Ts’ewulhtun Health Centre:

Navigating the waters of primary care innovation

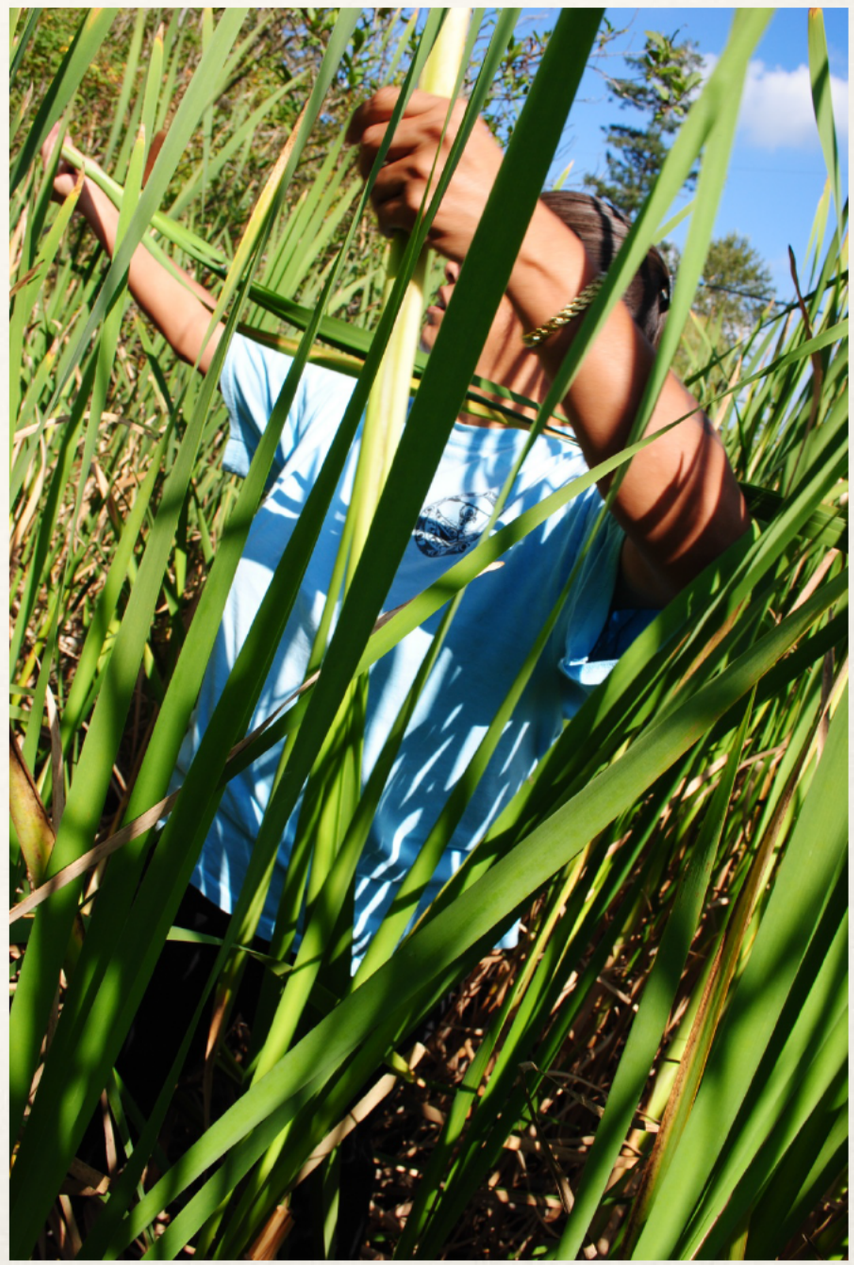
October 24, 2013

Common goals

- ***Collaborate to support best care for Aboriginal peoples in the Cowichan Valley***

- ***Pioneer an innovative, sustainable, culturally safe, wholistic primary care model that can be shared with other communities***

Where we are
Where we are going



- Describe current TWT physician services
- Describe proposed interim services
- Describe wholistic wellness center with integrated primary care services

Current TWT physician services

- 6.0 sessions per week
- Primary role supporting nursing and other team members
- Administrative role in developing primary care vision/community programs
- Conventional family practice not yet established

Types of clients we see . . .

- Clients with chronic pain in shared care with local MDs
- Clients for IUD insertions/fertility control/time sensitive referrals
- Families for immunizations with other concerns ie. cough, rash etc.
- Complex clients who are dissatisfied with current MD (system)
- Unattached clients who need care
- Elders with mobility issues for home visits
- TWT staff or CT members who have difficulty accessing own MD

Current challenges

- Limited continuity/fragmented care
- Disrupted/strained relationships with local physicians
- Limited admin support = underused health care professional skill
- Lack of stability of funding = limited visioning
- Space restrictions

Gold standard primary care

- “It has been demonstrated that when patients see their own providers, satisfaction rises, costs go down, revenues rise and clinical care and outcomes improve”

Alberta Access Improvement Measures. Accessed Aug 2013 http://albertaaim.ca/documents/WhatisAlbertaAIM.pdf

Gold Standard Culturally Safe Care

- "The core product is about human beings and *relationships* - messy, human, longitudinal, personal, trusting, informing, respecting and accountable relationships . . . partnering to make a difference over time."

- "The way to narrow health disparities is to put services into culture rather than culture into services."

Gottlieb K et al. (2008) Transforming Your Practice: What Matters Most. *Family Practice Management*

Interim primary care

- In order to develop a dedicated practice panel (~800-1200 clients) we need:

Physician clinical time	1.0 FTE
Physician community wellness & administrative time	0.2 FTE
Administrative support/Medical Office Assistant	1.0 FTE
Clinical exam rooms/supplies	1-2
Administrative space/supplies	1

Wholistic Primary Care Teamlets

THE SERVICE

- Relationship and community based
- Collaborative
- Culturally safe
- Accessible
- Innovative
- Exemplary care

THE OUTCOMES

- Client satisfaction with service
- Enhanced health and wellness
- Decreased use ER/walk-ins
- Staff satisfaction/low turnover
- Profitability/sustainability

Teamlet model

Bodenheimer, T et al. 2007. The teamlet model of primary care. Annals of Family Medicine. Vol 5. No. 5.

Blash, L et al. 2011. SCF – Nuka Model of Care Provides Career Growth for Frontline Staff. UCSF Center for the Health Professions.

1.0 FTE	**Family Physician**	• **coordinator of a client's overall health care.** • **builds relationships with the client and their family** • **liaison with outside care providers** • **co-creates client centered diagnostic and treatment plans.** • **operates at maximum scope of practice as a result of being fully supported administratively**
1.0 FTE	RN case manager	• focus on preventative health and wellness maintenance • works with the panel of clients on issues relating to chronic disease management, triage, phone-call care coordination. • supports the team to achieve best practice relating to screening and chronic disease management.
2.0 FTE	Health coaches	• mainstays of the relationship between the clients and the primary care team. • greet clients, rooms them, takes vitals, and reviews pre-visit questionnaires. • conducts the post-visit review with the client to check understanding of the treatment plan and follow-up. • technical skills including – throat swabs, EKGs, blood draws etc.

Typical teamlet visit

- Client and family greeted by Aboriginal health coach
- Meet with health coach and establish goals for the visit
- Health coach does initial history and data gathering (vitals etc)
- Family physician comes in and reviews concerns
- Family physician exits and health coach reviews plan including diagnostic tests, treatment plans, follow-up etc.
- Client leaves with a sense of clarity, satisfaction and empowerment about making informed choices about their health

Other key team players

1.0 FTE	Primary care clinic manager
1.0 FTE	Nurse Practitioner
2.0 FTE	Reception
1.0 FTE	Dietician
TBD	Social determinants of health advocate (social worker)
TBD	Occupational therapist
TBD	Physical therapist
2.0 FTE	Aboriginal liaison RNs for in-hospital clients

Primary Care Teamlet Integration

- Primary care teamlets will be embedded in a larger network of community health and wellness services.

- The various health and wellness teams working seamlessly together (current TWT teams, traditional medicine practitioners, others)

Wellness Centre - TEAMS

- Healthy families
- Healthy lifestyles
- Maternal child health
- Dental health
- Kwun’atsustul
- Khowutsun Sulhween Elder’s
- *Traditional medicine & spiritual wellness*
- *Integrative practitioners*
- *Primary care teamlets*

Wellness centre - OFFERINGS

- Sacred healing room
- Medicinal garden
- Exercise facility
- Community cooking facility
- Traditional cooking facility
- Artist in residence waiting room
- Clinical space for visiting specialists
- Laboratory services
- Diagnostic imaging
- Pharmacy

Educational excellence

- Ts'ewulhtun Health Centre is a highly sought clinical training experience for healthcare professionals.

- Expand and enhance educational opportunities for healthcare professionals and Cowichan Tribes members through:
  - Formalized relationships with post-secondary institutions
  - Centre-specific training programs (i.e. Health Coach)
  - Dedicated teaching space and resources

Teamlet primary care aligns with the 7 directives . . .

- Community driven, nation-based
- Increases First Nations client and family decision-making
- Improves primary care services
- Fosters meaningful collaboration and partnership
- Develops local human and economic capacity
- Is without prejudice to First Nations interests
- Functions at high operational standard

Short term vs long term

Short term

- Increase physician time to 1.2 FTE
- Increase administrative support

Long term

- Fully embrace wellness model
- Expand space

Huy tseep q’u