CKD Interest Group
Win.Win.Win!

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- Penticton Regional Hospital

The Current Situation in the Penticton Integrated Health Centre

- The Penticton Integrated Health Centre was opened in 2005 and integrated 3 chronic disease clinics into one centre
- DM, CKD and CHD
- Intention of integrating across specialty disciplines and between specialties and family physicians

The Penticton Integrated Health Centre

- Centre staff includes RNs, RDs, Pharmacists and Social Workers
- The RNs and RDs are trained within a specialty and are cross trained to enable care of patients with co-morbid diseases
- Provides 2 intro group sessions, group education sessions, problem solving drop-in, and telephone support and follow-up
- Renal clinic twice a week
- Heart Clinic twice a week
- Monthly Pediatric DM clinic

Areas for Improvement: Evaluation Confirms

- Communication between the centre and family physicians
- Maintaining the family physicians role as primary care giver shared appropriately with specialists
- Appropriate and timely referral
- Appropriate return of care
- Effective sharing of information between family physicians, specialists and the PIHC

PIHC :Areas for Improvement

- Limited integration within the clinic
- Integration between clinic and FPs needs development: role clarity, education, support, communication

Initiative: Penticton Integrated Health Center Education and Outreach Project

- To empower family physicians to play the leading role in the care of patients with complex chronic disease with competence and confidence through the continuum of care, integrated fully with specialty care clinics to provide best care in the right place at the right time

Family Physician Education and Outreach Project

- Enhance the current model of specialty care within the PIHC by defining a clearly structured relationship between specialists and family physicians
- Engaging local resources and providing additional outreach services to family physicians and their patients in rural and remote areas
- Enabling family physicians to work more efficiently in directing and coordinating the care of their patients with this chronic disease cluster

Proposed Initiative in the South Okanagan

Family physician Education and Outreach program

- Provide family physicians with integrated and harmonized decision support systems for this disease cluster

- guidelines, protocols, schedules, reminders etc.
- supported by a structured education program with learning objectives and curriculum
- aim to close the knowledge gap between family physicians and specialists to ensure that the primary care of the patient remains with the family physician

Proposed Interventions

- Structured FP education package based on FP needs assessment and grounded in reality to improve skills and confidence
- Work with FPs to develop clarity around roles and expectations
- Outreach case management (visits, telehealth)
- Outreach client self management support

Proposed Interventions

FP workload management

- Collaboration with existing initiatives that support PHC and CDM to achieve consolidated, single source toolkits and data management
- Support eMR implementation and interfacing with clinic database to provide single source data entry
- Goal : FP workload will not increase and may decrease

Expected Outcomes

- Increase the proportion of patients managed at best practice standards
- Improve achievement of guideline based clinical targets
- Reduce duplication of orders
- Increase patient and provider satisfaction
- Improve the proportion of patients referred appropriately for specialty care
- Reduce number of ER visits and acute care admissions

Potential Barriers

- Family physician fear of increased workload
- Inability to find funding/human resources
- Specialist agreement on roles and protocols
- IT
- Inability to consolidate PHC/CDM initiatives