Primary Care Strategic Elements

March, 2013

Recommended Components to Support Primary Care Engagement

Primary Care providers (physicians, practitioners and other staff who provide care in a primary care setting such as family health teams, community health centres, individual practitioner offices) play a central role in the care of seniors with multiple co-morbid conditions that interplay and can cause behavioural stress. The complexity of this population is increased by social supports (e.g. caregivers, dyads), as well as other health providers that need to be involved in care.

It is critical that those initiatives which target this complex population (e.g. Behavioural Supports Ontario, Health Links, Senior Strategy) engage and support primary care within the context of a broader integrated system in order to build competence in behavioural management and foster a integrated response to both prevention and complex care management.

As an opportunity to further define a standard approach to assessment, referral, and service delivery models, the Behavioural Supports Ontario Provincial Resource Team recommends the inclusion of the following critical strategic elements for a comprehensive primary care strategy.

- Primary Care Leadership
- Primary Care Engagement
- Education
- System Integration
- Tools & Processes to Support Patient Care

It is crucial that any strategy to engage primary care take a multi-pronged approach. The most effective strategies will include activities that fall under most, if not all, of the 5 strategic elements described below. While it is recommended that each element is included in LHIN primary care strategies, how this element is addressed will vary from LHIN to LHIN based on local needs. Appendix A provides a snapshot of current BSO primary care activities in the LHINs which address these 5 strategic elements. It is also recommended that LHINs continue to connect with and learn from each other as they test new approaches; and that supports such as the use of OTN, E-records and primary care champions are considered as enablers for any component. Finally, a successful strategy to engage the primary care sector will leverage and build on the relationships and linkages between primary care and other sectors that are critical to support this complex population (e.g. specialty services and geriatric psychiatry)

Any activities to address these components should address system accountability, interprofessional service delivery and capacity building processes and promote and support meaningful involvement of persons and families during planning and implementation.

01. **Primary Care Leadership**: Individuals or teams that have a designated responsibility for moving BSO Primary Care work forward will be more likely to see continued momentum. Consider including primary care committees or human resources dedicated to supporting system navigation and consulting with, educating and connecting to primary care providers around issues related to care of patients with psychogeriatric needs (e.g. regional medical lead, a primary care consultant or even a psychogeriatric resources consultant (PRC) dedicated to the primary care sector).

    Keys to Success:

    - Make supporting Primary Care an integral part of an individual or committee's responsibilities rather than leaving it to chance.
    - Find the "right" leadership – leverage relationships, include key stakeholders and opinion leaders, include those with an ability to build connections.
    - Use leadership resources to engage in ways that work for primary care (when, where, how is best for them)

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02. **Primary Care Engagement:** Primary care is often one of the first touch-points for older adults with responsive behaviours and their family caregivers. As such, it is imperative that primary care be included in a systemic strategy to support this population, and also that engagement with this sector is driven by shared solution finding. Consider specific events, consultations or other efforts to engage primary care in meeting the needs of this complex population. This could include providing information about existing BSO initiatives and how they support primary care goals, aligning with related initiatives such as Health Links, collaborating on projects of mutual interest (e.g. toolkit development), and working with primary care stakeholders to identify the needs of this population as well as their own needs to best support these patients.

    Keys to Success:

    - Engage primary care as partners and collaborators early in the development of initiatives to support those with complex care needs or the primary care sector itself.
    - Ensure genuine engagement and consultation opportunities – demonstrate the value of their input!
    - Consider initiatives / strategies that will fit into schedules of primary care providers.
    - Select primary care providers who have a keen interest and engage them as early adopters (e.g. FHTs or CHCs who have expressed an interest or even individual champions within these settings).
    - Foster relationships with your LHIN Primary Care Lead and other key decision makers to ensure BSO is on the Primary Care agenda.
    - Leverage medical directors to connect to broader primary care community.

03. **Education**: Primary care is seeking opportunities for further education specific to complex needs of older adults with responsive behaviours, and their caregivers. Consider training opportunities for physicians, NPs, and interdisciplinary primary care team members around

behavioural assessment and management. This could include formal training with targeted training events, CME workshops, journal clubs, case studies, case consultations or opportunities embedded into existing events and structures.

Keys to Success:

- Develop an understanding of the learning needs of target learners – What specifically do they need to know? What skills are needed?
- Incorporate interdisciplinary team learning opportunities whenever possible to foster team collaboration.
- Use a variety of learning strategies that are grounded in adult learning theory and the needs of target learners.

04. **System Integration**: With the integral role of primary care as the first touch point in care of those with complex needs, it is essential that we wrap services around primary care to enable better flow of information, referral and collaboration between Primary Care, specialist services and other community service providers. This could include specialty services, geriatric psychiatry, First Link, integrated records, client lead, memory clinics and integrated support for complex cases.

Keys to Success:

- Involve all partners across sectors in developing strategies for system integration.
- Ensure a person-centred approach to care informs all integration strategies.
- Embed mechanisms to link tertiary and specialized mental health work with primary care
- Explore opportunities and mechanisms for shared leadership models between specialty and tertiary care

05. **Tools & Processes to Support Patient care:** Primary care is seeking access to tools that will help them provide better in-the-moment care to patients with complex care needs and their families. Consider developing or providing access to standardized, best practice tools and processes to support care assessment and management. These could include low-tech solutions such as evidence-based toolkits, or hi-tech solutions such as OTN to support consultation and enable access to specialized resources.

Keys to Success:

- Understand what tools and processes are most needed by primary care providers
- Scan for existing tools and processes to avoid duplication. Then determine how existing resources fit the needs and adapt only as necessary.
- Use best practice evidence (research, practice-based and lived experience) when developing tools and processes.
- Ensure processes integrate Primary Care with other service providers and include all stakeholders in development.

Appendix A - Snapshot of LHIN Activities, March 2013

01. Primary Care Leadership	
HNHB	• Primary Care Committee (collaboration of primary care and geriatric specialists)
WW	• Primary Care Clinical Consultant
NSM	• Medical advisor- .2 FTE, non clinical • Establishing relationships with Health Links and Primary Care Network. • Medical Advisor Network in one region and Memory Clinic and Medically Complex Clinic starting in April
CL	• BSO Regional Medical Lead • Exploring relationship to Health Links; BSO Medical Advisor is keeping BSO on Primary Care Network agenda
CW	• PC focused PRC; CCAC primary care coordinators ; Primary Care Medical LHIN Lead
NE	• BSO Regional Medical Lead and 4 other BSO Medical Hub Champions • NE BSO Medical Advisory cmt. • Sustainability via NE BSO Regional Medical Champion and Medical Hub Champions
02. Primary Care Engagement	
HNHB	• BSO has been presented at the Primary Care Network Meeting. This group meets regularly and has representation from Primary Care Physicians across the HNHB LHIN. The LHIN Advisor, also the Improvement Facilitator is at these meetings with the assurance of making the links. • Meetings among the two LHIN Leads for BSO & Health Links, and the Implementation Leads of both projects to ensure a connection. The most important is building upon the existing models, such as the Integrated Community Lead (ICL) model for BSO – it is a close link to what is being shared as 'care coordinators' and this ICL model was also highlighted as a best practice in the Seniors Strategy by Dr. Sinha. • We have presented at two primary care conferences (Care of the Elderly – Perspective for Primary Care), McMaster Geriatric Medicine Grand rounds, the Regional Geriatric Program and other outreach to ensure BSO is presented, but that the primary care, geriatricians and geriatric psychiatry physicians have provided feedback. • We completed a Primary Care Survey for the HNHB, with 61 responses • In our sustainability planning, we sent a separate survey for the primary care committee from last year to ask their thoughts on sustainability, and met with 5 of the members in person • Ongoing involvement of a primary care (FHT) physician on the primary care toolkit over the summer and fall 2012, with more feedback recently to help us work to finalize and post the toolkit • McMaster University project - Occupational Therapists – interviewing key experts in primary care to ask about what models would work for the complex clients or those at risk; BSO Implementation Project Lead facilitating these meetings & listening in to understand the challenges. The OT Project will produce 11 papers and proposals with ideas, for which the LHIN will examine for whole or elements that can be incorporated. • Primary Care at planning system tables locally – BSO Kaizen events
WW	• Meetings with PC providers to identify their needs • BSS champions with CHC and specific FHTs, • Primary Care at planning system tables locally – BSO Kaizen events
NSM	• VSM • Meeting with PC providers, community and LTC, re role of medical advisor and BSO – how to refer and how they can support.- also how PC supports. • Plans to integrate BSO services with one Health Links. Entering discussion with others • BSS liaison champions with each HSP- including PC

	• BSO medical advisor has met with LHIN PC lead, FHTs and CHCs. • Attends BSS Kaizen events and Operations Committee. Advises to sub committees, e.g BSU
CH	• Fostered a relationship with the primary care lead and other decision makers to ensure BSO is on the primary care agenda. The physician director of the dementia network is also a member of the Champlain Primary care table and the Champlain Behavioural Support System Steering Committee.
CL	• Engaging with primary care teams 1:1 meetings re: BSO; identify supports, learning needs of primary care. • BSO Medical Advisor member of primary care network and HPAC • Plans to integrate BSO services with Health Links • Engaging FHTs and CHCs - meeting with those who expressed interest first, to be followed by remainders • BSO Medical Advisor has met with primary care LHIN lead, gave presentation re BSO to primary care network meeting, opportunity to continue engagement and link with monthly newsletter to primary care
CW	• PRC imbedded in FHT • PC LHIN Medical Lead engaged in BSO governance committee • Health Links to integrate BSO framework • Primary Care Integrated Seniors Team (SHIP) • PC Care Coordinators CCAC; 10 FHT and PRC • LHIN Medical Primary Care Lead
MH	• Engaging PC around development of new tools & clinical pathways
NE	• Medical advisory committee • Participation in Kaizens • Clinical Development Days • Meetings with PC providers • Integrated behaviour teams include physicians and NP's • Primary Care Lead invited to attend BSO medical advisory cmt
03. Education	
WW	• via PC PRC • JN club with physicians and FHT members monthly
NSM	• Facilitated 2 BPSD training sessions with MainPro credits – to 38 PC providers and LTCH medical directors .
SW	• Workshops currently being planned for spring 2013 for dementia BPSD targeting physicians. Primary care
CH	
CL	• Workshop planned for dementia BPSD targeting physicians. • Primary care engagement and targeted education sessions with interdisciplinary primary care teams • BSO Medical Advisor to speak at regional geriatric day (April)
CW	• Proposing model like NSM
NE	• CME workshops planned as part of the regular medical advisory cmt. Meetings • BSO awareness sessions in progress for FHTs and other Primary care
04. System Integration	
HNHB	• Common Client Record • Clinical Lead
WW	• Primary Care Memory Clinics
NSM	• Centralized intake • Working on common client record in one region. • Integrate support for Complex Cases
CL	• During engagement meetings providing information packages re First Link to primary care as was

	identified as need in primary care survey; advising of local specialized resources/ teams
CW	• EMR • First Link to Primary Care • BSO standard operations approach
05. Tools and Processes to Support Patient Care	
HNHB	• evidence-based toolkit (safety checklist, assessment tools, decision trees, treatment/ Management suggestions
WW	• OTN for Geriatric psychiatry clinic – Guelph and Rural FHT • OTN for Geriatric Medicine – rural FHT
SE	• Primary Care Dementia Assessment & treatment Algorithm (PCDATA)
SW	• OTN for Geriatric psychiatry clinic –Grey Bruce, Huron Perth, Oxford, Elgin, London Middlesex • 54/78(69%) LTC have OTN
CL	• OTN for Geriatric Outreach Team with • six rural LTCHs
CW	• Tools and processes to be developed; OTN used for medical clinics at acute care centres
NE	• OTN for Specialty consultations