Interprofessional Team Demonstration Initiative (ITDI) Toolkit

August 2015

Manitoba

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Funds to support the Interprofessional Team Demonstration Initiative were provided by the Manitoba Patient Access Network (MPAN). The main deliverable of the funding was the development of a provincial toolkit to assist and support in the implementation of interprofessional practitioners into fee-for-service (FFS) practices. This toolkit can be used by facilitators in all health regions to help FFS clinics explore the potential contribution and impact of various team members, select a provider, and successfully incorporate them into clinic practice as part of an interprofessional team.

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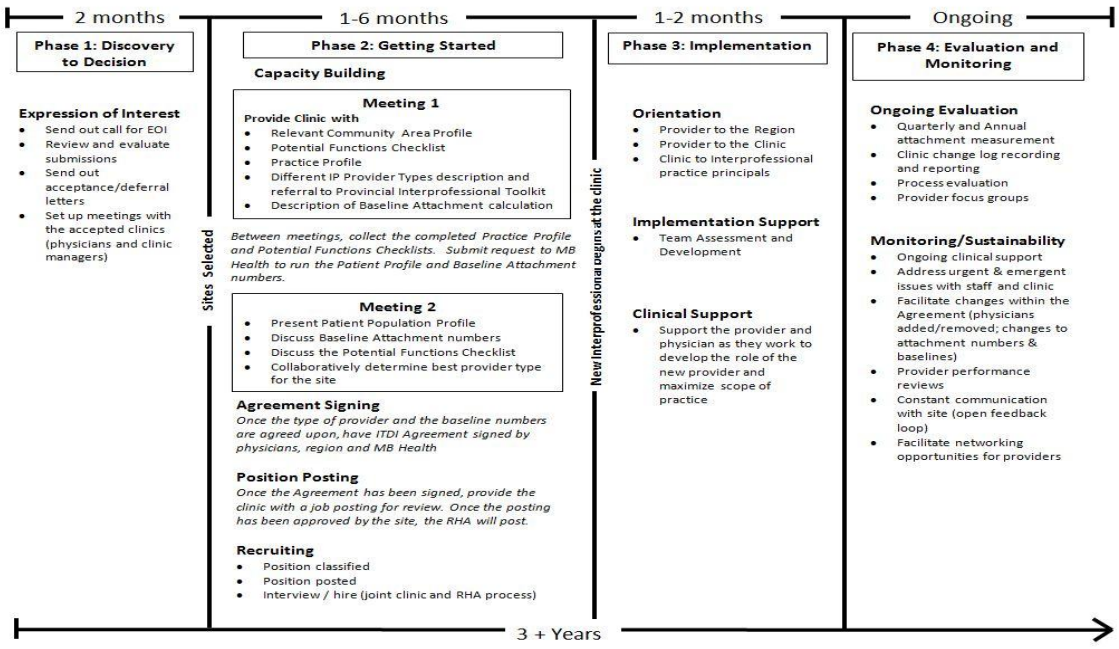
This toolkit was developed within the Winnipeg Health region, but is intended to be a resource for all of the health regions in Manitoba. Throughout the development of this provincial toolkit, best efforts were made to gather feedback, advice, and experience from many stakeholders and from all health regions across the province through an iterative evaluation process. Due to the fact that the regions were at differing stages of development with implementing this initiative, the majority of the work within this toolkit stems from the Winnipeg experience. This is identified as a limitation to the resource, and it is fully expected that regions may find that some aspects are relevant for their situation while others are not. This is a flexible document which provides several guiding principles and resources, and our hope is that all regions will benefit from it.

I. EXECUTIVE SUMMARY

The Manitoba government provided funding and support for the development of interprofessional teams within fee-for-service clinics throughout the province. This toolkit is designed to be a comprehensive resource that can be used as a guide by those who are working to establish interprofessional teams in primary care.

This toolkit provides guidance, resources and reference material for regional staff involved in the introduction of interprofessional team members into primary care fee-for-service practices within Manitoba. This toolkit includes evidence-informed tools and resources, and describes a step-by-step process that can assist in the collaborative identification of the competency-based needs and functions desired by a practice, the determination of the right provider and integration of the new provider into the practice.

The process of introducing an interprofessional provider into a fee-for-service practice can be broken down into four phases. The first is the *Discovery to Decision Phase* during which an Expression of Interest (EOI) is issued and applications are reviewed to identify practices that appear ready to take part in the initiative. The second phase involves *Getting Started* on building capacity and identifying key roles and functions that will best assist the practices in achieving the main goal of attaching new patients while also supporting accessible quality primary care. The third phase addresses the orientation and *Implementation* of the provider into the practice and the final phase is the continued *Evaluating and Monitoring* phase in which the progress of patient attachment is monitored and its impacts evaluated. Each of the phases is discussed in greater detail within this toolkit. The progression of these phases is shown in the table below and can be found in Appendix 24:



II. BACKGROUND

The development of collaborative interprofessional teams within primary care is a strategy that has been used nationally in Canada for more than a decade. Primary care teams that incorporate providers such as physician assistants, nurses, nurse practitioners and allied health workers are desirable for several reasons. One is the complementary nature of these team members' expertise to that of family physicians and their ability to contribute to comprehensive quality patient-centered care. Another is the ability to increase primary care access to address the difficulty many Manitobans experience in finding a family physician to accept them as a patient and provide them with ongoing comprehensive and continuous primary care.

According to the Canadian Community Health Survey, conducted annually by Statistics Canada, approximately 14 per cent of Manitobans (2005) do not have a regular physician, and of these, 62 per cent would like one. With expected population growth, the number of Manitobans who are without a family physician or nurse practitioner and are seeking one is approximately 116,000 (based on the CCHS percentages); it may be higher, if some of the remaining Manitobans who are believed to be without a regular family physician or nurse practitioner by choice begin looking for one.

In May 2012 it was proposed to the Manitoba Patient Access Network (MPAN) that one way to increase access in primary care would be to establish collaborative interprofessional teams within fee-for-service (FFS) clinics. It was hypothesized that by incorporating other care providers into primary care practices to provide clinical activities and services for many patients, the capacity of family physicians would be extended, therefore enabling the primary care practice to care for more patients as a team. Interprofessional team practice within primary care is not a new concept; however, movement in this direction has not been rapidly accepted or implemented in fee-for-service practices in Manitoba. Thus, proactive measures were necessary to accelerate adoption. In spring 2013, the Winnipeg Regional Health Authority (WRHA), together with Manitoba Health, Healthy Living and Seniors, began to implement the Interprofessional Team Demonstration Initiative (ITDI). The initial goal of the ITDI was to start with a small number of clinics (the early adopters) to pilot the processes necessary to engage practices and implement this initiative, which would permit for revisions and refinements in the future recruitment phases to follow.

The Discovery Stage of Phase One was initiated by mailing solicitations of a Call for Expressions of Interest (EOI) to all FFS physicians in Winnipeg. Once the EOI applications were reviewed and successful Phase One clinics were identified, the regional team began the process of meeting with these early adopting clinics. Recognizing that the transformation of primary care practice requires meaningful engagement and relationships amongst all involved, the establishment and maintenance of transparent communication between the practices, physicians, team members, health region, and Manitoba Health, Healthy Living and Seniors, were key throughout this initiative.

It is well documented that one of the most effective ways to encourage change for physicians is through the identification and support of physician champions. Physician champions are commonly early adopters who realize the benefits of the particular change, and are able to best articulate those benefits to other physicians and peers in a way that is easily understood and represents the realities of practice. Therefore, it was expected that the clinics involved in Phase One would be early adopters of the interprofessional team concept and act as physician champions for this initiative. Recognizing the importance of these first clinics and the role they may have in championing this initiative, the regional

team endeavored to be transparent and engaging with the early adopters to ensure their input was solicited and acted upon throughout the entire process.

Once the practices were readily engaged, the regional team facilitated a semi-structured meeting process in which the goals were to assist the practice in identifying the areas of service where they felt they would benefit the most by interprofessional support, and the type of interprofessional provider which would be the best fit to provide this support. Using a strengths-based approach, which identifies the strengths of an organization and attempts to build on them, there were some informative tools and team activities that were provided to the practices:

- summaries of the relevant community area profile(s)
- development of a clinic practice profile
- reflection on the patient profile data
- potential functions tool

Each of these tools is discussed in greater detail later in the toolkit, and blank copies of the relevant documents are included in the appendices. It is important to recognize that there was a great deal of work done between the RHA and the clinic to assess the current state of the practice, and what competencies the new interprofessional team member could bring to the clinic in order to benefit both the participating physicians and patients.

The provincial model for the ITDI agreement was that the interprofessional team member would be hired as an employee of the health region. The region, therefore, offered operational and clinical supports such as orientation for the new provider, collaborative interprofessional team orientation and evaluation resources. These steps were seen as critical to ensuring successful provider implementation.

The main goal of the ITDI is to increase patient attachment to the FFS practice. The ITDI agreement contains an annual stipend and variable payment component to be paid to the clinic annually based on their success in attaching new patients. The ITDI agreement was signed by all participating physicians within the practice, the health region, and Manitoba Health, as each played an integral role within the initiative. For more details on the specifics of the agreement, see Appendix 14.

WHY COLLABORATIVE HEALTHCARE TEAMS

An interprofessional team can be designed to increase a patients' access to the care they need when they need it. The College of Family Physicians supports interprofessional collaborative team based care as one way to ensure comprehensive patient-centred continuity of care[1]. The development and integration of collaborative interprofessional teams is a core component of the provincial My Health Team initiative. Interprofessional collaborative practice involves developing working relationships which acknowledge that each team member has an important role to contribute and that through collaborative work, all can learn new skills and approaches to care. Collaborative practice is an interprofessional process of communication and integrated decision making/care planning that allows

[1] College of Family Physicians of Canada. (2011). *A vision for Canada. Family practice, the patient's medical home.* Retrieved from www.cfpc.ca/uploadedFiles/.../PMH_A_**Vision**_for_Canada.pdf

the separate and shared skills and knowledge of team members to enhance comprehensive, patient-centred care.

Some of the benefits for patients can include:

- Increased ease in accessing care when they need it
- Improved patient safety
- Reductions in hospital admissions and lengths of stay
- Patient involvement in learning to manage their own health care (self-management)
- Improved quality of care as the services are more coordinated*

Benefits for providers and practices can include:

- Workplace and provider satisfaction
- Support of a team to provide a variety of care needs, such as prevention education, screening, nutrition counseling, mental health care, patient self-management, immunizations, home visits, and chronic disease monitoring
- Opportunity to understand the benefits (financial, care and personal) of working with other health professionals
- Providers have opportunities to learn new skills and approaches to care through the collaborative experience*
- Provides an environment for innovation*
- Allow providers to focus on individual areas of expertise, thereby increasing the effectiveness of care leading to better outcomes*

Benefits for health delivery system can include:

- Decreased burden on acute care facilities as a result of increased preventive and educational interventions and more effective management*
- Potential for more efficient delivery of care*

**Quoted from "Team Building Part A Resource Guide", Quality Improvement and Innovation Partnership, January 2009.*

III. PHASE 1: DISCOVERY TO DECISION

EOI AND APPLICATION REVIEW PROCESS

Order of events for the Expression of Interest process:

1. Call for Expression of Interest (EOI)
    - An EOI was distributed to all fee-for-service physicians within the region (a copy of the EOI is included in Appendix 2). The EOI included an application form, a list of qualifying criteria, a contact person to answer questions, and a closing date for the applications to be returned by.
2. Evaluation of all applications.
    - Once the EOI applications were received, there was a process of evaluating the applications in order to identify the clinics that were most ready for this initiative. This evaluation process was conducted by a group of stakeholders from the health region and Manitoba Health, Healthy Living and Seniors, who met together and discussed each application in accordance with the identified qualifying criteria. Only fully completed applications were considered. A copy of the EOI rating and evaluation forms can be found in Appendix 3.
3. All applicants were contacted.
    - Applicants that were identified as successful received a letter indicating as such and informing them of the next steps in the process.
    - If the application was incomplete, or showed promise yet there were some areas that needed clarification, the decision of acceptance was deferred and the clinic was contacted to arrange a meeting to discuss the process and the initiative in greater detail. It was then determined from there how best to proceed.
    - Applicants that were deemed unsuccessful were asked to consider becoming engaged through other means (ex: My Health Team community meetings, or applying for future expression of interest opportunities).

KEY STAKEHOLDER ROLES

An important aspect of team development is role clarity. This was true in this initiative as several stakeholders are involved, making it important to define the responsibilities and expectations of each party. The three stakeholders who signed each agreement were:

- The Health Region
- Manitoba Health, Healthy Living and Seniors
- The fee-for-service Clinic (in the case of large group practices, not necessarily all of the physicians in the clinic, only those wishing to be involved)

Some of the specific aspects of each stakeholder's role are explained next.

The Role of the RHA

- Identify regional staff, with clearly defined role(s), to facilitate the process and coordinate communication between all the stakeholders.
- Identify someone within the region who has existing relationships with the FFS clinic(s) to work closely with the physicians to support the completion of the Agreement.
- Facilitate the execution of the Expressions of Interest (recruitment of sites) process and evaluation of applications
- Engage the clinic(s) regarding their practice and their needs
- Work directly with the clinic(s) to assist them in identifying the type of interprofessional provider that would best meet their needs and support increased attachment of new patients without compromising access and quality of services.
- Advertise and post for the position of employment
- Facilitate the interview process in collaboration with the clinic representatives
- Hire the interprofessional provider as a health region employee
- Conduct the orientation of the new provider to the region and to services available to the population
- Facilitate the implementation of the new provider into the clinic (ex: support the development of interprofessional team competencies)
- Provide ongoing clinical support to the provider
- Provide ongoing support to the clinic such as Team Competency and Assessment Tools, and Collaborative care supports
- Coordinate and carry out the evaluation activities

The Role of Manitoba Health, Health Living and Seniors

- Support the initiative financially as per the agreement
- Ensure that the process is strategically aligned with other provincial strategies
- Participate in evaluating the EOI applications
- Align the evaluation activities with other MB Health, Healthy Living and Seniors evaluation strategies
- Provide support to the region throughout the process, when policy decisions are required
- Assist in all required provincial evaluation activities
- Support collaborative problem solving concerns regarding the agreements, analyze the EMR data submitted by the clinic to calculate the baseline attachment, quarterly and annual reviews of net change in new patient attachment.

The Role of the Clinic

- Demonstrate initiative towards increased attachment of patients to the practice
- Demonstrate a desire to work collaboratively with interprofessional providers
- Provide the space and equipment necessary to accommodate a new interprofessional provider
- To be actively engaged in developing/partnering with the My Health Team (MyHT) in their community area, where available
- Actively participate in evaluation activities
- Support quality improvement activities by sharing data and lessons learned with partners, peers and interested parties
- Participate with the Family Doctor Finder program

IV. PHASE 2: GETTING STARTED

Once the *Discovery to Decision* stage and EOI processes were complete, the regional team began the process of physician engagement by meeting with the accepted clinics. During this time of engaging the new practices, the goals were to build capacity and develop understanding around the initiative. Several new and/or existing resources and tools were used to help guide discussions and decision making during this process. A log of the proposed meeting agendas and tools can be found in Appendix 1.

PRACTICE SPECIFIC DATA

During the initial discussions there were several key tools and documents provided to the clinics. The purpose of these documents was to inform all physicians and practices of the basic demographics of their patients and the community areas they serve.

Community Area Profile

The RHA summarized neighborhood-level population health information from multiple published reports and collated the information into a succinct community area profile. This report included information on population size, age and gender breakdown, as well as rates of chronic diseases, mental health disorders, and key health risk factors. A copy of this profile was given to each practice to provide a high level summary of the community area they serve. Profiles of additional community areas were provided if requested, as some physicians felt they had a high percentage of patients from community areas outside of their practice location. An example of a community area profile can be found in Appendix 9.

Practice Profile

At the first meeting each clinic was given a Practice Profile worksheet to complete which requested key information regarding the make-up of the clinic staff, their roles and functions. Physician-specific information regarding the dates that each physician joined the practice, their days of clinic work, clinical EFT and billing numbers were also collected. This information was used in the creation of further documents, such as the practice's Patient Profile and Baseline Attachment Data. A brief explanation of the clinic's business model was also collected, as this provided key information of the dynamics of the practice, decision making process and the accountability structure. An example of a practice profile worksheet can be found in Appendix 4.

Patient Profile

The Patient Profile provided information on all patients seen by each physician during the previous 18 months. Patient profiles were developed by Manitoba Health based on billing data and the Health Insurance Registry. It is useful for each practice to review the types of patients they serve in their practice, both as a provider and as a clinic. The objective of developing practice-specific patient profiles was to provide the clinic with some key information to help guide them in choosing the type of interprofessional provider that would best support their patient population. The numbers in this document often differed from the baseline attachment numbers, as all patient visits were included in the Patient Profile, whether walk-ins, one-time visits, or regular patients. Demographic information on the patients such as age and gender were included in this profile, as well as the prevalence of chronic

diseases. The report also included a geographic summary of the number of patients who reside in each of Winnipeg's neighbourhood clusters and community areas, in addition to any rural municipalities and other health regions. An example of a Patient Profile can be found in Appendix 5.

Baseline Attachment (Panel Size)

The main goal of this initiative is to provide every Manitoba resident who wants one access to a regular family physician or nurse practitioner. One way to move towards this goal is to increase the attachment of patients to existing primary care providers. In order to determine if the number of patients that are attached to a provider increases with the introduction of a new interprofessional provider, a baseline attachment must be developed.

The development of the baseline attachment is a four step process conducted by Manitoba Health's Health Information Management (HIM) branch. HIM uses the information from the Practice Profile document including start dates, in-clinic days and the Patient Attribution Algorithm (See Agreement Appendix 3) to determine a baseline count of currently attached patients for each participating physician and, collectively for the clinic. The Patient Attribution Algorithm uses two sources of information: Medical Claims (Billing) data pertaining to each physician's individual billing number; and EMR data obtained through a regular EMR extract submission to Manitoba Health. If a practice does not regularly submit EMR extracts to Manitoba Health, this can be set up and coordinated through the regional facilitators and the Primary Care/Community Physician Information Systems (PCIS) Office of Manitoba eHealth. Details on this process can be found in Appendix 26.

The final baseline attachment number (the current active panel size) entered into the agreement is used as a benchmark for determining any changes in patient attachment volume following the introduction of the new provider. Attachment continues to be assessed quarterly and annually in order to determine the amount of an annual variable payment the clinic will receive in return for the three years of the Agreement.

NOTE: A physicians' baseline panel size must be at minimum 950 patients (for a 1.0 EFT or pro-rated accordingly) in order to be eligible to attribute new patients to the overall clinic's achievement.

ENGAGEMENT DOCUMENTS

Once the practices worked through all of their patient and baseline information, the next step was to provide them with information on primary care renewal and interprofessional provider types. The purpose for using these documents was to encourage practices to start thinking about what type of provider might best support their existing patient and community needs and their practice.

FAQs

A number of excellent questions arose from the early adoption practices throughout the engagement and implementation phases of the initiative. All questions were collected and collated into two FAQ documents, one addressing general questions and one addressing data-specific questions. As additional questions and situations arise, these documents were updated and circulated to participating practices. A copy of the FAQs can be found in Appendix 15.

Primary Care Renewal Initiatives Table and Diagram

There are several primary care renewal activities currently underway. As the activities are connected and support each other, it is important for clinics to understand the overall strategy, and not just the ITDI initiative. A diagram and table outlining various current strategies is located in Appendix 6. This document was used in the Capacity Building phase in order to help clinics to understand this initiative within the current context of the various primary care renewal activities happening simultaneously.

Potential Functions Checklist

A Potential Functions Checklist was developed to assist sites in selecting which type of provider would be best suited in their practice. The checklist is a comprehensive list of potential tasks and functions that could be accomplished by an interprofessional provider. Participating physicians were asked to complete the survey and indicate which tasks they would like assistance with and in what capacity. Examples of these functions include complete physicals, injections/immunizations, lifestyle/behavior counseling, women's health, laboratory/diagnostics order and review, and chronic disease management.

The results of the Potential Functions Checklist were collated, analyzed and matched to the most applicable profession's scope of practice. A discussion of findings was discussed with the practice and physicians during the *Getting Started* Phase. An example of the Potential Functions Checklist can be found in Appendix 10.

> *Clinic X held a staff meeting where each physician completed the Potential Functions Checklist independently. After completion, the clinic manager collated all of the survey responses and presented it at a meeting the following week. Common functions were identified and used as discussion points among the group in attempts to determine which type of provider would address their desired needs and functions.*

Round Table Discussion

Participating physicians were asked to discuss within their practices key areas in which they feel their practice could benefit from the introduction of an IP team member. Following this internal discussion, meetings were held with the participating physicians and members of the RHA's Primary Care Team to openly discuss the needs of the practice.

Each practice was provided with an Interprofessional ID Tool/table of positions which included a short summary of the potential roles and functions of Primary Care Nurses, Nurse Practitioners and Physician Assistants. This document was to be used as a discussion tool to assist the physicians in understanding the practice differences between these providers, and help them to identify which provider would best satisfy their needs (see Appendix 8).

A combination of both the survey results and the round table discussions were used to clarify each practice's decision making process in selecting which type of IP team member would be best suited in each practice.

THE AGREEMENT

The Interprofessional Team Demonstration Initiative agreement template was developed in partnership between Manitoba Health, Healthy Living and Seniors and the Region, and with input from a number of fee-for-service clinics. Once a practice agreed to participate in the initiative, three (3) site specific original copies of the agreement were drafted and given first to the clinic to be signed by all participating physicians interested in working with the interprofessional provider and who agree to attaching more patients. After the participating physicians signed the three (3) Agreements, they were forwarded to the Region and then the Province for signatures.

Process for getting the agreement signed:

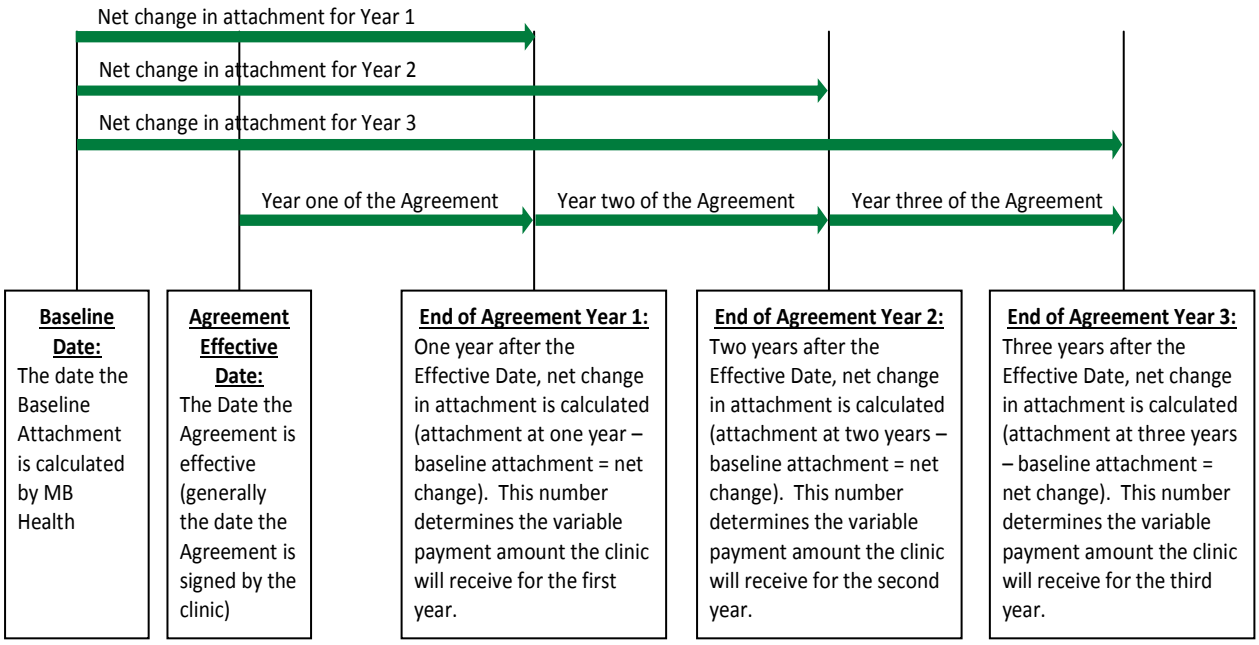
- Physicians each sign the three original copies
- A representative from the RHA signs each
- A representative from Manitoba Health signs each
- Once they are all signed, an original is given to each of the three stakeholders (clinic, RHA, MBH)

Changes to the Agreement

There are a number of situations that can arise which require revisions of the original ITDI Agreement. In these situations, an Agreement Amendment is required and can be processed in the same pathway as above. The process for amending the agreement is outlined in section A7 of the agreement. Templates were created in order to facilitate amending the existing agreement and can be found in Appendix 20/21.

- When do we need to change the agreement?
    - When a participating physician leaves the practice
    - When a new physician wants to sign on to the Agreement

The Agreement Timeline



As the engagement process moves at different rates for each practice, the timelines can be confusing if the important dates are not properly defined. Therefore, MB Health and the RHA developed a timeline which appropriately defines the Baseline Date and the Agreement Effective Date. It also shows how the annual variable stipend will be calculated based on those dates. It is important to be clear with practices that the annual payment will always be based on the baseline attachment that is agreed upon and entered into the agreement. Due to the fact that the baseline attachment is calculated prior to the agreement being signed, the first years' net change in attachment will most likely encompass more than 12 months. The diagram is designed to make this process easier to envision and can be found in Appendix 17.

INTERPROFESSIONAL PROVIDER RECRUITMENT

The process of provider recruitment involves meaningful engagement and transparent communication between the Region and the fee-for-service site. Through repetition and stakeholder feedback, various improvements ensued, which resulted in an effective process as outlined below:

1. Position description development
    - Existing union positions and descriptions were used for all provider recruitment postings. These positions were revised to reflect that an eligible candidate must have demonstrated knowledge and experience in primary care, in addition to any specific knowledge, training or criteria that was desired by the fee-for-service practice site.

2. Position posting
    - Each position was posted by the Region, so it was clear that the position was to be a regional employee, but intended to be located at a specific fee-for-service clinic site. An example of an interprofessional posting can be found in Appendix 13.
3. Interview Process
    - The interview was a collaborative effort which included staff from the clinic and a Regional representative.
    - Both the Region and the Clinic participated in the design of the interview questions and the actual interview process.
4. Selection
    - Selection of the successful candidate was a joint decision between the clinic and the Region. The selected candidate was hired as a regional employee.

ex: Site X went through the interview process with the RHA present and selected a provider. The provider ended up not being able to accept the position, therefore the process of posting, screening and interviewing had to be repeated. The site requested that the RHA perform the interview alone, and after final candidate(s) were selected, the site requested to meet each of them before the offer was made.

It is important for the regional human resources (HR) department to be aware of the upcoming employment opportunities and the ongoing process of this initiative. Therefore it is essential to have ongoing communication with the regional HR department to ensure they are well informed. When the HR department is engaged in the initiative, they are better able to step in and offer assistance as issues arise. They also play a role in keeping the unions informed and up to date on what is happening in this regard. In Winnipeg, the ITDI regional team met quarterly with the HR department representative in order to keep them in the loop of these unique positions (regional employees working outside of a regional site).

PRIVACY AND ACCESS

The IP team member was hired by the RHA but their actual work location is at the FFS clinic site. This has implications relating to privacy and access. This section supports the resolution of these implications.

Privacy and Access Context

The Personal Health Information Act (PHIA) does not differentiate between RHA and FFS responsibilities; it references 'health care facilities' and the responsibilities of 'health professionals'. Both 'health professionals' and 'health care facilities' are 'trustees' under the act. Trustees collect and maintain personal health information, having obligations as such under PHIA. However, because of this novel arrangement where an IP team member is hired by one trustee but working at another trustee site, it is important that privacy and access responsibilities are not forgotten in the process. For this reason, this section contains a checklist to ensure that PHIA **privacy** is assured and to allow the IP team member **access** to do their work effectively and efficiently.

Privacy and Access Checklist

Every IP team member should consider the following check list in order to confirm they have had their privacy and access needs addressed.

1. Establishing the IP Team Member in their working location:

   Has the IP Team Member:

   - ✓ completed Regional Manitoba-PHIA Training?
   - ✓ been given access to physical and logical locations to do their work?
   - ✓ had their EMR logon and user-ID set up completed?
   - ✓ been oriented to the roles used in the clinic to carry out work (ex: how Lab results are routed)?
   - ✓ identified the 'Privacy Officer' in the clinic?
   - ✓ read and become ready to apply any Information Sharing Agreements that the clinic has?
   - ✓ signed forms in the clinic (ex: Clinic Pledge of Confidentiality)?
   - ✓ clarified their access and privacy responsibilities to employer (RHA) and work-location (clinic)?

2. Ongoing Work Practices :

   Is the IP Team Member:

   - ✓ applying the clinic's privacy policies and practices fluently?
   - ✓ aware when more PHIA Training is required?
   - ✓ getting optimal access to do their work?

3. Exceptions:
   - ✓ Is the IP team member able to recognize and initiate a response when a privacy breach is likely or has occurred?

EMR

The interprofessional provider is to be fully integrated into the clinic's team. This includes being set up to work within the clinic's Manitoba approved EMR. The stipend that is set out in the Agreement for the clinic is intended to be used to cover overhead costs, such as setting up a new user in the EMR.

CLINIC READINESS

In order to ensure successful implementation, there are a number of things that can and should be done to prepare the clinic and patients for this impending change. Some things to consider working with the clinic on:

- ✓ Appropriate preparation and support of other staff in the practice (clinical and non-clinical). It is important that other staff understand the role of the new team member and the contribution they will make to the practice. Time is needed for these activities. It is also critical to provide a safe environment where questions, concerns and anxieties about this new role can be shared openly.
- ✓ Orient front-end staff to know how to appropriately schedule appointments for the new provider. Take into consideration that the provider may need longer appointments than the physician does, especially during the first few months while they get acquainted with the clinic and patients.
- ✓ Develop a well-thought out plan for introducing the new team member to patients and community.
- ✓ Address space and infrastructure issues.
- ✓ Identify any supply needs for the new provider such as computer, pager, or phone.
- ✓ EMR license for the new provider and appropriate time for training on the clinic's EMR
- ✓ Anticipate increase patient capacity and impact on practice, team, and clinic flow. Addition of a new team member may create additional demands for administrative support (additional resources may be needed), as well as increased supplies, storage space, etc.
- ✓ Ensure that all the legal and administrative requirements are known and understood and that requisite paperwork has been completed.

V. PHASE 3: IMPLEMENTATION

ORIENTATION

Orientation to the Region

New providers can expect to spend the equivalent of one week in formal orientation sessions with the RHA. There is also a component of continuous orientation through shadowing and group learning that will take place over time. If possible, efforts should be made to provide orientation to multiple new providers together to facilitate the establishment of camaraderie and networking opportunities

Some suggestions for orientation include the following:

- ✓ Shadowing of existing providers who perform similar roles/functions in other sites (ex: Quick Care Clinics, other fee-for-service sites with IPs in place)
- ✓ Orient to using available clinical and community-based services within the clinic, the Community Area and the RHA
- ✓ PHIA, email
- ✓ Discuss reporting processes and duty to report
- ✓ Training on shadow billing protocol for nurse practitioners
- ✓ Discuss all initiatives in primary care and other relevant service areas
- ✓ Register for additional orientation resources including PHIA, Public Health orientation, Health Behavior Change, as available and applicable

Orientation to the Clinic

Orientation to the fee-for-service practice should be provided by the clinic. Some suggestions for orientation areas include the following:

- ✓ Role clarity
- ✓ Day in the life…
- ✓ Scope of practice
- ✓ Gap identification
- ✓ Standards of practice/guidelines
- ✓ Physical environment
- ✓ Clinic processes
- ✓ EMR at the clinic
- ✓ Hospital linkages where appropriate

A handout, entitled "Preparing Your Site/Practice to Welcome a New Interprofessional Team Member" can be found in the Appendix. This evidence-informed document was developed based on a recent provincial evaluation on the integration of Physician Assistants into Primary Care practices. This may prove to be a helpful tool for clinics that are new to the process of developing interprofessional teams, as it provides specific ideas on how to ensure the implementation is successful.

IMPLEMENTATION AND CLINICAL SUPPORT

It is important to develop an implementation plan to introduce the new provider and share as part of orientation. This will support the provider and practice in maximizing the new role, ensuring efficiencies, and integrating the orientation components into practice.

As a regional employee, there are many ways that the Region can support the new providers as they work towards understanding their new role and maximizing their performance and scope of practice. Resources such as the providers Regional Manager, My Health Team (MyHT) community staff and managers are available to assist with guideline updates and skill training, answer questions and provide support to both the providers and the clinic when and where necessary.

A number of other tools and resources are available through the Region such as:

Teamwork Perceptions Questionnaire

The Team Perceptions Questionnaire is an optional tool that can be administered by paper or electronically (ex: survey monkey). It is adapted from the TeamSTEPPS Teamwork Perceptions Questionnaire. This tool allows for confidential feedback and can be completed prior to the IP starting and then on a regular basis (every two months) in order to see if there is progress in team development. A copy of the Teamwork Perceptions Questionnaire is available in Appendix 11.

Team Competency Assessment

The Team Competency Assessment is an optional but highly recommended, team assessment activity designed to help the team openly discuss how the clinic is currently functioning; and to identify the strengths and weaknesses of the team operation, which allows for the development of goals and objectives aimed at improving team collaboration. It is important to note that this activity often results in defining some changes that the clinic can make to the way they operate in order to optimize team functioning. A copy of the Teamwork Competency Assessment is available in Appendix 12.

Collaborative Care Training

Collaborative Care is when several health providers work together with patients/residents/clients, their families, caregivers and communities to provide high quality care. It involves engaging any health provider whose expertise can help improve the patient/resident/client's health. When health providers collaborate, new possibilities exist that were not there before. The Region is committed to providing information, resources and support to help individuals, managers, teams and facilities to integrate Collaborative Care into their daily work. Regional training opportunities can be found at:

http://www.wrha.mb.ca/professionals/collaborativecare/index.php

A handout entitled "Collaborative Care Competencies" can be found in the Appendix. This document is meant to be shared with clinics, physicians and other health care team members to orient them to the competencies of collaboration as developed by the Canadian Interprofessional Health Collaborative. It may be helpful for defining, implementing and maintaining collaborative care within the clinic practice.

VI. PHASE 4: EVALUATION AND MONITORING

EVALUATION

There is a strong commitment to align the evaluation of the ITDI process with other Primary Care Renewal evaluation activities currently being planned or carried out in the province. An evaluation framework was developed between the Region and Manitoba Health which strives to assess the impacts of the various primary care renewal strategies that are currently underway. The portions of that framework that are relevant for the ITDI analysis are outlined below:

1. **Attachment:** What has been the impact on the number of patients attached to the participating physicians?
2. **Accessible Care**: What has been the impact on access for the practice as a whole?
3. **Appropriate Care**: Are there impacts on the extent to which patients receive care in accordance with primary care prevention, screening and chronic disease management?
4. **Provider Experience**: What is the experience and satisfaction of healthcare providers in primary care involved in primary care renewal initiatives?
5. **Efficiency:** What is the impact of reallocating activities to interprofessional team members? How cost effective does this approach to IP practice appear to be? What is the impact on return visit rates and appointment supply?

Plans are in place to investigate each of these indicators through various evaluation activities within the Region and across the Province. Some activities have already occurred, or are being carried out in order to support the larger evaluation.

- ✓ **IP Provider Focus Group**: A focus group was held in order to capture implementation experience from all IP Providers who were in place at the time. Providers from three health regions participated; some in person, and some via video conferencing. The discussion at the session was focused on the provider's experience in orienting and practicing in a FFS clinic.
- ✓ **Process Survey**: In the Winnipeg region, all participating clinics are invited to participate in an online survey, approximately 90 days after the IP provider begins working at their clinic. The questions on the survey address the process of engagement and how useful the data and information tools were in helping them to determine the best type of provider for their clinic.
- ✓ **Quarterly Attachment Reports**: Each quarter Manitoba Health provides each participating clinic with a report on their net increase in attachment. This has helped clinics to identify whether or not the way in which they are using their IP Provider has helped in attaching more patients to the practice. An example of a Quarterly Attachment Report can be found in Appendix 18.

What to measure and why?

One strategy in achieving the government's goal of access to a primary care provider is to increase the number of patients who are attached to a physician or nurse practitioner. Another key strategy is to improve each person's access to quality primary healthcare. While these factors are important, it is equally important that the care they receive is appropriate, of high quality and is satisfactory to the patient.

The previously mentioned framework sections were developed with the key measurement goals in mind, each of which focus on the impacts that the introduction of an IP team member has on a family medical practice, at both the patient and provider level.

Evaluation Key Goal	Data Source
Attachment	EMR Medical Claims
Continuity and Service Utilization	EMR Medical Claims
Accessible Care	Third Next Available Appointment (manual tracking may be necessary on an interim basis) EMR
Appropriate Care	EMR (existing primary care indicators)
Efficiency	EMR Medical Claims Payments made by Manitoba Health Clinic Log (supervision time where applicable)
Provider Experience (Physician and Interprofessional Team Member)	Provider interview/focus group or survey EMR data

MONITORING/SUSTAINING

A number of actions are necessary to ensure that this initiative is appropriately managed and sustained by all parties. The role of the Region in sustainability may include the following actions:

- ✓ Provide ongoing clinical support to the provider
- ✓ Attend to urgent and emergent issues that arise with the clinic and/or providers
- ✓ Conduct performance reviews on the providers
- ✓ Facilitate changes within the agreement (adding/removing participating physicians)
- ✓ Continually monitor the quarterly and annual attachment reports produced by Manitoba Health
- ✓ Maintain constant communication with the clinic, creating an open feedback loop
- ✓ Facilitate knowledge exchange between all stakeholder groups
- ✓ Provide opportunities for the providers to network with one another
- ✓ Facilitate and support data collection and all evaluation activities

VII. LINKING PRIMARY CARE RENEWAL STRATEGIES

The ITDI has proven to be one of the driving forces in the success of other primary care renewal activities by establishing strategic linkages with other initiatives such as My Health Teams and the Family Doctor Finder. The common thread linking these strategies together has been physician engagement and collaboration among all stakeholders.

My Health Teams

All clinics that sign an ITDI Agreement, also must join the local My Health Team (MyHT) in their region, where available, thereby establishing a foundation for the development of MyHTs across the province. Although the MyHTs were tabled before the ITDI, the relationship building that occurs between the region and the clinic during the ITDI progression has proven to be beneficial and has provided a backbone for MyHT group development and discussions. The establishment of positive working relationships between the region and fee-for-service practices was instrumental in the development of trust among the MyHT partners, as well as opened up communication between clinics that had not been in regular communication or collaborative up to this point. The introduction of the new ITDI sites into developing MyHTs has stimulated MyHT growth and increased the sites' understanding of their potential influences and benefits. In communities where MyHT development has been slow to evolve, the introduction of an interprofessional team member in one clinic can establish a foundation for MyHT development, where there was no previous community representation.

By linking with MyHTs, there was evidence of opportunities to establish some congruence among common processes and to develop a common implementation plan. For example, the progressive path of the ITDI has demonstrated opportunities to streamline a number of processes which are common among both the ITDI and MyHT development such as:

- Practice Profiles
- Patient profiles
- Baseline attachment data
- Quarterly and annual net attachment reporting processes
- Orientation of new regional providers
- Agreement and amendment development and signing process

The ITDI has also been instrumental in the development of interprofessional primary care teams, which is the goal of the MyHTs. By introducing an interprofessional provider into fee-for-service practices, a patient-centred health team is established. This can feed into the community level MyHT network and connect care providers within and across geographic boundaries to provide seamless transitions in care while enhancing efficiency and supporting sustainability of the health system.

Having the ITDI and MyHTs in development at the same time within the same areas requires considerable attention to details and partnerships. It is beneficial for those working on these initiatives to be in regular communication and to provide updates on the status of the various sites and partners involved. It is also important to try to align the initiatives, agreements and the evaluation activities as much as possible so as not to cause duplication or create redundancy.

Family Doctor Finder

People living in Manitoba who need and wish a primary care provider are able to register with the Family Doctor Finder, and a Primary Care Connector will work to find a provider who meets their needs, in a suitable location. The introduction of interprofessional teams is one strategy to increase a physician's capacity to attach new patients, and physicians who receive interprofessional providers in their practice are encouraged to participate with the Family Doctor Finder program. Primary Care Connectors receive information from physicians joining the ITDI and work with these providers who are willing and able to accept new patients, and to connect registered patients to a physician in their practice.

Quick Care Clinics

The implementation of Quick Care Clinics is another provincial primary care renewal strategy that can be linked with the ITDI physicians and providers, as well as linking to their local MyHT. Through collaborative interviews with the Manager of the Quick Care Clinics, joint recruitment opportunities for common staffing positions such as nurse practitioners and primary care nurses were realized. Additional opportunities to improve attachment were also realized through Quick Care Clinics, as the staff were able to assist patients who do not have a regular primary care provider, and link them with the Family Doctor Finder to facilitate the attachment process. Utilizing the Quick Care Clinics as an opportunity for regional orientation, shadowing and EMR training was also advantageous for the new interprofessionals, as it provided some early exposure to primary care practice within a regional employment environment.

Other Provincial Primary Care Evaluation Activities

Attempts were made to actively engage with other primary care evaluation and research activities currently under way in the province. The purpose was to share lessons and to try to prevent overlap of activities.

VIII. PRACTICE REFLECTION AND KEY LESSONS

Progression through the ITDI has provided many opportunities to learn from our partners, the providers and various regional and provincial stakeholders. Some of these opportunities for learning occurred through everyday operational activities and communication, while other opportunities for learning occurred through more formal evaluation activities such as surveys, focus groups and direct requests for feedback. We have collated a brief list of key lessons and reflections that may assist future regional facilitators and partners in successfully implementing similar initiatives in their regions and fee-for-service practices.

1. Communication is key

Open and transparent communication, especially between the region and the clinic, was paramount to the success of this initiative. Clinics were surveyed after the IP provider was in place, and more than 80 per cent who replied indicated that the initiative was clearly communicated, meeting objectives were made clear, and if they had questions, they knew who to contact.

Communication within the clinic between the team members and new IP provider is also important for successful implementation of the role. The new interprofessional providers are in a unique position to help the practice identify gaps they may not have been aware existed. Through communication amongst the team, the new provider may be able to fill these gaps (ex: IP recognizes a large volume of patients present with chronic condition issues, therefore IP can 'train-up' and obtain certification on topic area such as CRE or CDE, to enhance services being provided within the practice).

Communication with the regional Human Resources (HR) department is important throughout the entire process. Activities such as position description development, posting, recruitment, hiring and ongoing issue resolution are highly dependent on a good working relationship with the regional HR body, as the IPs are regional employees who work within the fee-for-service environment and may require specific guidance should issues arise.

2. Engagement is key

Physician engagement is paramount to the success of the initiative. When physicians are engaged they may act as leaders among their peers, which in turn can improve the overall healthcare system performance. Transparent and consistent communication can help establish positive relationships and build trust among physicians and partners.

Key evaluation and monitoring activities have demonstrated that the level of engagement and time investment of the supervising physician has the potential to lead to substantial improvements in scope of practice and performance of the Interprofessional provider. Recognizing that the initial time and supervision investment by the supervising physician may appear substantial, this energy has been shown to drop off shortly after implementation and contribute to the confidence, independence and broadening of scope of practice of the interprofessional provider.

3. Clinic readiness determines timelines for implementation

It is important to recognize that each practice and provider may be at a different level of readiness when it comes to engagement in the initiative, and implementation of an interprofessional provider.

- Early adopting practices were found to be more engaged at onset and were quick to implement and perform any necessary internal practice redesign to accommodate the new IP team member.
- Middle adopting practices required more information and enhanced communication about primary care renewal initiatives, the potential benefits, and the process for implementation. This included re-establishing EMR data submissions, discussions on practice style, expectations of how they would use a new provider and what type of provider may be best suited for their practice's needs. These practices generally had a longer engagement period compared to the early adopting practices, but were quick to implement and introduce their providers into the practice once the recruitment began.
- Late adopting practices required greater attention and communication regarding the similarities and differences between each of the renewal initiatives (FDF, MyHT & ITDI), as well as enhanced support for practice changes. This included assistance with the practice's EMR use and optimization, establishing initial EMR data extract submissions, and orientation to the types of interprofessional providers that are available to select from and their unique scopes of practice. These practices generally had longer engagement and implementation periods, spanning over a number of months, and in some cases, up to a year.

4. Key pieces of orientation are required for successful implementation of an interprofessional provider into a fee-for-service practice.

Orientation responsibilities should be both inclusive and shared amongst region and site. Some examples of orientation components include:

- Early exposure (shadowing) of existing providers who perform similar roles/functions in other sites (ex: Quick Care Clinics, other fee-for-service sites with IPs in place). This helps in the development of camaraderie, networking and mentorship among peers (Region)
- EMR training specific to fee-for-service clinic environment (site)
- High level understanding of fundamental components and differences of a fee-for-service environment and business model (both)
- Orientation to the Health Region
- Clinic level orientation involving all team members

5. ITDI improves satisfaction among staff and patients

Although the formal evaluation of ITDI is not complete, many clinic outcomes and impacts have been reported by the participating sites.

- Physicians report improvements in work-life balance due to introduction of an interprofessional provider in their practice. Having the help of the new interprofessional provider has lifted some of the burden of care they were experiencing, especially for high paneled physicians.
- Providers report improved job satisfaction and that in their new roles; they feel like they are making a difference in the lives of patients.

- Patients report satisfaction, improvements in access and the enhanced recognition and treatment of immediate issues by their providers. Ex: A patient was able to be assessed by an ITDI-RN on the same day of symptom presentation and calling into the clinic, and was therefore able to receive treatment in clinic instead of having to go to an ER for immediate care.

6. Primary Care Renewal activities need to be bridged and coordinated

Physician engagement plays a key role in the successful integration and linking of renewal initiatives as involvement in one area of renewal usually means involvement in several activities (ex: Family Doctor Finder, MyHTs and ITDI). It is important to engage physicians in the full renewal plan, and not just one particular initiative, as the initiatives are closely linked. However, it is easy for confusion to develop over which initiative is which, and so clear communication is essential.

Implementation of primary care renewal activities should be complementary and aligned with other existing and ongoing initiatives in order to achieve and sustain system changes. It is therefore imperative that Regional facilitators be engaged and remain abreast of the broader research and evaluation activities that are underway to reduce redundancy, enhance overlap, and strive to achieve successful primary care renewal.

7. Some scopes of practice are a better match for specific primary care renewal initiatives than others

Having now had several IP providers in place for more than a year, it is apparent that some types of providers are better suited for the ITDI initiative, while others are better suited for MyHTs. For example, the scope of practice and practice style of PAs may be better suited to support ITDI practices as they are able to enhance attachment of patients to a physician. Likewise, an allied health professionals such as dieticians may be better suited to a MyHT where a collection of providers are looking to utilize a specialized resource or service which can be shared among practices and potentially offload some of their more time consuming chronic condition assessment and treatment modalities.

8. Clinic business approaches play a role in capacity building to increase attachment

It is important that the clinic's business approach be taken into consideration when making the decision to implement an IP team member. Each approach has the potential to impact the outcomes of the initiative in various ways, especially as it relates to attaching new patients.

We have encountered three main types of business approaches in primary care:

1. Solo practice - a single physician working independently in their self-owned practice.
2. Co-Located practices – multiple, independently run practices with no links to each other, but located together. Practice is owned by one of the physicians or a third party, and each practicing physician pays rent to the owner.
3. Associate model - physicians are shareholders in partnership business model.

The introduction of an IP team member may have a mild to moderate impact on access in a solo practice as the IP provider is able to support the physician's panel, thus creating capacity for that physician to take on new patients. However in a larger group practice, there are potentially a larger number of patients which the IP provider can support. Therefore there is greater potential for creating increased capacity for the practice to increase their overall patient attachment.

Practice	*Solo*	*Group*		
New patients able to be seen	*50*	*30*	*30*	*30*
Net change	*50*	*120*		

During the first EOI release process, MB Health and the region were open to accepting solo practices. However, this was reviewed prior to the issue of the second EOI, and the qualifying criteria were changed to include that an eligible practice must have at least two participating physicians. This decision was based on the overarching goal of increasing patient attachment as there is greater opportunity for team development and the potential to increase attachment in practices with multiple physicians.

IX. APPENDICES

PROCESS LOG: ITDI ENGAGEMENT WITH FFS CLINICS

1. Expression of Interest (EOI)

- EOI sent directly to all PCP in RHA
- All submissions were reviewed and seven clinics were selected to participate in phase 1 of implementation.

2. Physician Meetings

We conducted two meetings with each clinic. Below is an outline of which documents were provided and discussed at each meeting.

Meeting #1

- ***Primary Care Renewal Table:*** *A synthesis of the interdependent levels of primary care available to support patients and practices in the Winnipeg RHA.*
- ***Community Area Profile:*** *A synthesis of existing published data describing the community area surrounding the clinic.*
- ***Potential Functions Identification Tool:*** *A listing of potential tasks that the new Interprofessional provider could perform in the clinic. The purpose is to get the physicians to start thinking about how this new provider would support their practice.*
- ***Practice Profile:*** *This is filled out by the clinic, identifying their site information*

Between these two meetings, it is advantageous to collect the Practice Profile and the Potential Functions survey from the clinic. This will give you an opportunity to review these and have a fairly good idea of the type of IP that the clinic needs prior to the second meeting. Also, the Practice Profile provides the information needed in order to have MB Health run the Baseline Attachment numbers for the physicians.

Meeting #2

- ***Table of Positions:*** A spreadsheet showing the differences/similarities between three of the interprofessional positions.
- ***Patient Population Profile:*** Compiled by Manitoba Health using Medical Claims and/or PIN data. Provides an overview of the practice and the patients that are currently being served by the clinic (age, gender, chronic diseases, home communities)
- ***Baseline Attachment numbers:*** Present the numbers generated by MB Health

Optional tools/discussions:

- ***Instructions for Team Assessment***
- ***Team Competency Assessment:*** An outline of an assessment that could be done with the existing team to help facilitate collaboration within the clinic
- ***Teamwork Perceptions Questionnaire:*** A questionnaire that could be used to provide regular team feedback on collaboration

INTERPROFESSIONAL TEAM DEMONSTRATION INITIATIVE

Call for Expression of Interest

April 2015

Call for Expression of Interest

Interprofessional Team Demonstration Initiative

April 2015

1. INTRODUCTION

Primary care is the foundation of the health care system and a priority for Manitobans.

Summary of Expression of Interest for Interprofessional Collaborative Teams

Manitoba Health in partnership with the regional health authorities wishes to support fee-for-service practices to enhance access to primary care for Manitobans through the introduction of interprofessional collaborative teams. Funding is being provided for selected fee-for-service clinics to demonstrate and learn from the incorporation of a team member such as a nurse, physician assistant or an allied health provider into an interprofessional team applying the principles of collaborative care. This Expression of Interest (EOI) is for clinics who are interested in participating in this initiative and who would like to have a dedicated provider join their practice. Clinics who agree to participate are also committing to partnering with the RHA in the development of My Health Teams (formerly called Primary Care Networks), which will support practices in sharing resources across multiple clinics.

A key objective is to increase the number of Manitobans who have a family physician (Primary Care Home) through partnerships and interprofessional teams functioning within a collaborative care environment. The development of collaborative interprofessional teams is one of the strategic actions intended to support the broader goals of primary care renewal.

The interprofessional provider will work within the fee for service practice, but will be an employee of the RHA, which will pay salary and benefits. The practice will receive an annual contribution toward overhead and supervision costs, as outlined in an Interprofessional Team Demonstration Initiative Agreement. The WRHA Family Medicine/Primary Care program is willing to support practices with the completion of the application process and with the introduction of a new interprofessional team member to the practice, answering any questions that may arise. Please contact Sylvie Pelletier (contact information below) if assistance is required.

This initiative began in the spring of 2013. There is capacity to expand this opportunity to several additional practices who wish to obtain a provider and join My Health Teams (MyHT).

Interprofessional Teams Supporting My Health Team Development

The development of interprofessional teams is a core component of Manitoba Health's Primary Care Renewal strategy. Interprofessional teams can be designed to increase patient access to the care they need when they need it. The College of Family Physicians supports interprofessional collaborative team based care as one way to ensure comprehensive patient-centred continuity of care[2].

[2] College of Family Physicians of Canada. (2011). *A vision for Canada. Family practice, the patient's medical home.* Retrieved from www.cfpc.ca/uploadedFiles/.../PMH_A_**Vision**_for_Canada.pdf

Collaborative practice encompasses active communication and integrated decision making/care planning among an interprofessional team. It involves developing working relationships that acknowledge the important role of each team member in contributing to comprehensive patient-centred care. Through collaborative work all team members have the opportunity to learn new skills and approaches to care.

Some of the benefits for patients can include:

- Patients can more easily access care when they need it
- Patient safety
- Reduction in hospital admissions and lengths of stay
- Patient involvement in learning to manage their own health care.

Benefits for providers and practices can include:

- Workplace and provider satisfaction
- Support of a team to provide a variety of care needs, such as prevention, education, screening, nutrition counseling, mental health care, patient self-management, immunizations, home visits, and chronic disease monitoring
- Opportunity to focus on providing services that are uniquely in their expertise
- Opportunity to understand the benefits (financial, care and personal) of working with other health professionals

My Health Teams

A strategic action aligned with the development of interprofessional teams in fee for service practices is the creation of My Health Teams. MyHTs are a provincial strategy to achieve the vision that all Manitobans will have access to quality primary care. A MyHT is a network collaborative of family physicians and other health care providers working together in innovative ways to provide care for their patient population. The goals of MyHTs include:

- Improving **access** to primary care for all Manitobans.
- Demonstrating **quality** and **safety** in Primary Care.
- Increasing the focus on the patient and **patient-centred** primary care.
- Connecting care providers within and across geographic boundaries to provide **seamless transitions** in care.

Within Winnipeg, 6 MyHTs are currently under development. For additional information please visit http://www.gov.mb.ca/health/primarycare/pcn/index.html

2. GENERAL INSTRUCTIONS

2.1. Schedule

Event	Date
Issue Call for Expression of Interest	Wednesday, April 22, 2015
EOI Submission deadline	Friday, May 29, 2015
EOI Submission Evaluations Completed	Friday, June 12, 2015

2.2. EOI Information

A list of FAQs are attached to this EOI and are also available at:
http://www.wrha.mb.ca/professionals/familyphysicians/index.php

All interested applicants with questions about the EOI process, or who require assistance with the completion of the application, are invited to contact Sylvie Pelletier, WRHA, spelletier@wrha.mb.ca, 204-940-8567.

2.3. EOI Submission

All completed EOI submissions must be received by 4:00pm on **Friday, May 29, 2015**.

Only applications that are filled out in their entirety will be considered.

Completed EOIs can be couriered or emailed to:

Sylvie Pelletier
Family Medicine/Primary Care, WRHA
5th Floor, 496 Hargrave Street
Winnipeg, MB R3A 0X7
spelletier@wrha.mb.ca

3. SELECTION OF EOI SUBMISSIONS

3.1. Selection Process

1. Clinics submit proposals to the WRHA in response to this EOI.
2. All proposals will be reviewed and evaluated by a selection team, according to the criteria listed in section 4.
3. Decisions will be communicated to each applicant following the selection completion date referenced in section 2.1.

3.2. Submission Review

Expressions of Interest for this phase will be reviewed by a selection team. Only fully completed submissions will be reviewed. All considered applications must first meet the mandatory requirements as outlined in section 4 in order to proceed to the selection process.

Those applications meeting the mandatory requirements will be evaluated based on the sections outlined in the EOI application.

As part of the selection process, the WRHA and Manitoba Health may request interviews or consultations with the applicants. Applicants should clearly indicate the contact information for an individual(s) who will be available to answer questions about the proposal.

All clinics will be notified once applicants have been selected.

4. QUALIFYING CRITERIA

Mandatory selection criteria:

1. Interested applicants must be practicing in a group of two or more physicians at the same clinic. Family physicians participating in the agreement must have been practicing at the clinic in question for a minimum of 12 months, or have a minimum panel size of 950 (based on 1.0 full-time equivalent (FTE).
2. Willingness to actively partner with the RHA in development of a MyHT and willingness to sign the MyHT agreement.
3. Must be using a Manitoba-approved Electronic Medical Record (EMR) system for a minimum of 12 months.
4. Willingness to provide evaluation data to inform refinement of strategies regarding Interprofessional practice, including measurement of attached patients, access and quality impacts.
5. Willingness to apply the principles of collaborative care[3] and open to participating in interprofessional training to support the introduction of new team members and overall team functioning.
6. Willingness to explore a variety of office efficiency practices to support enhanced access (ex: quality improvement, Lean Six Sigma, advanced access).
7. Must have adequate space to support an Interprofessional team member.
8. Willingness to work collaboratively with the enhanced provincial Family Doctor Finder.

Selection will take into account the need to support interprofessional team development in fee-for-service practices across the region, thus supporting patient access to primary care in all Winnipeg communities.

Priority will be given to applicants who are geographically located in Winnipeg community areas where there are limited participating ITDI clinic sites.

In situations where a participating clinic supports many family physicians, a maximum of two interprofessional providers per site is being observed.

[3] http://www.wrha.mb.ca/professionals/collaborativecare/about.php

5. TERMS OF AGREEMENT

Accepted and participating clinics must be willing to sign an Interprofessional Team Demonstration Initiative Agreement, which will be made available following the submission deadline. Because these are pilot arrangements exploring new forms of practice in Manitoba, intended to foster learning, the term of the agreement will be for three years, but there will be an option to renew upon agreement of all parties.

If you have questions or require further information, please contact Sylvie Pelletier, WRHA, spelletier@wrha.mb.ca, 204-940-8567.

The deadline for submission is May 29, 2015.

Send to attention:

Sylvie Pelletier
Family Medicine/Primary Care, WRHA
5th Floor, 496 Hargrave Street
Winnipeg, MB R3A 0X7
spelletier@wrha.mb.ca

If you do not feel ready to submit a proposal, but are interested to explore this initiative further, you are invited to contact Sylvie Pelletier (contact information above), who will put you in touch with a member of the team who can answer your questions. We would be happy to meet with your clinic to explain the agreement in greater detail.

Expression of Interest Application for Interprofessional Team Development Funding

Section 1: Clinic Information

1. **Name of Clinic** _____
2. **Address** _____
3. **Phone Number** _____
4. **Name of Electronic Medical Record** _____

   ☐ Currently Implemented (Date implemented _____)

5. **Clinic Manager /Lead/ or Primary Administrative Contact** _____
6. **Primary Physician Contact for the Expression of Interest** _____
7. **Total Number of Physicians currently working at clinic** _____
8. **Identify the type and number of all medical and interprofessional providers that are currently working in the practice, as well as all administrative and support staff.**

Names *(please print)*	Provider Type / Position	hours/wk

9. **Please indicate which providers within this practice are willing to participate in this interprofessional team demonstration initiative.**

Names *(please print)*	How long have they been practicing at this clinic?

10. **Please provide a description of your current patient population, including your panel size, patient demographics, their healthcare needs and the community that you primarily serve.**

Section 2: Commitment to Primary Care Renewal Strategies

Please indicate your willingness to participate in each of the following strategies:

1. **Commitment to Objectives of this interprofessional team development initiative:**
   - ☐ Will dedicate the new clinical capacity resulting from this program to accepting new patients into the group practice.
   - ☐ Will work collaboratively with the Family Doctor Finder Program which will connect the practice with patients who are seeking a family physician (primary care home).
   - ☐ Will apply the principles of collaborative care.
2. **Commitment to My Health Teams:**
   - ☐ Will participate in the development of My Health Teams.

3. **Commitment to Research and Evaluation:**

    - Will support quality improvement activities by sharing data and lessons learned with partners, peers and interested parties.
    - Will participate in ongoing evaluation and measurement (ex: provincially required data extracts, supervision logs, focus groups).

Section 3: Impact of Interprofessional Provider on Delivery of Care

1. **Please describe how the introduction of an interprofessional team member will help your practice deliver care to patients.** Include how this will help your practice accommodate new patients.

2. **Have you had experience working with other providers?** ***(ex: nurses, dietitians, rehab, etc…)***

   ☐ **Yes**

   ☐ **No**

   If yes, please describe.

3. **What training or other preparations have your clinic considered to date to support interprofessional practice and team development?** ***(ex: understanding scope of practice of other providers, understanding patient population characteristics, communicating with team members, etc.)***

4. **Are you able to accommodate the new team member within your existing space?**

Section 4: Past Experience/interest in working in partnership with RHA or MB Health to support interprofessional teams in fee for service.

1. **Do you have any information that you would to add to your application for consideration?** ***(ex: Past successes at your clinic; innovative practices; clinic team development, existing interprofessional resources)***

ITDI Application Review

Name of Clinic: _____

Reviewer: _____

Part 1: Mandatory Qualifying Criteria

	Yes	No
Section 1: Using a MB Health approved EMR for a minimum of 12 months		
Section 1: Identified a lead contact		
Section 1: Participating physicians identified		
Section 1: Group of 2 or more physicians		
Section 1: All participating physicians practicing >1 year at clinic		
Section 2: Commitment to PC renewal Strategies all checked off		
Section 3: Application filled out in its entirety		
Section 3: Adequate space for provider indicated (Question #5)		

If all answers in Part 1 (above) are yes, continue with evaluation of application. If any answer is no, application is removed from review process.

Notes:

ITDI Application Review

Name of Clinic: _____

Reviewer: _____

Part 2: Application Discussion

Application Section 1:

1. Is panel description within range of initial panel size recommendations?

2. Does application demonstrate knowledge of the clinic's patient population?

Application Section 2: *completed*

Application Section 3:

3. Does the application demonstrate an understanding of how the introduction of an interprofessional provider will help the practice?

4. Does the application indicate how the interprofessional will support attachment of new patients?

5. Does the application indicate any experience working with other providers?

Application Section 4:

6. Is this clinic within a community area where there is a need for patient attachment?

7. Does this clinic have any past experiences with WRHA or Manitoba Health Programs? (eg. PIN, Shared care, ITDI, PCNs, etc.)

Notes:

PRACTICE PROFILE - SITE INFORMATION

Clinic Name, Address, phone	
Clinic Contacts	
Date of completion:	
Clinic Current Status & Goals	

PRACTICE PROFILES

Question	**Full Name**	**Role & Billing number**	**EFT**	**Details / starting date at this clinic**
All physicians participating in the Interprofessional Agreement, role, billing number and EFT				
All staff supporting participating physicians:				
Type of Practice/physician (eg. Solo, partners, association, contract, group, ownership, etc…)				

Participating Physicians: Gender, Age, and Years of Practice	Physicians	Gender	Age						Total years of practice
		M/F	20-30	30-40	40-50	50-60	60-70	70-80	
EMR (which vendor, how long has been in place)									
Other relevant information									

PATIENT PROFILE

Patient Profile - Medical Claims

Provider Visits Per Day: 27.5
Provider Days Per Year: 2063.3

Patient Population Profile - Medical Claims

Patient Age and Gender

Age Group	Gender		Total
	F	M	
0	33	36	**69**
1	39	19	**58**
2	29	32	**61**
3	23	23	**46**
4	32	29	**61**
5-9	128	122	**250**
10-14	134	138	**272**
15-19	256	248	**504**
20-24	365	304	**669**
25-29	422	298	**720**
30-34	409	300	**709**
35-39	413	307	**720**
40-44	537	318	**855**
45-49	570	443	**1013**
50-54	756	542	**1298**
55-59	793	517	**1310**
60-64	656	513	**1169**
65-69	606	463	**1069**
70-74	477	339	**816**
75-79	398	291	**689**
80-84	372	246	**618**
85+	530	245	**775**
Total	**7978**	**5773**	**13751**

Panel Size: 13751
Average Number of Visits Per Patient Per Year: 6.18

Medical Complexity - CCDSS Data

Number of Chronic Conditions	Number of Patients	Percentage of Patients
0	8427	61.61%
1	3227	23.59%
2	1353	9.89%
3	506	3.70%
4	162	1.18%
5	4	0.03%
Total	**13679**	100.00%

Medical Complexity - CCDSS Data

Chronic Condition	Number of Patients with Chronic Condition	Percentage of Patients with Chronic Condition
Ischemic Heart Disease	1434	10.48%
Heart Failure	551	4.03%
Diabetes	1490	10.89%
Hypertension	4201	30.71%
Active Asthma	443	3.24%

RHA/Community Area	District/Neighbourhood Community	Number of Patients
ASSINIBOINE SOUTH	ASSINIBOINE SOUTH	545
DOWNTOWN	DOWNTOWN EAST	344
	DOWNTOWN WEST	299
FORT GARRY	FORT GARRY NORTH	578
	FORT GARRY SOUTH	482
INKSTER	INKSTER EAST	50
	INKSTER WEST	100
POINT DOUGLAS	POINT DOUGLAS NORTH	159
	POINT DOUGLAS SOUTH	74
RIVER EAST	RIVER EAST EAST	498
	RIVER EAST NORTH	184
	RIVER EAST SOUTH	189
	RIVER EAST WEST	653
RIVER HEIGHTS	RIVER HEIGHTS EAST	476
	RIVER HEIGHTS WEST	770
SEVEN OAKS	SEVEN OAKS EAST	295
	SEVEN OAKS NORTH	66
	SEVEN OAKS WEST	152
ST. BONIFACE	ST. BONIFACE EAST	1547
	ST. BONIFACE WEST	1650
ST. JAMES - ASSINIBOIA	ST. JAMES - ASSINIBOIA EAST	181
	ST. JAMES - ASSINIBOIA WEST	174
ST. VITAL	ST. VITAL NORTH	937
	ST. VITAL SOUTH	1276
TRANSCONA	TRANSCONA	474
Winnipeg Health Region	Winnipeg - Urban	1
Prairie Mountain Health Region	Agassiz Mountain	2
	Asessippi	5
	Brandon East End	1
	Brandon North Hill	1
	Brandon South End	2
	Dauphin	1
	Little Saskatchewan	6
	Souris River	1
	Spruce Woods	8
	Turtle Mountain	2
	Whitemud	1
Interlake-Eastern Health Region	Arborg/Riverton	9
	Beausejour	29
	Eriksdale/Ashern	7
	Fisher/Peguis	11
	Gimli	36
	Northern Remote	1
	Pinawa/Lac du Bonnet	55
	Powerview/Pine Falls	11
	Selkirk	42
	Springfield	225
	St. Clements	132
	St. Laurent	16
	Stonewall/Teulon	66
	Whiteshell	14
	Wpg Beach/St. Andrews	130
Northern Health Region	Cross Lake/Pimicikamak CN	1
	Flin Flon/Snow Lake/Cranberry/	5
	The Pas/OCN/Kelsey	1
	Thompson/Mystery Lake	2

RHA/Community Area	District/Neighbourhood Community	Number of Patients
Southern Health/Santé Sud Region	Altona	5
	Carman	6
	Cartier/St. Francçois Xavier	46
	City of Portage La Prairie	8
	Hanover	19
	Lorne/Louise/Pembina	4
	MacDonald	82
	MacGregor	2
	Morden	5
	Morris	24
	Niverville/Richot	172
	Notre Dame/St Claude	14
	Red River South	18
	Rural East	11
	Rural Portage	3
	Seven Regions	2
	St. Pierre	50
	Stanley	2
	Ste Anne/La Broquerie	81
	Steinbach	48
	Tache	166
	Winkler	6

In-Practice Resource (ITDI) ***(Interprofessional Exclusively in Fee for Service)***	**Shared Resource (MyHT)** ***(Shared Interprofessional supports in My Health Team)***	**Community Based Linkages** ***(Access to Primary Health Care Supports addressing health and social determinants)***

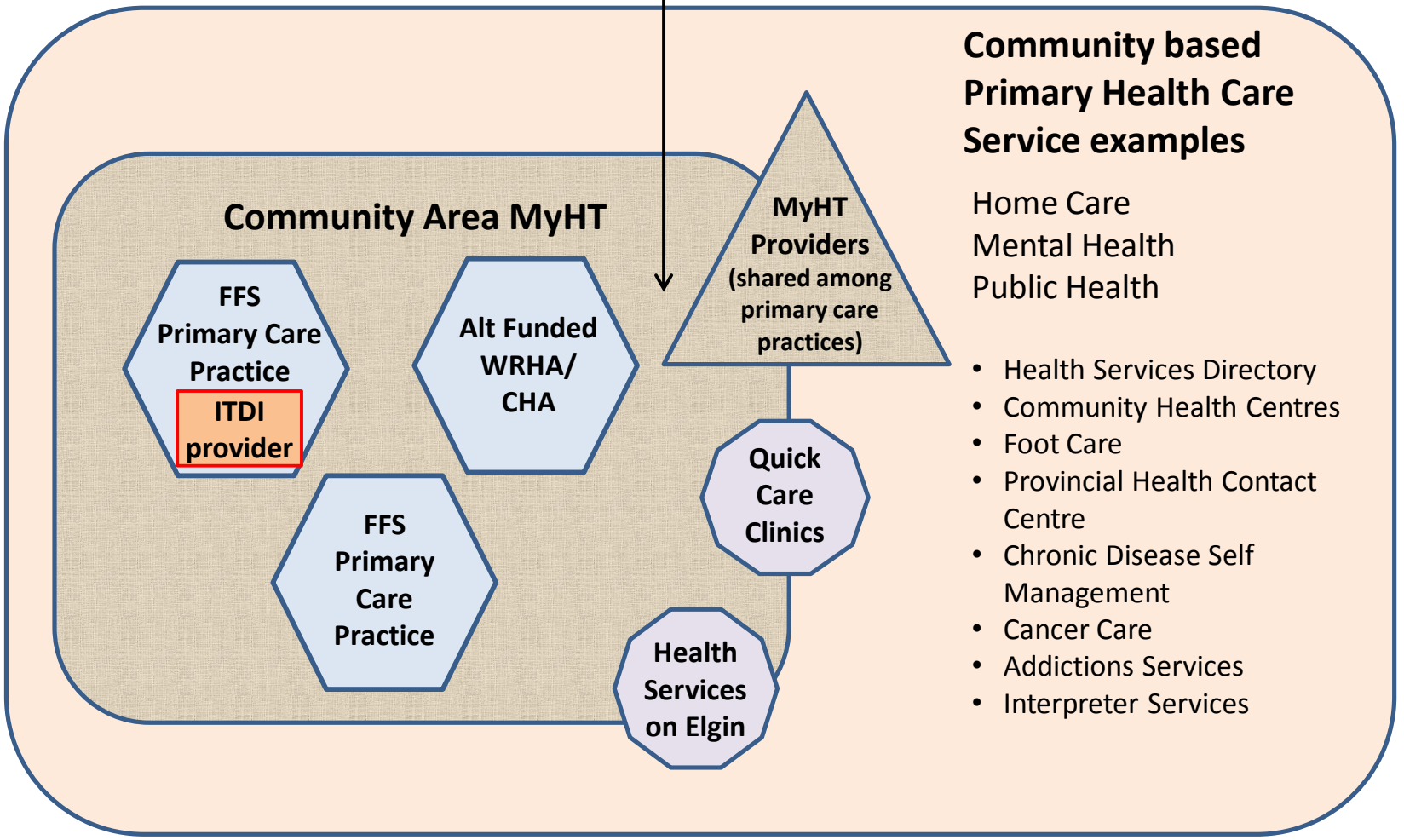
Dedicated Primary Care provider(s) working exclusively in 1 practice, supporting care of all patients within the practice - often with combination of specialized training /experience (Certification in Diabetes Education (CDE), Respiratory, Gerontology, immunization, mental health, urology, etc.) Scope of practice is determined by designation / competency / certification.
 	
Some examples of ITDI provider support are:
• Triages & telephone care
• Recognizes/initiates interventions/treatments
• Administers medication
• Performs comprehensive and focused health assessments
• Facilitates ordering of medication or prescribes independently (based on designation)
• Informs/educates meaning/ interpretation of all results
• Supports management of results
• Supports reproductive health/wellness, ex: STI management, PAP testing
• Counsels and supports on drug therapies, side effects, interactions
• Co-ordinates care/follow-up
• Performs/assists with procedures
• Provides ongoing patient education
• Facilitates links into available specialty and community resources
• Contributes to/initiates health plans
• Determines need/initiates consultation of
	Team comprised of several interprofessional providers as determined by the MyHT partners. These services may be mobile (attending partner clinics at their location) or provided from a central location. Type of support of the MyHT provider varies and is based on practice and population needs, as determined by the MyHT. The MyHT provider acts as an integrated care team member.
	
	Some examples of MyHT provider supports are:
	Based on competency/designation
	• Occupational Therapy – provides restorative support improving functional abilities and supporting mental health
	• Pharmacy - provides expert advice and opinion to the health care team, and to the patient regarding safe, effective and appropriate use of medication including medication reconciliation, consultation, etc.
	• Physiotherapy -supports functional and physical performance, preventing and managing pain, physical impairment, promoting fitness, health and wellness
	• Dietitian - assesses, designs, implements and evaluates nutritional interventions. Promotes the health of individuals, groups and the community.
	• Mental Health Counseling -addresses wellness, relationships, personal growth, mental health, and psychological illness or distress.
	
	Based on identified needs / practice/population and specialty/competency of MyHT members-
		Linking with existing services/resources to Primary care which may/or may not have previously been accessed.
		
		Some examples of supports through community based linkages are:
		• Home Care
		• Mental Health
		• Public Health
		• Health and Wellness
		• TeleCare- Telephone support for patients with:
		  • Diabetes (2 or less oral agents) & pre-diabetes
		  • CHF (manage care including electrolytes, etc.)
		• Health and Wellness (examples only):
		  • ReFit and Seven Oaks Wellness Institute:
		  - Individual and group exercise, nutrition and education, pre-screening prior to initiating exercise program, muscular strength and endurance, flexibility, and functional movement.
		  - Cardiac rehabilitation program
		  - Variety of other resources/services
		  • Youville Center - certified health educators (asthma and diabetes)
		  • Foot Care (at select sites)
		  • Alzheimer's society (cognitive changes)
		  • Manitoba Federation of Labour
		  • Health Services on Elgin

In-Practice Resource (ITDI) ***(Interprofessional Exclusively in Fee for Service)***	**Shared Resource (MyHT)** ***(Shared Interprofessional supports in My Health Team)***	**Community Based Linkages** ***(Access to Primary Health Care Supports addressing health and social determinants)***

other services/ team members
• Monitors/evaluates/adjusts health care plans based on efficacy/ change in condition/environment in collaboration with client/team
• Provides care in collaboration with family physicians including within clinic or within home environment
• Supports care related to chronic disease, mental health, principles of self-management, etc. (includes CDM quality indicators)
• Initiates specialty treatment/ management of care based on provider's certification/experience /availability of equipment. Examples include:
  • CDE-insulin start, titrate insulin, etc.
  • Respiratory-COPD/Asthma including PFT
  • Wound care/assessment/management
  • PVD/PAD assessment/screening including Ankle Brachial index (ABI) foot assessment, compression stockings measurements
  • Immunization
• Communicates with secondary & tertiary providers to ensure continuity of care
• Documents care electronically (within existing chart or provides copy of documentation electronically for chart)
	some additional supports may include
	• Certified Diabetes Educator CDE-titrate insulin, carb matching, etc..
	• Respiratory support-COPD/Asthma including PFT
	• PVD/PAD assessment/screening including wound assessment/Ankle Brachial index (ABI) wound care-compression stockings measurements, etc…
	• Smoking Cessation
	• Weight Management
	• Healthy Aging
	• Works collaboratively with practice – informs care suggests/makes recommendations
	• Documents care electronically (within existing chart or provides copy of documentation electronically for chart)
		• Support services to seniors
		- Peer led chronic disease self management
		• Improved linkage with Regional supports
		• Wound Care
		• Home care
		• Public Health
		• Health Services Directory
		• Age & Opportunity
		• Virtual Hospice
		• Addictions Foundation of Manitoba
		• Cancer Care Navigators
		• Mental Health
		• Etc.
		• Health Services inventory accessible through the Health Services Directory at http://wrha.mb.ca/healthinfo/directory/index.php
		• Communicates care to practice routinely or on an as needed basis as well as consults with/provides consult to practice as needed.
		• Works collaboratively with practice – informs care suggests/makes recommendations
		• Document care /agency/organization protocol and forwards to referring practitioner as needed.

Unattached patients

FAMILY DOCTOR FINDER



Community based Primary Health Care Service examples

Home Care
Mental Health
Public Health

- Health Services Directory
- Community Health Centres
- Foot Care
- Provincial Health Contact Centre
- Chronic Disease Self Management
- Cancer Care
- Addictions Services
- Interpreter Services

ROLES OF SOME INTERPROFESSIONAL POSITIONS IN PRIMARY CARE

Refer to http://www.gov.mb.ca/health/primarycare/pctit.html for the full MB Primary Care Interprofessional Team Toolkit

	Physician Assistants	Nurse Practitioner	Primary Care Nurse
General	PAs work as "physician extenders". Their scope of practice is related directly to the supervisory physician's practice.	A NP is a RN with advanced academic and clinical experience that enables them to diagnose and manage many common and chronic illnesses, and can practice independently.	A PCN is an RN who has extensive experience and/or training in a primary care setting.
What can they do?	PAs consult and collaborate with other health care professionals and extend the same services to clients as the supervising physician. Their scope of practice is often determined by the PA's level of experience and directly relates to the supervising physician's practice. • Facilitate Advanced Access by providing first response clinical triage and treatment initiation Take health histories • Prescribe medications • Perform physical exams • Order and interpret laboratory and diagnostic tests • Perform selected diagnostic and therapeutic procedures • Chronic disease prevention/screening and management • Provide patient education and counseling	NPs consult and collaborate with other health care professionals and provide nursing services in the areas of health promotion, illness prevention, chronic disease management, clinical intervention, palliation, rehabilitation, counseling and patient education. • Facilitate Advanced Access by providing first response clinical triage and treatment initiation • Take health histories Prescribe medications Perform physical exams • Order and interpret laboratory and diagnostic tests • Perform selected diagnostic and therapeutic procedures based on competency • Chronic disease prevention/screening and management • Provide patient education and counseling	PCNs consult and collaborate with other health care professionals and provide nursing services in the areas of assessment and screening, health promotion, illness prevention, chronic disease management, clinical intervention, palliation, rehabilitation, counseling and patient education. • Facilitate Advanced Access by providing first response clinical triage, assessment and intervention • Take health histories • Assist and supports with follow through on prescribed medical interventions and diagnostic testing. • Perform physical exams • Perform selected diagnostic and therapeutic procedures based on competency • Chronic disease prevention/screening and management • Provide patient education and counseling
Education	PA's hold Bachelor or Graduate degrees prior to beginning the Master's Level PA program, which includes advanced clinical and medical sciences with 48 weeks of didactic material and 52 weeks of clinical clerkship. PA's are trained as generalists in a primary care model. Some obtain post-graduate specialty training.	NPs are RN's who are Master's level prepared or equivalent with a minimum 1500 didactic and a minimum of 700 clinical hours while in a NP program. A BN and 4000 clinical hours post nursing degree are prerequisites to the NP Master's program.	A PCN must have an undergraduate degree in nursing or diploma in an approved education program, and have passed the Canadian Registered Nurse examination. Many PCNs have specialty training or certification in specific areas of primary care practice (ex: chronic disease, diabetes, wound management, etc.)
Supervision	A new or inexperienced PA requires greater supervision, but can work with a significant degree of autonomy once comfortable in a practice. The supervisory physician(s) must be available for consultation, either by phone or in person. A PA can work remotely as long as they receive a minimum of 8 hours of supervision a month.	The NP works with a significant degree of autonomy. The NP collaborates with the physician and other members of the health care team to deliver quality care.	PCNs work with a significant degree of autonomy. The PCN collaborates with the physician and other members of the health care team to deliver quality care.
Accountability and Liability	PA's require a contract of supervision with a licensed physician(s), a detailed practice description approved by the CPSM, and must be certified through the Physician Assistant Certification Council of Canada. Liability protection for physicians working with a PA is available through CMPA. PAs are responsible for ensuring that they have their own adequate liability protection through the Canadian Association of Physician Assistants (CAPA).	NPs are accountable and responsible for the quality of their own practice and conduct. Individual NPs serve a specific client population and area of nursing practice determined by her/ his competence. Liability protection is provided by the Canadian Nurse Protective Society. This protection protects the NP for defense of legal actions arising from the provision of professional nursing services.	PCNs are accountable and responsible for the quality of their own practice and conduct. Liability protection is provided by the Canadian Nurse Protective Society. This protection extends to the PCN for defense of legal actions arising from the provision of professional nursing services.

References: College of Registered Nurses of Manitoba: http://www.crnm.mb.ca/ Canadian Family Practice Nurses Association. Sample role description for registered nurse in family practice. Primary Care Interprofessional Team Toolkit. Manitoba Health October 2012. http://www.gov.mb.ca/health/primarycare/pin/docs/pinit.pdf Physician Assistants: The Growing Profession of Doctor Extenders. https://www.docsmb.org/physician-assistants Canadian Association of Physician Assistants: http://capa-acam.ca/ Canadian Medical Association. Physician Assistant Toolkit 2012) .http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/Physician_Assistants/PA-Toolkit_en.pdf. Winnipeg Regional Health Authority. Primary Care Nurse Position Description. Nurse Practitioner and Physician Assistant - What's the Difference? https://career.berkeley.edu/article/070209a-jv.stm Nurse Practitioners and Physician Assistants: Do You Know the Difference? http://capa-acam.ca/wp-content/uploads/ 2012/06/2007_Nurse-Practitioners-and-Physician-Assistants-Do-You-Know-the-Difference.pdf A Comparison of Physician Assistants and NursePractitioners(2012) http://umanitoba.ca/faculties/medicine/media/A_COMPARISON_OF_PANP_May_2012_%282%29.pdf

SAMPLE: COMMUNITY AREA PROFILE

Summary of Downtown – Point Douglas community area profiles.

The following is a synthesis of existing published data describing the Downtown and Point Douglas community area.

References:

WRHA

Health for All: Building Winnipeg's Health Equity Action Plan. Health Equity Indicator Resource Section

- Describes 54 health equity indicators by community areas (CA) and neighbourhood clusters (NCs), including household income quintiles and First Nations or Métis ethnicity

Community Health Assessment 2009/2010:
Population data categorized by community area (CA) and neighbourhood cluster (NC)

- Physical and social determinants of health
- Various primary care, physical and mental health status indicators
- Data from Manitoba Centre for Health Policy, Canadian Community Health survey (CCHS), Statistics Canada, Canada Census

A Profile of the Health of the Downtown Community (2012)
A Profile of the Health of the Point Douglas Community (2012)

MCHP

Métis Health Status and Healthcare Use in Manitoba. Martens et. al, 2010

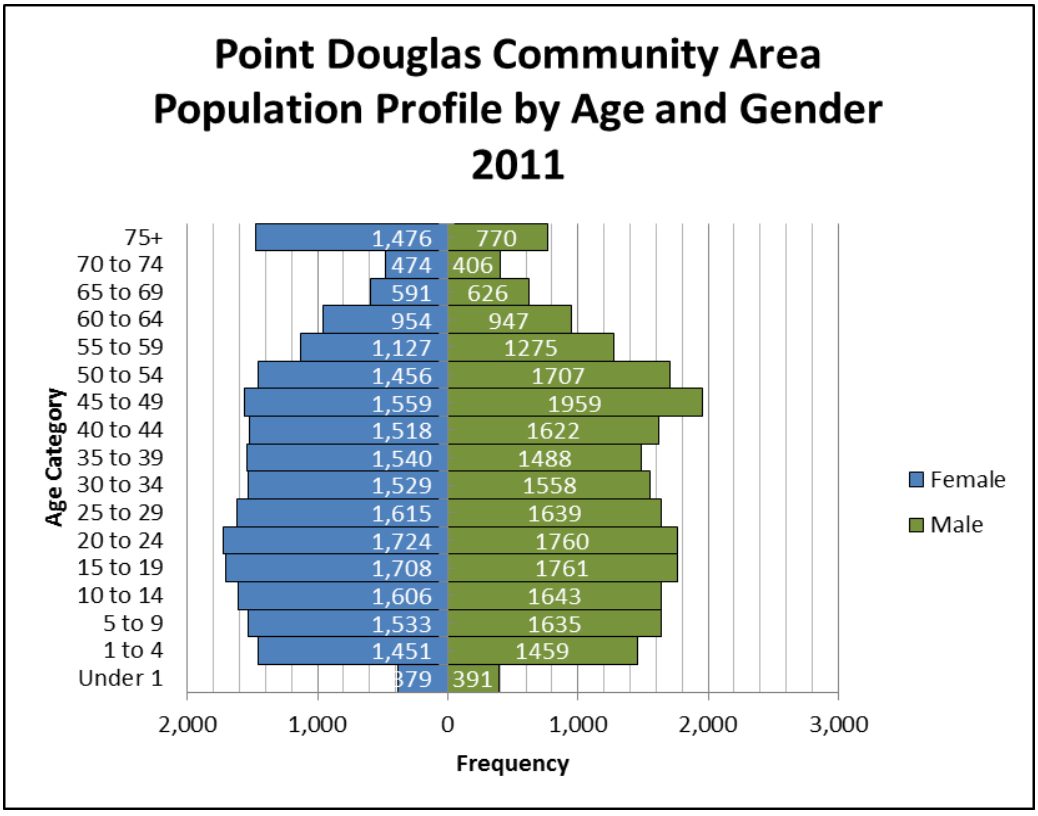
- Details Métis-specific rates of treatment prevalence, condition rates and health status indicators.
- Compares Métis population with Non-Métis population by health region and community area population
- Contains data from Community Health Assessment, Manitoba Center for Health Policy Population Health Repository, Canadian Community Health survey (CCHS), Statistics Canada, Canada Census and Manitoba Métis Federation.
- Population statistics by community are and neighbourhood cluster
- Physical and social determinants of health
- Various primary care, physical and mental health status indicators

Social Housing in Manitoba. Finlayson et. al, 2013
Describes the population of individuals living in social housing and compares them to the rest of the province on a number of health and social indicators

A Summary of Point Douglas CA's Demographics

As of June 1, 2011, the population of the Point Douglas CA was estimated to be 44,886, which accounts for 6.3 per cent of the population in the Winnipeg Health region.

- The total population in Point Douglas has increased by 7.1 per cent from June 1, 2006 to June 1, 2011;
- The ratio of male to female in the population was 1.01;
- Compared to other CAs, Point Douglas has a mid-range proportion of children and youth (30%) and seniors aged 65 and over (10%); the largest age group is 25-44 years old (28%);
- Twenty nine (29) percent of Point Douglas CA residents are aboriginal;
- Most people (94%) indicate that English is the most frequent language spoken at home, and 0.1 per cent of the population speaks French at home;
- The dependency ratio (children & elderly to working age population ratio) is 53.2 per cent or approximately 53 persons per 100.



Chronic Diseases

Treatment prevalence of diabetes, hypertension, and osteoporosis significantly increased, whereas stroke incidence and total respiratory morbidity significantly decreased over time. The current prevalence rates of most chronic diseases were higher than the Winnipeg's rate.

- Diabetes prevalence increased by 25.6 per cent over the two time periods (1998-2001 and 2003-2006) in Point Douglas CA; the increase was also significant in the two neighbourhood clusters (NCs) over time.
- Hypertension prevalence increased significantly (10.5%) in Point Douglas CA and its two NCs over the two time periods reported on 2000/01 and 2005/06.

- Ischemic heart disease prevalence remained stable between the two time periods (1996/97-2000/01 and 2001/02-2005/06).
- The stroke incidence decreased significantly by 38.6 per cent between the two time periods (1996/97-2000/01 and 2001/02-2005/06) in Point Douglas CA; the decrease was significant for both Point Douglas North and South NCs over time.
- Arthritis prevalence decreased by 3.0 per cent over two time periods (1999/00-2000/01 and 2004/05-2005-06) but the increase was not significant between the two time periods.
- Osteoporosis prevalence significantly increased by 10.8 per cent in Point Douglas over two time periods (1998/99-2000/01 and 2003/04-2005/06).
- Total respiratory morbidity remained stable with a 0.6 per cent increase in Point Douglas CA, which did not reach statistical significance over time.
- The prevalence of asthma in children increased by 5.8 per cent for two 2-year periods (1999/2000-2000/01 and 2004/05-2005/06), but the increase was not significant.

Mental Health Disorders

Treatment prevalence of mood disorder, anxiety, cumulative mental disorders and dementia increased significantly over time. The treatment prevalence of substance abuse decreased significantly over time. In addition, the prevalence rate of dementia was higher than Winnipeg's prevalence rate.

- The prevalence of mood disorders increased significantly in all CAs and Winnipeg overall; Point Douglas had a significant rate increase of 14.4 per cent over the two time periods (1996/97-2000/01 and 2001/02-2005/06).
- The prevalence of anxiety disorders increased significantly in all CAs and Winnipeg overall; Point Douglas experienced 18.0 per cent increase over the two time periods (1996/97-2000/01 and 2001/02-2005/06). Both Point Douglas North and South NCs accounted for the significant difference over time.
- The prevalence rates of personality disorder and schizophrenia remained stable in Point Douglas and its neighborhood clusters over the two time periods.
- Cumulative mental illness showed a significant increase (10.6%) over time.
- Dementia prevalence (in those aged 55 or more) increased significantly in the Point Douglas community area (10.3%) and Point Douglas South (NC) over time (11.7%).

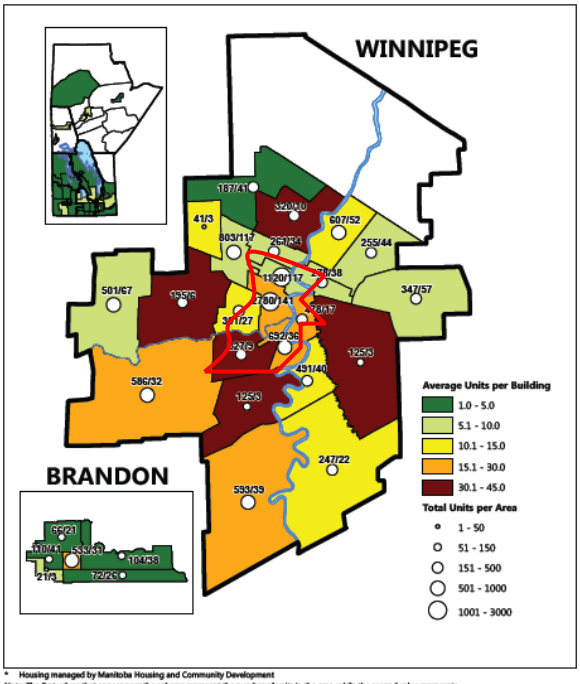
Health Risk Factors

- According to the Canadian Community Health Survey (CCHS) 2001-2005, a 32.6 per cent sample of Point Douglas respondents have indicated that they were current smokers (Winnipeg 22.1%).
- According to CCHS (2001-2005), approximately 36.2 per cent of Point Douglas respondents fall into an "active" physical activity category (Winnipeg 25.3%). This is statistically comparable ($p>0.05$) to the Manitoba average of 29.5 per cent but the numbers should be interpreted with caution due to the high variability of the rate for this area.
- Approximately 22.0 per cent of Point Douglas respondents (all CCHS waves) were categorized as "obese".

Social Housing

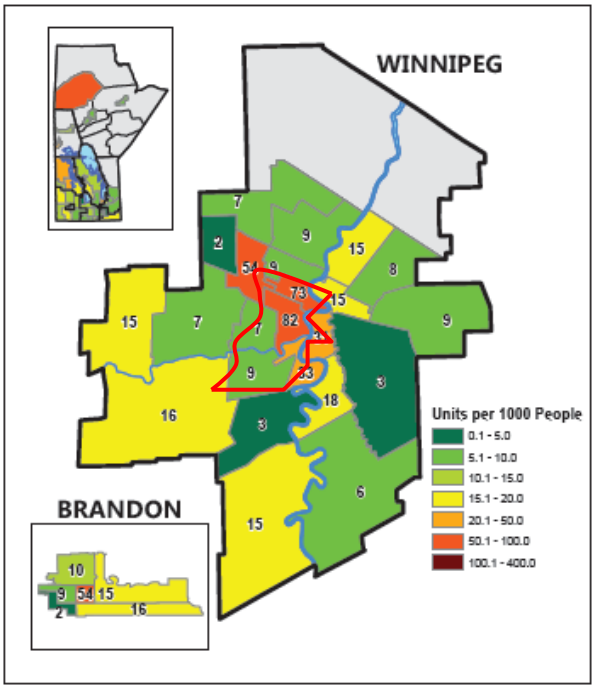
On average, 2.4 per cent of the Manitoba population lives in Social Housing. Central Downtown and Point Douglas have relatively high numbers of Social Housing Units available per 1,000 community residents and there a mid to high number of units per building.

Figure 3.2: Map of the Number of Social Housing Units per Building in Winnipeg, 2009



* Housing managed by Manitoba Housing and Community Development
Note: The first values that appear near the spheres represent the number of units in the area, while the second value represents the number of buildings

Figure 3.4: Map of the Number of Social Housing Units per 1,000 Residents in Winnipeg, 2009



* Housing managed by Manitoba Housing and Community Development

		Downtown		Point Douglas		Range
		Current Rate	Previous Rate	Current Rate	Previous Rate	(low CA – high CA)
Population		**2011**	**2006**	**2011**	**2006**	
		79,831	75,217	44,886	41,897	33,266 – 96,702
Population Distribution by sex		**2011**	**2006**	**2011**	**2006**	
	Male	40,729	38,132	22,646	21,111	16,797 - 45,854
	Female	39,102	37,085	22,240	20,786	16,839 - 48,961
Population Density		**2011**	**2006**	**2011**	**2006**	475.4 - 4625.6
(residents/sq.km)		4897.6	4614.5	4118	3843.8	
Percentage Age Distribution	**Children**	**2011**	**2006**	**2011**	**2006**	
	0-4 years	7%	6%	8%	7%	4% - 8%
	5-9 years	6%	6%	7%	7%	4% - 7%
	Youth					
	10-14 years	6%	6%	7%	8%	4% - 8%
	15-19 years	7%	6%	8%	7%	5% - 8%
	Adults					
	20-24 years	8%	8%	8%	7%	6% - 8%
	25-44 years	31%	32%	28%	29%	22% - 32%
	45-64 years	24%	24%	24%	23%	24% - 31%
	Seniors					
	65-74 years	5%	5%	5%	5%	5% - 9%
	75+ years	6%	7%	5%	7%	4% - 10%
Percentage Population Change		**Between 2006-2011**	**Between 2001-2006**	**Between 2006-2011**	**Between 2001-2006**	
	% Change Total Population	6.10%	16%	7.10%	15%	-4% - 16%
	% Change Male	6.80%	18%	7.20%	18%	-0.2
	% Change Female	5.40%	15%	7.00%	13%	-0.19
Dependency Ratio		**2006**	**2001**	**2006**	**2001**	
(Child & Elderly to Working Age Ratio)		44.00%	50.60%	53.20%	58.70%	43.5%-54.1%
Percentage of Lone-Parent Families		**2006**	**2001**	**2006**	**2001**	
	Female	83%	87%	83%	80%	81% - 87%
	Male	17%	14%	17%	21%	13% - 19%
Aboriginal Peoples Living in Geographic Area		**2006**	**2001**	**2006**	**2001**	
		17%	17%	29%	26%	4%-29%
Most Frequent Language Spoken at Home		**2006**	**2001**	**2006**	**2001**	
	English only	89.60%	89.70%	93.50%	94.10%	93.7% - 69.3%
	Both English and French	8.10%	8.00%	4.80%	4.50%	28.8% - 4.7%
	Neither English nor French	2.10%	2.20%	1.60%	1.40%	2.1% - 0.3%
	French only	0.10%	0.10%	0.10%	0.00%	1.2% - 0.0%
Median Household Income	Full CA	$30,307		$33,831		$74,992-
	North NC			$39,208		$30,307
	South NC			$22,923		
	East NC	$23,586				
	West NC	$39,692				
Children in families receiving income						
	North NC			31.5%		1.0% - 71.8%
	South NC			71.8%		
	East NC	47.8%				
	West NC	26.4%				
	CA Metis Population	60.8%		58.7%		Winnipeg Metis average 32.0%
	Winnipeg Population					Winnipeg average 16.4%

Data sources: Manitoba Health Population Health Registry File, June 2006; Manitoba Health Population Report, June 2010 (Stats Can estimates); WRHA CHA 2009/10; City of Winnipeg Census Data 2001 and 2006; MCHP Metis Report 2010; WRHA Health for All Indicator Report 2013

Chronic Conditions	Downtown Community Area				Point Douglas Community Area					
	Current Rate	Previous Rate	Social Housi Population	Metis Population	Current Rate	Previous Rate	Social Housi Population	Metis Population	Winnipeg Rate	Range (low CA – high CA)
Diabetes	10.3%	8.2%	21.4%	16.0%	11.3%	8.8%	25.1%	15.5%	8.2%	Assiniboine South 5.9%-
	2005/06	2000/01	2008/9	2006/07	2005/06	2000/01	2008/9	2006/07	2005/06	Point Douglas 11.3%
Hypertension	23.3%	20.3%		27.2%	24.8%	21.6%		27.7%	22.9%	Assiniboine South 21.3%-
	2005/6	2000/01		2006/07	2005/6	2000/01		2006/07	2005/6	Inkster 26.1%
Ischemic Heart Disease (IHD)	8.3%	9.0%		14.0%	10.0%	10.0%		14.9%	8.6%	Ft. Garry 7.8%-
	2005/06	2000/01		2006/07	2005/06	2000/01		2006/07	2005/06	Point Douglas 10.0%
Stroke Incidence Age standardized cases per 1000 residents	2.9/1000	4.0/1000			3.0/1000	4.3/1000			2.8/1000	St. Boniface 2.1/1000 –
	2005/06	2000/01			2005/06	2000/01			2005/06	River East 3.2/1000
Arthritis	22.4%	23.1%		31.9%	24.9%	25.4%		31.3%	19.9%	Ft. Garry 18.0%-
	2005/06	2000/01		2006/07	2005/06	2000/01		2006/07	2005/06	Point Douglas 24.9%
Osteoporosis	12.8%	10.4%		15.0%	11.3%	9.9%		13.5%	12.9	Inkster 10.0%- Assiniboine S &
	2005/06	2000/01		2006/07	2005/06	2000/01		2006/07	2005/06	St. James -Assiniboia 14.3%
Total Respiratory Morbiditv	13.5%	14.6%	19.9%	18.7%	17.5%	17.2%	25.8%	17.8%	12.5%	Ft. Garry 10.8%-
	2005/06	2000/01	2009	2006/07	2005/06	2000/01	2009	2006/07	2005/06	Point Douglas 17.5%
Asthma (All Ages) Age standardized cases per 1000 residents										Transcona 64- Inskter 90
Male	74	73			86	79			75.4	
Female	86	84			106	95			80.5	St. Vital 72-
	2006/07	2002/03			2006/07	2002/03			2006/07	Point Douglas 106
Asthma (Child)	15.8%	15.2%			18.0%	16.8%			16.4	Transcona & St.B 14.6%
	2005/06	2000/01			2005/06	2000/01			2005/06	Inskter 19.0%
Body Mass Index (BMI) % Normal +										
Underweight	53.7%				38.6%					
% Overweight +	29.8%				39.4%					
Obesity										
Obese									18.40%	River heights 11.2% -
Full CA	16.5%				22.0%					St. James-
North					20.2%					Assinaboine 26.2%
South					24.8%					
East	15.0%									
West	16.4%									
Overweight									34.10%	Downtown 29.8%
Full CA	29.8%				39.4%					- St. Vital 41.5%
North					43.3%					
South					37.5%					
East	33.4%									
West	28.5%									
Overweight & Obese				62.9%				62.9%		
	2005			2006/07	2005			2006/07		

Source: WRHA CHA, 2009/10; WRHA Metis Health Status 2010; WRHA Social Housing in Manitoba 2013; WRHA Health For All 2013

Primary Care Indicators

	Downtown			Point Douglas			
	Current Rate	Social Housi Population	Metis Population	Current Rate	Social Housi Population	Metis Population	Winnipeg Rate
Majority of care by a single PCP							72.0%
Full CA	66.8%	61.8%	60.9%	67.1%	52.5%	60.9%	
North NC				70.1%			
South NC				62.1%			
East NC	64.1%						
West NC	69.8%						
	2005/06	2008/09	2006/07	2005/06	2008/09	2006/07	
Complete Physicals	41.0%	45.0%		41.5%	44.5%		
	2008/09	2008/09		2008/09	2008/09		
Smoking			35.4%			35.4%	22.1%
Full CA	26.1%			32.6%			
North				29.4%			
South				39.2%			
East	32.6%						
West	22.6%						
	2001-2005		2006/07	2001-2005		2006/07	2001-2005
Substance Abuse Treatment Prevalence			8.1%			8.1%	8.3%
Full CA			14.5%			12.8%	
North				8.8%			
South				10.0%			
East	10.6%						
West	8.3%						
	2006/07		2006/07	2006/07		2006/07	

Source: WRHA CHA, 2009/10; WRHA Metis Health Status 2010; WRHA Social Housing in Manitoba 2013; WRHA Health For All 2013

Mental Health

	Downtown				Point Douglas				Winnipeg	Range
	Current Rate	Previous Rate	Social Housing Population	Metis Population	Current Rate	Previous Rate	Social Housing Population	Metis Population	Rate	(low CA–high CA)
Mood disorders and/or use of antidepressants/ mood stabilizers				25.5%				25.5%	20.3%	Inkster 15.8% - Point Douglas
Full CA	20.3% 2005/06	17.6% 2000/01			22.5% 2005/06	19.6% 2000/01		2006/07	2005/06	22.5%
Anxiety Disorders				11.0%				11.0%	8.3%	Fort Garry 6.8% –
Full CA	9.5% 2005/06	7.6% 2000/01		14.0% 2006/07	9.3% 2005/06	7.8% 2000/01		11.5% 2006/07	2005/06	Transcona 11.2%
Mood and Anxiety Disorder			39.0% 2008/09				43.5% 2008/09			
Substance Abuse Treatment Prevalence				8.1%				8.1%	8.3%	Inkster W 6.5-
Full CA				14.5%				12.8%		Transcona
North					8.8%					11.2
South					10.0%					
East	10.6%									
West	8.3%									
	2006/07			2006/07	2006/07			2006/07	2005/06	
Personality Disorder				1.52%				1.52%		
Full CA	1.80%	1.60%		3.00%	1.20%	1.30%		1.88%		Inkster 0.66%-
	2005/06	2000/01		2006/07	2005/06	2000/01		2006/07		Downtown 1.77%
Schizophrenia										
Full CA	2.70% 2005/06	2.50% 2000/01	8.50% 2008/09	3.50% 2006/07	1.90% 2005/06	1.80% 2000/01	5.10% 2008/09	2.00% 2006/07	1.20% 2005/06	Transcona 0.69% - Downtown 2.65%
Cumulative Mental Illness (One or more Mental Disorders)				32.7%				32.7%	25.6% 2005/06	Fort Garry 20.9% Point Douglas
Full CA	27.8% 2005/06	25.0% 2000/01		31.4% 2006/07	29.8% 2005/06	27.0% 2000/01		34.0% 2006/07		29.8%
Dementia (age 55 +)				13.5%				13.5%		
Full CA	12.5%	11.2%		17.0%	12.9%	11.6%		13.6%	11.5%	Inkster 9.68%- Point Douglas
	2005/06	2000/01		2006/07	2005/06	2000/01		2006/07	2005/06	12.9%

Source: WRHA CHA, 2009/10; WRHA Metis Health Status 2010; WRHA Social Housing in Manitoba 2013; WRHA Health For All 2013

POTENTIAL FUNCTIONS IDENTIFICATION CHECKLIST

Based on input from several sites, the following is a potential tool. Select from the activities below those that you would like to have a new team member perform, and which would have the most clinical impact for your site to accept 500 more patients into your practice.

Some examples of Potential Supports/ Activities Interprofessional may support	Please identify which activities you feel would be most helpful in supporting your practice in accepting 500 more patients	Comments
Lifestyle/behavior change counseling/teaching including: exercise, nutrition, smoking cessation, medication(knowledge of effects/side effects/interactions influencing adherence), stress/mental health, drugs/alcohol		
Complete referrals and/or links to community resources		
Injections/Immunizations		
Conducts a comprehensive assessment, including performing complete health history and documentation of (all medications/family, social/allergy, etc.)		
Clinical triage, assessment, and identify possible intervention		

Prevention/Screening and the Management of Chronic Diseases		
Independently dx/tx		
Well baby/child care/ assessment/immunization		
Provide women's reproductive health care		
Perform complete physical exam		
Plan/Provide ongoing monitoring /care of stable chronic diseases		
Recognize need for treatment adjustment including chronic condition		
Monitor and counsel patients on drug therapies, side effects and interactions		
Administer/Provide treatment/medication		
Laboratory/diagnostic:		
-Order		
-Specimen collection		
-Review results		
Inform and educate patients regarding the meaning and implications of test results and interventions		

Initiate action in response to results of investigation		
Insulin starts		
INR monitoring/adjustments		
Support with depression/anxiety issues		
Support with complex mental health issues		
Provide care for patients of the practice in:		
-Long term care		
-Hospital		
Provide home visits		
Wound care (knowledge appropriate dressing choice/ongoing management)		
Prep/Assist with procedures		
Excision/laceration repair (perform independently)		
Ear lavage		
Foot assessment/care		
Cryotherapy /KOH testing, etc.		

Other:		

Please list below the top 5 functions that the new Interprofessional provider could be spending the most time performing on a daily basis, in order of most time to least.

1._____

2._____

3._____

4._____

5._____

References:
Canadian Family Practice Nurses Association (2013). Sample Role Description for Registered Nurse in Family Practice for Adaptation to Your Primary Care Practice.
Ian W. Jones (June 2012). A Guide for the Utilization of Physician Assistants in Manitoba. Manitoba Health (2011). Primary Care Interprofessional Team Toolkit.
Quality Improvement and Innovation Partnership (January 2008). Team Development Resource Guide for Family Health Teams.www.qiip.ca
Winnipeg Regional Health Authority. Primary Care Nurse Job Description. Winnipeg Regional Health Authority (2003). Nurse Practitioner in Primary Care Job Description.

TEAMWORK PERCEPTIONS QUESTIONNAIRE

Please complete the following questionnaire focusing on the "team" at the health care setting where you work. By team we mean those health professionals that you work with every day to provide or support patient care.
Please circle the number in the column that corresponds to your level of agreement from ***"strongly agree"*** to **"strongly disagree."** Please answer every question, and select only one response for each question.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
General Team Structure						
1	The skills of our team overlap enough so that work can be shared when necessary.	1	2	3	4	5
2	Team members are held accountable for their actions.	1	2	3	4	5
3	Team members share information that enables timely decision making by the direct patient care staff.	1	2	3	4	5
4	Our team makes efficient use of resources (ex: staff supplies, equipment, information).	1	2	3	4	5
5	Team members understand their roles and responsibilities.	1	2	3	4	5
6	Our team has clearly articulated goals.	1	2	3	4	5
7	Our team operates at a high level of efficiency.	1	2	3	4	5
Our team members…						
8	…place the interest of patients at the center of interpersonal health care delivery.	1	2	3	4	5
9	…respect the dignity and privacy of patients.	1	2	3	4	5
10	…respect the unique cultures, values, responsibilities, and expertise of other health professionals.	1	2	3	4	5
11	…develop a trusting relationship with patients and their families.	1	2	3	4	5
12	…act with honesty and integrity in relating to patients, families, and other team members.	1	2	3	4	5
13	…effectively manage ethical dilemmas that arise in interprofessional teams.	1	2	3	4	5
14	…demonstrate high standards of ethical conduct and quality of care.	1	2	3	4	5

Adapted from the TeamSTEPPS Teamwork Perceptions Questionnaire

TEAMWORK PERCEPTIONS QUESTIONNAIRE

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Our team members…..						
15	…effectively anticipate each other's needs.	1	2	3	4	5
16	…monitor each other's performance.	1	2	3	4	5
17	...exchange relevant information as it becomes available.	1	2	3	4	5
18	…continuously scan the environment for important information.	1	2	3	4	5
19	…share information regarding potential complications (ex: patient changes, bed availability).	1	2	3	4	5
20	…meet to reevaluate patient care goals when aspects of the situation change.	1	2	3	4	5
21	…correct each other's mistakes to ensure that procedures are followed properly.	1	2	3	4	5
Our team members…						
22	…assist fellow staff during high workload.	1	2	3	4	5
23	…request assistance from fellow staff when they feel overwhelmed.	1	2	3	4	5
24	…caution each other about potentially dangerous situations.	1	2	3	4	5
25	…provide feedback to each other in a way that promotes positive interactions and future change.	1	2	3	4	5
26	…advocate for patients even when their opinion conflicts with that of a senior member of the unit.	1	2	3	4	5
27	…whenever they have a concern about patient safety, team member will challenge others until they are sure the concern has been heard.	1	2	3	4	5
28	…resolve their conflicts, even when the conflicts have become personal.	1	2	3	4	5
Our team members…						
29	…explain information about patient care to patients and their families in lay terms.	1	2	3	4	5
30	… relay relevant information in a timely manner.	1	2	3	4	5
31	…allow enough time for questions when communicating with patients.	1	2	3	4	5
32	… use common terminology when communicating with each other.	1	2	3	4	5
33	… verbally verify information that they receive from one another.	1	2	3	4	5
34	…follow a standardized method of sharing information when handing off patients.	1	2	3	4	5
35	…seek information from all available sources.	1	2	3	4	5
36	…listen actively to each other's concerns.	1	2	3	4	5

Optional:

Clinic Name:_____

Profession (Medicine, PA, Nurse, PT, OT, Administration, Pharmacy, other): _____

Interprofessional Teams in Fee-For-Service Clinics

This is an exciting time for your clinic, as you begin to prepare for the addition of a new interprofessional team member. There are several things that your clinic can do to ensure that your team is ready for this new initiative.

One of the things that you should consider doing in preparation is to spend some time conducting a team assessment with your current staff. Enclosed, you will find a **Team Competency Document.** This is an optional, but highly recommended, team assessment activity that has been designed to help your team openly discuss how the clinic is currently functioning. It is designed to identify the strengths and weaknesses of your team operation which allows for the development of goals and objectives aimed at improving your team's collaboration. It is important to note that you will likely need to facilitate some changes to the way your clinic operates as a result of this assessment.

You may decide to go through this with your team prior to the new interprofessional beginning in your clinic, or you may want to do this once the new team is established. There are benefits to both, and you may choose to do it more than once in order to facilitate constant growth in your team's functioning. This exercise can be completed with your team independently, or we are happy to have one of our Collaborative Care Team facilitators attend your clinic to conduct it with your team. The assessment should take approximately 1 hour to complete.

We are also enclosing a document outlining the differences between the various interprofessional roles. This document discusses the differences between a nurse practitioner, a physician assistant and a primary care nurse. Hopefully this information will help to better inform you of the unique aspects of each of these roles, and assist in the decision process of determining what type of interprofessional would be best for your clinic at this time.

If you have any questions or concerns, or you would like some support with the team assessment activity, please do not hesitate to contact one of our team:

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Ili Slobodian, *Program Specialist, Primary Care Program 204-799-9024, islobodian@wrha.mb.ca*

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Team Competency Assessment

This document is an adaptation of "Advancing Collaborative Care Teams, A Guide for Teams and Facilitators", developed by Kathleen Klaasen MN, Paul Komenda MD MHA and Susan Bowman BMR(PT). The original document has been condensed and other resources have been added in order to suit the needs of the clinics using this at this time.

I. Indicators of High Performing Collaborative Care Teams

Eight indicators of effective, high performing teams have been identified. These indicators, listed below, will provide the framework upon which to assess and evaluate your team.

1. The team has identified a standardized way to measure team performance. Team performance indicators are monitored regularly and guide team decision making.
2. Care is organized based on the goals of patients (as opposed to the needs of health care providers).
3. Team members have dedicated time for team development activities.
4. There is shared space in the environment for teams to work/socialize together.
5. The team has a defined team role statement and team goals.
6. Processes are in place for interprofessional care planning (collaborative care conferences).
7. Team composition and roles are defined by the needs of patients, scope of service, and the goal of optimizing scope of practice of health providers.
8. Standard operating procedures/clear role statements for all team members exist and minimize unnecessary duplication of service.

II. Team Self-Assessment

Purpose:

1. To have the team conduct a self-assessment using the eight indicators of high performing collaborative care teams
2. To identify possible areas for improvement (goals)

Who to invite: Entire team if possible.

Set up: Write each of the eight indicators on separate pieces of flip chart paper. Draw a line down the centre of each piece of paper. Write "What we do well" on the left hand side of the paper. Write "What we could do better" on the right hand side.

Sample:

#1: The team has identified a standardized way to measure team performance. Team performance indicators are monitored regularly and guide team decision making.

What we do well	What we could do better

How to facilitate the session:

1. Depending on the size of the group, divide into small teams of 2-3
2. Post each of the indicators on the wall around the room. Each small team will start at a separate indicator.
3. Each team will spend approximately 5 minutes per indicator writing down their thoughts, either right on the paper, or on post-it notes, then sticking those on the paper. Each small team should have the opportunity to reflect on each of the eight indicators.
4. Afterwards, the facilitator should go through each indicator and highlight what was identified.
5. As a large group, goals should be identified in order to address some of the issues that came up under "What we could do better".

The 8 Indicators and probing questions to facilitate discussion:

1. The team has identified a standardized way to measure team performance. Team performance indicators are monitored regularly and guide team decision making.
    - How do you know your team is doing a good job?
    - What indicators do you measure ex: patient satisfaction, trending of patient outcome measures, wait times, access, workload etc?
    - How and with whom is this information shared with?
    - Is the information used to change practice and team processes?
2. Care is organized based on the goals of patients (as opposed to the needs of health care providers).
    - How are patient goals and objectives identified? How are they evaluated?
    - Are they developed with the patient (rather than for the patient)?
3. Team members have dedicated time for team development activities.
    - Do you have regular team meetings that are not focused solely on patient care issues? Have you ever engaged in a team development/team-building activity?
    - Does the team ever take time to reflect on team communication and team processes?
4. There is shared space in the environment for teams to work/socialize together.
    - Is there a shared lunch room?
    - Is there space for formal and informal team discussion and dialogue?
    - How are spaces referred to – "nursing station", "doctors lounge" vs. more collaborative, inclusive language?
5. The team has a defined team role statement and team goals.
    - How were the role statement and goals developed? When were they developed?
    - How often are they reviewed?
6. Processes are in place for interprofessional care planning (collaborative care conferences).
    - What processes are in place? How are they working?
    - Are the right players at the table?
    - How are patient goals embedded into interprofessional care planning processes?
7. Team composition and roles are defined by the needs of patients, scope of service, and the goal of optimizing scope of practice of health providers.
    - Can team members clearly articulate the role of other members of the team? What are the needs of patients? How were these assessed?

- Do you have the right members of the team in light of patient needs? If vacancies arise, would there be any consideration given to changing team composition?
- Do team members feel that they are working to their full scope of practice?

8. Standard operating procedures/clear role statements for all team members exist and minimize unnecessary duplication of service.
   - Does the team use an interprofessional team assessment form?
   - Are the same questions asked of patients by multiple health providers?
   - Do clinical practice guidelines, protocols exist that aim to standardize care in an evidence informed manner?

III. Resources

Curran V, Sargeant J, Hollett A. Evaluation of an interprofessional continuing professional development initiative in primary health care. J Contin Educ Health Prof 2007 Fall;27(4):241-252.

Ovretveit J. Does clinical coordination improve quality and save money? The Health Foundation June 2011.

Reeves S, Goldman J, Sawatzky-Girling B, Burton A. CIHC Library: Knowledge transfer & exchange in interprofessional education: Synthesizing the evidence to foster evidence-based decision-making. Available at: www.cihc.ca/library/handle/10296/326?mode=full&submit_simple=Show+full+item+record. Accessed 5/17/2012, 2012.

Mickan S, Rodger S. Characteristics of effective teams: a literature review. Aust Health Rev 2000;23(3):201-208.

Johnston S, Green M, Thille P, Savage C, Roberts L, Russell G, et al. Performance feedback: an exploratory study to examine the acceptability and impact for interdisciplinary primary care teams. BMC Fam Pract 2011 Mar 29;12:14.

Weaver SJ, Salas E, King HB. Twelve best practices for team training evaluation in health care. Jt Comm J Qual Patient Saf 2011;37(8):341-349.

Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative: http://www.eicp.ca/en/toolkit/communication/default.asp

Canadian Interprofessional Health Collaborative: A National Interprofessional Competency Framework: http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf#page=15

Adapted from the TeamSTEPPS Teamwork Perceptions Questionnaire

EXAMPLE OF INTERPROFESSIONAL JOB POSTING

WINNIPEG REGIONAL HEALTH AUTHORITY
PRIMARY CARE NURSE

POSITION TITLE: Primary Care Nurse (PCN)

PROGRAM: Primary Care

REPORTS TO:

CLASS: Nurse 3 **UNION:**

QUALIFICATIONS REQUIRED FOR THIS POSITION

Education: A Baccalaureate in Nursing is preferred
Basic Cardiac Life Support certificate required
Certification in Diabetes or Asthma Education (or attained within 2 to 3 years of employment) preferred

Experience: Minimum of three years of directly related experience in a primary health care, community health nursing, northern nursing, and/or ambulatory care nursing with an emphasis on primary care services (primary and secondary prevention, intervention, maintenance/support, and palliation). A combination of other nursing experiences would be considered.
Demonstrated clinical skill in physical examination and nursing intervention.
Demonstrated commitment to interdisciplinary teamwork.
Proven commitment to and knowledge of primary care and community health.
Experience with mental health counseling would be beneficial.
Working knowledge of computers and keyboarding.

OTHER:
Subject to a criminal records check and child abuse registry check.

Physical Demands and Working Conditions:
- Physical capable of performing duties related to position, including assisting clients with physical and mental challenges during clinic visits, lifting a variety of clinic equipment and teaching materials, and arranging meeting rooms for group teaching activities.
- May be required to providing primary care nursing services in a variety of clinic settings, including a primary care clinic site, temporary clinics in community settings, the client's home, and/or within a private physician practice.
- Owns or has access to transportation suitable for the performance of PCN duties.

Registration/Licenses:
Registration in good standing with College of Registered Nurses in Manitoba.
Possession of a valid Manitoba Class 5 driver's license.

POSITION SUMMARY

Consistent with the principles of primary health care, provides access to first level basic health care within the scope of nursing practice for individuals, families, groups and communities. As a member of an interdisciplinary community area team, the Primary Care Nurse provides comprehensive health care with an emphasis on healthy living, illness prevention (primary and secondary), health

education, chronic disease management, clinical intervention, and palliation. Develops and implements a health plan with clients and evaluates success in meeting this plan. Provides ongoing service coordination and links clients with resources.

MAIN FUNCTION:

The PCN:

- Actualize the mission, vision, and values of the Winnipeg Regional Health Authority.
- Applies the principles of Primary Health Care as stated by the World Health Organization Declaration of Alma Ata 1978 as the basis of all PCN work.
- Synthesizes knowledge from *The Canadian Taskforce on Preventative Health Care* and professional nursing theory focusing on the health of individuals and their families.
- Focuses on a shared client population in partnership one or more family physicians in the clinic.
- Provides care to individuals across the life span within the context of their environment.
- Provides expertise in the promotion of wellness.
- Provides expertise in the prevention of disease and/or disability and the management of chronic diseases/conditions within a primary care setting.
- Practice aims to prevent the onset of disease and/or disability, minimize complications arising from conditions, maintains optimal physical and emotional functioning, and promote self-determination/management by the individual client.
- Practice is client-centered with a strong emphasis on an interdisciplinary team approach. The PCN is an integral member of the team, providing support to the maximization of each disciplines' scope of practice.
- Works as a navigator on behalf of the client to ensure the appropriate links/referrals to other human services that would enable the client to achieve their health goals.
- Adopts a long-term approach to client care consistent with the philosophy of family-centred nursing and as a means to ensuring continuity of care for the client.

POSITION DUTIES AND RESPONSIBILITIES:

The Primary Care Nurse is knowledgeable regarding and has expertise in:

- Clinical triage, assessment, and intervention
- Prevention/Screening and the Management of Chronic Diseases
- Health education for individuals and groups
- Health system and services
- Professional responsibility and accountability
- Administrative responsibility and accountability

1. Clinical Triage, Assessment, and Intervention

Clinical triage, assessment and intervention represent a core component of primary care practice, and are provided by telephone or in person. The triage function assists in determining the right response at the right time and place for the client's presenting problem. Comprehensive assessment requires a holistic approach, attention to clinical and psychological risk, and an intuitive capacity. Appropriate nursing interventions are based on knowledge of best practice, research, and a complex understanding of health system resources and their availability.

1.1. Provides telephone and in person triage services including recognizing deviations from normal. Identifies urgent from non-urgent, and provides appropriate services or referral.

1.2. Applies recognized guidelines and best practices to screening, monitoring, and nursing assessment of client's physical and emotional well being.

1.3. Conducts a comprehensive assessment, including a complete health history (medical, presenting condition/problem, functional abilities, social context, cultural well-being, emotional, individual coping strategies, support systems, value systems), completes physical examination, and any other information relevant to the development of the health plan.

1.4. Applies nursing process including assessing client status, analyzing, developing a nursing diagnosis, implementing a plan of care and evaluating the outcome of interventions and services.
1.5. Assists and supports the client to follow through on prescribed medical interventions and diagnostic testing. Informs and educates clients regarding the meaning and implications of test results and prescribed interventions.
1.6. Identifies and, within the scope of nursing practice, manages common developmental milestones (ex: reproductive health, prenatal, childhood developmental stages), disease prevention (ex: immunization, sexual practices), acute and chronic illness related conditions (ex: STI, colds, arthritis, asthma, diabetes) affecting children and adults.
1.7. In collaboration with the client, the family physician, and other members of the interdisciplinary team, initiates and/or contributes to the development of a health plan.
1.8. Regularly monitors, evaluates, and adjusts the health plan based on effectiveness of interventions and/or changes in condition or environment, in collaboration with the client, family physician, and team members.
1.9. Encourages maximum independence and accountability for self-care according to the client's capacity.
1.10. Supports the client to find personal balance in adjusting to the developmental stages of living with optimal dignity and self-determination.
1.11. Coordinates services to the client to the extent that it is required.
1.12. Initiates or participates in client care case conferences in order to ensure coordinated, comprehensive and holistic services. Consults with the family physician and other members of the health care team.
1.13. Documents accurate and pertinent client information in a timely manner.
1.14. Assists other primary care team members with physical examinations and clinical procedures as needed.
1.15. Provides specific services outside the scope of nursing practice within *Delegation of Function* protocols.

2. Prevention/Screening and the Management of Chronic Diseases

Prevention and screening activities within the primary care setting are found at both the primary and secondary level of chronic disease/illness/injury/disability prevention and management. These activities are guided by The Canadian Taskforce on Preventative Health Care and related best practice and research documents. Assessment and management of chronic diseases in the primary care setting requires a proactive, holistic approach to client care, *emphasizing the interaction of mind, body, and spirit. Screening and monitoring consistent with National guidelines and best practices is integral to identifying at risk individuals.*

2.1. In collaboration with the client and other service providers, conduct risk assessments related to the prevention of injury and/or disability, and develop appropriate health plans to reduce/prevent risks.
2.2. Engage and motivate the client in primary and secondary preventive activities (individual or group) and self-care. Acquire and maintain a comprehensive understanding of recommended screening for the early identification of chronic disease, including the expertise to recognizing deviations from normal results.
2.3. Monitor client compliance with risk reduction plans and/or self care. Deviations from the care plan and/or exacerbation in the client's condition are reported to the family physician for follow-up.
2.4. Assist and support the client in recovering from acute episodes of chronic disease, including exacerbation or deterioration of a chronic condition.
2.5. Assist and support the client in life transitions, including palliation and death.
2.6. Acquire and maintain expertise in the management of chronic diseases, consistent with National guidelines and best practices.

2.7. Acquire and maintain certification or stays current in one or more chronic diseases or other population-specific roles (ex: certified diabetes educator, certified asthma educator).
2.8. Act as a resource to other members of the health care team with the regards to the primary care management of chronic diseases.
2.9. Refer clients to the appropriate programs and services to assist in the primary or secondary prevention of injury, disability, or care of chronic disease (ex: Home Care, Seniors Health Resources, Society for Manitobans with Disabilities).

3. Health Education for Individuals and Groups

Health education is a major component of primary care clinical services, and occurs through out the continuum of care (prevention to palliation). This work can be done in a variety of settings (ex: clinics, schools, private physician offices, homes, and community) on either an individual or group basis. Health education is a means to empower the client with the knowledge required to make healthy living choices and to participate in effective self-care.

3.1. Identify educational requirements and readiness of clients as a component of an overall health assessment.
3.2. Encourage maximum independence and accountability for self-care by providing the necessary information to the client to achieve competency.
3.3. Employ health promotion and health education strategies to support behaviour changes conducive to health (ex: smoking cessation, physician activity, nutrition/diet). Jointly with the client, define and incorporate these strategies into the health plan.
3.4. Provide education related to healthy living, prevention, care and treatment, individual and family adjustments, and support systems as appropriate to the client situation.
3.5. Acquires, develops, and evaluates teaching materials and tools, with consideration for cultural, physical, intellectual, and environmental factors.
3.6. Develop and provide a variety of educational approaches to address health topics, including individual and group sessions, and offer these in a variety of setting, conducive to optimal access.
3.7. Incorporate the principles of adult education, as appropriate, in the planning and delivery of health education.
3.8. Effectively *uses a variety of communication strategies, ex: written, verbal, non-verbal, electronic*, secondary data sources, group facilitation, and presentation skills.

4. Health Systems and Services

Primary Care is the most commonly used entry point to the health. Access to diagnostic services, specialist or hospital care, rehabilitative services, and community based services is facilitated from the primary care setting. A comprehensive understanding of health system resources, referral protocols, and eligibility criteria for many health services is required.

4.1. Acquires and maintains a comprehensive understanding of health/social services and referral processes, including diagnostic services, specialists, hospital care, rehabilitation and support programs, educational programs, and community based health agencies.
4.2. Refers clients to the most appropriate inter and intra-sectoral services in a timely and supportive manner. In addition, the PCN provides support to the family physician and other members of the team to access services on behalf of the client.
4.3. Advocates for client services when this is necessary.
4.4. Establishes and maintains effective working relationships across programs and services within the local organization/Centre as a means to further integration of services and support coordinated client services delivery.
4.5. Establishes and maintains effective professional relationships and partnerships with other organizations in order to benefit system integration, efficient service utilization, effective collaboration, and optimal client care.
4.6. Is a source of primary care expertise in settings that cross disciplines, programs, and sectors.

5. Professional Responsibility and Accountability

Primary Care Nurses work with a significant degree of autonomy, while participating as a core member of the interdisciplinary primary care team. They are accountable for the quality of their own practice. They must maintain competency, strive for excellence, and ensure that their knowledge is evidence-based and current. They are accountable to initiate strategies to address the prevention of complications of illness or disease in individuals, promote healthy living in individuals and families, and maintenance of optimal functioning for an individual in a chronic disease or palliative state.

5.1. Recognizes personal attitudes, beliefs, feelings and values about health in their interactions with clients and their families.
5.2. Applies a comprehensive understanding of the scope of nursing practice within a primary care setting, including policies and procedures related to "Delegation of Function".
5.3. Participates in the development and implementation of individual Delegation of Function Agreements with physicians and nurse practitioners, consistent with College of Registered Nurses of Manitoba, College of Physician and Surgeons, and WRHA guidelines, policies and procedures.
5.4. Maintains and applies evidence-based knowledge and the nursing process.
5.5. Demonstrates the ability to reflect on personal and team practice through a systematic evaluation of professional competencies, acceptability, quality, efficiency, and effectiveness of practice.
5.6. Demonstrates understanding of and ability to use research findings to guide the delivery of services.
5.7. Takes preventative and/or corrective action individually or in partnership with others to protect individuals in an unsafe, incompetent, or unethical circumstances.
5.8. Practices in accordance with relevant legislation (ex: Child and Family Services Act, Personal Health Information Act, Registered Nurses Act, Medical Act, Public Health Act, Mental Health Act).
5.9. Practice is guided by the principles of Primary Health Care.
5.10. Understands, interprets and implements the mission, vision, and values of the Winnipeg Regional Health Authority.
5.11. Systemically seeks professional development experiences consistent with current primary care practice, new and emerging issues, changing needs of client populations, and research (ex: certificates in chronic diseases education).
5.12. Develops and implements an individualized plan for professional growth and development including participation in professional organizations and activities, workshops, seminars, and staff development programs.
5.13. Advances primary care nursing through participation in professional development and practice development activities, by mentoring students, orientating staff and participating in research and quality assurance initiatives.

6. Administrative Responsibility and Accountability

Administrative responsibility and accountability promotes effective and efficient organizational operation and data collection. Primary Care Nurses are responsible to complete relevant functions and are accountable to the organization, the team and their clients to provide service in the most effective and efficient manner.

6.1. Provides supervision, mentorship, orientation, observation and teaching opportunities to students ensuring that program goals and objectives are met.
6.2. Demonstrates leadership in Primary Care programs and services (ex: chronic disease management, reproductive health, shared care models, orientation, workplace safety and health).
6.3. Participates in the planning and development of primary care policies, procedures, and operations.

6.4. Identifies and collects performance and quality improvement data and initiates corrective actions.
6.5. Maintains productivity standards and practices effective time management and prioritization of work.
6.6. Completes documentation, accurate statistical data, and reports in a timely manner
6.7. Completes relevant administrative functions and documentation (ex: educational requests, vacation requests, occurrence reports, complaint processes, and expense accounts).
6.8. Actively participates in relevant meetings and committees (ex: team, program, community)
6.9. Participates in the orientation and training of new staff.
6.10. Assumes responsibility for management, maintenance and control of inventory (supplies, drugs, resources and equipment).
6.11. Participates in interdisciplinary meetings, task forces, and projects.
6.12. Participates in relevant staff wellness-related initiatives at the work-site.
6.13. Adheres to WRHA and site polices and procedures.
6.14. May be required to perform other duties and functions related to this job description not exceeding above stated skills and capabilities.

References:

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Manitoba Health. Primary Health Care Nurse Practitioner. Survey of Regional Health Authorities of Manitoba. December, 2001.

Consultations:

Primary Care Nursing Practice Council. Winnipeg Regional Health Authority. November 27, 2003.

Primary Health Network of Manitoba. (Representatives from Regional Health Authorities across Manitoba. December 6th, 2003.

Focus Group – Representatives of Community Area Directors, Community Care Program Directors, Manitoba Health, Centre du sante. December 11, 2003.

Health Science Centre. Human Resource Department. Classification Review.

WRHA Human Resources Department.

Agreement for Funding and Participation in the Interprofessional Team Demonstration Initiative

This Agreement is effective as of _____, 201__. ("**Effective Date**").

BETWEEN:

THE GOVERNMENT OF MANITOBA,
as represented by the Minister of Health
(called "Manitoba"),

- and –

_____ **Regional Health Authority**
(called the "RHA")

- and –

_____ **Clinic**
a corporation duly incorporated pursuant to
the laws of Manitoba.
(called the "Clinic")

WHEREAS one of Manitoba Health, Healthy Living and Seniors (MHHLS)'s strategic priorities is the need to address primary care renewal and to ensure all Manitobans have access to a family physician by 2015, one strategy includes facilitating the integration of non-physician providers into fee-for-service physician practices as members of an Interprofessional Team;

AND WHEREAS clinics in Manitoba may be interested in participating in Primary Care Networks (PCNs) and, as an adjunct to PCNs, integrating non-physician providers within interprofessional teams in their own practices;

AND WHEREAS Regional Health Authorities have an interest in helping to ensure that their residents have access to a family physician for regular, ongoing quality primary care and therefore in increasing the capacity of primary care clinics to attach more patients;

AND WHEREAS interprofessional teams within fee-for-service practices in Manitoba are new, and approaches to establishing, funding and sustaining them have not been well established or evaluated;

AND WHEREAS the Manitoba eHealth program of the Winnipeg Regional Health Authority ("WRHA") will import data extracts from the Clinic for the purpose of this and

other programs, as Manitoba's agent for this limited purpose;

AND WHEREAS Manitoba has an agreement with the WRHA for the purpose of Manitoba eHealth providing information management services;

NOW THEREFORE in consideration of the foregoing premises and the mutual covenants and provisions reflected in this Agreement, Manitoba, the RHA and the Clinic agree to enter into an Interprofessional Team arrangement on a demonstration basis and to evaluate and learn from this arrangement as a basis for future interprofessional team care, as follows:

1.0 Term of Agreement

1.1 This Agreement shall be effective as of the Effective Date and shall remain in full force for thirty six (36) months unless terminated under section 12 or extended under section 11.

2.0 Definitions

2.1 The following definitions apply for this Agreement:

"**Attached Patient**" means a patient who is considered to be receiving ongoing primary care from the Clinic and has been identified and recorded as such according to the process described in Appendix "3."

"**Baseline List of Attached Patients**" or "**Baseline**" means the list of patients agreed to be attached to the Clinic just before or at the time that this Agreement becomes effective, and to which later lists of patients produced at later times are compared to calculate the Net Change in Attachment;

"**Clinic**" means the group of Participating Physicians designated in this Agreement. "Clinic" includes the Interprofessional Team Member for the sole purpose of measuring patient attachment. The "Clinic" expressly excludes other physician members who may practice in the same location but who have not signed this Agreement.

"**EMR Data Extract**" means an extract of primary care data produced by the Clinic's EMR, and provided to Manitoba eHealth, as MHHLS's agent, as described in Schedule A;

"**EMR**" means the Electronic Medical Record software used by the Clinic;

"**Enrolled Patient**" means a patient with whom the Clinic has reached an explicit agreement that the Clinic will be that patient's provider of regular, ongoing primary care, and which outcome has been documented by the Clinic in its EMR as described in Appendix 3. Enrolment of patients is optional for the Clinic.

"**Interprofessional Team Demonstration Initiative (ITDI)**" means the provincial initiative, participation in which is governed by this Agreement;

"**Interprofessional Team Member (ITM)**" means the non-physician clinician employed by the RHA who is made available to the Clinic to assist in providing primary care as directed by the Clinic;

"**ITM Data Extract**" means a data extract, supplementary to the current EMR Data Extract, which provides information about the activities engaged in by the Interprofessional Team Member. The ITM Data Extract may be superseded by a more complete EMR Data Extract during the term of this Agreement;

"**Manitoba Primary Care Quality Indicators Guide**" means the document provided by MHHLS on its website defining Primary Care Indicators and describing how data is entered and collected in order to calculate them, as amended from time to time. This document is available at:
http://www.gov.mb.ca/health/primarycare/providers/pin/docs/mpcqig.pdf

"**Net Change in Attachment**" means the net increase in the number of patients attached to the Clinic (including any Enrolled Patients) between the Baseline and a particular subsequent measurement of attachment, as described in Appendix 3;

"**New Attached Patient**" means a patient attached or enrolled subsequent to the Baseline and seen at least once by the Clinic since the Effective Date;

"**New List of Attached Patients**" means the list of patients indicated as Attached or Enrolled in an EMR Data Extract submitted by the Clinic subsequent to the determination of the Baseline List of Attached Patients;

"**Clinic Lead**" means the individual designated by the Clinic to act as the key contact with the RHA and with MHHLS regarding this Agreement and the incorporation of the Interprofessional Team Member into the Clinic;

"**Participating Physicians**" means the co-located physician(s) who agree to incorporate the Interprofessional Team Member into their primary care team and to direct his or her efforts in providing primary care, under the supervision of one or more of their number, as attested by the signature of said physicians on this Agreement;

"**Primary Care Indicator**" means an individual measure as outlined in the Manitoba Primary Care Quality Indicators Guide;

"**Stipend**" means the fixed annual payment to the Clinic as a contribution to the overhead and supervision costs incurred by the Clinic in relation to engagement of the Interprofessional Team Member, as described in Appendix 1;

"**The PCIS Office**" means the Manitoba eHealth staff responsible for Primary Care Information System (PCIS) initiative;

"**Variable Payment**" means the payment to the Clinic the magnitude of which varies according to the Net Increase in Attachment achieved, as described in Appendix 1;

"**Vendor**" means the Clinic's provider of EMR software;

"**Year**" means Year 1 or Year 2 or Year 3 of this Agreement;

"**Year 1**" means the twelve-month period beginning as of the Effective Date and ending twelve months later;

"**Year 2**" means the twelve-month period beginning as of the end of Year 1 and ending twelve months later;

"**Year 3**" means the twelve month period beginning as of the end of Year 2 and ending 12 months later;

"**this Agreement**" means this document and all referenced Schedules and Appendices.

3.0 Obligations of the Clinic

3.1 The Clinic agrees to:

a) orient, train and integrate the Interprofessional Team Member into its primary care practice and to provide day-to-day direction and medical supervision as required, based on the Interprofessional Team Member's scope of practice, individual competencies and the role which the Clinic assigns to the Interprofessional Team Member;

b) exercise its best efforts to achieve a minimum of 500 New Attached Patients for regular, ongoing primary care as a result of the assistance provided by the Interprofessional Team Member, and to attach more than 500 new patients if possible, over the term of the Agreement; and

c) comply with all other applicable terms and conditions of this Agreement.

4.0 Obligations of the RHA

4.1 The RHA agrees to:

a) Collaborate with the Clinic to help determine the type of Interprofessional Team Member to hire;

b) Facilitate recruitment of the Interprofessional Team Member and, in the event that the Interprofessional Team Member leaves the employ of the RHA during the term of this Agreement, to use all reasonable efforts to replace the Interprofessional Team Member as soon as possible;

c) Pay the salary of and provide staff benefits of the Interprofessional Team Member;

d) Provide the Interprofessional Team Member with an orientation to the RHA and its relevant policies;

e) Work with the Clinic to establish performance expectations for the Interprofessional Team Member, such as number of visits per week;

f) Provide professional support and guidance to the Clinic Staff, and the

Interprofessional Team Member as necessary;

g) Provide support as required to promote interprofessional practice/team development;
h) Facilitate access to RHA services;
i) Comply with all other applicable terms and conditions of this Agreement.

5.0 Obligations of Manitoba

5.1 Provided the Clinic performs its obligations under this Agreement, Manitoba agrees to:

a) provide funding to the RHA for the Interprofessional Team Member's salary and benefits;
b) pay the Stipend and Variable Payment to the Clinic as outlined in Appendix 1;
c) offer tools and support to assist with the selection and integration of an Interprofessional Team Member, through its agent the WRHA, acting as an interprofessional practice facilitator,
d) share feedback and lessons learned as a result of evaluation activities; and
e) comply with all other applicable terms and conditions of this Agreement.

5.2 Manitoba's funding responsibility to the Clinic with respect to the Interprofessional Team Demonstration initiative is limited to providing funding to the Region and to the Clinic as specified in 5.1above.

6.0 Funding

6.1 Manitoba agrees to provide funding to the RHA for payment of salary and benefits to the Interprofessional Team Member, who will be the RHA's employee.

6.2 In consideration of the Clinic fulfilling its roles and responsibilities as outlined in Schedule "A" and section 3.0 hereof, Manitoba agrees to provide the Stipend and the Variable Payment to the Clinic subject to deliverables as described in Appendix 1. Items outside of this Agreement will not be eligible for reimbursement and neither Manitoba nor the RHA will have any obligation with respect to same.

6.3 The payment of any funds to the Clinic under this Section 6 is further conditional upon the Clinic not being in default of its obligations pursuant to Schedule "A" of this Agreement.

6.4 Nothing in this Agreement creates any undertaking, commitment or obligation on the part of Manitoba respecting additional or future funding for the Clinic, or any activities, enterprises or projects related to or arising out of same.

6.5 All payments by Manitoba under this Agreement are subject to and expressly conditional upon the Legislature of the Province duly appropriating funds in the fiscal year in which they are required to be paid.

7.0 Records, Documents, and Information

7.1 The Clinic agrees that all records pertaining to the attachment of patients and service provided to patients by the Clinic shall be available to MHHLS upon request, for the purpose of verifying the records contained in one or more EMR Data Extracts and ITM Data Extracts. All such records will also be available to the RHA for the purpose of reviewing the Interprofessional Team Member's professional development and, if required, to investigate any complaints or incidents. Such records may contain personal health information, the disclosure of which is authorized under section 22(2)(g) of *The Personal Health Information Act.*

7.2 Where an examination of records by Manitoba under 7.1 reveals any inconsistency with the EMR Data Extract and/or ITM Data Extract, Manitoba may perform a more in depth review of the records. If, in the opinion of Manitoba, that review reveals that one or more services reported in either Data Extract did not occur, or did not occur on the time and date reported, Manitoba may:

(a) reduce payments in accordance with Appendix 1, section 1.3.1.2,

(b) terminate the Agreement under section 12.1, or

(c) take action under both clause (a) and (b).

7.3 Manitoba shall have access to all written reports produced or prepared by or for the Clinic for presentation to third parties in connection with the activities contemplated by this Agreement. The Clinic agrees to provide to Manitoba copies of any of the foregoing upon Manitoba's request. Manitoba shall not disclose such reports without the Clinic's consent, which shall not be unreasonably withheld.

8.0 Confidentiality of Information

8.1 The Clinic expressly acknowledges it may have access to information (including Personal Health Information) which may be of a highly confidential and sensitive nature. Accordingly, while this Agreement is in effect and at all times thereafter, the Clinic and any officers, employees or agents of the Clinic:

a) shall, in respect of all personal health information, comply with the principles and provisions of *The Personal Health Information Act* including any regulation enacted thereunder and with any rules or directions made or given by Manitoba;

b) shall treat and retain as confidential all other information, data, documents, knowledge and materials acquired or to which access has been given in the course of, or incidental to, the performance of this Agreement;

c) shall not disclose, nor authorize, nor permit to be disclosed, to any person, corporation or organization, now or at any time in the future, such information, data, documents, knowledge or materials referred to in subsection (b) without first obtaining written permission from Manitoba; and

d) shall comply with any rules or directions made or given by Manitoba with respect to safeguarding or ensuring the confidentiality of the information, data, documents, knowledge or materials referred to in subsection (b).

8.2 Manitoba expressly acknowledges that it will be collecting information (including personal health information) through its agent, the WRHA acting as Manitoba eHealth, information which may be of a highly confidential and sensitive nature. Accordingly, while this Agreement is in effect and at all times thereafter, Manitoba shall ensure:

a) it uses or discloses the personal health information collected pursuant to this Agreement only for the purpose of this Agreement or for another purpose authorized by law;

b) its agent the WRHA does not use or disclose the personal health information collected on Manitoba's behalf for the purposes of this Agreement, except to Manitoba; and

c) its agent the WRHA has reasonable security systems and policies in place, with respect to the personal health information collected under this Agreement.

9.0 Clinic Responsibility and Indemnification

9.1 The Clinic shall use due care in the performance of the obligations under this Agreement to avoid injury to any person, loss to any property and infringement of any rights.

9.2 The Clinic shall be solely responsible for and shall save harmless and indemnify Manitoba and the RHA, their officers, employees and agents from and against all claims, liabilities and demands with respect to:

a) any injury to persons, (including, without limitation, death), damage or loss to property, or infringement of rights caused by or related to this Agreement, the performance of this Agreement or the breach of any term of this Agreement by the Clinic, or any officer, employee, agent or contractor of the Clinic; and

b) any omission or wrongful or negligent act of the Clinic, or of any officer, employee or agent of the Clinic, in relation to the operation of the IPT Demonstration Initiative, including, without limitation, any breach of the confidentiality, protection of privacy or security requirements, as detailed in Section 8 hereof.

10.0 RHA Responsibility and Indemnification

10.1 The RHA shall use due care in the performance of the obligations under this Agreement to avoid injury to any person, loss to any property and infringement of any rights.

10.2 The RHA shall be solely responsible for and shall save harmless and indemnify Manitoba and the Clinic, their officers, employees and agents from and against all claims, liabilities and demands with respect to:

a) any injury to persons, (including, without limitation, death), damage or loss to property, or infringement of rights caused by or related to this Agreement, the performance of this Agreement or the breach of any term of this Agreement by the RHA, or any officer, employee, agent or

contractor of the RHA; and

b) any omission or wrongful or negligent act of the RHA, or of any officer, employee or agent of the RHA, in relation to the operation of the IPT Demonstration Initiative, including, without limitation, any breach of the confidentiality, protection of privacy or security requirements, as detailed in Section 8 hereof.

11.0 Suspension or Extension

11.1 Manitoba may suspend or extend the time frames for this Agreement in writing if necessary by reason of circumstances beyond the control of the Clinic or through no fault of the Clinic.

11.2 In particular, should the Interprofessional Team Member leave the employ of the RHA, or be unavailable to provide service to the Clinic due to a long-term disability, Manitoba may extend the term of this Agreement by the duration for which the Clinic is without the services of the Interprofessional Team Member.

12.0 Termination Rights

12.1 Any party may terminate this Agreement prior to the end of its normal term, provided that it sends the other parties written notice ninety (90) days in advance of the termination date.

12.2 In the event of termination under clause 12.1 the Stipend and Variable Payments will be payable for the period since the last Year-end on a pro-rated basis. The specific details are described in Appendix 1.

12.3 Upon the termination of this Agreement, the RHA will use its best efforts to place the Interprofessional Team Member in another qualifying fee-for-service Clinic which signs a new ITDI agreement, as soon as possible.

13.0 Survival of Terms

13.1 Those provisions which by their very nature are intended to survive the termination or expiration of this Agreement shall survive, including without limitation: Sections 7.0 (Records, Documents, and Information); 8.0 (8.0 **Confidentiality**); 9.0 (Clinic Responsibility and Indemnification); 10.0 (RHA Responsibility and Indemnification); and 14.0 (14.0 Independent **Contractor**).

14.0 Independent Contractor

14.1 It is expressly agreed that the Clinic is acting as an independent contractor in performing the services hereunder. This Agreement does not create the relationship of employer and employee, or of principal and agent between Manitoba and the Clinic or between Manitoba and any officers, employees or agents of the Clinic. Likewise this Agreement does not create the relationship of employer and employee, or of principal and agent between the RHA and the Clinic or between the RHA and any officers, employees or agents of the Clinic.

15.0 No Assignment of Agreement

15.1 The Clinic shall not assign or transfer this Agreement or any of the rights or obligations under this Agreement without first obtaining written permission from the other parties.

15.2 This Agreement shall be binding upon the successors and any permitted assigns of the Clinic.

16.0 Entire Agreement

16.1 The preamble shall form an integral part of this Agreement.

16.2 This document and the attached Schedules and Appendices contain the entire Agreement between the parties. There are no undertakings, representations or promises, express or implied, other than those contained in this Agreement. In the event of any conflicts or inconsistencies, the provisions of this document shall govern over the Schedules.

16.3 A waiver of any breach of a provision hereof shall not be binding upon a party unless the waiver is in writing, and the waiver shall not affect such party's rights with respect to any other or future breach.

16.4 The parties agree that the terms of this Agreement are based upon the relationship between the parties existing at the date of this Agreement, and that, by virtue of entering into this Agreement, no party binds itself to contract with the other parties on the same terms in the future.

17.0 Amendments

17.1 No amendment or change to, or modification of, this Agreement shall be valid unless it is in writing and signed by all parties.

18.0 Notices

18.1 Any notice or other communication to the Clinic under this Agreement shall be in writing and shall be delivered personally to the Clinic or an officer or employee of the Clinic or sent by registered mail, postage prepaid, or by way of facsimile transmission, to:

_____ (Print Name)

_____ (Address)

_____

_____ (Fax)

18.2 Any notice or other communication to the RHA under this Agreement shall be in writing and shall be delivered or sent by registered mail, postage prepaid, or by way of facsimile transmission, to:

_____ (Print Name)

_____ (Address)

_____

_____ (Fax)

18.3 Any notice or other communication to Manitoba under this Agreement shall be in writing and shall be delivered or sent by registered mail, postage prepaid, or by way of facsimile transmission, to:

Barbara Wasilewski, Executive Director
Primary Health Care
Manitoba Health, Healthy Living and Seniors
1090 – 300 Carlton Street
Winnipeg, MB R3B 3M9
Fax: 204-943-5305

18.4 Any notice or communication sent by registered mail shall be deemed to have been received on the fifth business day following the date of mailing. If mail service is disrupted by labour controversy, notice shall be delivered personally.

19.0 Applicable Law

19.1 This Agreement has been executed and delivered in the Province of Manitoba, and its interpretation, validity and performance shall be construed and enforced in accordance with the laws of Manitoba and of Canada as applicable therein.

19.2 The Services are being purchased under this Agreement by the Government of Manitoba, and are therefore not subject to the Federal Goods and Services Tax (Registration Number R107863847). The Clinic represents and warrants that Goods and Services Tax has not been included or quoted in any fees, prices or estimates and shall not be included in any invoice provided, or request for payment under this Agreement.

IN WITNESS WHEREOF the Minister of Health, or designate, for and on behalf of The Government of Manitoba, the RHA, by its duly authorized signing officer, and the Clinic, by its duly authorized signing officer, have signed this Agreement for Funding and

Participation in the Interprofessional Team Demonstration Initiative, each on the dates indicated below.

Signed in the presence of:

THE GOVERNMENT OF MANITOBA
as represented by

_____
WITNESS

_____
MINISTER OF HEALTH or designate

_____
DATE

Corporate Seal:

FOR THE CLINIC

_____
WITNESS

_____
SIGNATURE

_____
DATE

_____
WITNESS

_____
SIGNATURE

_____
DATE

FOR THE RHA

_____
WITNESS

_____
SIGNATURE

_____
DATE

Participating Physicians

NAME: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____

NAME: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____

NAME: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____

NAME: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____

NAME: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____

SCHEDULE "A"

CLINIC ROLES AND RESPONSIBILITIES

This is Schedule "A" to the Agreement for Funding and Participation in the Interprofessional Team Demonstration Initiative between the Government of Manitoba, as represented by the Minister of Health and _____ RHA and _____ Clinic (the "Clinic"), made effective _____ (the "Agreement").

A1. Orientation and Supervision of the Interprofessional Team Member

a. The Clinic will provide orientation and training to the Interprofessional Team Member.

b. The Clinic will integrate the Interprofessional Team Member into its administrative and clinical processes and will provide direction on matters such as work hours and work focus.

c. The Clinic will designate a supervising physician to oversee the work of the Interprofessional Team Member, as required, given the Interprofessional Team Member's scope of practice, background and individual competencies.

A2. Information Management Practices

a. The Clinic will establish and maintain procedures for entering data on the Attachment (and, if the Clinic so chooses for new patients, the enrolment) of patients (see Appendix 3) and for Primary Care Indicators (used for evaluation of this initiative– see Appendix 2) into the Clinic's electronic medical record (EMR) to ensure consistent and accurate reporting and to assist with training users.

b. The Clinic will facilitate the Interprofessional Team Member's use of the EMR, including providing access to a computer and licensed software.

c. The Clinic will establish and maintain a plan to monitor data entry quality to ensure Primary Care Indicator data is captured in a consistent and reportable manner on an ongoing basis.

d. The Clinic will collaborate with the Vendor and the PCIS Office, as may be required, in implementing specifications for EMR programming to support the Primary Care Indicators. The Clinic will implement a new version of the EMR if required in order to support evaluation.

A3. Data Collection and Reporting

a. The Clinic will consistently follow the Clinic's data entry procedures (A2.a.) and data monitoring plan (A2.b.) in the documentation of patient attachment/enrolment and entry of Primary Care Indicators.

b. The Clinic will provide EMR and ITM Data Extracts to MHHLS through its agent, the Manitoba eHealth program of the WRHA, on a quarterly basis through the secure electronic data transmission process established by Manitoba eHealth for this purpose. Clinics who are also participating in the Physician Integrated Network (PIN) or in the EMR Adoption Program should note that the EMR Data Extract format for this Agreement will be the same as used in those initiatives and only one EMR Data Extract needs to be submitted each period.

   i. The purposes of providing the EMR and ITM Data Extracts are 1) to enable MHHLS to calculate the Net Change in Attachment in order to determine the Variable Payment due to the Clinic, and 2) to facilitate evaluation of the Interprofessional Team Demonstration Initiative.

   ii. The disclosure to MHHLS by the Clinic and its physicians is authorized under the following sections of *The Personal Health Information Act:*

      section 22(2)(g)(i), which states that personal health information may be disclosed to another trustee who requires the information to evaluate or monitor the quality of services the other trustee provides; and

      section 22(2)(i), which states that personal health information may be disclosed to the government, another public body, or the government of another jurisdiction or an agency of such a government, to the extent necessary to obtain payment for health care provided to the individual the personal health information is about.

   iii. The Clinic will at a minimum submit four complete quarterly EMR Data Extracts per year while this Agreement is in force, each representing a three-month period ending December 31, March 31, June 30 or September 30 of the current Year. Clinics which are not participants in the Physician Integrated Network will submit monthly EMR Data Extracts. All Clinics will submit quarterly ITM Data Extracts.

   iv. EMR and ITM Data Extracts will be submitted no later than 30 calendar days after the month-end or quarter- end dates indicated in the preceding clause.

   v. The Clinic will ensure that the EMR Data Extracts include records for Attached Patients and (if the Clinic elects to enroll new patients) Enrolled Patients.

   vi. The Clinic will ensure that each Data Extract includes all the data elements required for each patient record, as outlined in the most current version of the Manitoba Primary Care Quality Indicators Guide.

   vii. If a Data Extract does not conform with clause v. or vi. the Clinic will be asked to implement changes to improve data quality. MHHLS and the PCIS Office of Manitoba eHealth will assist the Clinic in resolving its data discrepancies.

c. The Clinic will record on a monthly basis, and report to MHHLS on a quarterly basis, “Third Next Available Appointment” information, in order to monitor the impact on timely access as part of the evaluation of this initiative.

d. The Clinic will complete the Interprofessional Team Demonstration Initiative Event Log and submit it to MHHLS on a quarterly basis.

A4. Patient Attachment and Enrolment

a. The Clinic will record the addition of New Attached Patients or Enrolled Patients in its EMR as described in Appendix 3.

b. The Clinic will also update its EMR to reflect that patients are no longer attached where this is the case (ex: where patients leave the clinic or become deceased), as described in Appendix 3.

A5. Evaluation

a. The Clinic will participate in the ongoing evaluation of the Interprofessional Team Demonstration Initiative through the activities described in Appendix 2.

A6. Clinic Leadership

a. The Clinic will identify, at minimum, one individual as a Clinic Lead for the purposes of this initiative. The Clinic Lead may or may not be the physician who supervises the Interprofessional Team Member on a day-to-day basis.

b. The Clinic Lead(s) will ensure all participating physicians of the Clinic are regularly apprised of the status of the incorporation of the Interprofessional Team Member into the Clinic's practice, the Net Change in Attachment and the status of the evaluation.

A7. Physician Participation

a. Only the physicians indicated as Participating Physicians in the signature block of this Agreement or added by an amendment to this Agreement are considered to comprise the Clinic, to be parties to this Agreement, and to be in-scope for the Baseline and calculating Net Change in Attachment.

b. Should the Clinic wish to add a physician who was not a participant as of the Effective Date , the Clinic must send a written request to all other parties of the intent to add the physician to the Agreement with the proposed effective date that he/she would be added. Provided none of the other parties object, MHHLS may agree to amend this Agreement to incorporate the new physician. The Clinic's written notice of intent to add the physician, as well as written confirmation from the new physician and MMHLS shall be attached to this Agreement and will constitute an amendment to this Agreement.

c. From time to time it is anticipated that a Participating Physician may move from the Clinic, retire, or may no longer wish to participate in the initiative. In such a case, the Participating Physician may be removed from this Agreement by sending written notice to all other parties of his/her intent to move, retire, or no longer participate with the intended effective date of his/her removal from the Agreement. Such written notice shall be attached to this Agreement and will constitute an amendment to this Agreement as of the stated intended effective date.

d. MHHLS shall provide written confirmation of any amendments as per A7.b. and A7.c. to all parties to this Agreement in a reasonable time period.

A8. Other Contractual Attachment Commitments

a. This Agreement does not release the Clinic from other commitments to increase the number of patients attached to the Clinic. This includes but is not limited to Clinic participation in a Primary Care Network. Where the Clinic participates in a PCN and utilizes the services of shared PCN resources as provided under a PCN service plan, the contribution of those resources to the Net Change in Attachment is to be accounted for separately from the contribution of the Interprofessional Team Member. Only the contribution of the Interprofessional Team Member is to be used in calculating the portion of the Net Change in Attachment which is to be used for calculating the Variable Payment under this Agreement, as described in Appendix 1.

A9. Support of Family Doctor Connection Program

a. The Clinic will work in good faith with the RHA's Primary Care Connector to accept patients who have requested a primary care provider through the provincial Family Doctor Connection Program.

b. Patients accepted through the Family Doctor Connection Program who are attached or enrolled by the Clinic and receive at least one visit subsequent to the Baseline will be considered Newly Attached Patients as described in Appendix 3.

A10. Invoicing

a. The Clinic will submit invoices for payment of the:

   i. Stipend to be submitted at the start of each Year, and

   ii. Variable Payment to be submitted at the end of each Year, if and as payable per terms of Appendix 1.

b. Invoices may be sent by fax, email, or mail to:

   Primary Health Care
   Manitoba Health, Healthy Living and Seniors
   1090 – 300 Carlton Street
   Winnipeg, Manitoba R3B 3M9
   ATTN: Administrative Assistant
   Fax No: (204) 943-5305

   Email: PHC@gov.mb.ca

c. All invoices shall contain the information illustrated in Appendix 5, satisfactory in form and content to Manitoba.

SCHEDULE "B"

RHA ROLES AND RESPONSIBILITIES

This is Schedule "B" to the Agreement for Funding and Participation in the Interprofessional Team Demonstration Initiative between the Government of Manitoba, as represented by the Minister of Health and _____ RHA and _____ Clinic (the "Clinic"), made effective _____ (the "Agreement").

B1. Hiring the Interprofessional Team Member

i. The RHA will collaborate with the Clinic to help determine the type of Interprofessional Team Member to hire.

ii. The RHA will develop the position description, in collaboration with the Clinic.

iii. The RHA will facilitate recruitment and selection of the Interprofessional Team Member, in collaboration with the Clinic.

iv. In the event that the Interprofessional Team Member who has been integrated within the Clinic leaves the employ of the RHA, the RHA will use its best efforts to hire a new Interprofessional Team Member as soon as possible.

B2. Payment of Interprofessional Team Member's Salary and Benefits

i. The RHA will pay the Interprofessional Team Member's salary and benefits.

B3. Orientation and Support of Interprofessional Team Member

i. The RHA will provide the staff member engaged to be an Interprofessional Team Member with an orientation to the RHA and its relevant policies.

ii. The RHA will address any professional standards, professional development and union issues, if applicable.

iii. The RHA will work with the Clinic to establish performance expectations for the Interprofessional Team Member, such as number of visits per week;

iv. The RHA will provide support, as required, to promote interprofessional practice/team development.

B4. Reallocation of Interprofessional Team Member Upon Termination

Upon the termination of this Agreement the RHA will facilitate the engagement of other Clinics in order to place the Interprofessional Team Member with a new Clinic who agrees to participate.

SCHEDULE "C"

MANITOBA ROLES AND RESPONSIBILITIES

This is Schedule "C" to the Agreement for Funding and Participation in the Interprofessional Team Demonstration Initiative between the Government of Manitoba, as represented by the Minister of Health and _____ RHA and _____ Clinic (the "Clinic"), made effective _____ (the "Agreement").

C1. Interprofessional Team Facilitation Toolkit and Training

i. Through a sub-contract arrangement with the Winnipeg Regional Health Authority (WRHA), MHHLS will provide a Toolkit and supporting documentation and training to enable the RHA to facilitate the engagement of Clinics in the Interprofessional Team Demonstration Initiative and to support them in integrating the Interprofessional Team Member into the Clinic's operations.

C2. Evaluation

i. Manitoba will lead and support the evaluation of the Interprofessional Team Demonstration Initiative as outlined in Appendix 2.

C3. Funding for Interprofessional Team Member Salary and Benefits

i. Manitoba will provide funding to the RHA for payment of the Interprofessional Team Member's salary and benefits.

C4. Clinic Funding Contribution and Reimbursement

i. Provided the Clinic performs its obligations under this Agreement, MHHLS will provide a funding contribution as described in Appendix 1.

ii. Upon the receipt of appropriate documentation as specified by Manitoba, Manitoba will provide reimbursement for travel and lodging required to attend any evaluation meetings, in accordance with the amounts and guidelines set out in the General Manual of Administration for the Province of Manitoba. These amounts will be in addition to the funding contribution.

Appendix "1"
Funding Contribution to Clinic

1.0 Clinics will receive a funding contribution from MHHLS in two parts, as identified below:

1.1. Annual Stipend - Contribution to Costs

1.1.1. A Stipend of $30,000 per annum in Year 1 of the Agreement, and $20,000 per annum thereafter, payable at the beginning of each contract Year, shall be payable to the Clinic upon receipt of invoice to Manitoba as a contribution to the overhead, supervision and other costs incurred by the Clinic associated with and in relation to engagement of the Interprofessional Team Member. The stipend amount is based on the provision of full-time services by the Interprofessional Team Member (ex: 1 FTE: 260 8-hour days (2,080 hours) per annum, inclusive of vacation and statutory holidays or such other number of hours as is stipulated in the applicable collective agreement for the Interprofessional Team Member). The Stipend will be pro-rated if the Member provides services on a part-time basis. The stipend amount will also be pro-rated if the Agreement is terminated prior to its expiry.

1.2. Variable Payment

1.2.1. A Variable Payment, payable at the end of each contract Year, intended as a further contribution to overhead, supervision and other costs, the amount of which is determined based upon and reflective of the Net Change in Attachment of patients attached to the Clinic since the Baseline Date. The method for determining the Net Change in Attachment is described in Appendix 3.

1.2.2 As stated, the actual Variable Payment will be calculated annually, upon submission of the first EMR data extract after the end of each contract Year and paid to the Clinic upon receipt of invoice to Manitoba. Unless otherwise agreed to in writing by MHHLS, the RHA and the Clinic upon the date of signing this Agreement (and appended hereto), due to the nature of the Clinic's practice, the Interprofessional Team Member, or other relevant factor, the amount payable for each Year will be determined as indicated in the following table:

Net Increase in Attachment Compared to Baseline	Amount Payable
<500	$0
500 – 749	$20,000
750 – 999	$30,000
1000 – 1200	$40,000
1201 +	$50,000

1.3. Payment in the Event of Early Termination

1.3.1 Should the Agreement be terminated prior to its normal termination, as provided in section 12, payment of the Stipend and the Variable Payment will be made on a pro-rated basis for the period since the last Year-end, in the following manner:

1.3.1.1. The Stipend amount and Variable Payment amounts will be determined using the tables in 1.2 of this Appendix as if the next Year-end following the termination date had been reached.

1.3.1.2. The Stipend and Variable Payment amounts determined per 1.3.1.1 will be reduced by multiplying them by the following fraction: the number of complete calendar months since the last Year-end, divided by twelve.

1.4. Payment in the Event of Suspension of Agreement/Extension of the Term

1.4.1. In the event that Manitoba decides to suspend the Agreement or extend the term due to the circumstances described in section 11.2, then:

1.4.1.1 The Variable Payment will continue to be made as described according to section 1.2.3 while the Agreement is suspended.

1.4.1.2. Stipend payments will not be paid while the Agreement is suspended. However, when a new Interprofessional Team Member joins the Clinic the annual Stipend will again apply. The Stipend for the Year in which the new Interprofessional Team Member joins the clinics will be pro-rated based on the number of full months during which an Interprofessional Team Member was working in the Clinic during the contract Year. In subsequent Years of the Agreement, the full Stipend will be payable.

Appendix "2"

Participation in Evaluation

1.0 Evaluation Objectives

1.1 Since this is a Demonstration Initiative, evaluation and learning are key goals. Evaluation objectives include:

1.1.1. Evaluating the facilitation process and toolkit used to help Clinics explore the potential impact of Interprofessional Team Members with different professional backgrounds on the Clinic;

1.1.2. Evaluating the impact on family physician activities within the Clinic;

1.1.3. Evaluating patient and provider perspectives on the integration of an Interprofessional Team Member into the Clinic;

1.1.4. Evaluating the impact of the Interprofessional Team Member on patient access (Note: there is no accountability to improve timeliness of access under this Agreement, but a goal of evaluation is to identify any impact on timely access);

1.1.5. Evaluating the impact of the Interprofessional Team Member on primary care quality as measured by the Primary Care Indicators (Note: there is no accountability to improve quality of case under this Agreement, but a goal of evaluation is to identify any impact on quality.)

2.0 Use of Quantitative Data for Evaluation

2.1 The Clinic agrees to the use of data submitted per section A3 of Schedule A for evaluation of the Interprofessional Team Demonstration Initiative.

3.0 Participation in Qualitative Evaluation Activities

3.1 The Clinic members agree to actively participate in evaluation activities such as a provider survey, provider focus group and/or provider interviews, and to help facilitate patient participation in similar evaluation activities.

4.0 Sharing of Evaluation Results and Lessons Learned

4.1 The Clinic agrees to the sharing of evaluation results, including both quantitative and qualitative information, with other any interested parties as long as the Clinic-specific results are designated anonymously (ex: Clinic 'A') or are aggregated with the results of other Clinics.

Appendix "3"

Measuring Attached Patients

1. Baseline Measurement of Attached Patients

1.1 As part of the process leading to signing of this Agreement, the Clinic and Manitoba exchanged information concerning patients for whom there was evidence of attachment. Based on this information and related discussion, the Clinic and Manitoba agreed upon the list of patients who were considered to be attached as of the Baseline or starting point for measurement of changes in attachment. The Baseline List of Attached Patients is described in Appendix 4.

2. Recording Attachment of New Patients Subsequent to the Baseline

2.1 The Clinic will record the attachment of all new patients accepted for ongoing primary care from the time the Baseline List of Attached Patients is established until the termination of this Agreement.

2.2 The Clinic will do so by establishing an EMR record for each New Attached Patient and

2.2.1 If the Clinic chooses to enroll new patients – ex: to have an enrolment discussion with each new patient – and the patient and Clinic reach mutual agreement to establish an ongoing primary care relationship, the Clinic will record this fact by entering the date of the enrolment conversation in the Enrolment Start Date field in its EMR record for that patient; or

2.2.2 If the Clinic chooses not to enrol new patients, the Clinic will enter in the appropriate field in that patient's EMR record the name of the clinician who will provide regular ongoing primary care for that patient; or, if the patient will be provided ongoing primary care by the Clinic as a whole and not by an individual clinician, the Clinic will enter "Clinic" in this field.

2.3 The Clinic agrees <u>not</u> to enter a clinician name in the field referred to in clause 2.2.2 for patients whom it has not accepted for ongoing primary care but to whom it provides episodic care.

2.4 The Clinic agrees that, if it implements a new EMR version for which the procedures noted in the prior sections 2.2 and 2.3 must change, the Clinic will adopt the relevant new procedures to record newly attached patients. The new procedures will be attached to this Agreement as a schedule.

3. Recording that a Patient Is No Longer Attached to the Clinic or One of Its Clinicians

3.1 When the Clinic or patient decides that a patient will no longer be provided ongoing primary care by the Clinic, or the patient becomes deceased, the Clinic will remove the name of the clinician (or the word "Clinic" if the patient was attached to the Clinic as a whole) from the field in that patient's record referred to in 2.2.2, prior to running and submitting the next EMR data extract.

4. Calculation of Net Change in Attachment

4.1 Clinics will submit data extracts as described in Schedule A, but the Net Change in Attachment will only be calculated for purposes of the Variable Payment using the extract immediately following the contract Year-end, while the Agreement remains in force.

4.2 The Net Change in Attachment will be calculated according to the following steps:

4.2.1 The patients of the Clinic shown as attached or enrolled in the current EMR extract will form the New List of Attached Patients.

4.2.2 Any patients who are included in the New List of Attached Patients but are deceased or no longer residents of Manitoba according to the Manitoba Health Insurance Registry will be removed from the New List of Attached Patients.

4.2.3 Any patients in the New List of Attached Patients who have not been seen by the Clinic since the Effective Date, as reflected in billing data, will be removed from the New List of Attached Patients.

4.3 The number of patients in the Baseline List of Attached Patients will then be subtracted from the number of patients remaining in the New List of Attached Patients, to calculate the Net Change in Attachment.

4.4 For additional clarity, the obligation of a Clinic to attain a specific attachment level under the Agreement is in addition to any other attachment obligations that the Clinic may have. A Net Change in Attachment calculated for the purposes of the Agreement may not be used for the purpose of satisfying any other contractual attachment obligations or commitments which the Clinic may have.

5. Attribution of Net Change in Attachment

5.1. Where the Clinic participates in a Primary Care Network as well as the Interprofessional Team Demonstration Initiative, each New Attached Patient can only be attributed to either the PCN or ITDI. Unless otherwise agreed to between the parties and included as an amendment to this Agreement, the following method will be used to attribute the Net Change in Attachment to ITDI or PCN:

a) (Hours provided to the Clinic by ITM / Total Hours provided to the Clinic by ITM and all PCN provider resources) x 100 = Percentage of the total increase in attachment attributed to the ITM for this Agreement

b) (Hours provided to the Clinic by all PCN provider resources / Total Hours provided to the Clinic by ITM and all PCN provider resources) x 100 = Percentage of the total increase in attachment attributed to all PCN provider resources for the PCN

c) The percentage of professional services provided to the Clinic by the Interprofessional Team Member and the percentage of professional services provided to the Clinic by shared PCN provider resources will each be calculated based on the number of hours of service provided by these resources to the Clinic for the Year. For example, if the ITM provided 2080 hours to the Clinic for the Year and all PCN provider resources collectively provided 520 hours to the Clinic for the Year, then 80 per cent (2080/2600) of the Net Change in Attachment would be attributed to ITDI and 20 per cent (520/2600) would be attributed to PCN.

d) The information on the number of hours provided to the Clinic by all shared PCN provider resources and the ITM will be recorded weekly and taken from the PCN event log and the ITDI event log.

Appendix “4”

Baseline Attachment Information

The parties agreed on _____ that the number of patients in the Baseline List of Attached Patients was _____.

The parties agreed to share the following information on the patients who were included in the Baseline, for greater certainty in calculating the Net Increase in Attachment

PHIN	Patient Name	Clinician to Whom Patient Is Attached

Appendix "5"

Invoice Sample

Clinic Name
Clinic Contact Names
Clinic Address
Clinic Phone, Fax, Email

INVOICE

Primary Health Care
Manitoba Health, Healthy Living and Seniors
1090 – 300 Carlton Street
Winnipeg, Manitoba R3B 3M9

Fax No: (204) 943-5305
Email: PHC@gov.mb.ca

ATTN: Administrative Assistant

DATE	DESCRIPTION	AMOUNT
01 Sept 2015	Interprofessional Team Demonstration Initiative Year 2 Annual Stipend	$20,000.00

TOTAL: $20,000.00

INTERPROFESSIONAL TEAM DEMONSTRATION INITIATIVE – FAQS

A number of excellent questions have arisen from the early adoption sites implementing the Interprofessional Team Demonstration Initiative (ITDI). We have taken all questions and have collated them into this FAQ document. As additional questions and situations arise, we will update the FAQ document and circulate it.

Q1. What is the expected timeline to attach 500 new patients into the practice?

There is no expected timeline for the attachment of the new patients. Once the Interprofessional Team Member has begun working at the clinic, there will be a period of time for learning and adjustment of tasks and functions. Following this adjustment period, it is expected that the attachment process will begin on a gradual basis. The variable payment under the ITDI Agreement ("the Agreement") becomes payable at the end of each agreement year in which the net increase in attachment equals or exceeds 500 patients. Please refer to the ITDI Data and Measurement FAQs for how attachment and change in attachment are measured, and to Appendix 1 of the Agreement for more details on how attachment affects payment.

Q2. Who are the patients that we can attach? Can we choose our own patients or will they be chosen for us?

Newly attached patients are determined by the clinic. Many family physicians have patients with family members who do not have a Primary Care Physician. Some clinics may wish to attach family members of existing patients. New patients can also be referred to the practice by the new Family Doctor Finder Program (previously known as the Care Connect or the Family Doctor Connection program), which will match a patient seeking care to a practice best suited for their needs, and in the community of their preference. For more information, visit http://www.gov.mb.ca/health/familydoctorfinder/ or call 204-786-7111.

Q3. How and when are payments to the clinic made?

There are two types of payments to clinics.

1. A Stipend is paid at the beginning of each agreement year. (The first contract year starts on the Effective Date of the agreement.) The Stipend for the first year is $30,000 and the Stipend for subsequent agreement years is $20,000.
2. A Variable Payment is made, if applicable, at the end of each agreement year. The amount of the Variable Payment is based on the net increase in attachment at the end of each Agreement Year, compared to the initial Baseline measurement of attached patients.

Please refer to the ITDI Data and Measurement FAQs, and Appendix 3 of the Agreement, for a detailed explanation of how attachment and change in attachment are measured, and to Appendix 1 of the Agreement for more details on how attachment affects payment.

Q4. How do I receive my Annual Stipends and Variable Payments?

Manitoba Health, Healthy Living and Seniors (MHHLS) require you to submit an invoice in order to receive the Annual Stipends and Variable Payments. The Annual Stipends are a fixed amount that you will invoice MHHLS for at the beginning of each year of the Agreement. To determine the Variable Payments you will work with MHHLS to calculate the net change in attachment. When that number is agreed upon, you will invoice MHHLS for the corresponding amount payable. For details see the Agreement, Appendix 1, "Funding Contribution to Clinic".

The invoices should be labeled "Invoice" and include the following information: name of clinic; address and contact information; the date, description and amount of the payment. An example of an invoice is provided in Appendix 5 of the Agreement. MHHLS will accept the invoice by email, fax or mail at:

Attention:

Primary Health Care Branch
Manitoba Health, Healthy Living and Seniors
1090 – 300 Carlton Street
Winnipeg, Manitoba R3B 3M9
ATTN: Administration Assistant
Fax: 204-943-5305
Email: PHC@gov.mb.ca

Q5. What happens if we have a new physician join our clinic who would like to be involved in this initiative and sign the agreement?

The circumstances under which a new physician joins a clinic and the implications for attachment, can vary significantly from case to case. If a new physician is joining your clinic and you would like to have him or her involved in this arrangement, please contact your RHA contact for the ITDI initiative to discuss the circumstances. If all parties agree, an amendment will be made to the Agreement to include the new physician under terms that respect the intent of the Agreement.

Q6. How will the Interprofessional Team Demonstration Initiative be evaluated?

Because this is a Demonstration Initiative, it is important to evaluate and learn from the process and results. This information will help participating clinics, the region and Manitoba Health to identify what worked well and what should be changed in future such arrangements. The following summarizes key evaluation goals and data sources.

Evaluation Key Goal	Data Source
Implementation	ITDI Agreements Participant Surveys ITDI Expressions of Interest
Attachment	EMR Medical Claims

Evaluation Key Goal	Data Source
Continuity and Service Utilization	EMR Medical Claims
Accessible Care	Third Next Available Appointment (to be determined) EMR
Appropriate Care	EMR (existing primary care indicators)
Efficiency	EMR Medical Claims Payments made by Manitoba Health Clinic Change Log (supervision time where applicable)
Provider Experience (Physician and Interprofessional Team Member)	Provider interview/focus group or survey EMR data
Integration	Patient Survey
Patient Centricity	Patient Survey

Q7. What are the Interprofessional Team Member's contracted hours of work?

The maximum hours of work are informed by Manitoba Labour Agreements and/or union contracts. The assignment of working hours is negotiated and agreed upon between the Interprofessional Team member and the site. The RHA will ensure that the site is aware of the expected hours of work based on the team member's affiliated collective agreement.

Q8. Who approves the Interprofessional Team members vacation/sick days?

The Interprofessional Team member's vacation/sick time is informed by the provider's associated collective agreement. For questions on this, please contact the RHA contact for ITDI.

Q9. Who should we contact if we would like to discuss any issues relating to our Interprofessional Team member?

If you would like to discuss matters that are clinical in nature, you should contact the Primary Care representative from your health region who is overseeing ITDI to discuss the circumstances.

Q10. How will the billing work? Who can and can't the physicians bill for? What if the Interprofessional Team Member sees the patient but wants to consult with their supervising physician? Is that then a billable patient/service?

Two key objectives of the introduction of interprofessional teams are to improve access to continuous care (attachment) and to enhance work-life balance for physicians. It would run

counter to both these objectives for both the physician and the Interprofessional Team Member to see each patient at every visit.

Manitoba Health understands that in some cases there will be a clinical need for the physician to see a patient who has also been seen by the Interprofessional Team Member during the same visit to the clinic. When this is the case, it is expected that the physician will bill for seeing the patient. However, part of the evaluation of the initiative will include reviewing how often this occurs across all physicians and clinics, as it may impact the efficiency of the initiative.

According to Manitoba Health's Fee-for-Service/Insured Benefits experts on this topic, the following guidance has been provided:

- Physicians may only submit claims for services they personally rendered and cannot submit claims for services rendered by a Physician Assistant.
- Physicians may only submit claims for services rendered in accordance with the terms and conditions of the Physician's Manual.
- The terms and conditions of the Physician's Manual must be relied upon by physicians in determining the appropriate tariff to bill.
- Physicians must maintain documentation of patient care sufficient to substantiate any claims submitted in relation to services provided to the patient.
- There are no tariffs in the Physician's Manual for supervision/training of a PA or nurse, phone consultations with a PA/nurse, or review of patient charts in relation to the patient care provided by a PA/nurse.

With regard to the last bullet, the only funding contributions available to address these activities are the Stipend and Variable Payment provided for in the Interprofessional Team Demonstration Initiative Agreement.

Q11. How will Interprofessional Teams be supported?

Relevant team development resources (such as interprofessional collaborative practice sessions/facilitation) may be accessible to the practice at no cost. Please contact your RHA contact for ITDI to be connected with the appropriate resource.

Q12. How do we share one interprofessional team member among all of our physicians in our group?

The implementation of an Interprofessional Team Member will be a unique process in each clinic and will be addressed on a case-by-case basis. Relevant regional resources may be available (such as interprofessional collaborative practice sessions/facilitation) and may be accessible to the practice at no cost. Please contact your RHA contact for ITDI to be connected with the appropriate resource.

The number of physicians that can be supported by one Interprofessional team member is dependent on various factors such as the team member's profession, scope of practice, their intended role and function within the clinic team and the physicians' practice style. Please contact your RHA representative to discuss your clinic's questions and concerns in this regard.

Q13. Who covers the cost of the team building/orientation sessions that are necessary in order to change the practice dynamics?

There are no additional payments or reimbursements available beyond the stipend and variable payment described in the Agreement. The stipend for the first year is higher than for subsequent years, reflecting the extra time that will be required from the practice in initial orientation and team-building. Relevant regional resources (such as Collaborative Practice facilitation) may be accessible to the practice at no cost to assist with team building and orientation.

Q14. What happens if the new provider doesn't work out well in my practice? Is there a "friendly uncontested separation clause" in the Agreement?

Yes; Section 12.1 of the Agreement states that "any party may terminate this Agreement prior to the end of its normal term, provided that it sends the other parties written notice ninety (90) days in advance of the termination date." As the Interprofessional Team member is an employee of the RHA, the region assumes responsibility for the employee as stated in section 4.0 of the Agreement for Funding and Participation Contract.

Q15. What happens to the newly attached patients if the Interprofessional Team member leaves my practice?

As indicated in section 4.0 of the Agreement, if the Interprofessional Team Member leaves the practice, the region will work collaboratively with the practice to recruit as quickly as possible to find a suitable replacement. If this occurs, the clinic is still eligible to receive the variable payment for maintaining the net increase in attachment while waiting for the Interprofessional Team Member to be replaced. The clinic also has the option of terminating the Agreement, as per the answer to the previous question.

Q16. What happens after the end of the 3 year (36 month) agreement period?

This initiative is part of the broader goal of renewing Primary Care in Manitoba. Manitoba Health and the Region intend to continue to support interprofessional practice. However, before the expiry of these agreements, an evaluation of this particular approach to staffing and funding of interprofessional practice will be undertaken to determine whether it should be continued or a different approach explored. Therefore, it is possible that clinics will have the option to sign a new agreement, associated with a new arrangement; but it is also possible that a decision will be made to continue the current arrangement and to offer extension of the existing agreement.

INTERPROFESSIONAL TEAM DEMONSTRATION INITIATIVE – DATA AND MEASUREMENT FAQS

The Interprofessional Team Demonstration Initiative requires good data management and measurement to inform payment and evaluation. There are several measurement activities that will occur within the agreement timeframe, the most important one being the measurement of the net change in attachment over time. This is in keeping with one of the key objectives of the Manitoba government, that all residents will have access to a family doctor by 2015. The following questions will help in explaining this process further.

Q1. What is "Attachment"?

Attachment refers to the existence of an ongoing care relationship between a provider/clinic and a patient, where the provider sees himself/herself as the "regular" or provider "most responsible" for that patient's primary care.

Currently the best strategy available to determine 'attachment' involves looking for credible evidence of an ongoing care relationship. Such evidence may exist in:

- A clinic's EMR data, as long as the clinic has established a practice of recording patients who receive ongoing care and distinguishing them from "one off" or episodic care; and
- Medical claims data.

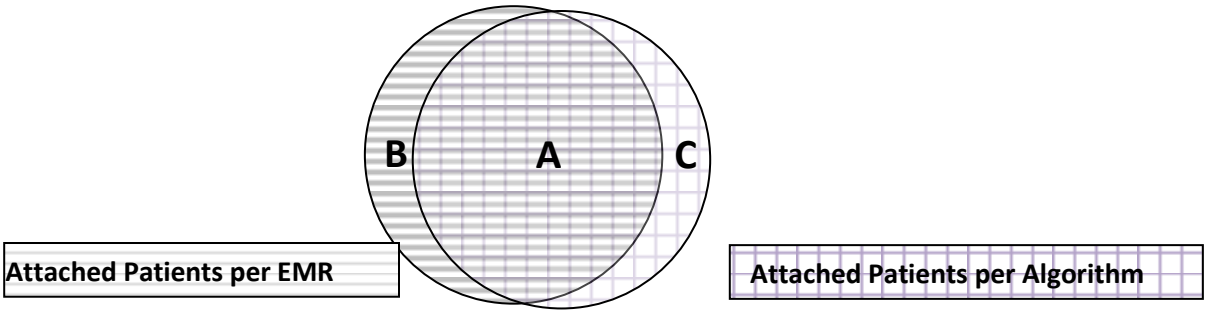
Q2. How is "Net Change in Attachment" measured?

1. Measuring Baseline attachment.

The first step is to measure the number of patients attached to the physicians involved in this arrangement BEFORE the interprofessional team member joins the clinic. This measurement is called the "Baseline attachment" or "Baseline list of patients".

To measure the Baseline, both the clinic's EMR data and medical claims data are used. A Four-Step Continuity of Care Algorithm is applied to the medical claims data to detect evidence of attachment. These two sets of information – the EMR data and the Algorithm results - are then compared, as follows.

The set of patients assigned in the EMR to one of the physicians participating in the ITDI agreement is compared to the set of patients who appear attached to those physicians according to the Four Step Algorithm:



Patients who appear in both sets (A) are automatically considered to be attached. Patients indicated as attached in the EMR data but not the Algorithm (B) are considered to be attached unless the clinic identifies a data error in their EMR. Patients identified as attached only by the Algorithm are discussed between Manitoba Health and the clinic; they will be considered attached unless there is a good rationale for excluding them.

Once this discussion has concluded, the Baseline list of attached patients is recorded and used in all measurements of Net Change in Attachment. This change is measured at regular intervals by comparing a new list of attached patients to the Baseline.

1. Measuring Net Change in Attachment subsequent to the Baseline

Attachment is measured again at the end of each agreement year (for payment purposes) and on a quarterly basis (for information only). All measurements of attachment after the Baseline measurement will normally use only the EMR data, so it is vital that clinics record new attached patients in their EMR accurately, or the clinic may not receive proper credit for these patients. Provision of regular EMR extracts is a requirement of participation in this initiative.

It is important to note that clinics may have agreed to pilot patient enrolment (PIN clinics) or might voluntarily choose to record new patients as "enrolled". Enrolled patients will be detected and counted in measurements of attachment based on the EMR data. However, clinics should only record patients as enrolled if there has been an explicit conversation with the patient and an agreement to an ongoing "most responsible" provider/clinic relationship. For more information on how to record patients as "enrolled" contact Michelle O'Keefe, Primary Health Care, Manitoba Health, Healthy Living & Seniors, at 204-788-6391 or Michelle.O'Keefe@gov.mb.ca.

When net change in attachment is measured subsequent to the baseline:

- The patients in the Baseline list are checked to see if they are still shown as attached or enrolled in the new EMR extract. If not (ex: because they have died, left the province or joined another clinic) they will be subtracted from the number of patients in the Baseline list.
- Newly attached or enrolled patients will be added to the new count of attached patients, provided that they have had at least one visit to the clinic since the Effective Date and are not also attached to another clinic.
- The net change in attachment is then calculated as:
    - Number of patients in the Baseline list
    - *Minus* number removed since the Baseline
    - *Plus* number of new patients added who have had at least one visit since the Effective Date and are not attached to another clinic.

Q3. How does the Four Step Continuity of Care Algorithm work?

Manitoba Health Information Management scans medical claims data to identify four types of evidence of attachment:

Step 1: Patients who received 100 per cent of their primary care visits to your group of providers over the most recent three year period. A minimum of three primary care visits over the three year period is required to count the patient as attached to this group of providers.

Step 2: Patients for whom a physician within your group of providers was the only Chronic Disease Management Tariff claimant for this patient in the last year.

Step 3: Patients who received the majority (> 50%) of their primary care visits in the past three years from your group of providers and for whom one of your providers performed a complete physical exam within the period. A minimum of three primary care visits over the three year period is required.

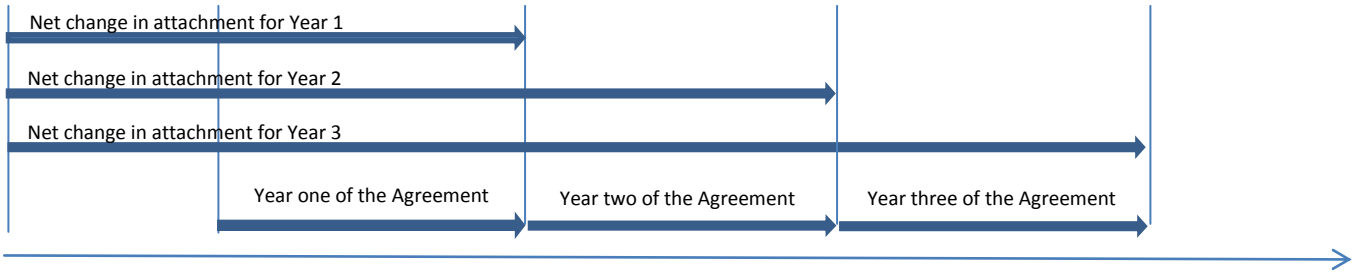
Step 4: Patients who received the majority of their total primary care visits (> 50%) from your group of providers over the most recent three year period. A minimum of three primary care visits over the three year period is required.

Note: Because the algorithm looks back three years, its value may be limited where the clinic has been open less than three years, a physician has been practicing less than three years or a physician has recently joined the clinic. Validity of the algorithm will be reviewed on a case-by-case basis in these situations.

Q4. When is attachment calculated?

Baseline measurement of attachment is done just before the Interprofessional Team Member joins the clinic. Thereafter, the Net Change in Attachment is calculated at the end

of each Agreement Year to determine the Variable Payment for that year. The Net Change in Attachment will also be calculated, for informational purposes only, and reported to the clinic at the end of each quarter of each agreement year. Please refer to Appendix 1, section 1.2.2. of the Agreement. Below is an example timeline to show how this process works:



Baseline Date: The date the Baseline Attachment is calculated by MB Health	**Agreement Effective Date:** The Date the Agreement is effective (generally the date the Agreement is signed by the clinic)	**End of Agreement Year 1:** One year after the Effective Date, net change in attachment is calculated (attachment at one year – baseline attachment = net change). This number determines the variable payment amount the clinic will receive for the first year.	**End of Agreement Year 2:** Two years after the Effective Date, net change in attachment is calculated (attachment at two years – baseline attachment = net change). This number determines the variable payment amount the clinic will receive for the second year.	**End of Agreement Year 3:** Three years after the Effective Date, net change in attachment is calculated (attachment at three years – baseline attachment = net change). This number determines the variable payment amount the clinic will receive for the third year.

Q5. How do you calculate attachment if there are multiple interprofessional Agreements and Providers at the same site?

Generally, a provider will only be involved in one Interprofessional Agreement. Since attachment can be measured for each individual provider, it will not be difficult to attribute changes in attachment to each specific ITDI Agreement. This is further explained in appendix 3, point 5 of the Agreement.

Q6. If I have signed both an ITDI Agreement and a My Health Team (MyHT) Agreement (previously known as the Primary Care Network Agreement), are newly attached patients allocated to both initiatives?

Net change in attachment can only be allocated to one of the Agreements; either the ITDI agreement or the MyHT agreement. The net change in attachment is calculated once each period, regardless of whether the clinic is participating in one or both initiatives; then, if the clinic is participating in both, a method is needed to attribute some portion of the net change to ITDI and some portion to MyHT. Unless all parties to the ITDI Agreement agree in writing to another method, the default method for attributing net change in attachment will be as follows (taken from Appendix 3 of the Agreement):

- (Hours provided to the Clinic by ITM / Total Hours provided to the Clinic by ITM and all MyHT provider resources) x 100 = Percentage of the total increase in attachment attributed to the ITM for this Agreement
- (Hours provided to the Clinic by all MyHT provider resources / Total Hours provided to the Clinic by ITM and all MyHT provider resources) x 100 = Percentage of the total increase in attachment attributed to all MyHT provider resources for the MyHT
- The percentage of professional services provided to the Clinic by the Interprofessional Team Member and the percentage of professional services provided to the Clinic by shared MyHT provider resources will each be calculated based on the number of hours of service provided by these resources to the Clinic for the Year. For example, if the ITM provided 2080 hours to the Clinic for the Year and all MyHT provider resources collectively provided 520 hours to the Clinic for the Year, then 80% (2080/2600) of the Net Change in Attachment would be attributed to ITDI and 20% (520/2600) would be attributed to MyHT.
- The information on the number of hours provided to the Clinic by all shared MyHT provider resources and the ITM will be recorded weekly and taken from the MyHT event log and the ITDI event log.

Q7. What is the difference between a Patient Profile and the Baseline Attachment?

At one of the initial clinic meetings, the region will provide both a Patient Profile and Baseline Attachment information. These are two sets of clinic data designed for related but different purposes.

	Patient Profile	Baseline Attachment
Purpose	To help clinics determine which type of interprofessional team member (which profession) would be most helpful, considering the clinic's mix of patients.	To help determine Baseline attachment for measurement purposes, as described above.
Timeframe on which data is based	Past 18 months	Past 36 months
Patients Included	Every discrete patient who was seen in the past 18 months.	Every patient indicated as attached in either the EMR, the medical claims data or both.
Other data	Patient characteristics such as	Whether patient is attached only

	Patient Profile	Baseline Attachment
	age groups, gender, community area/region of residence, number of chronic conditions reported	in EMR, only in medical claims or both. Which Algorithm step patient is included in (See Q3 above for explanation of steps)

Q8. How will the Interprofessional Team Demonstration Initiative be evaluated?

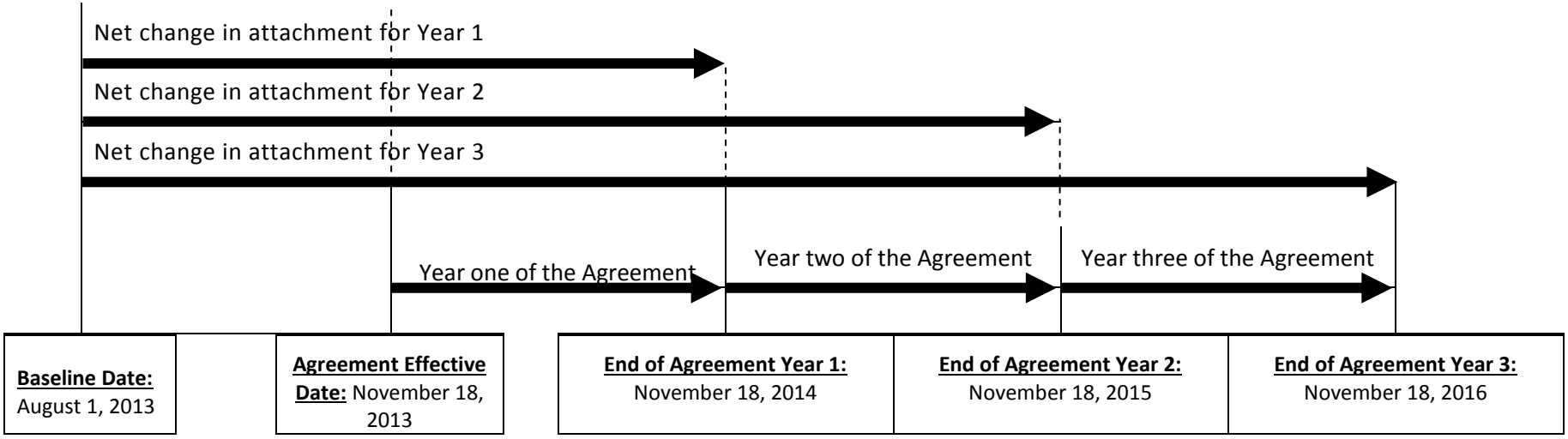
Because this is a Demonstration Initiative, it is important to evaluate and learn from the process and results. This information will help participating clinics, the region and Manitoba Health to decide what worked well and what should be changed in future arrangements. The following summarizes key evaluation goals and data sources.

Evaluation Key Goal	Data Source
Implementation	ITDI Agreements Participant Surveys ITDI Expressions of Interest
Attachment	EMR Medical Claims
Continuity and Service Utilization	EMR Medical Claims
Accessible Care	Third Next Available Appointment (to be determined) EMR
Appropriate Care	EMR (existing primary care indicators)
Efficiency	EMR Medical Claims Payments made by Manitoba Health Clinic Change Log (supervision time where applicable)
Provider Experience (Physician and Interprofessional Team Member)	Provider interview/focus group or survey EMR data
Integration	Patient Survey
Patient Centricity	Patient Survey

Q9. If we would like to discuss any issues relating to our clinic's data, who should we contact?

For any questions relating to your clinic's data, please contact Michelle O'Keefe, Primary Health Care, Manitoba Health, Healthy Living & Seniors, at 204-788-6391 or Michelle.O'Keefe@gov.mb.ca.

CLINIC ITDI AGREEMENT TIMELINE



November 18 of each year: Determination of Variable Payment based on net change in attachment

Interprofessional Team Demonstration Initiative: Quarterly Attachment Report

Date of Report:

Issued by: Manitoba Health (MHHLS)

Clinic Information	**Clinic Name:**	
	Physicians Included in the Agreement:	
	Interprofessional Team Member Role:	
Original Baseline	**Data used in the baseline**	
	Baseline attachment date	
	Baseline attachment #	
Previous Quarter	**Date of last report**	
	Attachment count of last report	
	Net change in attachment on last report	
Current Quarter	**Data used in this count**	
	Date of measurement	
	Current count	
	Losses since last report	
	Net change in attachment *(current count – losses - baseline attachment #)*	

INTERPROFESSIONAL CLINIC CHANGE CHECKLIST

Instructions: The purpose of this checklist is to document any changes in either the services or organization of the clinic. Any change can have a direct impact on the interprofessional practice. The checklist should be filled out monthly by the clinic representative.

Date of Survey:	
Site:	
Physician(s):	
IP Provider:	

	Type of Change		Check if Yes	Date of Change	Description/ Details/comments
1. Changes within the Clinic	***Service Changes***	New services offered			
		Services expanded			
		Existing services restricted			
		Existing services closed			
		Changes in clinic hours			
		Changes in types of patients seen			
		Other			
		No Changes			
	Staffing Changes	Vacant position (other IP team members)			
		New IP team position created			
		Turnover (new staff person added, existing position)			
		Other			
		No Changes			
2. Changes in the practice or role of the interprofessional provider		Changes in scope of practice of IP or role change			
		Changes in scope of practice of other IP team members or role change			
		Patient Acceptance			
		IP performance issues (positive or negative)			
		Staff / stakeholder acceptance			
		Other			
		No changes			
3. Changes with PA Supervision		Initial physician stopped supervising PA			
		New physician supervising PA			
		Other			
		No Changes			

TEMPLATE FOR ADDING A PHYSICIAN TO EXISTING ITDI AGREEMENT

Date: xxxxx

Lead Physician Name
Clinic Name
Clinic Address

Re: ITDI Agreement between Manitoba Health, WRHA and XXXX Clinic

To Whom It May Concern:

This letter is to inform all parties of our intent to have Dr. xxxxx added to our existing ITDI agreement. Should there be no objection from the other parties to the Agreement, the proposed effective date for this addition is (date).

The baseline attachment of (insert baseline number) for (name of physician) will be added to this clinic's original baseline for the purposes of determining the net gain in attachment.

Clinic's original baseline:
New physician's baseline:
New Clinic Baseline:

Sincerely,

Lead Physician named on agreement

Note: this must be sent to MB Health and to WRHA, along with a confirmation letter from the new physician (template for this below)

TEMPLATE FOR CONFIRMATION LETTER FROM PHYSICIAN

Date: xxxxx

Name of Physician
Name of Clinic
Clinic Address

Re: ITDI Agreement between Manitoba Health, WRHA and XXXX Clinic

To Whom It May Concern:

This letter is to confirm my desire to be added to the Interprofessional Team Demonstration Initiative agreement between Manitoba Health, Winnipeg Regional Health Authority, and xxxx Clinic, effective (date).

Sincerely,

Name of physician

TEMPLATE FOR REMOVING A PHYSICIAN FROM AN EXISTING ITDI AGREEMENT

Date: xxxxx

Physician Name
Clinic Name
Clinic Address

Re: ITDI Agreement between Manitoba Health, XXXXRHA and XXXX Clinic

To Whom It May Concern:

This letter is to inform all parties of my intent to be removed as a Participating Physician from the Interprofessional Team Demonstration Initiative agreement with XXXX Clinic, as of (date). Please consider this letter as an amendment to the agreement.

Sincerely,

Name of Physician

Note: This must be written by the physician who intends to no longer participate. A copy of this letter must be sent to the clinic, MB Health and to Region.

PREPARING YOUR SITE/PRACTICE TO WELCOME A NEW INTERPROFESSIONAL TEAM MEMBER

Once you have decided to have a new Interprofessional (IP) member join your team, there are several things that you can do to ensure that your clinic is prepared before that person starts.

1. ***Develop a process and structure to lead implementation*** of the new role, and make sure that all key staff members are involved. In a small practice it may be appropriate for all staff members to be involved in planning. In a larger practice, it may be more effective to identify a core group (representing various professional and service areas). Decide what structure will support this collaboration. Is it a steering committee that meets every two weeks on Friday afternoon? What are the roles and responsibilities this group will take on?
2. ***Develop a welcome and orientation plan for your new IP.*** This includes: clinic processes, site layout, location of supplies, explanation of the roles of the other team members, etc.
3. ***Address space and infrastructure (ex: computer) issues.*** Space may be at a premium, but the new professional will need both clinical and administrative space. Also, identify any supply needs such as computer, pager, or phone.
4. ***Organize your operation to accommodate the anticipated increase in patient flow.*** Be aware that addition of an IP role will create additional demands for administrative support (additional resources may be needed), as well as increased supplies, storage space, etc.
5. ***Develop and implement a strategy for patient education and notification.***

   It is important to have a plan in place for informing your patients about the planned change in your practice before your IP arrives: experienced sites note that appropriate preparation increases patient acceptance. Some suggestions that others have found helpful include:

   - *Provide written information on the role of the IP*
   - *Place welcoming signs and photos in reception areas, introducing the new IP*
   - *Make sure that front desk staff have the orientation and information they need to explain the IP's role and make appropriate appointments.*
   - *Personally introduce the IP to the patient for the first contact. Explain the role, how the IP works with you, the benefits to the patient of this new arrangement (ex: reduced wait times for appointments) and the fact that the physician will continue to be overseeing care.*
   - *Make sure that the IP is never presented as "second-best" care, but part of a strategy of interprofessional care designed to increase patient access.*
6. ***Identify and develop a strategy for notifying your stakeholders.*** Experienced sites have found that much inefficiency and confusion can be avoided if those in referral/consultant roles are educated about the IP role within your practice. Especially important are a) pharmacists, and b) laboratory and imaging services. Depending on your practice, there may be other sectors that also need to be informed. One proactive strategy used by other practices is the delivery of a personal letter to local pharmacies and labs with which you have a working relationship.
7. ***Collaboratively develop a monitoring trouble shooting plan.*** No matter how much thought and attention has been put into planning for the introduction of this new role, there will be unanticipated challenges. Having a plan for monitoring and responding to these challenges will make it easier to respond to unforeseen events.

COLLABORATIVE CARE COMPETENCIES

Interprofessional collaboration has been described as a…" process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided". *(Way, Jones & Busing, 2000)*

The Canadian Interprofessional Health Collaborative has developed a national competency framework that describes the competencies necessary for effective interprofessional collaboration.

I. PERSON-CENTRED CARE

Each person is the expert in their own health experience. Health providers recognize people are at the center of their health-care story. A person's family members can also provide valuable insight into a person's health.

II. ROLE CLARIFICATION

When creating their own roles, health providers also consider the roles of others as part of the larger health-care team. Along with understanding and describing their own roles, health providers are able to describe the roles of other health providers.

This understanding helps avoid duplication and gaps in service. In turn this improves teamwork, frees time for health providers to work to their full scope of practice and ensures more effective planning, implementation and evaluation services.

III. INTERPROFESSIONAL COMMUNICATION

Interprofessional communication occurs when health providers communicate with each other, with people and their families in an open, collaborative and responsible manner. This type of communication builds trust and understanding.

An environment of mutual respect is essential for Interprofessional communication. Respectful Interprofessional communication hinges on transparent, honest interaction. Respect helps to facilitate a positive environment in which to set shared goals, create collaborative plans, make decisions and share responsibilities.

How I Collaborate:

I seek to know the experience of those I care for, respect and strive to understand their needs, and work with them to develop their care plans that acknowledge their choices.

I understand when knowledge and skills are unique and when they are shared amongst team members. I use this information to design and implement health-care plans that best meet people's needs, maximize each health provider's time and distributes the workload more appropriately among team members.

I ask questions, communicate to be understood, seek input and listen respectfully to generate options for care. I make time for communication with other health providers.

I share leadership with people receiving care and/or the leadership is shared amongst the health providers.

I actively engage in addressing disagreements and responding to all types of conflict. I acknowledge that different perspectives, philosophies, beliefs, areas of expertise can contribute to conflict. I create a safe environment where differing opinions are welcome.

IV. COLLABORATIVE LEADERSHIP

Leadership roles are based in the need for a specific expertise at any given point in time. In collaborative leadership, people receiving care can be leaders or the leadership can be shared amongst the health providers.

Collaborative leadership involves sharing accountability for team process and improved outcomes among all team members including the person receiving the care. Collaborative leaders must balance taking control with encouraging leadership roles to emerge.

V. INTERPROFESSIONAL CONFLICT RESOLUTION

Acknowledge that different professional perspectives (which may involve differing philosophies, beliefs and areas of expertise) can contribute to role ambiguity, role overload and goal differences. However, it is the richness of the diversity of perspectives that can bring health teams to better solutions and outcomes.

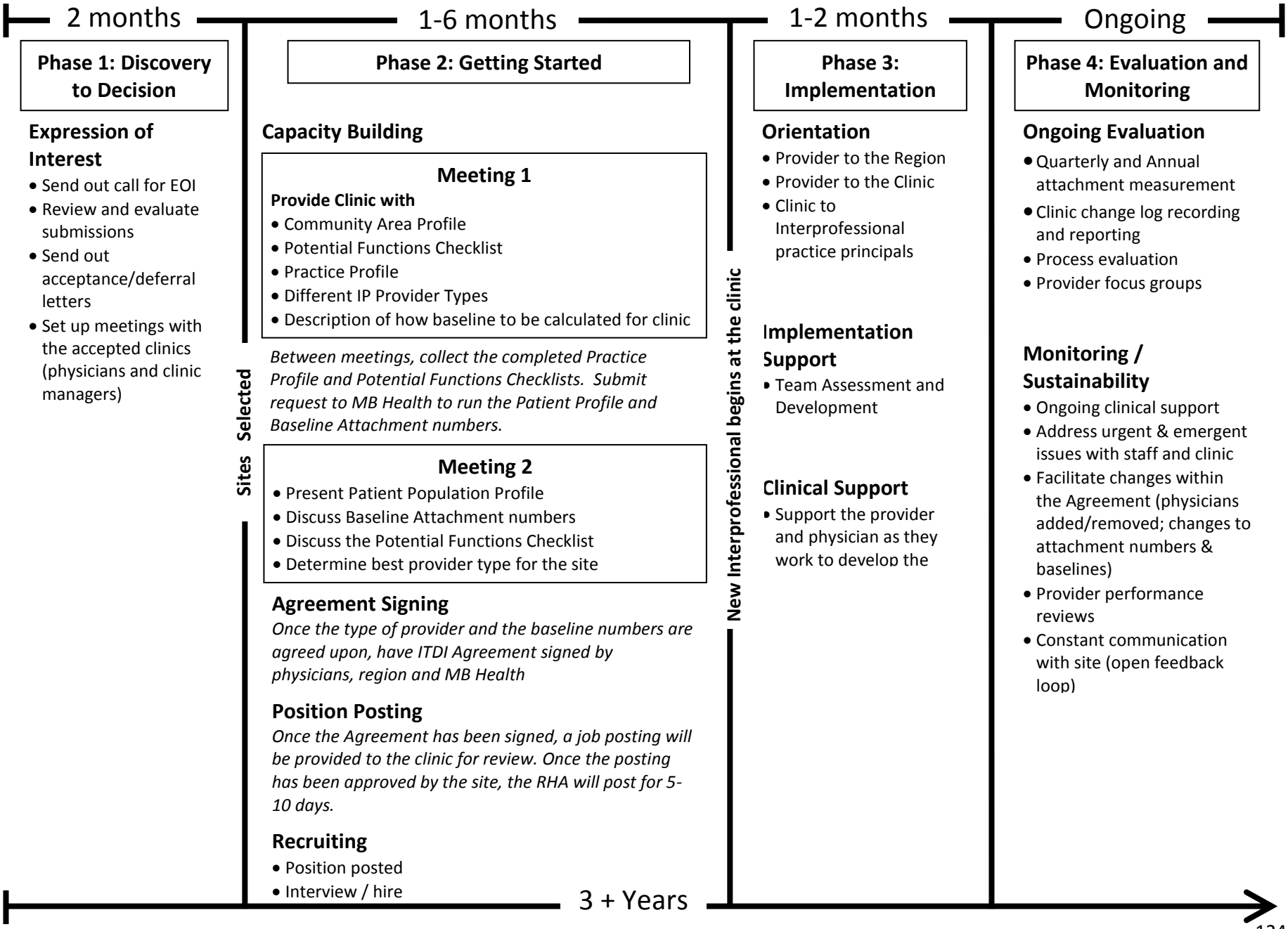
A conflict positive perspective incorporates the idea that differences are a part of a healthy, constructive interaction. In being self-accountable when conflict arises, health providers can aim to address and/or resolve the conflict, which creates healthier environments for everyone and improved outcomes for the patient.

VI. TEAM FUNCTIONING

Refers to the degree to which the team has become a cohesive unit with mutually supportive working relationships involving all team members.

I value and practice trust, mutual respect, availability, open communication and attentive listening. I promote safe and effective working relationships with every member of the health-care team to ensure the people I serve receive the maximum benefit from the team's collective expertise.

ITDI TIMLINE GRAPHIC



MANITOBA HEALTH ATTACHMENT ALGORITHM

Creation of Patient List

The patient list provided was created using the Manitoba Health Physician Claims Administrative database. The database contains all claims submitted to Manitoba Health by individual physicians for services they provide.

Focusing on primary care visits contained in this database, the following four step process was used to create a list of individuals that are identified as regular patients for your group of providers.

An individual is included in your patient list if they meet the criteria in at least one of the following four steps:

Step 1:

A patient who receives 100% of their total primary care visits to your group of providers over the most recent three year period. A minimum of three primary care visits over the three year period is required.

Step 2:

A physician within your group of providers is the only Chronic Disease Management claimant in the last year for the patient. No minimum number of visits is required.

Step 3:

The individual receives the majority of their total primary care visits (> 50%) from your group of providers plus one of your providers also performed a complete physical on the individual over the most recent three year period. A minimum of three primary care visits over the three year period is required.

Step 4:

The individual receives the majority of their total primary care visits (> 50%) from your group of providers over the most recent three year period. A minimum of three primary care visits over the three year period is required.

Getting EMR Submissions Started with Non-Adoption Clinics:

******This process can take up to 2 weeks to complete******

1. Region to ensure the clinic is aware that the ITDI agreement identifies regular reporting via EMR data extracts as required, and that MHHLS will analyze the submitted information for the purposes of the ITDI baseline.
2. A clinic representative must email the Region stating that they are knowingly sending an extract and agree to its use for the purpose of developing a baseline for the ITDI.
3. Once email authorization is received, it is forwarded to the following at MHHLS:
    - Michelle O'Keefe (MHHLS)
    - Lindsay Storie (MHHLS)
    - Colleen Witwicki (PCIS)
4. Region to contact PCIS (Colleen) to obtain a clinic site ID number (four digits)
5. Each clinic must then identify their private IT company and contact person (for Jonoke sites, it is currently Nathan). Colleen (PCIS) will have the PCIS technical lead contact the clinics private IT representative to set up the cloverleaf courier on the clinics EMR, which will enable the transfer of information to MHHLS.
    a. There may be some cost to the clinic for installing the cloverleaf, as it may be through hard copy CD/DVD.
        i. Obtaining the software to install may take up to two weeks to receive.
        ii. The installation process takes 15-20 minutes.
6. If this is a SWEP site then clinic must inform the Region & PCIS, as SWEP has the cloverleaf on their server, but cannot submit EMR extracts to MHHLS.
7. Once the cloverleaf courier is installed and the clinic has an ID number, the site needs to contact their EMR Vendor (QHR or other) to turn on the data extract module, map the extract to their current EMR configuration and assist with their first submission. The vendor needs to be involved in the first extract to set up the courier and map the data to the report.
8. Once this is all set up, actually sending the EMR extract to MHHLS involves 3 clicks.