Project Spread Profile:

Princeton Access to Specialist Care

Home Division	South Okanagan Similkameen Division of Family Practice
Division Membership	South Okanagan Similkameen Specialists, Princeton area GPs
Project Scope (community(s))	Princeton and surrounding area
Timeline (months)	January 2014 – January 2015
Health Authority	Interior Health Authority

PROJECT BACKGROUND

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.

The Princeton Local Health Area (LHA) serves approximately 5,400 people in Princeton, Hedley, Coalmont and the surrounding area. 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.

Despite the size of the community, demand for specialty care is high, 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. There is also a higher prevalence of anxiety/depression, diabetes mellitus, heart failure and asthma.

Patients from Princeton with significant health concerns often had to travel to Penticton or Kelowna for investigations and specialist appointments. Barriers to travel prevented about 30% of Princeton area patients from receiving specialist care, creating an added burden on rural family doctors.

PROJECT GOAL

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.
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.

BENEFIT FOR PHYSICIANS

- Increased number and variety of specialist clinics in Princeton
- Improved processes, knowledge transfer, and relationships between specialists, family physicians, other healthcare providers, and patients
- Improved physician and healthcare provider experience by reducing the burden through increased access to specialists
- Provided Princeton physicians with customized education and relationship-building opportunities through on-site CMEs with visiting specialists

BENEFIT FOR PATIENTS

- Patients experienced a reduced burden of travelling to specialist appointments
- Specialist availability nearly tripled (increasing from 4 – 11) to include the addition of: respirology, general internal medicine, nephrology, urology, rheumatology, general surgery, orthopedics, and methadone services

GAPS AND DELIVERABLES

Key Deliverables are numbered and further indicated with an asterisk (*)

Problem Identified	Baseline Data – start of project	Strategies and *Deliverables	Success Indicator
What was the specific problem identified	List any data collected at the start of the project if applicable	How did you approach the problem? What was the identified solution/deliverable?	How did you measure your access in completing this deliverable?

Problem Identified	Baseline Data – start of project	Strategies and *Deliverables	Success Indicator
Princeton patients did not have adequate or accessible access to specialist care	Barriers to travel prevented about 30% of Princeton area patients from receiving specialist care, creating an added burden on rural family doctors.	• Among other priorities, the Princeton working group identified that their community needed better access to specialist care and more efficient appointment bookings for Princeton patients when they have to travel to Penticton.	Specialist availability nearly tripled (increasing from 4 – 11) to include the addition of: respirology, general internal medicine, nephrology, urology, rheumatology, general surgery, orthopedics, and methadone services Thirteen specialists delivered 46 clinics totalling more than 500 patient appointments 100% of patients reported their experience as excellent or good During a 10-month period, 184 patients were surveyed (Jan – Oct 2014). The survey 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.

Problem Identified	Baseline Data – start of project	Strategies and *Deliverables	Success Indicator
Princeton Family Physicians identified the need for improved relationships and knowledge sharing opportunities with specialists	Princeton doctors were isolated in their rural practice and had significant concerns about the sustainability of retaining physicians under the challenging circumstances.	• It was understood that specialist outreach would create 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. Family Physicians reported 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 was a drastic improvement since the project interim report in July 2014.

RECOMMENDATIONS TO SPREAD COMMUNITIES

General Lessons Learned

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

Stakeholder Perspectives

In the table below, record specific lessons from different stakeholder perspectives

Title	Notes
Physician Champion(s)	Family Physicians reported 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. *"Having specialist outreach clinics has improved my ability to provide patient care tremendously,"* said one family physician. *"I am very grateful for their existence."*
Health Authority	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 out- reach 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."*

Specialists	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. All of the specialists found that the quality of care they were able to provide at the out- reach 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.
Patients	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."*

PLANNING

As a result of informal 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, Interior Health priorities, and the goals of the Doctors of BC Rural Issues Committee.

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.

ENGAGEMENT & IMPLEMENTATION

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

EVALUATION

Several provider and patient surveys were collected over the study period.

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.

SUSTAINABILITY

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. All parties felt confident that the initiative will be sustained after the project's completion in 2016. Subsequent projects including the Telemedicine initiative built upon this success by offering virtual platforms for patients to efficiently connect with specialists.

BUDGET SUMMARY

Planning	
Engagement & Implementation	
Evaluation	
Sustainability and Spread	
TOTAL	

SharedCare Partners for Patients

BRITISH COLUMBIA

doctors of bc
British Columbia Medical Association

SUPPORTING SPREAD

A detailed final report and project charter for this project are available upon request.

For more information contact:

Home Division Executive Director:
Tracy St. Claire, SOS Division of Family Practice
tracy.stclaire@sosdivision.ca

Project Manager:
Kathleen Jagger, SOS Division of Family Practice
Kathleen.jagger@sosdivision.ca

Regional Shared Care Liaison:
Sarah Forster, Shared Care
SForster@doctorsofbc.ca

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