South West Primary Care Alliance

Wednesday, August 15, 2018
1:30 – 2:30 pm
Location: **St. Thomas Elgin General Hospital**
Room R-40
189 Elm Street, St. Thomas

Minutes

√	Anusha Perera	√	Anne-Pascale Bartleman	√	Elsie Osagie	√	Jillian Toogood
x	Joyce Lock	x	Kate Underhill	√	Kelly Jones	√	Kristin Richter
x	Laura Van Dam	x	Michael Fernando	x	Rick Goodhew	√	Stephanie Johnston
√	Tracy Nancekivell	√	Kellie Scott	x	Melissa Tenbergen	√	Alexa Attard
√	Jessica Johnston					√	Frank Rubini

Item	Topic
	Welcome and Introductions Melissa Tenbergen. is my Co-Chair but she was not available today The LHIN is not currently able to provide food for meetings. This meeting was scheduled immediately after Primary Care Rounds which have lunch provided and this was felt to be a good time for many people.
1.	Update on **Elgin SRIT** meetings: • Primary Care meets with the other sectors, LTC, MH, PH, CSS • At our last two SRIT meetings, we determined we have patients in the healthcare system who may not be in the right place, maybe they needed long term care but no longer do, and can't afford LTC. • We had a workshop around transitions of care, Home to LTC, Hospital to LTC and Hospital to Home, we spent the time mapping out strategies • We are following up with those that came out and creating task groups • recommend Discharge summaries, going to LTC from hospital • Our Aug meeting focused on MH, the program never seems to fit the person you have in front of you. • CMHA now has a supervisor appointed • Peer supports are looking at the seriously mentally ill and trying to improve that. • The Elgin MH&A Network did not previously include Primary Care and we are reorganizing to include Primary Care. A navigation system will find the type of care your patient requires. The need the feedback of Primary Care so that it works well. • Elgin only has two priorities and other SRITs have 3 to 5
2.	Update on **CPSO Continuity of Care Guidelines** and Elgin response: • At our last meeting we talked about the CPSO Continuity of Care Policy, this will affect NPs indirectly but feedback is sought from MDs to CPSO • They outline that family doctors or referring physician should provide the details for the patient appointment and details where to park etc. for an appointment that we are not booking. Melissa and I drafted a letter and if you want suggested changes we can add your name to it, so that the document is collective.

	If you ask the average patient they think they will get a call from the specialist rather than the referring physician and there is multiple back and forth. The OMA has done a draft policy concurring with what we are feeling on this There is some support from specialists who also feel they should be doing notifications **ACTION: Kellie will circulate the draft letter with the minutes, please advise if you would like to add your name in support.**
3.	Feedback on new **IV Antibiotics Orde**r Form for patients receiving IV Antibiotics in the community: • Dr. Louise Moist, Nephrologist and the LHIN Internal Medicine Clinical Lead and Dr. Sameer Elsayed Infectious Diseases are working on this new IV Antibiotic order form, they would like to ask this group for their input • This would allow patients to get their IV antibiotics at home rather than through hospital visits • Questions: • What is the turnaround time for the order form? • Some didn't know that you could order IV antibiotics in the community - the patient needs to meet the criteria for receiving their IV antibiotic at home • they have not provided the dosage for renal antibiotics – often this causes back and forth with pharmacies – would be nice to have this on the form when prescribing • is the form the prescription? Are we also sending to pharmacy • Do we have to do a home care referral, do we fax to home care and they forward to pharmacy? • Does the patient need to pay for their IV antibiotics? **ACTION: Kellie will forward this feedback on to the team working on the form and will circulate the final version in PDF and Telus EMR form when available.**
4.	**Antibiotic Prophylaxis for Dental Procedures:** • Consistently get requests for Antibiotic prophylaxis or the dental surgery will be cancelled, Also for patients who've had orthopedic joint replacements • there is evidence that there is no need for antibiotics and their own associations have a joint statement • would it be helpful to circulate to physicians so that you can send back the evidence noting it is is not needed • If the dentist or orthopedic surgeon feels they need it, they can prescribe it but this is often downloaded to primary care • Maybe we should also need to inform our receptionists? So consistent messaging is given when patients call. • Put up posters in physician office and dentist offices as patients have often been told for years they must have this and this is challenging for us to say no to them. **ACTION: Kellie will communicate this with Orthopods and with the Dental Association for Elgin, also share with your front line staff talking to the patient. Kellie will forward feedback on to Antibiotic Stewardship group to see about posters/advocacy at hospital level.**
5.	New processes for **Diabetic Foot Ulcers**: • Defer the new process to the next meeting • There was some funding for off-loading devices, boots to allow the wound to heal. There is a screening algorithm so that you can identify if your patient is high/medium/low risk and this will go to H&CC and then go to the Wound Care team • In Elgin we do not currently have a wound care provider? • There is one in West Elgin and is not close enough to St. Thomas

	• I have heard that they do not have an ENT **ACTION: Kellie will follow up with HCC Director for Elgin to see if it is accurate that there is currently no wound care nurse and advise the group. Next meeting the team will present the new process.**
6.	Palliative Care **Supports in Elgin for you and your patients:** • The Palliative Care outreach team started a couple of years ago. Now the patient can see their own physician for palliative care. We have NPs who can go the patients home. You do not need to use the NPs, the Palliative Care team has dieticians, spiritual supports and care coordinators as well. Most patients will have a Coordinated Care Plan. • Initially most physicians were referring their patient to PCOT, but now 80-85% of physicians are continuing to care for their patient as MRP with the added support of the PCOT team and on-call support.
7.	**Outside Use Billing** on hospitalized patients: • there are certain codes that the hospital is billing that negates the Primary Care billing in FHO models • Kellie Scott &. Mike Toth met with the Chief of Staff and they acknowledged that they are having issues in the billing department, shortage of staff/staff turnover, there were billing for the past six months at once which may have led to a large hit to access bonuses • We provided a list of our codes to the hospitalists and alternatives to bill that do not hit access bonus. • There is also advocacy to OMA for negotiation between OMA and the Ministry, taking it out of the basket of codes or having a separate code for Hospitalist physicians to use • our colleagues are not trying to steal our money and they should be paid for the services they are providing, but we wanted them to know there is an alternative way to bill that would impact us less financially
8.	Additional Topic – **Denial of referrals based on geography**. Patients are being denied access to facilities that are not in their home location: • The MOH states that no patient should be denied access because of where they live, the MH trauma program rejected two of our referrals recently because they only see patients who live in L/M, no similar program exists in Elgin • The Clnical Leads have brought this forward to the LHIN senior leadership and it is being addressed at several levels – LM Clinical Leadis talking to London Chief of outpatient Psychiatry and CEO level discussions as well. • This seems to be most common in mental health, likely due to capacity issues but we'd like help to identify any other types of referrals being rejected on basis of geography. **ACTION: for All, if you get a referral turned down because of geography let me know, we need to show them explicit examples (ask if patient is ok with sharing specific patient information to help with this)** • This discussion led to discussion about **Mental Health** in general: • Child and adolescent MH referrals are available through Welkin • CMHA through the OTN Hub. There has to be someone there present with the patient, if we have a place where we can refer someone, it could be scheduled shift for someone to be covering the OTN • That is something we can talk to with our CHCs? There is an OTN room here at the hospital. Maybe we can talk to our Chief of Psychiatry here? • Discussion about when we refer to psychiatry - when I get the impression that the patient needs a psychiatrist, you need diagnostic clarity, most in the room said they do not refer for regular anxiety or mild depression, maybe some do? • When you deal with our Chief of Psychiatry on the phone he is really good and he was going to set himself up in eConsult

	• You sign up for eConsult through OTN and ask specialists questions this way (without the patient being seen). Contact shelley.brown@ontariomd.com • have a regularly scheduled session, i.e. over lunch – they do this at EEFHT in Aylmer using sessionals, and use them more creatively and find the psychiatrist who is good at the teaching part – helps increase skill of primary care so referrals not needed in future • How do I get people to participate? Could FHT clinics that have this invite other docs to attend? At EEFHT, this is the way that your patient is triaged otherwise you will not be referred. So you need to be there • Hospitals assumes that if you are in a FHT you have a social worker therefore, why are you reaching out – frustrating as we are only referring when we feel we've exhausted our resources. • everyone has a different comfort level with MH patients • Psychiatry is discharging patients back to the family physician, many am comfortable to follow the patient to increase capacity for new consults – many patients seem to be followed a long time and may not need this. Fear of not being able to get them back in is a barrier. **ACTION: Kellie to follow up with the Chief of Psychiatry to inquire if he has set up eConsults. Re-establishment of Elgin Mental Health and Addictions Network including Primary Care as a partner, should help to address some of these issues** **ACTION: Kellie to follow up with the Chief of Psychiatry to inquire if he has set up eConsults**