional 24/7 Emergency Room
- Group medical practice established through a signed, practice agreement
- Adequate clinic space available for the public and practitioners and made more welcoming through displays of art
- Increased volume of patients seen by the group practice from 130 patients per day
- Increased accessible group practice hours from 139 hours per week
- Site Operational Agreement signed off by Interior Health and Practitioners
- Community education related to use of de-fibrillator initiated
- Positive community supports

Longer Term Measures or Indicators: November 1st, 2013 to June 30th, 2014

- A signed off and implemented plan for improved access and supports from specialists including: specialist visits, transportation of patients to specialists, tele-health consultations and use of Rapid Access to Specialist Expertise program
- Clinical measures identified by the practitioners and supported by the Steering Committee, such as: reduction of narcotic prescribing; improved chronic disease management through group medical visits and demonstrated increased patient confidence

- Emergency management data connected to Interior Health's Emergency and Trauma statistics
- Identify indicator(s) for improved pre-natal care to meet the needs of women in Princeton
- Plan with time frame in place for skill maintenance for physicians, NP, nurses and other health care providers related to the ER
- Interior Health shares information on the actual costs of ER operation with the Steering Committee
- Emergency care protocols implemented for ER coverage, patient transportation and roles of paramedics
- Opportunities identified by Interior Health for paramedics to assist workload demands for patient care in Princeton
- Immediate deployment of HART with hospital by-pass protocol in place
- Plan of Action from BCAS related to patient transportation improvements, including vehicle readiness
- Healthy Community targets identified for Princeton through the Healthy Living Coalition
- Description of services of the Group, Collaborative Practice shared with the public

(j) REGULAR REPORTING TO THE PUBLIC INCLUDING THROUGH LOCAL MEDIA

Regular reporting to the public is a role and responsibility of the Princeton Health Care Steering Committee.

Leaders involved in the development of the Action Framework**Sponsor:** Andrew Neuner, Community Integrated Health Services for Interior Health**Lead to achieve signed off framework and model:**

Valerie Tregillus, Inter-Divisional Strategic Council

Working Group to develop the Framework:

- Maja Karlsson, Interior Health (IH)
- Dr. Curtis Bell, IH
- Claire Ann Brodie, IH
- Susan M. Brown, IH
- Cherie Whittaker, IH
- Dr. David Smith, Family Physician
- Dr. Eva Idanwekhai, Family Physician
- Dr. Adams, Family Physician
- Dr. Devinder Sandhu, Family Physician
- Tanya ter Keurs, Nurse Practitioner
- Dr. Johan Boshoff, South Okanagan Similkameen Division of Family Practice
- Ed Staples, Community Leader
- Marilyn Harkness, Community Leader
- Brad Hope, Community Leader
- Lori Motluk, IH
- Dr. Brad Raison, IH
- Elaine Byrne, IH

Additional leaders participating and contributing their expertise to the process:

- | | |
|---------------------------|---------------------|
| • Linda Sawchenko | Dr. Jonathan Slater |
| • Darlene Arsenault | Gina Sloan |
| • Dr. Murali Venkataraman | Terrie Crawford |
| • Dianne Kostachuk | Brent Hobbs |
| • Kelly Murphy | Patricia Park |
| • Heather Cook | Michael MacDougall |
| • Marjorie Holland | Jane Bird |
| • Lex Baas | |

HEALTH CARE STEERING COMMITTEE

DRAFT Terms of Reference

July, 2013

It is understood that these Terms of Reference will evolve as the new model of health care is implemented under the guidance of the Princeton Health Care Steering Committee from July 2013 to June 2014. It is expected that the Princeton Health Care Steering Committee will expand its mandate to include health as well as health care, working in conjunction with the South Okanagan Similkameen Healthy Living Coalition Society.

1.0 PURPOSE and PRINCIPLES

The Princeton Health Care Steering Committee (the Committee) will provide the mechanism for Interior Health, the Town of Princeton and the Regional District of Okanagan-Similkameen and the Cascade Clinic to work together to support stable, sustainable and accessible health care in Princeton. The South Okanagan Similkameen Division of Family Practice is an important partner in this model.

The principles guiding the Committee are:

- ✓ Trust of the people will be earned
- ✓ Inclusivity will provide strength
- ✓ Effectiveness will be measured
- ✓ Transparency is key

2.0 OBJECTIVES

- To implement the signed off Action Framework entitled “To Sustain an Effective Health Care Model for Princeton and Surrounding Areas”; including a Site Agreement between Interior Health and the Physicians as well as a Practitioner Practice Agreement, signed by existing and incoming physicians and NP.
- To address local health care related issues brought to the Committee
- To monitor and report upon progress of Princeton issues with system implications that can only be solved by the health system – such as Interior Health, Ministry of Health, British Columbia Medical Association and Provincial Health Services Authority.

3.0 SCOPE

In scope: any component agreed to in the Action Framework “To Sustain an Effective Health Care Model for Princeton and Surrounding Areas”.

Out of scope: anything not agreed to in the Action Framework.

4.0 MEMBERSHIP

- Community Medical Director – Dr. Curtis Bell
- Interior Health Community Integrated Health Services Area Director – Claire Ann Brodie

- Interior Health Community Integrated Health Services Administrator – Susan Brown
- Regional Chief of Staff – Dr. Brad Raison
- Town Council Representative(s) – Jason Earle
- Representative of the Regional District of Okanagan-Similkameen – Brad Hope
- Regional District of Okanagan-Similkameen & Vice “Support our Health Care” representative – Ed Staples
- Representative of the Physicians
- The Nurse Practitioner
- Manager of the Cascade Clinic
- British Columbia Ambulance Service – Paul Swain or Ian Fitzpatrick
- Member of the South Okanagan Similkameen Division of Family Practice
- Public Member(s)*
- Ad Hoc: Maja Karlsson, Andrew Neuner, VP Community Integrated Health , Valerie Tregillus and Lannea Parfitt, IH Communications

*One or two members of the public could be chosen by the Town and Regional District through a process such as submission of interest by citizens.

NOTE: Other stakeholders/interested parties may be invited to particular meetings as required to address specific issues.

5.0 MEMBERS ROLES AND RESPONSIBILITIES

- Members take on a twelve months commitment
- Participate in regular Committee meetings. If not able to attend will appoint an alternate.
- Provide oversight or participate in Working Groups as necessary.
- Recognize that some topics discussed will be of a sensitive nature. Members commit to keeping these sensitive discussions confidential.
- Act as a representative of sponsoring organization or colleagues and report back to organization or professional colleagues
- Declare any conflict for any agenda items or discussions held by the Council.

6.0 DECISIONS AND RECOMMENDATIONS

- Decisions will be made by consensus on issues within the Mandates and Scopes of Responsibilities of the people on the Steering Committee
- Any issue outside the Mandates and Scopes of Responsibilities will result in recommendations only and be referred to the organization with the autonomy and fiduciary responsibility or the regulated professional responsibility

- Rationale for decisions must be captured in the Minutes. (Examples: data attached to Minutes; community input (source); collective advice provided by physicians and NP)
- The Committee's processes will respect the autonomy, roles and fiduciary responsibilities of Interior Health, Princeton and the Regional District, as well as the autonomy and professional and regulated accountabilities of the physicians and nurse practitioner.

7.0 EXTERNAL MEETING COMMUNICATIONS WITH THE COMMUNITY

While the Committee meetings will be held in camera, there is recognition by all members that open and transparent communication about discussions held during the meeting with various interested community groups is essential.

- Prior to the end of each meeting, committee members will determine which items are to be shared with the public, how and by whom (an update to Princeton Town Council or a joint news release are two possible examples).

8.0 ACCOUNTABILITY

The Committee will be equally accountable to the Town of Princeton, the Regional District of Okanagan-Similkameen, Interior Health leadership and the Practitioners.

9.0 RESOURCES AND BUDGET

Costs for the Committee will be shared between Interior Health the Town of Princeton and the Regional District.

10.0 MEETINGS

- The Committee will determine dates and times of meetings based upon member availability
- Agenda will be distributed at least 2 days before the meeting.
- Meeting notes/summary will be taken to record action points and will be brought forward to next meeting. Taking notes will be a shared responsibility between all Committee members. Meeting notes will be distributed with the agenda at least 2 days before the next meeting.
- Meetings will be Co-Chaired by Interior Health and the Town or Regional District member

Interviews completed with: NP Tanya ter Keurs, Dr. David Smith, Dr. John Adams, Dr. Eva Idanwekhai

Office Information:	
Question	1. How many patients do you have?
Summary	<p><u>Total Pts between all providers:</u></p> <ul style="list-style-type: none"> • Range – 4600 – 5900 pts • The high number likely includes an overlap of some patients since pts in Princeton seem to move around. It might be important to determine if there is a way to figure out the “unattached” number
Question	2. How many active patients/charts do you have?
Summary	<ul style="list-style-type: none"> • ~3700 pts have been seen by at least one provider in Princeton in the last 18 months
Question	3. Describe your patient demographics (if possible).
Summary	<ul style="list-style-type: none"> • Each provider has a bit of a “niche” population that seems to complement the other providers • Not sure how many Pediatric patients there are in town, but it seems that it is a very small part of everyone’s population – are there just few children, or are they not attached, or other? • Gender proportions – Each provider indicated that they had a larger female population than male; is this reflective of the community demographics, that women access care more frequently than men, or is there a large under-served male population? • Both Dr. Adams and Smith have an older/chronic care population. New group of providers at Cascade may want to determine if they would like to plan to “share” this more complex population or if the 2 new docs will simply assume these patients.
Question	4. Do you have paper charts or an EMR?
Answers	<p>Dr. Eva – EMR Tanya – EMR Dr. Adams – Paper (uses many flowsheets to guide care, particularly of the complex pts) Dr. Smith – Paper charts and Meditech; uses chronic care flowsheets; keeps at the front of the chart)</p>
	a. If you have paper charts, how would you like to have these managed once the new physician starts?
	b. If you have an EMR, which do you have? Would you expect that a new physician would take over your EMR? What is the yearly licensing fee? When you do need to renew your license?
Summary	<ul style="list-style-type: none"> • Paper – see end for chart transitions summary • EMR – Osler isn’t really great for either provider, but have just signed another 1 year contract. Would like to be able to consider MedAccess, but not sure if it would be worth it to switch to a different EMR
Question	5. What is your typical appointment length?
Summary	<ul style="list-style-type: none"> • Appt times – varied, and would likely be a good idea to plan the schedule based on the preference of the provider. • Cascade Clinic EMR has the capability to colour code types of appointments. This capability has been used by all practitioners. Recently Dr. Eva has also begun to colour code walk-in appointments vs. booked appointments and indicates that this has been helpful as well.

	<ul style="list-style-type: none"> Several practitioners indicated that the group may also want to consider setting aside certain times of the day/days of the week for “special” appointments such as Paps, full physicals, MH, Counselling, etc.
Question	6. Who works in your office? What does each person do? Who does your billing?
Summary	<ul style="list-style-type: none"> Between 4.6 to 5.0 FTE support staff between paid staff and spouses total between all providers. Currently at Cascade have only 1.6 FTE for 2 providers; current providers have already indicated that this isn’t enough for all the work that they have to do for 2 providers including billing. May be enough if billing is contracted out. Historically in this community the physicians aren’t very involved in the billing process; this is an area of opportunity (depending on the EMR capability); but would be important to start from the beginning having the physicians enter some billing data as they are seeing pts.
Question	7. Staff Transition: When you retire, does all your staff intend to retire as well? Would they have any interest in continuing work with a new physician? If so, would you recommend any of them to the new physician(s)?
Summary	<ul style="list-style-type: none"> There are some experienced people available in the community to add to the Cascade clinic office staff Having someone with some leadership skills working in the office seems to make a lot of difference Providers who employ their own staff seem more content with staff responsibilities than those who do not.
Question	8. Do you have any computers in your office?
Summary	<ul style="list-style-type: none"> All providers have computers Having a separate “office” space away from the patient care space is very important for efficiency
Question	9. How long is the wait list to get an appointment in your office?
Summary	<ul style="list-style-type: none"> Wait list is avg ~1 week at this time across the community and with some providers specifically, but evidence seems to be that if extended hours, open booking system, planned walk-in clinic time existed, most non-urgent patients could be seen at quite short notice (within 1-2 days)
Question	10. How do you deal with patients who call in and “need” to be seen today?
Summary	<ul style="list-style-type: none"> Lots of “urgent” pts are likely directed to go to the ER Lots of “double booking” – which may not be the most efficient way to see patients; if schedules were re-arranged to have open spots or if one provider was always doing a “walk-in” this double booking could likely be significantly reduced. Likely a good idea to consider this with booking system at Cascade once new providers start; particularly for ER on-call days
Question	11. Do you, or have you done any group medical visits? If yes, what is/was your target patients group?
Summary	<ul style="list-style-type: none"> Princeton patients have had opportunities over the years (and even now) to attend group “education” sessions. Not really evidence that these were truly “Shared Medical Visits” in the true sense where the visit replaces most individual pt visits for the same condition. Need to follow up with Dr. Kirkpatrick (from Oliver) to determine if/how she plans to continue with her groups (currently being done in Dr. Adams’ office). This is likely an opportunity, but would need to be planned in a thoughtful manner with interested practitioners.

Office Transition:	
Question	1. What specific date would you like to have the transition to the new physician(s) occur?
Summary	<ul style="list-style-type: none"> One group of patients will be available for transfer by mid September. The second group will likely be available at the end of the year. <p>DECISION POINT: Need to be decide how pts will be allocated to the new docs – to whom and how? Also, will the pts be clinic patients or will they be attached to the new physicians?</p>
Question	2. How would you like to have your charts transitioned to the new physician?
Summary	<ul style="list-style-type: none"> If either new physician were to start work in either Dr. Smith or Dr. Adam’s offices, the charts could stay there until work starts at Cascade. Both docs are ok with the charts being transported to Cascade once they close their practices. Still need to figure out logistics of transport and set exact dates.
Question	3. Would a new physician be able to work in your office temporarily if required?
Summary	<ul style="list-style-type: none"> Both Dr. Smith and Dr. Adams are open to temporarily (or permanently) offer their offices to new and/or existing practitioners if extra space is required.
Question	4. Would you be willing to spend some time with the new physician(s) to share your knowledge and understanding of patients in general in your community, what you have found works, and any specifics about certain patients so that continuity of care is maximized?
Summary	<ul style="list-style-type: none"> Physicians are willing/interested to support new docs in various ways NP is happy to share her role with the new physicians and support new physicians in various ways, but will leave Administrative tasks to another clinic contact (i.e. related to orientation)
Question	5. What do you plan to do to communicate with your patients about the upcoming change?
Summary	<ul style="list-style-type: none"> Dr. Adams – has already begun to communicate that he is retiring in the fall and that there is a new doctor who will assume their care.
Clinical Information:	
Question	1. Is there any specific training or clinical skills that you feel any new physicians need to have to successfully take over the care of your patients?
Summary	<ul style="list-style-type: none"> Billing support ER Skills (i.e. ACLS/ATLS) Empathy/listening skills CDM/Chronic Care skills and interests Suggestion: take advantage of CME opportunities
Question	2. Are there any minimum service requirements that a new physician would need to meet? e.g.: at least 4 days per week, must be open one evening, providing care off-site?
Summary	<ul style="list-style-type: none"> Things to consider include: <ul style="list-style-type: none"> Clinic booking schedule for on call vs. just clinic days Hold consistent/regular hours Consider Saturday/extended evening clinics Determine if transportation is an access barrier – if it is, does a downtown rotating clinic need to be set up or something else? How would this be set up?
Question	3. Do you provide any care off-site or at other facilities? Do you have any private contracts through a local industry or other organization? Do you offer home visits or residential site visits?

Summary	<ul style="list-style-type: none"> Off site services include, but may not be limited to: Residential Care, Home Visits, Youth Clinic <ul style="list-style-type: none"> Need to determine transfer of care of retiring physician's Residential Care pts Would be worthwhile to determine consistent visiting parameters for Res Care so staff and physicians all know what to expect Home visit frequency and criteria seems to be very different between providers <ul style="list-style-type: none"> May want to set up more consistent decision making criteria for whether a patient is eligible for a home visit or not
Question	4. Do you provide on-call services? If so, to what degree? What is your typical rotation? With whom do you share this responsibility?
Summary	<ul style="list-style-type: none"> Nothing typical right now During the transition period, may want to consider how to best use the RGPLP days. With only 3 docs providing on call, will likely be best if the 3 in town cover the weeknights and then the weekends can be covered by locums (at least some of the time) so that the ER could be opened up for more hours
Other/Miscellaneous:	
Question	1. Are there any "tips" you would like to share with any new physicians coming to your community that will make their work in the community more successful?
Summary	<ul style="list-style-type: none"> Consider including some of these points in the "Welcome to Princeton" package for the new docs <ul style="list-style-type: none"> Know where to refer patients to (e.g. community services, Specialists, etc.) Follow your comfort level; don't feel pressured to do something that is outside your comfort zone Phone ER docs in Penticton and Kelowna for support – helpful to make you feel less isolated Get yourself and your family involved in the community; lots of things to do You'll meet more people and feel more a part of the community Be open on Saturday am (90% of the time); makes a big difference in the community Small community; be aware that you won't have much privacy Gas gauge in the city vehicle doesn't work Don't use the IH vehicle (need to clarify – what is the issue?)
Question	2. How have you managed to be one of the long-standing physicians in the community, living and working within a small community such as this one (i.e. what are your success factors?)
Summary	<ul style="list-style-type: none"> Very practitioner specific information provided. Examples include: <ul style="list-style-type: none"> Healthy Social Life Spend time with your family Be nice to the staff in the hospital Princeton has an amazing climate – cool nights, no AC needed, very little wind, lots of activities Provide excellent patient care with good follow up

Things that need to be in place before the physicians start:

Items:

1. Fix billing issues at Cascade
2. Deal with space at Cascade Clinic by September 2013 before the new docs come for 4 or 5 practitioners (3 or 4 docs and 1 NP)
 - Ensure in any kind of renovation/changes that there is separate “office” space for providers to do paperwork
 - Consider wireless laptops so that providers can bring computers with them from office to office to facilitate usage of the EMR
3. Adequate staff are required at Cascade so that all necessary tasks can be done:
 - All current tasks
 - Rooming/Placing the patients
 - Clinic room base level stocking; currently don’t have lists – as a group, all providers need to determine clinic room stock lists that the admin staff can follow
4. Agreement between IH and Physicians
 - Must involve physicians having input and working hand in hand with the staff
 - Strong site administration – equality w/Physicians so everyone is included
5. Ensure that access to Cascade is not a barrier for Princeton residents
 - Set up transportation for patients who live downtown to get up to the Cascade clinic
 - Other
6. Osler EMR – both providers at Cascade expressed concerns of functionality of the EMR (slow, lots of crashes, poor technical support and doesn’t interface well with IH systems)
 - Soon after new physicians start, begin process of deciding if EMR will stay the same or be changed. Interest has been expressed about MedAccess, but need to determine if this is possible, or if it is only Profile(Intrahealth) that can be installed in an IH operated office.
7. Involve the community
8. On call/In-hospital/Residential Care:
 - Set up on call expectations for all providers
 - ER Call Days – need to consider how clinic days will be booked; maybe the ER doc only does walk-in clinic
 - Set up clear in-hospital care expectations – including expectations for “unattached patients”
 - Set up clear Residential Care expectations
9. Strong relationships with locums
 - Determine what kind of locum support is required and who should be responsible for orientating locums
10. Clearly define role of the NP for the benefit of all the physicians to enhance the collaborative practice
11. Confirm through signed written agreements specific end dates for retiring physicians.
12. Physician Practice Agreement
 - Could include an Income Agreement
 - E.g. Merge Scheme –part salary, part FFS
 - Legal transfers, etc
 - Yrs in community + age – NHA (on call etc.)
 - Would need an agreement between all providers to make this work
13. Division of New Patients to Cascade Clinic
 - Determine if it will only be new physicians who will take on the new patients until they have a

full roster, or whether existing providers will also take on some of these new patients.

- Will Cascade Patients be “Clinic” patients or will they be “Owned” by individual practitioners?
14. Once the new physicians are in Princeton, need to set aside a “planning day/teambuilding day” where all providers and management can come together to finalize agreements/documents, etc.
 15. Arrange new Physician Orientation Package/List
 - Determine responsible person (i.e. Cherie or other)
 - Arrange all numbers/passwords
 - Arrange for labs to auto-fill (in inboxes)
 - Set up clinic rooms properly:
 - Stocked with (e.g.): pap-smear, requisitions, updated referral list, BP cuff, scales, Snellan eye charts (10 or 20 feet)
 - Programmed Chubb cards for all areas (PH, Res Care, Clinic)
 - Osler orientation (need someone locally trained)
 - Ensure all providers know how to do billing coding on Osler
 - Create stamps
 - Order Business Cards
 - Orientation to IH email and expectations for usage
 - Update Telephone lists
 - Resources in town and referrals out of Princeton – this was started last year (locum orientation manual) – find out where in the process this is and finish
 16. Set up meeting with Practice Support Program Coordinator to determine which (if any) of the modules might be helpful for the practitioner group
 17. Develop some sort of “Welcome to Princeton” package that includes practice stuff as well as community stuff



Interior Health

Site Operational Agreement

Cascade Medical Clinic and Princeton General Hospital Emergency Department

Princeton, BC

The Site Operational Agreement referred to in the Princeton Action Framework is currently under development. This is a document that requires feedback from a broad list of stakeholders including the Practitioners.

Items that will likely be part of the document include, but are not limited to:

- Roles and Responsibilities
 - Decision Making Accountability
 - Clinic Management
- Term and Renewal Agreement
- Lease Agreement
- Occupancy Fees/Overhead Costs
- Shared Communication Strategy
- Overarching Patient Care Principles for Medical Clinic Operations
- Quality Expectations for Medical Clinic Operations

It is anticipated that this document will be completed over the summer of 2013 and be ready for implementation by September 2013.

The Group, Collaborative Practice Description and Agreement referred to in the Princeton Action Framework is currently under development. This is a document that will be finalized once the group of Practitioners have begun to work in Princeton, BC.

Topics that will be included as part of this document include, but are not limited to:

- Principles
- Individuals Involved
- Leadership
- Agreement Type
- Communication
- Decision Making Accountability
- Service Locations – definitions of each
- Clinic Management
- Common Patient Care Principles
- Practice Model and Organization of Care
 - Target Patient Population

- Services to be Provided
- Coverage to be Provided
 - Primary Care Clinic
 - Emergency Department
- Inpatient Beds
 - Residential Care Patient Allocation Process
 - Wait List Management
 - Documentation
 - Clinic Operations for Visits
 - Types of Service (examples include: Group Visits, Third Party Insurance, Full Exams, Procedures, etc.)
 - Technology
 - Other Team Members (e.g. Specialists, Allied Health Providers)
 - Primary Care Clinic Staff (e.g. Administrative Staff, RN/LPN, etc.)
- Roles and Responsibilities
- Practitioner Supports
- Infrastructure
- Barriers
- Compensation
- Funding
- Contradictions to Implementation of this Agreement
- Sign off of Agreement including effective dates and frequency of review

Group, Collaborative Practice Description and Agreement

Cascade Medical Clinic, Princeton General Hospital Emergency Department, and Ridgewood Lodge

Princeton, BC

The Group, Collaborative Practice Description and Agreement referred to in the Princeton Action Framework is currently under development. This is a document that will be finalized once the group of Practitioners have begun to work in Princeton, BC.

Topics that will be included as part of this document include, but are not limited to:

- Principles
- Individuals Involved
- Leadership
- Agreement Type
- Communication
- Decision Making Accountability
- Service Locations – definitions of each
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- Practice Model and Organization of Care
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 - Services to be Provided
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 - Primary Care Clinic
 - Emergency Department
- Inpatient Beds
- Residential Care

- Patient Allocation Process
- Wait List Management
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- Clinic Operations for Visits
 - Types of Service (examples include: Group Visits, Third Party Insurance, Full Exams, Procedures, etc.)
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- Other Team Members (e.g. Specialists, Allied Health Providers)
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- Contradictions to Implementation of this Agreement
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