THE SASKATCHEWAN COLLEGE OF FAMILY PHYSICIANS

LE COLLÈGE DES MÉDECINS DE FAMILLE DE LA SASKATCHEWAN

A CHAPTER OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
UNE SECTION DU COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

SASKATCHEWAN
MEDICAL ASSOCIATION

Patient’s Medical Home Saskatchewan

Symposium report

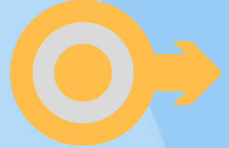
Presented by the Symposium Planning Committee (Dr. Janet Reynolds, Bonnie Brossart, Margaret Baker, Dr. Cathy Maclean, Dr. Mark Fenton, Karen Earnshaw, Dr. Sarah Bates, Andrea Kohle, Emmett Harrison, Shona den Brok) with support from CAMBIAR Consulting.

PATIENT'S MEDICAL HOME SASKATCHEWAN

Symposium Report At-A-Glance

2 Co-hosts

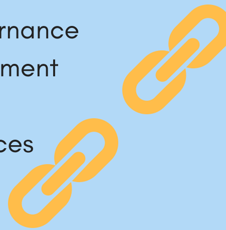
5 Objectives



1. Gather thought leaders to discuss and unify Saskatchewan's approach to improving patient health via implementation of the Patient Medical Home (PMH) vision;
2. Increase awareness of the PMH vision, goals and value;
3. Introduce PMH success stories and considerations for implementation in Saskatchewan;
4. Identify areas of alignment between PMH and the Saskatchewan 2012 Primary Healthcare Framework; and
5. Identify how participants can contribute to the advancement of the PMH vision in Saskatchewan.

4 Identified Gaps

1. Ownership & Governance
2. Sustained Commitment
3. Role Clarification
4. Dedicated Resources

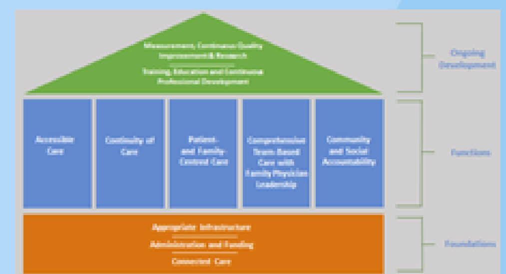


8 Priorities

1. Confirm ownership & governance of the PMH vision in Saskatchewan and have them develop a comprehensive implementation plan
2. Disseminate the event report to participants and the public and create key messages
3. Conduct a needs assessment and patient and community consultation
4. Conduct a meeting with government to establish clear commitments
5. Enable and resource health informatics and research
6. Engage and involve multiple jurisdictions
7. Conduct a 'go and see' roadshow
8. Conduct and disseminate a review of the "Patient First" report

125+ Committed Agents of Change

1 Home!

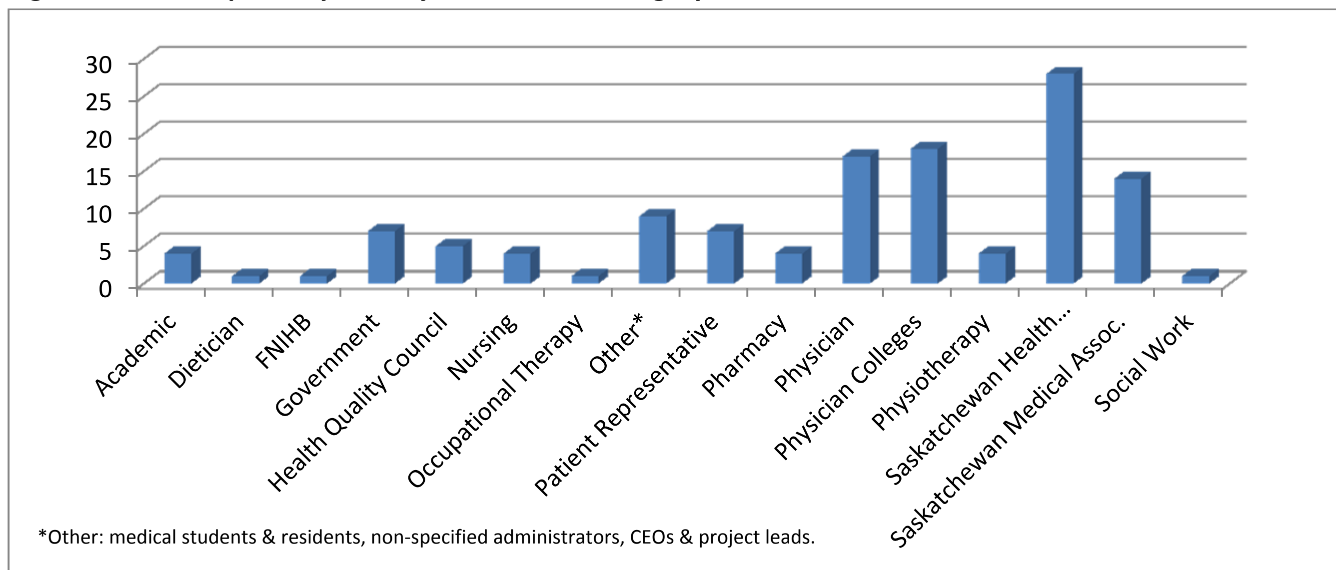


Patient’s Medical Home Saskatchewan: Symposium Report

I. Details & Design

In the spring of 2018, the Saskatchewan College of Family Physicians struck a committee to plan Saskatchewan’s first symposium to discuss and explore the Patient’s Medical Home approach to primary care. Co-hosted by the Saskatchewan Medical Association (SMA) and supported by the College of Family Physicians of Canada (CFPC), the event was held on June 18, 2018 and drew over 125 participants from various organizations and professions (see figure 1.1). The interest in this event exceeded the committee’s expectations, an indication that Saskatchewan is ready to discuss new ways of offering primary care.

Figure 1.1 - Participants by *Primary* Professional Category:



The symposium met specific objectives (see below) through a purpose-driven agenda that included: story-telling (*patient fireside chat*), awareness building (*principles and value of the Patient’s Medical Home vision*), best practice modeling (*Alberta success story*), sponsorship and alignment (*advancing the Patient’s Medical Home in Saskatchewan*) and interactive design (*small group work and prioritization*).

Objectives:

1. Gather thought leaders to discuss and unify Saskatchewan’s approach to improving patient health via implementation of the Patient Medical Home (PMH) vision;
2. Increase awareness of the PMH vision, goals and value;
3. Introduce PMH success stories and considerations for implementation in Saskatchewan;
4. Identify areas of alignment between PMH and the Saskatchewan 2012 Primary Healthcare Framework;
5. Identify how participants can contribute to the advancement of the PMH vision in Saskatchewan.

II. Participant Input

Participants were assigned to one of the ten Patient's Medical Home pillars and provided input and expertise that can help to identify what is needed to help ready Saskatchewan to adopt a PMH vision (see table 1.1). Each group was also asked to provide a 'tweet-like' call to action specific to their assigned PMH pillar (see dialogue boxes).

Table 1.1: Saskatchewan PMH Readiness Analysis

PMH Description	Strengths & Opportunities	Weaknesses & Barriers	Considerations
Connected Care: Practice integration with other care settings and services, a process enabled by integrating Health Information Technology.	• Low # of EMR vendors in SK facilitates agility and communication • Ministry already supporting and funding integration • Leverage out-of-province environmental scans • Saskatchewan success stories already exist	• Lacking plan for implementation/resourcing of indigenous populations • Silos between and within organizations prevents integration • Fee For Service payment model not ideal for implementation • Union contracts need to better-facilitate team-building • Change support is needed	1. Who owns/leads? 2. How dependant is team EMR adoption for success? 3. Dedicated oversight is needed 4. Linkage of EMR & EHR is needed
Administration and Funding: Practices need staff and financial support, advocacy, governance, leadership, and management in order to function as part of the community and deliver exceptional care.	• Single health authority provides opportunity for unified approach • Primary care structures exist and can easily advance to PMH vision • Existing champions and academic centres are poised to advance PMH • Funding available for alternate physician payment models	• More information is needed to understand how PMH vision integrates with specialty care • Geography and rural resources in SK creates complexity in implementation (more telehealth and innovation is needed) • Family physicians are not unified (re: funding, ownership and scope) • Inconsistent standards could limit outcome realization • Coordinated vision is needed	5. Funding models needed to support PMH adoption 6. Physician engagement or change capacity is critical 7. Timely and appropriate data is needed to appropriately monitor, measure & support/fund 8. SK EMR strategy needs to be enhanced to support PMH adoption

"SK needs maturation & modernization of EMR to enable interdisciplinary teams in order to provide #connectedcare, guiding by a shared vision."

"The Saskatchewan Patient`s Medical Home IS attainable if appropriately funded to support flexibility; patient needs; the `right' care with the `right' provider and the `right' time."

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SMA SASKATCHEWAN MEDICAL ASSOCIATION

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PMH Description	Strengths & Opportunities	Weaknesses & Barriers	Considerations
Appropriate Infrastructure: Physical space, staffing, electronic records and other digital supports, equipment, and virtual networks facilitate the delivery of timely, accessible, and comprehensive care.	• Symposium, unified SHA, EHR viewer and efforts to advance the "PMH 2.0" provide a positive foundation to launch implementation • PMH provides opportunity for re-aligning SK primary care	• Lack of funding (or reallocation) to support infrastructure • Information technology enhancement is needed • Mobilization of knowledge and facilitation of professional time needed to advance PMH • Improved access to data is needed • Culture and shared vision lacking	9. Need to identify best practice and existing models and success factors 10. Address/acknowledge that 20% of physician practices are paper-based 11. Payment models alone will not change practice approaches
Community and Social Accountability: Practice is designed to acknowledge and address aspects of the social and cultural context of the patient's experience, for individual and community benefit.	• First Nation's leaders have great knowledge • Senior population/groups offer both expertise and opportunity/need for PMH implementation • Influencers, existing models and technology is poised for change	• Clarity regarding scopes of practice • Funding to support physicians and implementation • Lack of trust between patients, administration and providers • Low political will in SK to advance and resource a new model • Culture of silos in primary care • Geography poses challenges	12. Grassroots engagement and political will to identify concerns and shape implementation is needed 13. Deeper understanding and cultural competence is needed before advancing implementation 14. Transparency, communication and accountability is critical
Comprehensive Team-Based care with Family Physician Leadership: Broad range of services offered by an interprofessional team. The patient does not always see the FP but interactions with all team members are communicated efficiently.	• Leverage direction from provincial government • Identify and grow champions • Physician leadership and expertise can advance the PMH implementation • Incremental implementation helps to mitigate risk and supports a bolder approach	• More data on population health, equity of care and service usage is needed to establish PMH success • Government structure and funding to support PMH implementation • Clarification and awareness of roles and responsibilities is needed • Shared vision and purpose is needed • Integrated Information technology is needed to appropriately support team-based care	15. More awareness and support is needed on interprofessional education (IPE) 16. Infrastructure (space, resources, etc.) needed to enable team-based care

"Infrastructure is foundational to a successful PMH which ties patients, providers and information together."

"Collaborative approach to #IPE on #PMH key for effective implementation – takes ALL Sask partners and infrastructure to improve care for patients."

"Patients have spoken. Physicians are ready. The SHA is committed. Let's do it! #teambasedcare #patientsmedicalhome2018 #bettertogether."

Patient's Medical Home Saskatchewan: Symposium Report

PMH Description	Strengths & Opportunities	Weaknesses & Barriers	Considerations
Patient- and Family-Centred Care: Family practices must respond to the unique needs of every patient and every family, creating an environment that understands context and enables patient support.	• Opportunity to merge to a single EMR with access to all providers and patients (patient portal technology expansion) • Patient advisors, committees and representatives are poised to provide input toward sustainable adoption and coordination	• Cultural, historical biases and language barriers pose challenges for patient-centred approach • Jurisdictional issues (federal-provincial) can inhibit re-allocation and support needed for new model • Patient navigation and education is lacking to facilitate PMH approach • Transportation, cultural competency and trust issues needs to be addressed to enable PMH vision	17. Communities need to be part of the decision-making process 18. Enhanced trust between professions and groups is needed 19. How and what data is obtained needs to be reviewed and directed to support a PMH model
Continuity of Care: Patients live healthier, fuller lives when they receive care from a responsible provider that journeys with them throughout their lifespan.	• Panelling or Rostering of patients can be implemented easily • EHR Viewer access can be enhanced/better-leveraged • EMR optimization and more timely communication between providers can facilitate PMH vision • Patient education of the system opportunities can facilitate adoption	• Funding is lacking to support transitions and continuity across care needs • Inequities in patient rostering is likely without deliberate design to avoid such issues • Patient portal requires work and a 'culture shift' to enable PMH values	20. Health Quality Council Reports will aide measurement and provincial rostering 21. Alignment and expertise of e-health, SMA, EMR reporting will enhance data management for PMH vision 22. An enhanced patient-centred approach to data management is needed

"Nothing about us, without us. #PMH2018. Expand current patient involvement to create broad-based cutlural and socio-economic awareness of cummunity needs thus making all stakeholders accountable to each other"

"Continuity of Care = continuity of information, that is, information that follows the patient throughout the system. #cultureofaccountability #datashadowing #healthyinformation"

Patient's Medical Home Saskatchewan: Symposium Report

PMH Description	Strengths & Opportunities	Weaknesses & Barriers	Considerations
Accessible Care: Adopting advanced and timely access, virtual access, and team-based approaches, accessible care ensures that patients can be seen quickly.	• Extended clinical operations and unnecessary service reduction can facilitate PMH principles • Allied health can be optimized to enhance and empower patient care • Opportunity to standardize/streamline prescription renewals	• Fee For Service model does not incentivize PMH values • Trust is currently built around productivity and not service tracking • Lack of information technology interoperability will limit patient access • Culture supports an over-reliance on quick wins versus robust and long-term reform	23. Re-allocate funding to enable and incentivize team-based care 24. Develop a patient-education strategy 25. Patient, population and prevention needs require tailored approaches
Training, Education and Continuous Professional Development: Emphasis on training and education ensures that the knowledge and expertise of FPs is shared with the broader care community to improve the health of all Canadians.	• Integrated professional development can be easily enhanced • IPBL University of Saskatchewan Health Sciences program can be better leveraged • Education (DME) sites can be used for PMH work	• Lack of shared vision • Role clarification and scope • Champions must be formally identified and supported • Pay schedules do not facilitate PMH adoption • Provider burnout and clinical demands	26. Attention must be paid to first train and enhance communications (telephone, text, EMR, etc.)
Measurement, Continuous Quality Improvement & Research: Family practices strive for progress through performance measurement and continuous quality improvement. Patient safety is always a focus, and new ideas are brought to the fore through research.	• Linked connected care and Prince Albert project is paving the way for a PMH vision. • Mentorship (in and out of province) is available • Quality improvement tools and student education channels can facilitate culture change	• Data/information privacy issues can slow or limit agility and adoption • EMR provider priorities do not always facilitate or align to interoperability needs • Provider knowledge, time and connectivity are limited	27. Enhanced skills and ability to measure results and integrate data is critical 28. Data collection must be integrated into day-to-day operations and incentivized 29. Citizen Health Information Portal (CHIP) is poised to support PMH implementation

"Accessible care is about the right care 4 the patient in the right environment, responding to community needs by the right team 4 the right outcome using increased value, data-driven sytems that R integrated across professional & cultural boundaries."

"Information follows the patient through the health system in a network of connected and accountable care providers. #healthyinformation #SKrocks #datashadowing"

"Build on SK's expertise & skills to use data that improves care: incentivize-integrate-align. #startnow #withpatients"

III. Stakeholders:

Participants identified a long list of required partners, stakeholders and champions deemed critical to a successful Patient's Medical Home Adoption in Saskatchewan (see Figure 1.2). Given the number of stakeholders required to implement a successful Patient's Medical Home vision, careful consideration of roles for each stakeholder along with how and when to engage them is needed.

Figure 1.2 – Word Cloud of critical stakeholders for PMH adoption in Saskatchewan:

IV. Priorities

To build momentum participants participated in a discussion and identified the following priorities to advance the adoption of the Patient's Medical Home vision in Saskatchewan:

1. **Confirm ownership & governance of the PMH vision in Saskatchewan and develop a comprehensive plan, with a common vision, roles, funding, and needs identification**
2. **Disseminate the event report to participants and the public and create key messages stakeholders can use to build momentum and engage champions**
3. **Conduct a needs assessment and patient and community consultation to develop a path for implementation**
4. **Conduct a meeting with government to establish clear commitments to fund PMH and align payment models**
5. **Enable and resource Health Informatics and research: EMR must be integrated, must follow the patient and EHR must support patient empowerment**
6. **Engage and involve multiple jurisdictions (federal government, metis and indigenous groups, municipalities, SHA Community Advisory Networks, etc.)**
7. **Conduct a 'go and see' roadshow and promising practice assessment to inform the planning process**
8. **Conduct and disseminate a review of the Patient First report to inform PMH work**

V. Gaps

Trust, communication and sponsorship are fundamental to gaining buy-in and adoption for transformational change. Understanding and making visible efforts to address stakeholder gaps is an effective way to support this work. To that end, participants were asked to write down one gap that needs to be addressed before full adoption can be realised. These gaps fell within themes as follows:

Theme 1: Ownership & Governance

"Who is leading the charge or is responsible for developing and implementing a shared vision and ensuring we agree to the principles of the PMH so it may be recognized across the province?"

- Cross-jurisdictional plan is needed with concrete next steps
- A project owner and decision-making process for implementation is needed
- An interdisciplinary working group and patient advisory committee should be struck

Theme 2: Sustained Commitment

"I need full and sustained support" "I need confidence and assurance that [Ministry of Health/SHA/Physicians/SMA/Professions] are committed to move forward with a PMH vision."

- Funding commitments and allocation/re-distribution (from Ministry of Health)
- Demonstrated commitment to a long-term and sustainable strategy
- Strong leadership to guide who/when/how we will move forward

Theme 3: Role Clarification

"We need the 'right people' doing the 'right work' and not being dictated by traditional [historical] models"

- What is my [specialists/indigenous groups/students/community/health care professions/patients (representatives from first nations)/SCPOR/Family Medicine Area Leads] role within this work?
- How can we facilitate interprofessional communication to enable team-based care?
- What is the role of the Community Advisory Network (and who is responsible for clarifying this, Ministry of Health or SHA)?

Theme 4: Resources

"How do I modify my existing clinic to become a PMH – what are the steps and what do I need to start?"

- We need evidence to document best practice and identify patient/population/care gaps
- A fully functioning and integrated EMR [and EHR] is needed
- A better understanding and focused financial support, remuneration (for all professionals) and incentives that drives PMH adoption is a definite gap
- Information gaps: practice data, outcomes data, patient/community education, project updates

VI. Commitment

Symposium participants represent a large body of committed change agents who can be guided and supported to turn this event into a movement that drives adoption of a Patient's Medical Home vision. The following list of participant commitments represents a small but powerful demonstration of the readiness for a new primary care model in Saskatchewan.

Participants will…

"Share a national vision, expertise, resources and success stories ◦ Engage ◦ Develop and launch physician practice reports by fall 2018 ◦ Engage entire team, including patients/communities to gain information about primary care networks and to build evidence-based approaches ◦ Implement EMR enhanced usage strategy to enhance effectiveness for physicians ◦ be a strong advocate for adoption of PMH in SK ◦ Continue to promote implementation, not just concept of PMH and build practice panel reports with HQC ◦ Discuss the PMH model with my colleagues and other health care professionals (including clinic director) ◦ Seek greater detail about functioning PMH models ◦ provide good access at the right time to the right provider in the patients' own community ◦ Spread the PMH gospel ◦ Support PMH providers in working to their full scope/potential ◦ Do a much better job of community engagement ◦ Educate all stakeholders on redesigning to migrate to a PMH model ◦ Start the conversation with Colleges and other stakeholders ◦ Enhance the relationship with community leaders to better understand their needs on a regular basis ◦ Evaluate my own practice to bring awareness and align to PMH locally ◦ Educate patients ◦ Align services to make PMH successful and enable the right services are accessible to the client, closest to their home ◦ Support the demonstration of PMH in Prince Albert ◦ Educate at least three colleagues on the PMH and share the website model ◦ Continue to advocate for PMH and connected care through my career – it works! ◦ Apply other ways of collecting data ◦ Form a working group at my practice to move PMH forward ◦ Explicitly reference elements of the PMH model into day-to-day operational decisions in our clinic ◦Dedicate time to learn more about PMH model ◦ Be an advocate for change in my community ◦ Listen and learn ◦ Encourage and advocate for EMR/FAX capabilities to management ◦ Continue to seek to understand how this already aligns with our PHC teams in the SHA and seek what's missing and where to focus ◦ Ensure patient access to my services and provide good patient and family-centred care ◦ Educate and publicize ◦ Help to ensure CANS are implemented in a way that ensures they are empowered to represent the voice of the people ◦ Support family physicians in receiving an understanding meaningful patient data ◦ Provide positive support for the model and recommend realignment of resources where needed ◦ Develop an informatics-enabled workplace and EMR ◦ Evaluate my current practice through a PMH lens and identify shortfalls ◦ Determine what I can do in my clinic to serve our patients better ◦ Be a champion for PMH and explore opportunities to advance this in SCPOR ◦ Continue to focus on a Patient First strategy ◦ Share resources with any health care provider in the province ◦ increase my knowledge related to IPE ◦ Learn from FP/GPs in Saskatchewan– what their hopes and fears are regarding PMH ◦ Develop PHC Networks that would support teams ◦ Build regular QI patient feedback starting with EMR tracking of CDM targets ◦ Give up some responsibility to others (trust) ◦ Assess our clinic to see how far we are on PMH scale ◦ See the patient where they are and work with their goals ◦ Build on expertise, skills to use data that improves care, incentives and integration ◦ Promote a PMH philosophy with PFAs and encourage their availability to serve as my practice grows ◦ Ensure that the conversation continues within the context of adopting a PMH model and endorse its utility within my profession ◦ Help providers understand what they need to do to foster integrated clinical communications ◦ Share the PMH framework with my team as a tool for developing our relationships with family physicians ◦ Spread the word and continue to collaborate ◦ Report back to our Executive Council and managers ◦ Dialogue with stakeholders (SHA, SMA and Ministry of Health) ◦ Promote the ideals to PMH ◦ Promote PMH in SHA as a key method for improving the patient experience and health outcomes ◦ Link Access ◦ Research different PMH models ◦ Keep speaking out from a patient perspective ◦ Be an ambassador for concept as a key principle needed to develop high-quality transitions from acute care to community ◦ Promote among my colleagues and invest in PMH myself ◦ Advocate for people to gain full access to their medical records ◦ Share information regarding the PMH model with SSOT ◦ Start a PAC at WestWinds ◦ Share more stories to help guide needs assessments and focus groups ◦ Ask patients what they want in their care ◦ Hire an educator to develop a curriculum around PMH pillars for FM residents and faculty ◦ Advocate for model and how it aligns with the strategic direction of the health system ◦ Ensure that patient an family advisory groups are developed and CANS are supported and structured effectively ◦ Bring a new physician on board with the PMH model ◦ Help educate my peers on the importance of PMH ◦ Continue to be involved and connected in order to move this model forward ◦ Include prevention and promotion targets in the patient medical home conversation ◦ improve outcomes through adoption of PMH ◦ Share information with my colleagues ◦ Continue to provide a voice for those who are often over-looked, ignored and unseen ◦ bring concepts to key meetings in my professional circles ◦ Continue to support connected care for the people of Saskatchewan (Indigenous health, Prince Alberts demo site, PCN network development ◦ Move commitment to primary care research in my practice ◦ Help with analysis of unmet needs in the community"