Sante Ouverte - OPEN HEALTH - Niverville - Vision

Objective

To create a single door access to appropriate primary health care for the town of Niverville, and the surrounding geographic area , with the intention to move towards a 24 hour access, seven days a week. This services to include access to primary care clinicians, whether these be physician, nurse practitioner or physician assistant. It will also include primary health care nurse, chronic disease team, public health, family first and mental health, none of these are expected to have 24-hour availability but would hope to move towards extended hour availability. There would also be access to lab services with the actual analysis being carried out off site.

The clinician services would include the variety of services currently offered with the addition of extended hours on site and telephone availability. There is no intention to create an emergency room. CTAS 1 & 2 will be treated with first aid measures while EMS are called to transport to the nearest open emergency room.

There would be a gradual transition to a 24/7 care, envisioned to take five years to fully develop.
The realization of this objective will require the cooperation of several organizations which already have a track record of working together. These include, but not limited to, the Town of Niverville Council, Southern Health/ Sante Sud Regional Health Authority, Heritage Holdings, Niverville Medical Clinic as well as the relevant departments of Manitoba Health.

History

In 2003 the local town council started work to renovate the building on 2nd Ave., South that had previously been part of a chicken hatchery. Then, working with the Regional Health Authority of that time, staff were located to provide the start of a primary health care service to the town and surrounding area. Initial services included a Primary Care nurse, Mental Health, Public Health and Family First. Initial physician services were provided half a day from St Pierre as well as a physician coming from the city on Saturdays.

In the summer of 2005 two physicians relocated to the town and started working from three rooms in the same building, rented from the Regional Health Authority. One of these physicians had been working as the Medical Director in Primary Care for Manitoba Health. Very quickly these two physicians became full-time and, in 2007, a third physician was recruited. At this point because of increasing numbers both in the town and being serviced by the clinic, the medical clinic with the help of the town, renovated an upstairs location while the rest of the primary care services were relocated to an adjacent empty space within the same building.

From early in 2006 the various care providers form what is now known as the Niverville primary care team and has been responsible for working together in various health initiatives as well as working out how to collaborate better in the provision of primary care. There has been a free flow of relevant clinical information including the sharing of the physicians and electronic medical record with various staff to better inform decisions.

2009 saw the addition of a nurse practitioner to the clinical picture, co-located with the physicians, sharing the same electronic medical record and looking after her own clients group. This further added to the richness of the medical team

2014 saw some early work with the town and Heritage Holdings to look at providing adequate space for future medical needs for this area. It was realized that the current space occupied by the medical staff would be insufficient for more than three clinicians and had some obstacles for access as well as for training. Various options were discussed and the one that seems to be the best suited to provide services, both now and in the future as well as attracting further clinicians to this work was to build a new clinical area as part of the Heritage Life Lease complex. In the exploration of this proposed site it became apparent that there would be adequate space to look at pulling together, under one roof, all the frontline primary care services that currently operate.

Current picture

The Niverville Medical Clinic (NMC) currently has three full-time physicians and one nurse practitioner as well as having a learner for at least 10 months of the year. It also employs 6 full or part-time staff.
It has over 6000 open charts and still is accepting new patients. It provides comprehensive primary care to all ages including minor procedures, prenatal care, child development, reproductive health as well as end-of-life care. Its physicians also are involved in the on-call rotation at St Pierre as well as inpatient care in that same hospital. The also provide care to the attached 80 bed personal care home. The clinic also houses a travel health clinic that provides full services as a regional resource.

The clinic on average sees 1500 clients per month which include a mixture of scheduled, urgent and same-day appointments. Hours are already offered into the evening and the clinic usually starts each day at 830 taking some unscheduled appointment who know to turn up.

The clinic has had an electronic medical record for nine years as well as using social media such as Facebook, and its own website, to try and inform its clients about its services and availability. The website also offers a patient portal to book their own appointments.

This is provided out of a space of approximately 1700 ft.^{2} which is proving inadequate for its function.

At the inception of this clinic, the town had a population less than 2000, nine years later it is approaching 5000 and is expected within the next 10 years to exceed 7000. The community has a significant amount of local industry as well as serving as a bedroom community to Winnipeg. We regularly see clients from surrounding communities from as far away as St. Malo, St Pierre, St Adolphe and St Agathe. We have allowed ourselves and geographic limitation that excludes Winnipeg, those who are east of Highway 12, west of Highway 75 and north of Highway 1 and the perimeter.

The plan

I will attempt to put the broad strokes to our proposed Health Centre realizing that there are a lot of details missing and that require careful and diligent discussion between those parties involved.
However, the underlying philosophy is to provide a single door entry to primary care for the community. This will be complemented by the collaborative care offered by the various practitioners within the centre to ensure that the client receives the best care available by the best able practitioner in the most timely manner. Implicit in this is the timely referral of that client to an appropriate external provider if the resources cannot be offered within the centre. These all need to be established as deliverables that can be measured and reported. We have found that the team that we have assembled over the last few years has the potential to fulfill this aspiration for our community.

One of the underlying driving forces of the towns work over the last 10 years has been the ability to age in the community. This is seen in the development of firstly The Manor for Assisted Living and Supportive Housing, and then the personal care home. Now the life least complex will complete this progression. In the same way we want to minimize the need for our clients to leave the community for services that can be found and provided here.

Although we are the largest community in Manitoba without a hospital, there is no desire of the author to create a hospital by the back door as we have at least three quality hospitals within easy distance who are far better suited to look after emergency care.

We are currently planning to develop a new 5300 ft.^{2} ground-floor site that will be attached to both the life lease building and the assisted living building. This will have its own access to 2nd Ave., South as well as access west into heritage Lane and the current parking for staff found there.

The plan is to create a single reception with attached administrative area that will direct clients to one of three clinical areas or pods. Each of these clinical pods would have five clinical rooms, each approximately 100 to 120 ft.^{2}. A fourth clinical area would serve as an urgent care centre with a larger room acting as a clinical treatment room. Adjacent to one of the pods would be a space used for lab services.

Initially we had created a staff area on the ground-floor but I think to better accommodate mental health we have the possibility of moving a staff lounge/ conference area to the basement so that our prime real estate on the ground floor is used for clinical services. We do realize that the staff lounge is an important part of building and maintaining the team and is an important item however I think it can easily be accommodated in the basement without losing any of these qualities.

Into these clinical pods will move the four current clinicians, usually with one learner attached as well as our primary care nurse, public health nurses (2), chronic disease team (2), and mental health team (2). Each of the clinical parts will be served by a staff member trained to take blood pressures, heights and weights and maintain the rooms. Each pod has a small waiting area to which clients will be directed after registering at reception.

The clinicians will not have separate office space but will share a communal space with privacy divides.

The whole centre will be serviced by one software application which I presume will be Accuro. It will be essential, as we see, that the clinicians maintain secure off-site access.

My understanding is that there will be minimal cost considerations in the move of clinical staff from one location to the next, if the existing space is given up for redevelopment. There is a significant increase in the amount of space that the medical clinic occupies but I think this will be compensated by the increased efficiency and also the longer hours of service provided.

Currently the RHA provides services run from 8:30 to approximately 4:30, 5 days a week.

The medical clinic run services from 8:30 to 5:00 on three days a week with extended hours on Tuesday and Thursday to 7:00. Occupancy of the new clinical space is not expected before spring of 2017 but might be earlier. It is expected that in 2017 the offered hours will be largely unaltered. It is also expected that after-hours care will be provided through a local emergency room probably with telephone triage to an on-call physician as per expectations of the College of Physicians and Surgeons of Manitoba

Stepping stones to 2022

As an important part of the plan Development, probably taking place in 2017, there will be some work on our local needs assessment as to what services clients would like to see and at what hours would they like to access those services. It would also be useful to know for what services people actually leave town to access.

2018

The hope is to provide services from 0600 hrs. through to 2000 hrs. Monday to Friday with 0600 hrs. to 1300 hrs. on Saturday. Telephone triage for the rest of the time is expected to be

provided by an on-call physician, although the question of a nurse practitioner or physician assistant being part of this rotation is to be discussed.
Some of this change in hours will be accomplished on the medical staff by staggering and deliberately scheduling physicians into these hours. It may be that we will have physicians who only work afternoons or only work mornings. This will depend also on some recruitment initiatives. It also allows us to discuss partnerships and whether, with new hiring and a gradual turnover of staff, whether staggering and overlapping of work hours can also work for the RHA. It would be good to be able to provide mental health and public health outside of the 9 to 5 office hours. I can see the benefit for reproductive health for our teenagers as well as mental health access for our commuters.

2019

Addressing some of the needs raised in the 2017 needs assessment will be addressing some of the diagnostic challenges. Looking at having lab services, certainly Monday to Friday. Also possible discussions with private providers to look at the establishment of x-ray and EKG services. It is suggested that the x-ray services would be off-site but that we also look to purchase of an electronic EKG package that would fit with the current EMR. At the same time there would be an ever greening of the current electronic spirometry package which is currently eight years old.

It would be hoped, by the deliberate recruitment and securing finances through the yearly budgeting process, to extend access to an urgent care component to 2200 hrs. Monday through Saturday, with access 1300 hrs. to 1800 hrs. on Sunday. Telephone triage will be provided for the remaining hours by clinicians, including nurse practitioners and physician assistants, on expectation that contractual limitations have been resolved by that time.
Triage will include the ability to offer over the phone next day appointments with their care provider using the online medical record.
The extension of hours in this year would only be to the urgent care component and would exclude expanded hours for mental health and public health

2020

At this time it might be advisable to discuss the geographic area covered by this center so as to mesh with that provided from Steinbach so as to try and cover the area east of the river from these two centres. This will also depend on the level of service provided through St Pierre and whether the clinicians serving in that location would be willing to join with the clinicians in Niverville to provide this service.

This year would see scheduled appointments with clinicians from 0600 hrs. through to 2000 hrs. Monday to Saturday with urgent care provided till 2200 hrs. Sunday access would be from 1300 hrs. to 2200 hrs., urgent care only. Access to care will continue to be provided by telephone triage. However now with the additional service, that, when clinically indicated, clients can be

seen by prior arrangement, at the health centre between the hours of 2200 hrs. and 0600 hrs. the following morning.

An example of this might be the client who telephones the duty clinician who decides that it would be appropriate to examine the clients in person at the Health Centre and would set up a rendezvous time to see that clinician. There are some safety concerns.

By this time the options available to our local population, is to:-

- call 911 direct or proceed to an open Emergency Room
- Call health Links for advice
- Call the clinic on-call mobile for advice and be reassured or have the physician now call 911 on their behalf
- call the clinic on-call mobile and be offered an appointment the next day with their Primary Care Provider
- Call and be offered a clinical consultation urgently at the Health centre

At the end of this year, a needs assessment and analysis of data from the last two years would be useful to find out if further expansion of hours is needed and in what area. This information would be used by the Regional Health Authority and the other partners to determine what would be next steps. This will also depend on what other services are currently being offered in the region. Other unknown factors will be population density, changes in demographic and success in recruitment and retention.

It is conceivable, even likely, that we might reach this stage by 2022 and not 2020 but the steps are clear and definable. I also fully understand that they are totally negotiable and that in the course of the next 18 months discussions between all those parties involved will be required to solidify an agreed-upon timetable.

Benefits

There are numerous quantifiable and qualitative benefits to the above scenario. These include:

1) Reducing the load on nearby emergency rooms for non-emergency cases. I suggest that as part of our ongoing measurement we should look at postcodes of those who attend Winnipeg and Southern Health emergency rooms.
2) Reduced use of walk-in clinics in the city for episodic care. This will promote better continuity of care and more rational use of both medication and investigations
3) Better outcomes for chronic disease as we are able to provide care at the time better suited to the lifestyle of our commuter population
4) Retention and recruitment. We are building up on one of the strengths that we already have of a cohesive, forward thinking and innovative healthcare group which I think will place us at an advantage when it comes to attracting quality healthcare providers. We also become an attractive place for learners who may then return as qualified professionals

5) We already have the team in place working well together, this plan is an example of the bottom up approach rather than a top-down and so we work from the strong place of having consensus amongst the providers at the start, with a track record of having worked together.
6) I hesitate to claim cost-saving however with the one door policy we do make this more efficient for our clients and the sharing of information across a single platform has the potential to cut down on tests and prescriptions.
7) I think we are proposing a plan that is a win for the town, a win for the medical staff and a win for the Regional Health Authority. However , although a significant amount of capital is being used, the costs will largely come out of money already set aside by the Medical Clinic and the Regional Health Authority to pay their existing staff and rental costs

Hurdles

The ability to realize this scenario does depend on the following:-

1) The success in recruiting new clinicians to this model with its extended hours
2) The ongoing partnership between the various providers both at higher administrative and clinical environment
3) The ability of Manitoba Health to respond to requests through the yearly budget for new staff that might be required in subsequent years
4) Of the need for other businesses in the town to also identify the role in supporting this, for example physiotherapy also currently provides early morning appointments and afternoon and late evening appointments. However the pharmacy is closed on Saturday.
5) Other plans in Manitoba have not withstood the trial of the test of time when the original initiators moved on. It is going to be important that this plan is rooted in the fabric of this town and not dependent on one or two individuals who very likely will not be here in 10 years.

The Name

It is becoming increasingly apparent that the name attached to the current primary health care indicates its location but not its client group. As we move forward it may be worthwhile thinking of an appropriate name that encapsulates the philosophy as well as the region. Niverville Medical Clinic Is a legal term that we use to pay the bills however it does not necessary need to be the sign over a door to physician's office especially when that door is actually access to a lot more. It is also true that this healthcare facility provides services to a far wider area and so I wonder whether now the time to think of a more appropriate name is. The name will still contain a geographic reference I suspect but it also must denote the scope of what we want. It is not just an urgent care, is not just a primary care centre and that is why the use of the word 'access' perhaps best defines and am not sure if it is technically possible to

trademark such a term as has been indicated but perhaps there is another word that can be used indicating that we do provide services in our area.

Next steps

This document is written as a discussion document in which everything is up for discussion and nothing is sacred. With the one exception that the concept of one door access to the team is paramount.
I would suggest that the broad brush strokes need to be agreed on first before we look at the questions of who is paying what, who reports to whom and they very processes of how people access care from so many providers under one roof.

I'm happy to answer questions or received comments on this paper was it would suggest that this would be much better over a glass of some red substance and offer my house at any time to come together and talk about this!

22/6/15
ver1.1

Dr. Chris Burnett