PRINCETON ACCESS TO SPECIALIST CARE

South Okanagan Similkameen Shared Care
Princeton Access to Specialist Care Advisory Committee

IMPLEMENTING A STRUCTURE
TO SUPPORT RURAL OUTREACH

Phase One: **FINAL REPORT**

September 2015

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EXECUTIVE SUMMARY

AIM

The aim of the Princeton Access to Specialist Care project was to improve and sustain access to specialist care in the Princeton area, and to support Princeton family physicians.

Patients from Princeton with significant health concerns often need to travel to Penticton or Kelowna for investigations and specialist appointments. Barriers to travel prevent about 30% of Princeton area patients from receiving specialist care, creating an added burden on rural family doctors. Initiated in the fall of 2013, the intention of the project is to improve health outcomes and quality of life of Princeton patients, and to increase the likelihood of retaining Princeton family physicians.

INTENDED OUTCOMES

- Increase number and variety of specialist clinics in Princeton
- Improve processes, knowledge transfer, and relationships between specialists, family physicians, other healthcare providers and patients
- Improve physician, healthcare provider and patient experience

MAJOR OBJECTIVES

An interdisciplinary project team, including representatives from Princeton family physicians, Penticton specialists, their MOAs, Princeton General Hospital (PGH) management and staff, Community Integrated Health Services administration, and Shared Care project staff set out to:

- Develop, implement and test outreach clinic formats to provide appropriate specialist care in Princeton
- Provide Princeton physicians with customized education and relationship-building opportunities through on-site CMEs (Continuing Medical Education) with visiting specialists
- Engage feedback from physicians, healthcare providers and patients about their experience with the new approaches to care

EXECUTIVE SUMMARY

MOST SIGNIFICANT RESULTS

Time Frame: Jan.1 2014 – Jan.31 2015

- Specialists visiting Princeton nearly doubled, increasing from 7 to 13
- Specialities available nearly tripled (increasing from 4 to 11) to include: respirology, general internal medicine, nephrology, urology, rheumatology, general surgery, orthopedics, and methadone services.
  Psychiatry, pediatrics, cardiology, and mental health substance use (MHSU) specialists continued to provide clinics in Princeton
- Thirteen specialists delivered 46 clinics totalling more than 500 patient appointments
- Nine CME sessions were held for Princeton clinicians by seven different specialists
- 100% of patients reported their experience as excellent or good
- Princeton physicians reported significant improvements in their ability to provide optimal patient care
- Specialists found the outreach rewarding as patient acuity and the appreciation of the community validated their efforts
- All parties feel confident that the initiative will be sustained after the project's completion in 2016

INTRODUCTION

HEALTH AND CARE IN PRINCETON BC

For patients and healthcare providers in Princeton, British Columbia, access to specialist care and advice has been challenging due to geographic isolation and the difficulties associated with travel. Situated along Highway 3 on the eastern slopes of the Cascade Mountains, Princeton is a rural, isolated community in the Similkameen Valley in the Southern Interior of BC. Princeton is 115 km from Penticton, the largest centre in the region with approximately 33,000 people, and is 282 km from Vancouver.

> *"When I arrived in October 2013 it became stunningly clear how isolated Princeton really is,"* said a Princeton family physician. *"If you are young, independent and have resources, Princeton is a great town just a few hours to Vancouver and Kelowna. But if you are older, frail and have health problems and need care, Princeton is an isolated underserved community on a desolate icy highway. It also feels this way if you are a new young family medicine graduate now practicing on your own for the first time."*

Princeton, BC

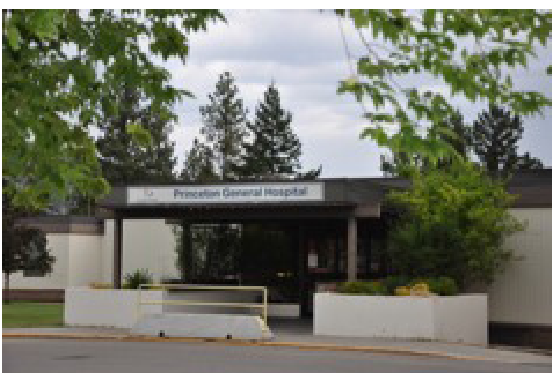
INTRODUCTION

The Princeton Local Health Area (LHA) serves approximately 5,400 people in Princeton, Hedley, Coalmont and the surrounding area.[1] Travelling for healthcare is a challenge for many individuals, particularly given the LHA has a disproportionate number of residents over 65, and lower family incomes on average than BC overall.[2]

> *"The last Stats Canada [census] showed we're not a growing community with young families, we're a growing community of older people,"* says the Princeton General Hospital (PGH) Site Manager. *"Because we're an elderly population, we have chronic disease."*

Demand for specialty care is high, despite the size of the community, posing a significant challenge for the limited number of family doctors in Princeton. As in many other small communities, isolation and access to resources contribute to residents in the LHA having significantly lower birth-weights and higher than expected standardized mortality rates from chronic lung disease, lung cancer, pneumonia, influenza, drug-induced deaths than in BC overall[3]. There is also a higher prevalence of anxiety/depression, diabetes mellitus, heart failure and asthma.

The LHA is served by a small local hospital that has experienced a decline in services since the 1980s. At one time, PGH had an operating room (OR) and maternity suite. Today PGH is a six-bed facility, with a four-bed emergency department, staffed by one Licensed Practical Nurse (LPN) and one Registered Nurse (RN). There are x-ray and lab services during the day and on call at night. Adjacent to the hospital is a 37-bed residential care facility. Recently, renovations have turned the former OR into the Cascade Medical Clinic, locating the doctors and one nurse practitioner, on site in a six-room clinic attached to the hospital.



Princeton General Hospital

Cascade Medical Centre and ER entrance

1 Princeton Local Health Area Profile (2013). Interior Health Information Management. Retrieved from https://www.interiorhealth.ca/AboutUs/QuickFacts/PopulationLocalAreaProfiles/Documents/Princeton%20LHA.pdf (last accessed June 30, 2014) ["Princeton LHA Profile"]

2 28% of the LHA's residents are 65 and over, compared to 16% in BC overall (Princeton SES Profile; based on 2012 data). The average family income in Princeton was $60,135 compared to $80,511 in BC overall (Princeton SES Profile, note 2; based on 2005 data)

3 The Princeton LHA Profile (note 1)

INTRODUCTION

In 2011, Princeton had three family physicians (two of whom were more than 70-years-old and ready to retire) facing community health care needs that were beyond their capacity. The community went through a health care crisis, culminating in emergency department closures due to a lack of physicians. The community rallied together to create the Save Our Hospital Coalition (SOHC), which was later renamed the Support Our Health Care Society. The society joined Interior Health to form the Princeton Health Care Steering Committee (PHCSC), including representatives from the Princeton community, Town Council, the Regional District of the South Okanagan Similkameen, Interior Health, and the South Okana-gan

Similkameen Division of Family Practice. Together, the PHSC developed an action framework to address the crisis.

In the fall of 2013, three new physicians were recruited to Princeton — two through the Rural Physicians for British Columbia incentive program and another via the International Medical Graduate Return of Service program.

THE INCEPTION OF THE SHARED CARE PROJECT

In anticipation of physician changeover, the retiring Princeton family physicians met with the South Okanagan Similkameen (SOS) Shared Care and Division staff, and Penticton specialists to explore what support or improvements could benefit the new Princeton physicians and their patients. Among other priorities, they identified that their community needed better access to specialist care and more efficient appointment bookings for Princeton patients when they have to go to Penticton.

A handful of specialists (in pediatrics, cardiology, psychiatry, and MHSU) were already visiting Princeton as a part of their regular practice. However, patients still had to travel to Penticton, Kelowna or further afield to see other specialists. Many chose not to go to a specialist at all due to the cost and/or difficulty of travelling. In addition, Princeton doctors were isolated in their rural practice and had significant concerns about the sustainability of new physicians under the challenging circumstances.

As a result of these conversations, and in alignment with the Princeton Health Care Steering Committee Action Framework, the Princeton Shared Care project was established to address better access to specialist care. The project also aligns with the BC Ministry of Health priorities[4], Interior Health priorities, and the goals of the Doctors of BC Rural Issues Committee.

4 *Particularly Priority 4, to "strengthen the interface between primary and specialist care and treatment." British Columbia Ministry of Health (February 2014). Setting Priorities for the B.C. Health System. Retrieved from : http://www.health.gov.bc.ca/library/publications/year/2014/SEtting-priorities-BC-Health-Feb14.pdf*

PROJECT ACCOMPLISHMENTS

ENGAGEMENT, PLANNING AND PROCESS

After the initial informal meetings, Shared Care physician and project leads held a larger group meeting in Princeton to discuss needed improvements. The broad range of stakeholders in attendance included the three Princeton physicians, the nurse practitioner, Princeton medical office assistants (MOAs), Princeton hospital administration, site manager and registration clerk, and eight Penticton specialists (three in person, and another five by teleconference).

At this meeting, stakeholders explored many opportunities, including expanding outreach in Princeton, creating more efficiencies for patients that have to travel to Penticton, and utilizing telehealth. In an effort to limit the scope of the project, the group decided that their first priority would be broaden the specialty outreach clinics coming to Princeton.

This would accomplish two central objectives:

- Improve patient access to specialist care
- Improve family physician relationships and knowledge sharing with specialists

Following this, a project advisory committee was formed, including one Princeton family physician, two Penticton internists, the SOS Community and Integrated Health Services Administrator, the PGH Site Manager, the Cascade Medical Clinic Office Manager, and Shared Care staff.

The committee developed a project charter identifying its purpose: *"to improve and sustain access to specialist care and support to Princeton physicians in providing optimal care."* The intended long-term goals were better health outcomes and quality of life for Princeton residents, and increased likelihood of retaining Princeton physicians.

ELEMENTS THAT LED TO PROJECT SUCCESS

The project aligned with and responded to a need identified by the community. All of the partners, in particular the specialists, were committed and united around the common goal of improving rural patient care in the Princeton community. In addition, the partners felt a collective sense of ownership over the project. Key resources crucial to the project included:

- Shared Care Committee (SCC) funding allowed for project management, partner engagement, and interim travel funding for specialists until provincial funding was approved
- Interior Health staff time and dedication, as well as space and equipment
- Northern and Isolated Travel Assistance Outreach Program (NITAOP) funding to cover physician travel expenses in the long term

PROJECT ACCOMPLISHMENTS

IMPLEMENTING A SUSTAINABLE MODEL FOR OUTREACH CLINICS

The Advisory Committee set out to develop a structure to support outreach. Steps and lessons learned are documented below for other communities to adapt and use. Implementation of this model was a success because of ongoing, rigorous use of the Quality Improvement Cycle PDSA (Plan, Do, Study, Act).

OUTREACH CLINIC SET UP	WHAT WE DID AND LESSONS LEARNED
What specialties were needed and how often?	• Initially a family physician MOA manually tracked specialist referrals, which proved to be a time consuming extra task. • Unsuccessful attempts were made to retrieve data from the Electronic Medical Record (EMR) newly implemented in the Family Practice clinic. • Instead, we met with the family physicians (FPs) and nurse practitioner (NP) to determine priority specialties. This proved accurate and enabled specialists to respond to a collective request from the Princeton clinicians.
How did we determine which specialists were able to come and how often?	• Based on the priority list established by Princeton clinicians, Shared Care specialist and project leads approached department heads individually to start discussions and determine whether travelling was possible. • The internists on the advisory committee were the first to test the model, and frequency was determined by their availability and the level of demand (number of referrals), which has worked well across all specialities.
How did we get over the deterrent of specialists having to travel?	• NITAOP travel funding (for travel time and expenses) is applied for annually in October and approved for the fiscal year (April through March). This poses a challenge because specialists that decide to start outreach in November, for example, cannot receive funding for 18 months (until the next April). • A significant benefit of the Shared Care project funding was that physician travel was covered until the NITAOP funding came through. This also gave specialists the opportunity to trial outreach without a long-term committment.
Where were the clinics held and what equipment was required?	• Health Authorities are responsible for providing space and administrative support for outreach clinics. • The Site Manager at PGH committed significant effort to repurpose former patient rooms and storage areas into two clinic rooms and an adjacent patient lounge. • Each clinic room was set up with a desk, computer, printer, phone, internet, patient chairs, and exam bed. Fine tuning was necessary to meet all specialty needs (medical carts were added, lighting was changed, etc.). • The ability for hospital and FP clinic staff to be responsive to specialist needs has been crucial to the project's success.

PROJECT ACCOMPLISHMENTS

OUTREACH CLINIC SET UP	WHAT WE DID AND LESSONS LEARNED
How was the clinic space booked?	• Specialist MOAs contacted the PGH registration clerk who was able to take on the logistics of booking the space, setting up the rooms and directing patients.
How were the patient referrals handled?	• Specialist MOAs advised the FPs, via a faxed letter, of the clinic inviting referrals and offering a CME (Continuing Medical Education).
Who booked patient appointments?	• Using the existing referral process, specialist MOAs pooled Princeton referrals and booked patients according to triage strategies.
How did we orient specialists and their MOAs to the process?	• The project lead developed an orientation package and met with specialists and their MOAs. • Originally this consisted of a binder to help specialists organize and prepare for the clinics including tabs for requisitions, checklists, data collection tools etc. • After the study period, a quick reference sheet was developed with protocols and key contacts.
How did we incorporate Continuing Medical Education (CME)?	• At first specialists would include the offer to do a CME in the faxed letter notifying the FPs of the upcoming clinic. • After the first year the Princeton FPs suggested that CMEs occur by default rather than by request, as more connection was being sought after by all physicians. • A set time over lunch was established, and the FP MOA would confirm the CME and survey the FPs for specific topics. • Often the FPs and NP brought a specific question or case example. A round table format was used for discussion. • CME credits are provided by the Division of Family Practice.
How did we collect data on the clinics to measure change?	• During the study period, the specialist orientation binder included data collection tools (specialist survey, patient survey, and day sheet) • After the first year, clinics were tracked based on bookings and comparison with NITAOP usage reports received by the Community Integrated Health Services (CIHS) Administrator.

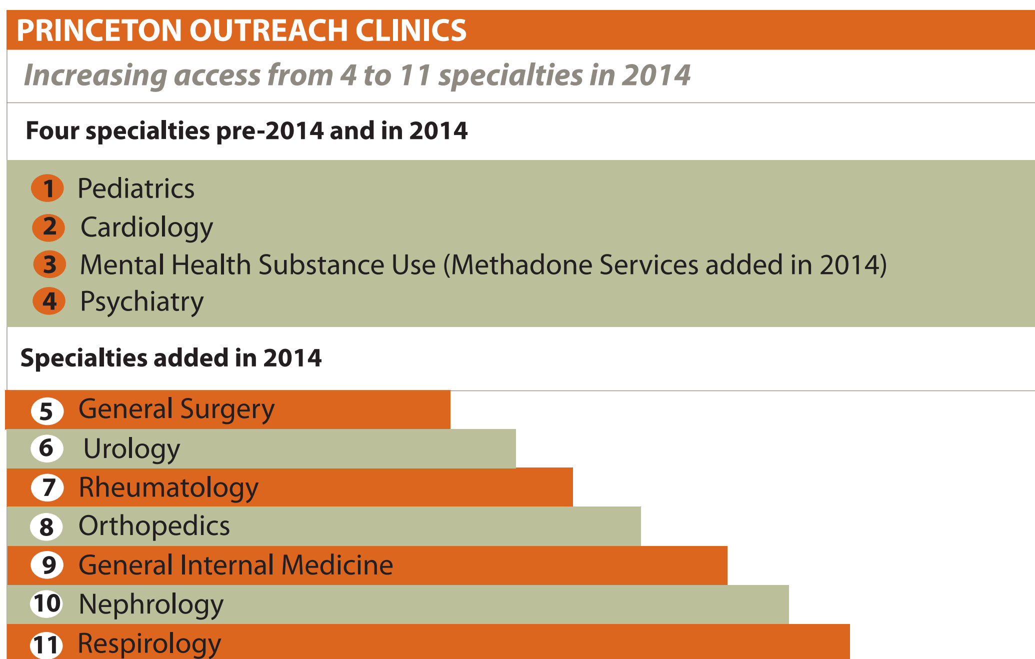
PROJECT ACCOMPLISHMENTS

INCREASED ACCESS TO SPECIALIST CARE

Over a one year period the number of specialists visiting Princeton nearly doubled (from 7 to 13); and the variety of specialities available nearly tripled growing from 4 to 11 different specialties. Prior to the project, specialists in psychiatry, pediatrics, cardiology, and MHSU were already visiting Princeton. In 2014 this grew to include respirology, general internal medicine, nephrology, urology, rheumatology, general surgery, orthopedics and methadone services. Ophthalmology, gynecology and neurology were also explored, but weren't attainable due to equipment or other issues.

Thirteen specialists delivered 46 clinics totalling more than 500 patient appointments overall, greatly improving Princeton's access to specialist care. [5]

The table below illustrates the expansion of specialty clinics in 2014:



5 *Data was collected from 40 out of 46 specialist clinics in Princeton Jan 2014-Jan 2015. The 40 clinics for which data was collected had a total of 443 patient appointments and an average of 11 appointments per clinic. The assumption is that the additional 6 clinics with an average of 11 appointments would equal 509 appointments overall.*

PROJECT ACCOMPLISHMENTS

During a 10-month period, 184 patients were surveyed (Jan – Oct 2014). Overall the data indicated that an estimated 31% of patients received care who otherwise would not have. For these patients, barriers including weather conditions, the cost of travel (gas and food), time off work, not being able to travel without help, and finding child care had kept them from care in the past.

> *"I'm on welfare. It costs $35 every time I go to Penticton for appointments,"* said one patient. *"By bus there's only a small window of time for each appointment."*

On the surveys, 37.4% of patients said they had missed specialist appointments in the past because of difficulty travelling. In contrast, with the outreach clinics, 96% of patients kept their appointments. Sixty percent of patients surveyed had an annual household income of $30,000 or less; 25% had $16,000 or less annually. Fifty-three percent of patients were 70 years of age or older, and 10% of patients were over 90 years of age.

For many patients, outreach has meant the difference between accessing specialist care and going without.

> *"I couldn't travel because I was paralyzed,"* explained one patient. *"I had to rely on everyone else, friends and my son. But they have jobs. When you have people like Dr. Walker coming to town it makes it 10 times easier to say, 'Yes I'll go'. It takes one big part of it right out of the equation."*

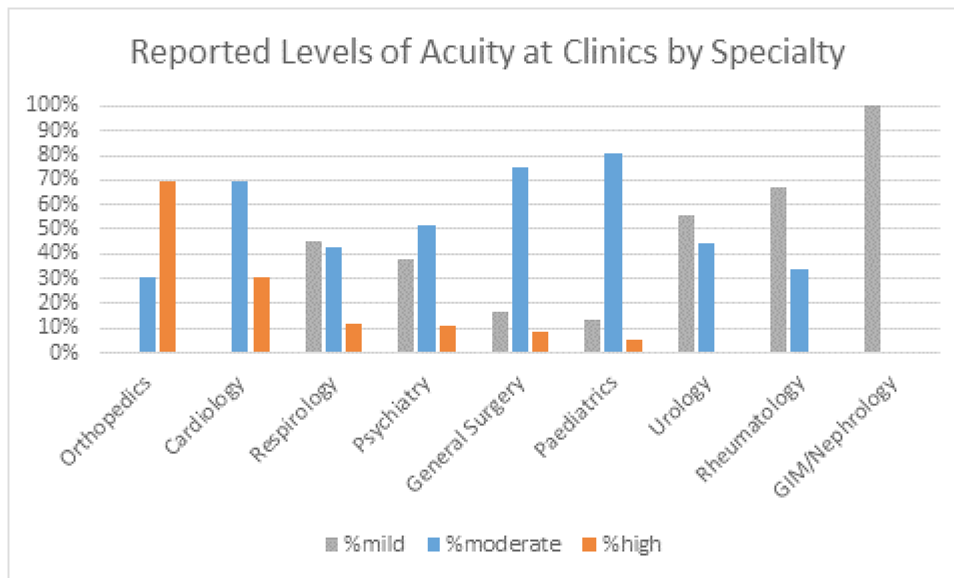
Some patients miss appointments because travelling is difficult, while others are unable to travel at all.

> *"There were a couple of people that were referred to me, and were sitting on the list for a long time be cause they were just not physically capable of travel,"* said one specialist. *"One lady had rheumatoid arthritis and she had had a severe compression fracture in her spine. She was immobilized for months. If I hadn't have gone there, she would never be able to see a specialist. It's a lot for the GPs to manage."*

> *"I've had a couple of patients where the GP had indicated this person was unlikely to drive into Penticton to come and see me,"* added another specialist. *"We had one gentleman who could have died from a cardio or pulmonary event without having had some intervention. For me to be able to go out and reach a few of these lives—maybe we make a difference."*

PATIENT ACUITY

Patient acuity was rated by the specialists for 269 of the 443 appointments during the study period. Acuity per specialty is delineated in the table below. Overall, 13% of patients were rated high, 54% moderate, and 33% low acuity. It is difficult to draw definite conclusions regarding acuity because it varies considerably given the diversity of specialities and medical issues involved. However, it was not expected that many of the patients would be highly acute because patients are triaged at the time of referral, and highly acute patients are seen at the next available appointment, whether that is in Princeton or Penticton.



THE PATIENT AND CAREGIVER EXPERIENCE

One hundred percent of patients rated the overall quality of their visit as excellent or good. For Princeton patients, outreach added to their independence and contributed to decisions to remain in their own community.

> *"This kind of caring and provision makes it possible for [my parents] and me (an hour away) to rest easy knowing their medical needs will not be ignored or delayed,"* explained the daughter of an elderly couple receiving specialist care in Princeton.

Patients who needed support to attend appointments were relieved when they did not have to ask their friends or family to take them to Penticton.

> *"People can find that extra 15 minutes to come and pick you up here and take you back home again and carry on with their day, but when you've got to travel to Penticton, you're writing it off,"* explained another patient.

Working patients are very grateful to not have to take a day off work. Twenty-six percent of patients said that having to get the day off work had been a barrier in accessing specialist care.

PROJECT ACCOMPLISHMENTS

THE HEALTH AUTHORITY EXPERIENCE

The PGH is a small community hospital and much of what used to be clinical space was rededicated to offices and storage. The key challenge for the site manager and other staff members was finding space and equipment for the clinics that would meet the specialists' needs, but do so while working within the existing budget.

Despite the added workload (for the site manager and registration staff in particular), supporting outreach has contributed to job satisfaction.

> *"It's been a really good experience for myself, personally, to be part of a project that you believe in,"* said the PGH site manager. *"I always have believed that if we can give care at home, it's a good thing for patients."*

The staff at PGH are long-time residents of the Princeton area. Because of their strong connection to the community, they were passionate about the project, ensuring that the clinics (as one specialist noted) "operated like clockwork".

THE SPECIALIST EXPERIENCE

Specialists found that doing outreach clinics added a welcome variety to their practice. Responding to an underserved population, being an asset to the team of health care providers in Princeton, and meeting grateful community members all contributed to an overall rewarding specialist experience.

Excerpts from interviews with specialists describing the experience:

> *"I enjoy the fact that the patients appear grateful for me coming there. It echoes back to an older way we practiced and it's a little bit more personal."*

> *"An important side benefit is just getting to know the Princeton physicians. If a GP feels more comfortable to pick up the phone it improves access via telephone, and the family doctors are just that much more comfortable. It might prevent some referrals that they can just stickhandle on their own."*

Some of the challenges for specialists included time away from their offices, the drive, and not interacting enough with the Princeton physicians. Their MOAs pointed out that it can be difficult to schedule patients on only one particular day, as there is less flexibility and can require additional patient follow-up if a clinic is not booked well in advance. Overall, however, specialists found that the positives outweighed the negatives, and unanimously encouraged their colleagues to participate:

> *"Don't hesitate to do it because it's actually quite rewarding. You see interesting patients with some complicated conditions. You know you are doing good and being a big help."*

IMPROVED SUPPORT FOR PRINCETON PHYSICIANS

Outreach creates the opportunity for on-site CMEs, which is a rare privilege for most rural clinicians. A small group learning environment is valuable to the clinicians because the expertise can be tailored to their specific needs. Nine CME sessions were held for Princeton clinicians by seven different specialists in 2014. These sessions have been critical to the project's success as Princeton physicians report feeling significantly better able to serve their population.

> *"Having specialist outreach clinics has improved my ability to provide patient care tremendously,"* said one family physician. *"I am very grateful for their existence."*

The opportunity for specialists and rural referring clinicians (family physicians and nurse practitioner) to connect in person to improve their working relationships is one of the key values of outreach. Better relationships result in more streamlined patient care because it becomes easier to contact one another when a question arises. It also helps the specialist determine what is too much to ask, or what the family physician is capable of doing in terms of patient care, at times preventing a return trip to the specialist.

> *"It's been great to meet [the family doctors] and know who they are,"* added one specialist. *"Once you've met them, especially doing a presentation, and they are asking questions, you get an idea of how much knowledge they have in a few complicated areas. If I send them a letter with instructions, I know they'll feel comfortable."*

More physician to physician contact was consistently requested in the evaluation interviews by both specialist and family physicians. Nevertheless, many specialists said that although they did not see the family physicians as much as they would have liked, having physically met them did make it easier to have further telephone conversations about patient care plans.

Princeton family physicians (from left) Colleen Black and Ella Monro, and nurse practitioner Viola Brown, participate in a nephrology CME in the PGH Education room with Dr. Brian Forzley

PROJECT ACCOMPLISHMENTS

IMPROVED PROCESSES AND KNOWLEDGE TRANSFER

Family Physicians report being very satisfied with specialist consult notes, indicating that for the most part it was clear what the next steps were, and who was responsible for what. This is an improvement since the project interim report in July 2014.

> *"I think all of our consultants have been very clear in each of their consultation notes in saying if they want me to do something specific, they indicate that,"* said a Princeton family physician.

The project has created the opportunity for the physicians to fine tune how they work together to meet patient needs.

Specialists and their MOAs also reported being more satisfied with referral letters over the course of the project. Only a few inappropriate referrals were noted throughout the trial period. Some specialists found that referrals were generally of higher necessity than what they would see in their regular practice.

> *"All referrals were appropriate and unlike larger cities none were 'soft' or unnecessary,"* said one specialist.

Seventy-five percent of patients surveyed reported understanding very well the next steps in dealing with their care. All of the specialists found that the quality of care they were able to provide at the outreach clinics was the same as or better than in their office. This was a significant finding, as one of the initial concerns from specialists about outreach was whether patients may still need to travel to Penticton for diagnostic tests after attending outreach clinics.

A variety of diagnostic strategies have been put in place in Princeton to mitigate the need for patients to still travel to Penticton. This ranges by specialty, from the cardiologist using a hand held echo cardiogram to do initial assessments to determine if further care is needed, to the respirologist working in tandem with a respiratory therapist (RT) (with support of Interior Health). In this instance, the respirologist has found that the quality of care she is able to provide in Princeton (with the concurrent work of an RT doing site diagnostics and education) is better than in her office in Penticton. The psychiatrists pointed out, however, that with acute Princeton patients they are less able to provide timely care than they would be able to provide to Penticton patients. Going forward, telemedicine is being expanded and may help address this need.

PROJECT CHALLENGES

The project team worked together to address numerous challenges (such as date conflicts, maintaining privacy while directing patients to the clinics through the hospital, troubleshooting computer and internet issues etc.) to accommodate up to nine clinics per month. They addressed diverse equipment needs (such as weigh scales, beds and chairs, lighting, medical cart supplies, computers, printers, long distance calling, hospital chub cards etc.), accommodating thirteen different specialists.

Whenever possible the logistics committee worked within existing workflow patterns rather than adding new processes. For example, the existing structure for referring patients to a specialist was used for outreach as well – in referral letters the FP/NP identified if a patient preferred to be seen in Princeton or simply could not travel. Asking specialists to fill out an additional day sheet to track acuity, follow-ups vs. new consults, wait times etc., was onerous for some specialists and their offices.

A few challenges persist which threaten the sustainability of outreach should they not be adequately addressed:

Unreliable Internet Access: The Health Authority has had difficulty ensuring reliable internet access. The wireless router signal strength in the clinic rooms varies and at times is very slow. This has contributed to challenges with access to their EMR and remote transcription causing significant frustration for some specialists.

Remote Transcription Challenges: From the inception of the project, specialists have asked to use Interior Health's electronic patient medical record system (MEDITECH) to dictate their consultations. The request has been declined due to budget constraints and the stance that outpatient clinics are not the health authority's transcription responsibility[6]. The specialist request is two pronged:

- Having hospital access to a rural patients' most recent specialist consult notes would provide better coordinated team-based care across facilities, practitioners, and geography, likely preventing unnecessary procedures and stress to the patients and their families
- A reliable transcription method is required for specialists to do outreach. At a cost and inconvenience, the specialists have all developed their own non-internet reliant workaround (varying from dictaphones, to private transcription services like Workflow). This lack of IH technical backing is a deterrent for specialists who have gone out of their way to provide outreach

The Advisory Committee continues to work with IH to address these challenges.

6 *As of Sept. 24, 2015, IH agreed in principle to Meditech transcription for outreach clinics. It is expected to take some time to operationalize.*

PROJECT CHALLENGES

NITAOP Funding Obstacles: The Northern and Isolated Travel Assistance Outreach Program provides the travel funding that makes these clinics possible. Funding is applied for once a year (in October for SOS) in a joint submission through the Community Integrated Health Services Administrator. The funding cycle requires physicians to wait up to 18 months depending on when they determine they are interested in doing outreach (i.e., deciding in November would mean that the specialist could not be funded until April, 18 months later). The Shared Care project funding mitigated this by covering physician travel while they waited for NITAOP funding, which enabled physicians to trial outreach when their interest was highest. In addition, challenges with timely NITAOP reimbursement and inefficient issue resolution have been a problem for some outreach physicians (causing delays of 5 months and more) resulting in another significant deterrant.

Lack of Allied Health Travel Resources: Allied health support such as rheumatology or diabetes nurses significantly enhance outreach efforts, but funding for their travel is not readily accessible. Fortunately, collaborative projects are contributing to change in this arena. Recently, as a result of collaborative work in COPD and outreach combined, RT services have been re-organized in the South Okanagan Similkameen to provide more diagnostic and education services to rural communities.

Lack of Support and Coordination for Specialists: With the project winding down, questions remain around who will support specialists to troubleshoot the issues they encounter, and how emerging specialty gaps will be successfully filled. These questions are being explored by the Advisory Committee as we test outreach sustainability in 2015.

Roadblocks to seamless internet access, remote transcription, travel funding, and allied health support have required significant time and resources from the project team and participants and still remain unresolved. Nonetheless, thirteen of thirteen specialists who trialed the clinics continued outreach despite the challenges. The value of the work and responsiveness of the team to one another's concerns have enabled the group to collectively weather the challenges while continuing to advocate for improvements.

RECOMMENDATIONS

Speciality outreach through this project has proven invaluable to the community of Princeton, showing early evidence of better health outcomes and quality of life for rural patients and their families. In addition, rural outreach has contributed to better job satisfaction for all healthcare providers involved, particularly making a difference for the retention and recruitment of family physicians to this isolated community.

The Project Advisory Committee recommends that specialist outreach be cultivated in other communities by:

- Working together with specialists to discuss real community needs and developing collective strategies to address them
- Fostering host-site shared ownership by including frontline staff in the development of outreach space as well as providing adequate resources to support added workload
- Creating frequent opportunities for rural physician to specialist contact through co-location of the clinics, coordinated break times, CME and shared lunches
- Committing to rapid resolution of issues to enable specialists to spend their time with patients, not dealing with logistical challenges
- Addressing systemic barriers related to NITAOP administration and accessible electronic medical records to promote seamless team-based rural patient care

By sharing this work, we hope that other communities are inspired to reach out and collaborate with specialists, and create rewarding partnerships in rural patient care.

APPENDICES AVAILABLE UPON REQUEST

A.) Princeton Access to Specialist Care Phase One: Evaluation Findings
Prepared by Sarah Vander Veen, Evaluator (April 2015)

B.) Princeton Access to Specialist Care: Project Charter and Evaluation Framework (2014)

C.) Sample Media Reports (2014 – 2015)

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South Okanagan Similkameen
Division of Family Practice
A GPSC initiative

SharedCare
Partners for Patients

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doctors of bc
British Columbia Medical Association