


Nursing in Your Family Practice Initiative:

Primary Health Care – Capital District Health Authority, NS

Taming of the Queue Conference
Ottawa, March, 2009

Patsy Smith *Consultant on behalf of Primary Health Care, CDHA*

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The Capital Health Program

A program of supports for family physicians and family practice nurses working in fee for service practices in Nova Scotia

- Funded by Primary Health Care, Capital Health with support from industry partners
- Launched in March, 2007
- 3 program intakes (4th April, 2009)
- 35 teams

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The Model

- Full scope of practice
- Highly integrated team environment
- Holistic approach
- Health care encounters as opportunities (non-selective patient visits)
- Patient fully participates in care
- System development to support application of clinical practice guidelines

Business Case

- Fee for Service
- No “upfront” funding requirement
- Increase number of patient visits each hour (2-3)
- Physician must interact with patient in order to bill
- Additional revenue generated covers expenses associated with integrating a nurse

* Nurse must be working to full scope of practice and providing care for complex or time intensive patients.

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Program Elements

- Physician resource manual and recruitment
- Nursing education program
- Resource kit
- Support for integration
- Collaborative team days
- Lecture series

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Motivational Interviewing
1. Ask questions, Minimize statements
2. Express Empathy
3. Take a curious, nonjudgmental stance
4. Learn to sit with ambivalence
5. Avoid argument


General Information

Integration Support

- Scheduling
- Office efficiency
- Space
- Organization
- Communication
- Full scope practice
- E-mail and phone support

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Collaborative Team Development

- Three team events: Diabetes, COPD, CV
- Network participating practices
- Primary Care providers as experts
- Focus on:
  - Communication
  - Role clarification and collaboration in practice
  - Best practices
  - Clinical challenges
  - Electronic records

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Patient Mr. G B

Lecture Series

- Monthly education event
- Goals
  - Networking
  - Continuing education
  - New physician engagement
  - Identification of issues
  - Information sharing

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Program Evaluation (phase 1) Components

- Provider Survey
- Service description survey
- Project tracking form
- Team survey

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Program Evaluation (phase 1)

Key Outcomes:

- Significantly enhanced access
- Nurses practicing in expanded scope
- Provider satisfaction
- Enhanced screening and prevention

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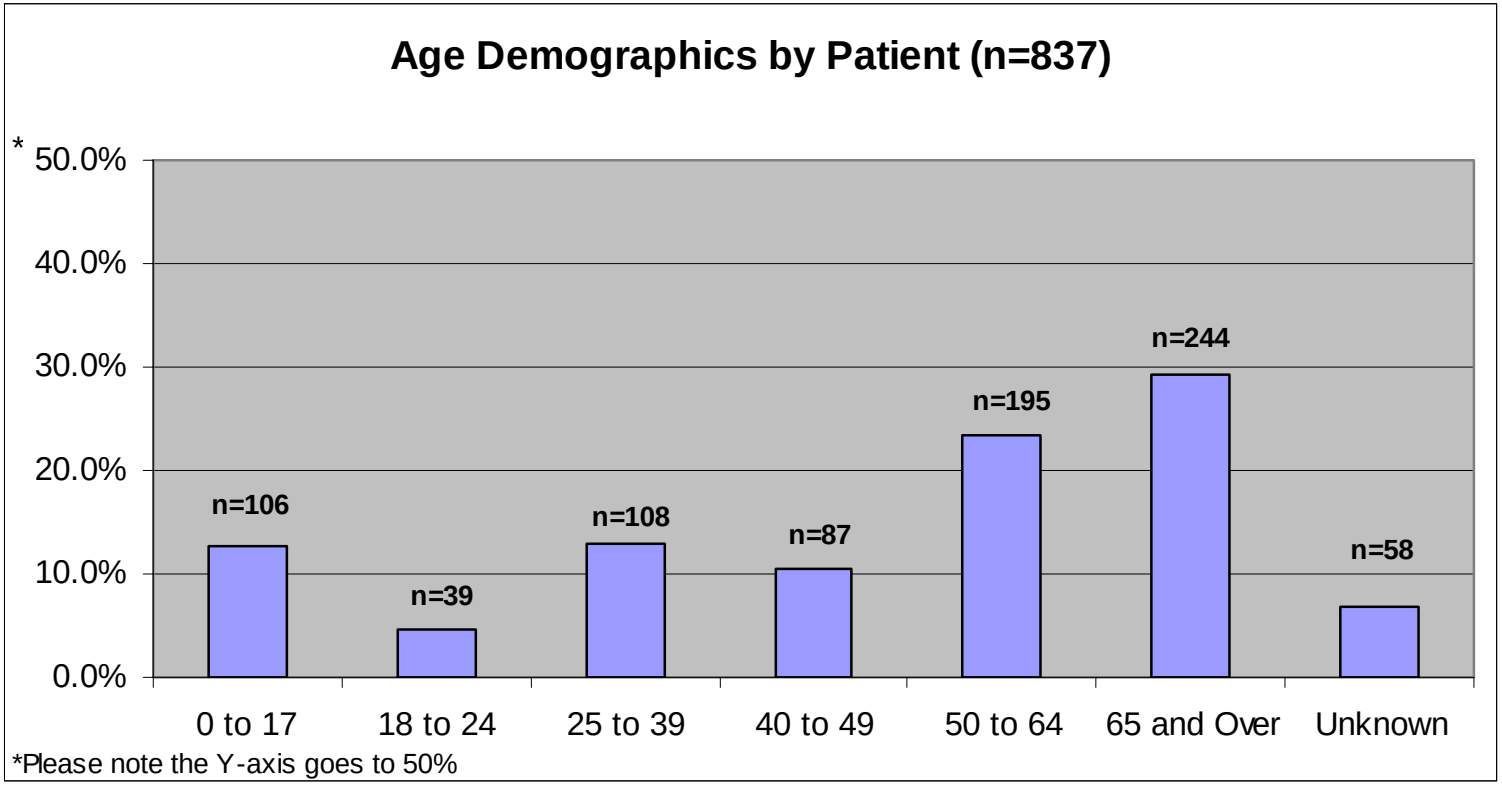
Patient Age Demographics



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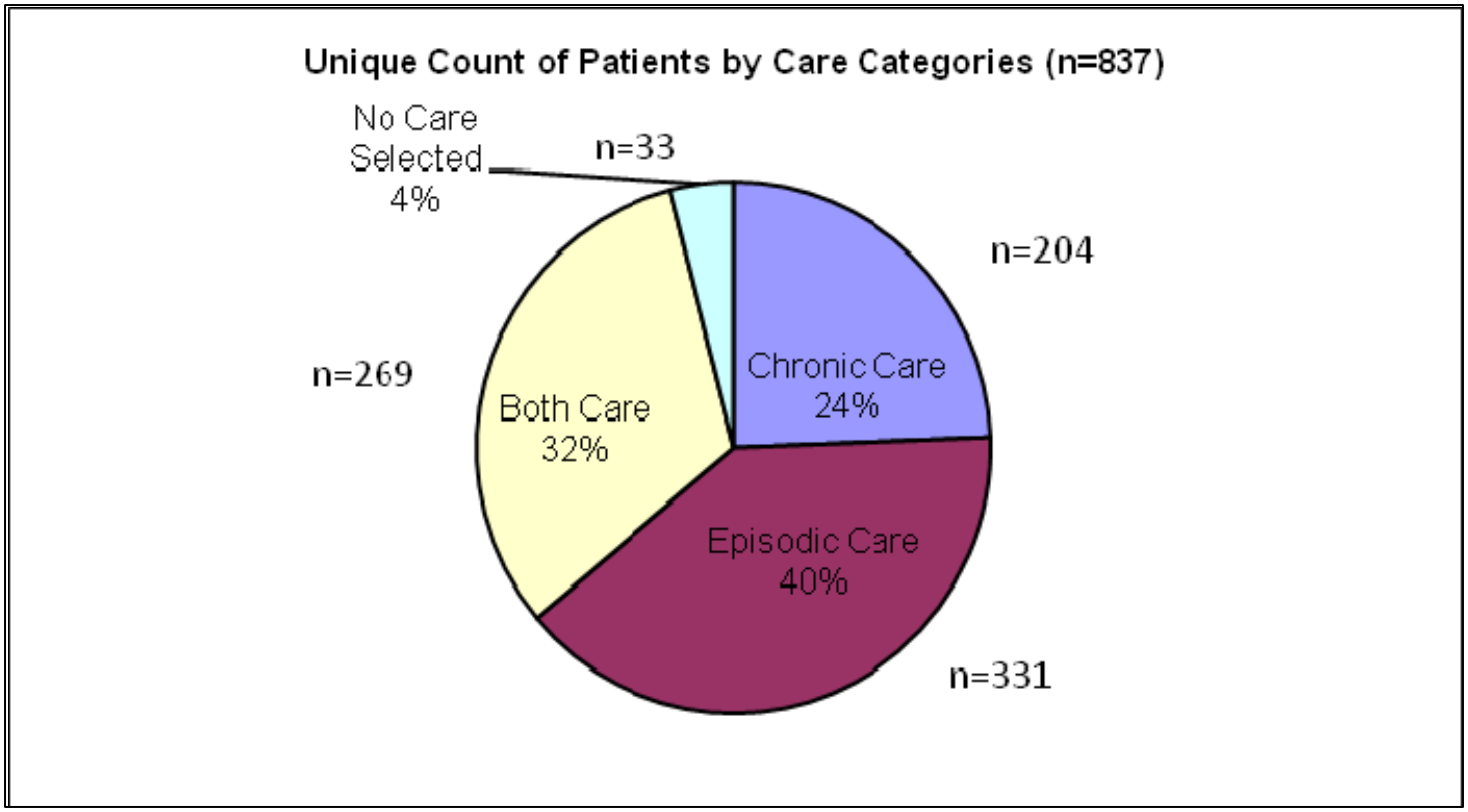
Type of Patient Care Demographics



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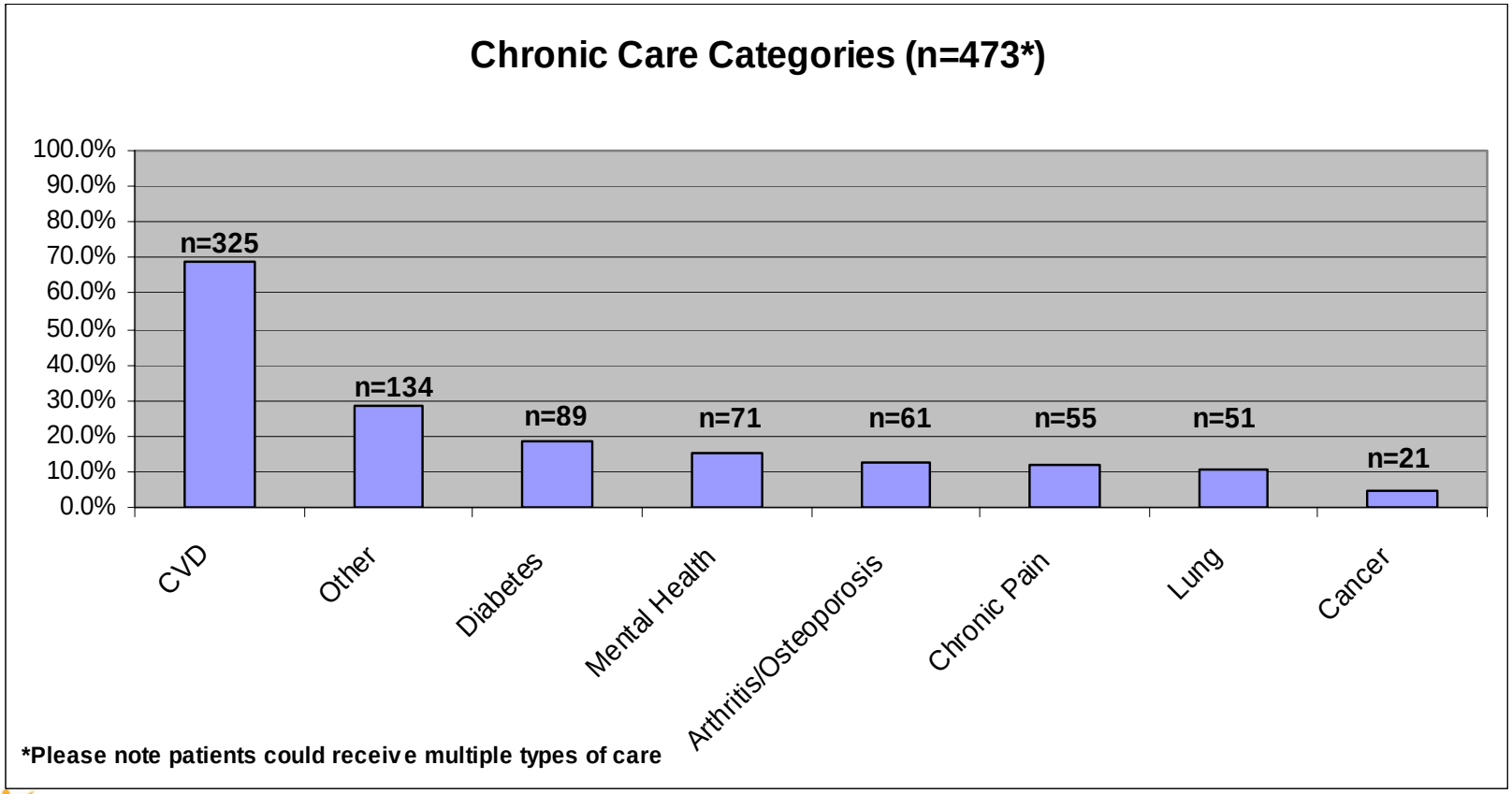
Categories of Chronic Care



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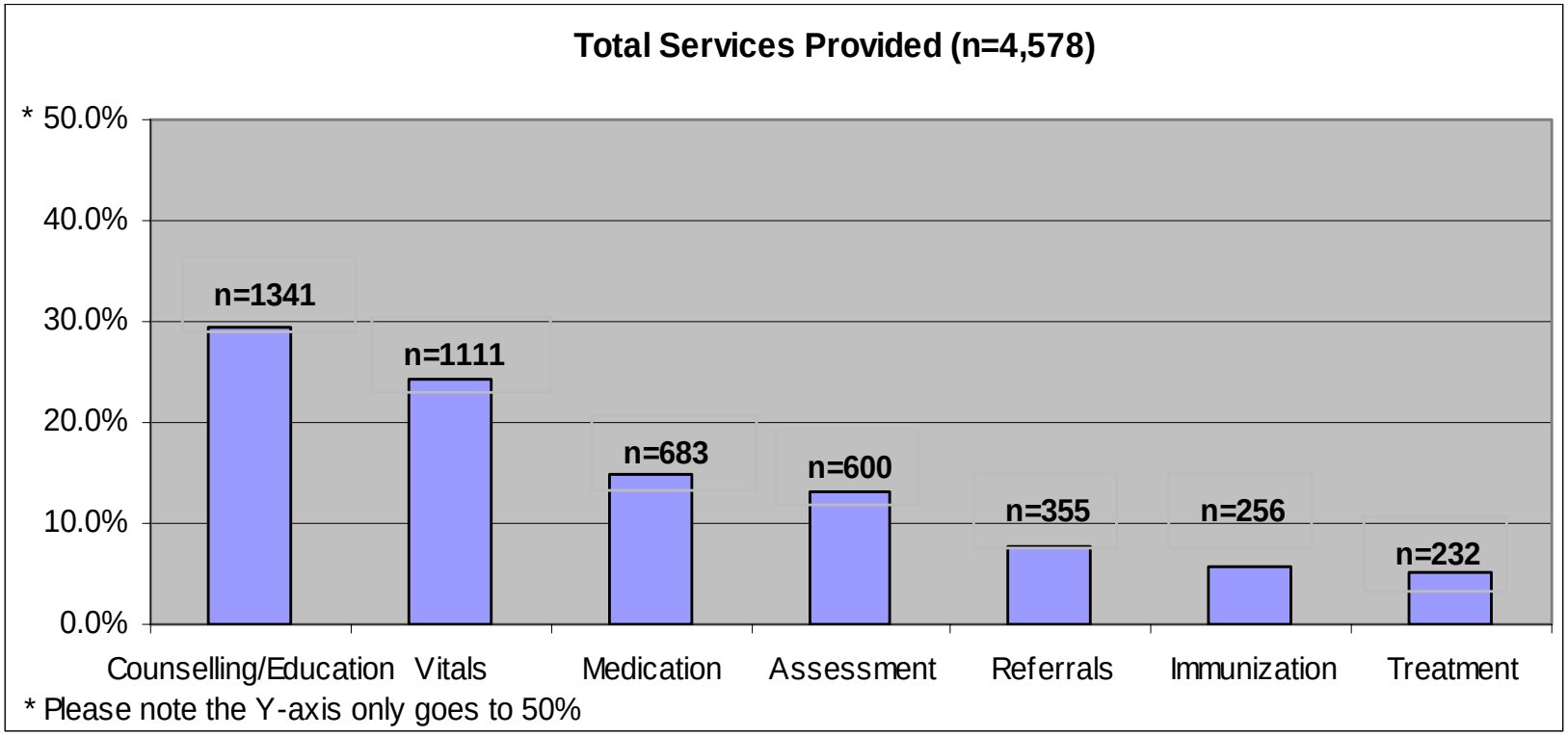
Types of Services Provided



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Access

- Practices accepting new patients

  Pre: 20% indicated yes
  Post: 70% indicated yes

- Impact on wait times to book a regular appointment

  70% indicated wait times have decreased
  30% indicated wait times remain the same

- Absorbed patients from a practice who is downsizing or closing

  60% indicated yes

Patients/hour

- On average, practices were able to schedule approx. 2 additional patients each hour – This translates to an increase in capacity of ~ 40%
- Able to accommodate more urgent care patients
- Reduces wait times for appointments
- Should reduce ER visits and walk-in visits

Increasing Capacity

- Diabetes education and insulin starts
- Procedures: 24 hour BP monitoring, ABI, minor procedures, IUDs, cervical screening.
- Coordinating “specialist” visits
- Advancing the threshold for patient referral
- Electronic records
- Research
- Student mentorship

Decreasing Demand

- Health promotion, screening and immunization
- Risk factors (Smoking, nutrition, activity, stress, sexual health)
- Early detection and intervention (HTN, DM2, COPD, Cardiac disease)
- Aggressive chronic disease management (achieving targets, action plans, CPG)
- Education and enhancing self management skills

Facilitating Referral

- Decreased wait time to see family practice team
- More timely referral
- Increased awareness of community resources and how to access
- Enhanced information to assist in triaging referrals

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I believe patient care has improved, more services can be offered on-site and I am more content with my job.
(Physician Survey Response)

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It really has enhanced the quality of care to my patients overall. The establishment of this new collaborative approach after 17 years of solo general practice is quite an achievement in itself and this to the credit of the program.
(Physician Survey Response)

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Benefits

- Enhanced care
- Improved access
- Improved work-life situation
- Team approach
- Increased capacity

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Program Evaluation (phase 2)

Spring, 2009

- Chart audit
- Patient satisfaction survey

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Integration support is key!

- Mentorship
- Practice support
- Networking with peers
- Ongoing education
- Specific to primary care context (providers as experts!)

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Thank-you

- Shannon Ryan, Manager PHC, Principal investigator
  shannon.ryan@cdha.nshealth.ca
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