Living with Illness Nominee

Rapid Access to Consultative Expertise - RACE

Section 1: Improving the Quality of Care (40 points)

1.1 Briefly summarize the team or initiative. (max 150 words)

Patients with chronic conditions often navigate multiple care interfaces and may experience fragmented care. Ideally the locus of care should remain with the family physician (FP), with support from specialty care.

In 2010, Providence Health Care partnered with the Shared Care Committee, (a joint committee of the BC Ministry of Health and the BC Medical Association), and Vancouver Coastal Health to facilitate collaboration between specialists and FPs. Rapid Access to Consultative Expertise - RACE an innovative model of shared care was developed where FPs can call one number, choose from a selection of specialty services and be routed to the specialist for "just-in-time" advice.

Interviews and surveys measured use, benefits, areas for improvement, and knowledge transfer. 75% of the calls were returned within 10 minutes, 90% of calls were <15 minutes in length, 60% of calls avoid a face-to-face consult with a specialist and 32% avoid an emergency department visit.

1.2 Explain the team or initiative in more detail. (1,000 words max)

The Problem
Patients with complex chronic conditions often navigate multiple care interfaces and may experience fragmented care and poor outcomes. This is particularly apparent in large urban environments where family physicians are often more disconnected from hospital care, and no longer have collaborative working relationships with specialists. Specialists and family practitioners (FPs) at Providence Health Care (PHC) were increasingly distressed at this situation and its impact on the patient journey.

In late 2009, a needs assessment and community consultation process was initiated to identify gaps in current service delivery for patients with chronic disease. Focus groups with specialists, FPs, and patient groups were held to identify gaps and areas for improvement. Incorporating the perspectives and values of the patients and caregivers from the beginning and throughout the process was a central focus. Emerging themes included the need for improved communication; improved access to specialty care; and improved relationships between FPs and specialists.

In 2010, a partnership was formed between PHC and the Shared Care Committee (SCC) (a joint committee of the BC Ministry of Health Services and the BC Medical Association) in collaboration with Vancouver Coastal Health (VCH) to:

1) Identify gaps in the care process for patients with chronic diseases, and
2) Develop and test prototypes for improvement.

The goal of the overall project was to redesign collaboration between specialists and FPs in the development, implementation, sustainability and spread of FP to specialist interactions with the intended results of improved population health outcomes, improved patient and provider experiences, and reduced per capita system costs.

This nomination focuses on one component of the overall project, an innovative model of shared care involving a telephone advice line where FP can call one phone number and choose from a selection of specialty services for real-time telephone advice. With the Rapid Access to Consultative Expertise (RACE) model, the call is routed directly to the specialists cell phone or pager for “just in time” advice.

The Team
This work was carried out through the collaboration of the Shared Care team, a group of highly committed individuals including patient representatives, specialists, FPs, clinical/administrative leaders, quality improvement and change specialists, as well as input from the BC Shared Care Committee. The structure for how the work was carried out is described below.

Executive Steering Committee:
This committee provides high level, overall direction and leadership for the project. Its role is to build a strategic vision for change, ensure strategic alignment with the organizational vision and provide linkages with Provincial and Regional stakeholders. Membership includes representation from VCH and the SCC to ensure appropriate interface with regional and ministry initiatives. All improvement processes were guided by the Executive Steering Committee.

Advisory Committee:

The Advisory Committee has representation from key stakeholder areas, including patients, specialists, and clinical/administrative leadership. The advisory committee leverages the knowledge and wisdom of the members to articulate gaps and opportunities and makes recommendations on how to proceed.

Working Groups
Working groups are established and meet on an ad-hoc basis. Taking the recommendations from the advisory committee, the working group determines what the prototype will look like, how and where it will be trialed, and the scale of the trial.

Why this Prototype
Based on encouraging results from a PHC pilot project where FPs could page a cardiologist, RACE allows FPs to call one number, choose from a selection of specialty services and speak to the specialist usually within a few minutes. The prototype began with 5 specialty areas and based on the needs of family physicians, has grown to include 17 specialty areas. Additional specialty areas will continue to be recruited in response to the requests of FPs.

Billing codes facilitate physician remuneration via the Medical Services Plan. Following the cardiology pilot of RACE a billing code was put in place for specialist remuneration for the service. Based on feedback to the MoH from our team, a few months later a billing code was put in place for FPs to allow them to bill for the call. Again based on feedback from our team a billing code was put in place for specialists to bill for calls initiated by a nurse practitioner.

Methodology
This project focused on the application of the "Triple Aim" principles and the Model for Improvement to drive efforts, understand current state, define goals and understand if changes lead to an improvement. Focus groups were held to identify gaps in current care, and patient representatives were involved in all aspects to ensure inclusion of their perspective.

1. A gap analysis was performed through several focus groups with patients, specialists, and FPs. The focus group findings led the project team to decide where to concentrate the improvements.

2. The Institute for Healthcare Improvement (IHI) "Triple Aim Framework" was used throughout the process to guide improvements. IHI identifies the need for simultaneous improvement in three critical objectives to lead to better models for providing healthcare. All aspects of the project strived for improvement in:

- The health of the population
- The care experience of the patient and health professional
- The per capita cost

3. Application of the Model for Improvement was utilized. This model, identifies four key elements of successful process improvement:

- Specific and measurable aims
- Measures of improvement tracked over time
- Key changes that will result in the desired improvement
- A series of testing "Plan, Do, Study, Act – PDSA cycles" allowing the team to trial and refine change ideas prior to implementation

4. Protocols for specialist and FPs were developed to provide guidelines and ensure consistency in quality.

5. Evaluation, approved by the Research Ethics Board was designed so each phase informs the format of the next, promoting continuous quality improvement. Methodology was a combination of qualitative and quantitative measures. Interviews/surveys measured use, benefits, areas for improvement, and knowledge transfer.

Several factors were key to the success of this project including leadership, engagement of champions, partnerships and collaboration with internal and external stakeholders.

1.3 How did the team or initiative improve care in one or more of the following dimensions of quality: acceptability, appropriateness, accessibility, safety, effectiveness, equity and/or efficiency? (1,000 words max)

Acceptability
In order to provide respectful care that meets patient and families preferences, needs and values we have included patient representation in all aspects of this work. Patients were invited through the Patient Voices Network (PVN) to be part of the Shared Care team from its inception. They are full members of the team with the role to provide the patient perspective. They take back the ideas and decisions from the meetings and validate the information with their counterparts at PVN. A provincial patient focus group was conducted through the PVN. This was performed to further validate recommendations and decisions of the initiative and ensure broad patient representation.

Below is a comment from a patient regarding RACE.

"As a person living with a chronic condition, I have had to navigate through a very complex medical system to ensure I receive proper care. I know that it is difficult for a FP to handle all of the various problems that arise particularly when a patient has multiple co-morbidities. GP's have an incredible background of information on many different diseases and conditions, but it is quite unreasonable to expect diagnostic and treatment perfection in such a rapidly changing and complex medical environment. I think the RACE program is a wonderful idea because it will allow my GP to access expertise on a specific problem without my having to be referred and having to wait a number of months to see a specialist when perhaps only minor advice might be needed. Conversely, if my problem is not minor, it will ensure that I am given an appropriate referral. In the medical system where good care relies on good communication RACE is an important program to help keep everyone aware of recent changes in medical treatments and aware of how to handle problematic symptoms."

Appropriateness
Patients with complex chronic conditions often navigate multiple care interfaces and may experience fragmented care and poor outcomes. As care systems become more complex, coordination of services across primary, secondary, and tertiary care has become fragmented and poorly coordinated. This can impact continuity of care as patients with chronic diseases move through the system, encountering inconsistent bilateral communication between specialists and family physicians, and little or no coordination of care.

The right patient should be seen by the right provider at the right time. With the RACE model of shared care, often the locus of care can be maintained with the primary care provider. This allows the FP to coordinate care, ensuring a holistic approach is maintained with specialist input when appropriate.

RACE enriches family practice by providing a collegial and CME-eligible educational experience that directly links physician learning to practice in real time. A frequent FP user of RACE describes his experience below.

"... It is fantastic to be able to get answers immediately that I normally would either
- refer to a specialist and have to wait months for an appointment,
- try and look up online but not be confident of the answer,
- play telephone tag or fax back and forth with a specialist regarding the clinical situation or,

- just take my best guess with the clinical situation.

It has given me a level of professional satisfaction, professional empowerment and improved patient care."

One specialist who participates in RACE describes his experience as:
"I like RACE because it allows me to answer a family physician's questions directly. It gives me great pleasure to be able to help my colleagues. It is satisfying to be able to give reassurance, to provide helpful advice in real time and to share my knowledge..."

Accessibility
RACE is a novel strategy to enhance patient care. RACE allows FPs to call one number, choose from a selection of specialties and speak to the specialist usually within minutes. For traditional referrals, patients often wait months to see a specialist, however minor advice may be all that is needed. RACE is available Monday to Friday from 0800-1700 hours and is meant to provide support to FPs while they are in their office seeing patients. While any FP could call any specialist, prior to RACE, it was on a "catch me if you can" basis and there was no guarantee that a specialist would call back in a timely manner. RACE is accessible to all FPs across Vancouver Coastal Health. Some of the specialty areas are available across health authorities and 4 services are currently available provincially.

For specialists, RACE reduces waiting lists by potentially eliminating those consultations characterized by easily answered clinical questions allowing the specialist to see the patients that truly require specialty care.

RACE provides structure to promote easy accessibility while allowing for sustainability through an organized rotation. Patients may have their healthcare issue dealt with in their FP office instead of needing to see a specialist. Data indicates RACE is viewed as a model that reduces costs by avoiding unnecessary emergency department (ED) visits and face-to-face consultation, supports FPs, and utilizes specialist services more appropriately.

Efficiency
An Advisory committee with representation from key stakeholder areas, including specialists, clinical/administrative leadership, and patients was formed to spearhead this work. FPs from across VCH are included to ensure a perspective from across the health authority. Patient representation is integral to the success of this project. Patients were invited through PVN to be part of the Shared Care team from its inception.

Several FPs have given examples of how RACE has improved efficiencies in the care of their patients. One FP describes how when he calls the RACE line, knowing that the response rate is fast, he asks the patient to wait in reception. When he receives the call back, he asks the patients to come back to the exam room, puts the phone on speaker and they both listen to what the specialists suggests for care.

Another frequent user of RACE has shared case studies where RACE has impacted his practice. Two of his case studies have been published on the UBC Continuous Professional Development "This Changed my Practice" website http://thischangedmypractice.com/race-hotline/.

Section 1 score: /40

Section 2: Evidence (25 points)

Provide clear evidence that the nominee has improved the quality of care. Evidence of results can be quantitative or qualitative. (1,000 words max)

Guided by the IHI "Triple Aim" principles, formal structured evaluation was conducted by Scott Lear, Associate Professor, Faculty of Health Sciences, Simon Fraser University and Pfizer/Heart and Stroke Foundation Chair in Cardiovascular Prevention Research at St. Paul's Hospital. The Triple Aim Framework looks for simultaneous improvement in 1) the care experience, 2) per capita cost, and 3) population health. Methodology of the formal evaluation was two-fold and based on qualitative interviews/focus groups and quantitative surveys.

Over all metrics from the first 3 years include the following.

The evaluation was designed to provide outcomes related to the "Triple Aim" framework.
(>5,000 calls, data based on 40% of calls)

- 78% of calls answered within 10 minutes
- 90% of the calls <15 minutes
- 60% avoided face-to-face consults
- 32% avoided ED visits

Most Common Reasons for Call:

- General management, diagnostic, therapeutics

Most Common Recommendations:

- Medication, additional testing, reassurance of plan
- Cost savings – up to $200/call

1) Enhance the care experience by providing knowledge translation for FPs, improve specialist/FP interface through better communication and simplify the patient journey. The survey/interviews illustrated;

- User satisfaction was unanimous–all FPs would use the service again
- Over 95% of FPs would recommend the RACE line to their colleagues
- RACE was viewed as an excellent resource for FPs–access to RACE transformed how FP seek prompt assistance
- RACE us seen as a means to improve relationships between specialists and FPs

The "real time" consultations were seen as additional value. 83% of respondents believed it helped manage care for their patients. RACE was viewed as:

- A user-friendly 'decision support system'
- A tool that improves clinical judgment
- A mode to receive medical education
- A way to Increase knowledge capacity
- A service that enhances overall practice efficiencies

2) Improve population health may be influenced as access to care is enhanced;

- Our goal was 100% response time within 2 hours. The data demonstrate >90% of the calls were returned within 1 hour, and 77% of the calls were returned within 10 minutes. Our aim was to have calls returned in "real time" preferably while the patient was still in the FP office. Considering that visits are often 15 minutes in length, we were able to meet that aim.
- The aim was for 95% of calls to be <15 minutes in length. Data show that 90% of calls were <15 minutes in length allowing for an interaction that does not interfere with the flow of the day.
- Several FPs stated RACE allowed for: better medication management, improved effective triage through rapid and timely advice, and "practical and specific advice" on the best way to manage patients within the confines of their office
- Access to a face-to-face consult with a specialist may be improved as specialists can see the patients they really need to see and not those who care may only require advice that is easily communicated via telephone.
- The number of calls to RACE has continued to increase as more specialty areas are added and as more FPs are aware of the service.

3) Control or reduce per capita cost of health care
- All FPs noted RACE reduced the number of unnecessary referrals to specialists
- Some FPs noted that RACE prevented ED visits

Based on the opinion FPs regarding the call, the specialists gathered information from the FP at the end of the call. This data showed in 60% of the calls a face-to-face consult with a specialist was avoided and in 32% of the calls an ED visit was avoided.

Based on this data, a simple cost modeling exercise by the evaluation group factoring in direct costs showed a saving of up to $200 per call depending on the specialty called.

To gather more specific and rigorous data we modified the data collection tool to include the following questions.

Specialist to ask FP: beginning of call

"If RACE did not exist, would you"
- ☐ Refer the patient to a specialist
- ☐ Send to ED
- ☐ Try to phone a specialist you know
- ☐ None of the above/other _____

Specialist to ask FP: end of call

"Did the RACE conversation": (check only one)
- ☐ Avoid a face to face consult

Or
- ☐ Avoid an ED visit
- ☐ Avoid both consult/ED visit
- ☐ None of the above/other_____

Initial data from these questions shows: Without the RACE line in place, of the 39% of patients who would be referred to a face to face consult, 80% of the calls avoided a face to face consult and of the 9% that would have been referred to the emergency department, 72% of these visits were avoided."

RACE is viewed as a service that:

1. Enhances the care experience by providing in time educational advice for the FP. Patient experience is enhanced as they receive information while at their appointment instead of having to wait to see a specialist and consults may be avoided thus avoiding redundant travel and time off.
2. Potentially improves population health as patients are receiving timely care in their GP office instead of waiting to see a specialist as well as utilizing specialists care more appropriately.
3. At least controls per capita cost of health care through avoiding unnecessary consults or emergency visits.

Section 2 score: /25

Section 3: Spread and Sustainability (15 points)

3.1 How will this team or initiative's work be sustained, if applicable? (500 words max)

The RACE model of care has steadily grown from 5 services to 17 specialty services with plans to continue to grow based on the access needs of FPs. Simplicity of the system has been key to the ongoing success. Ensuring the model continues to be easy to use and valuable for patient care will ensure sustainability. Periodic check-ins through surveys ensures the model continues to provide appropriate support for FPs.

Ongoing resources required for this model of care are minimal. The calls are routed through a simple TELUS telephone line and 4 telephone trees direct the calls to the correct specialty area. The cost for the telephone line structure is $120 per month. Administrative support of approximately 1 day per month is required to ensure coverage schedules are in place and to re-route the phone numbers to the correct specialist.

A national cost modeling exercise on RACE done through the Canadian Foundation for Health Care Improvement (not yet published) shows a dramatic cost savings if this model were to be implemented across the country. Locally, a cost modeling exercise completed by the evaluator for RACE calculated a direct cost savings per call of up to $200 depending on the specialty area.

Through support from PHC, the Shared Care Committee and VCH, a RACE brand was recently created. We embarked on the branding strategy including a RACE logo to ensure that RACE would be widely recognized by potential users. A dedicated RACE website was launched in June 2013 www.RACEconnect.ca and a communication plan was put in place to promote RACE as a consistent quality service for FPs. The marketing objective was to ensure all FPs across VCH were aware of RACE. The Practice Support Program (PSP) coordinators are being leveraged to promote RACE during their one:one visits with FPs in their offices. RACE updates are being given at numerous venues including Division of FP meetings, PSP learning sessions, and other provincial meetings. Ongoing feedback from specialist groups and FPs is solicited to make improvements to the service.

Among other successes, the RACE model has recently been selected by Accreditation Canada as a Leading Practice for 2013. With the ongoing support from PHC, the Shared Care Committee, VCH, and the specialists providing the service, the RACE model of care will continue to succeed.

Collaboration with Vancouver Coastal Health is essential for sustainability. Although PHC led the initiative, VCH specialists and FPs are integral participants of all areas of the work. The regional Primary Care Council, Departments of Family Practice, University of British Columbia Department of Medicine, Ministry of Health, BC Medical Association, and Divisions of FP were all key in developing the prototypes. PHC's partnership with the Shared Care Committee was the driving force permitting this project to move forward.

3.2 How will the findings or successes of this team or initiative be shared or spread to other units, wards, locations or across other disciplines, if applicable? (500 words max)

Through this initiative, PHC has taken Provincial leadership in shared care; while the prototype is designed to address the PHC/ Vancouver medical environment, the objective was to develop a strategy which is scalable and transferable throughout the province in differing medical contexts.

Based on the positive results of the evaluation, the decision by the steering committee was to spread the lessons learned from developing and implementing the RACE service to other health authorities across the province of BC. Depending on the needs of the areas across the province would determine what type of service would be the best fit – initiating a RACE like service for the different areas or joining with the existing RACE service.

Physician leadership is essential in scaling out the prototype and learnings to all health authorities across BC and our shared care physician leads have travelled to all of the health authorities for face-to-face meetings. "RACE in a box" was developed which contains all the information required to initiate a telephone advice line and this is available for other regions who are considering implementation of a telephone advice line. RACE is meant to fill a gap in care where FPs do not have access to specialists in their area. Careful attention must be given to ensure that existing, established communication patterns and relationships are not disrupted. The RACE model recognizes the importance of local networks and the intent is not to interfere in any way at the local level. Frequent calls come to our team from FPs across the province. Our consistent messaging is that we encourage family physicians to access local specialists where they can. If they do not have access to those specialists, then they may want to consider using RACE .

Of the 17 services available, 11 are specific to VCH, 2 services cover both VCH and Fraser Health Authority and 4 specialty areas are provincial services. Provincial services are encouraged when there are not many specialists in a particular area or when the bulk of specialists are located in the lower mainland area.

In the Northern Health Authority, "Northern Partners in Care" have initiated a RACE like line and Vancouver Island Health and Fraser Health Authorities are determining how a telephone advice model may fit their needs. Our team regularly gets calls from across Canada with inquires regarding RACE. Our approach is to share everything and facilitate other organizations to implement similar services.

Section 3 score: /15

Section 4: Innovation (10 points)

How is this work innovative? How does it contribute new thinking towards this area of care or improvement? (500 words max)

As an organization, PHC is committed to achieving excellence in patient care and building a culture of innovation, quality and safety is a priority. Based on literature, the RACE multi specialty telephone advice line, an innovative prototype facilitating shared care is the first of its type in Canada. While chatting to physician colleagues was common practice in the past, due to the disconnect between primary care in the community and specialty care in the inpatient setting, FPs often do not have the opportunity to cultivate relationships and networks with specialists. RACE provides a unique opportunity for shared care, maintaining the locus of care with the FP while receiving support from specialty care.

Although this work may involve simple concepts the solutions and prototypes involved in changing work processes can often be complex. The simplicity of the RACE line has been key to the success of the model. FPs can pick up the phone, dial one number, choose the specialty they would like to speak to and be routed directly to the specialist's cell phone. There is no complex technology or middle step to navigate through.

Inquires have come in from across Canada on the structure, logistics and outcomes of RACE. In 2012, the RACE shared care team presented 12 abstracts at various conferences and the team was invited to speak at several conferences including The Canadian Medical Association, Canadian Foundation for Health Improvement and the Institute for Health Care Improvement.

RACE is currently showcased on three different national platforms for innovations in health care.

1. Health Council of Canada Innovation Portal which supports identification, sharing, and uptake of innovative practices that have been demonstrated to strengthen Canada's health care system. http://innovation.healthcouncilcanada.ca/ip?keys=Rapid+access+to+consultative+expertise&=Search&tid=All&tid_1=All&term_node_tid_depth=All&tid_2=All&field_ip_publication_date_value%5Bmin%5D%5Byear%5D=&field_ip_publication_date_value%5Bmax%5D%5Byear%5D=

2. Canadian Medical Association Referral/Consult Process Toolbox showcases success stories and illustrates lessons learned from across Canada. http://www.cma.ca/advocacy/intraprofessional-communications

3. International Centre for Health Innovation at Western University online resource to promote knowledge translation and sharing of best practices across jurisdictions. This "innovation map" of Canada provides a snapshot of the trends and achievements related to innovation across the country. http://sites.ivey.ca/healthinnovation/health-innovation-map-of-canada/

RACE addresses the critical challenges faced between specialists and FPs and is viewed as a model that reduces costs by avoiding unnecessary ED visits and face-to-face consultation, streamlines patient care, supports FPs, and utilizes specialist services more appropriately. This grass root collaborative project was championed by a dedicated team of physicians, leaders, and patients who fostered a culture of

innovation and improvement developing strategies and prototypes for shared care to serve as a model for the provision of chronic disease care across British Columbia.

Section 4 score: /10

Quality of Submission: /10

Appendices?

Yes

TOTAL score: /100