



# Program Design: Finding the Match Between Patients, Programs and Staff

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# Objectives



- Georgina NPLC History
- Community Needs Assessment
- Business and Operational Plan
  - Program Development
- Group Work on Your Plans
- Sharing of Plans
- Questions

# Georgina NPLC History

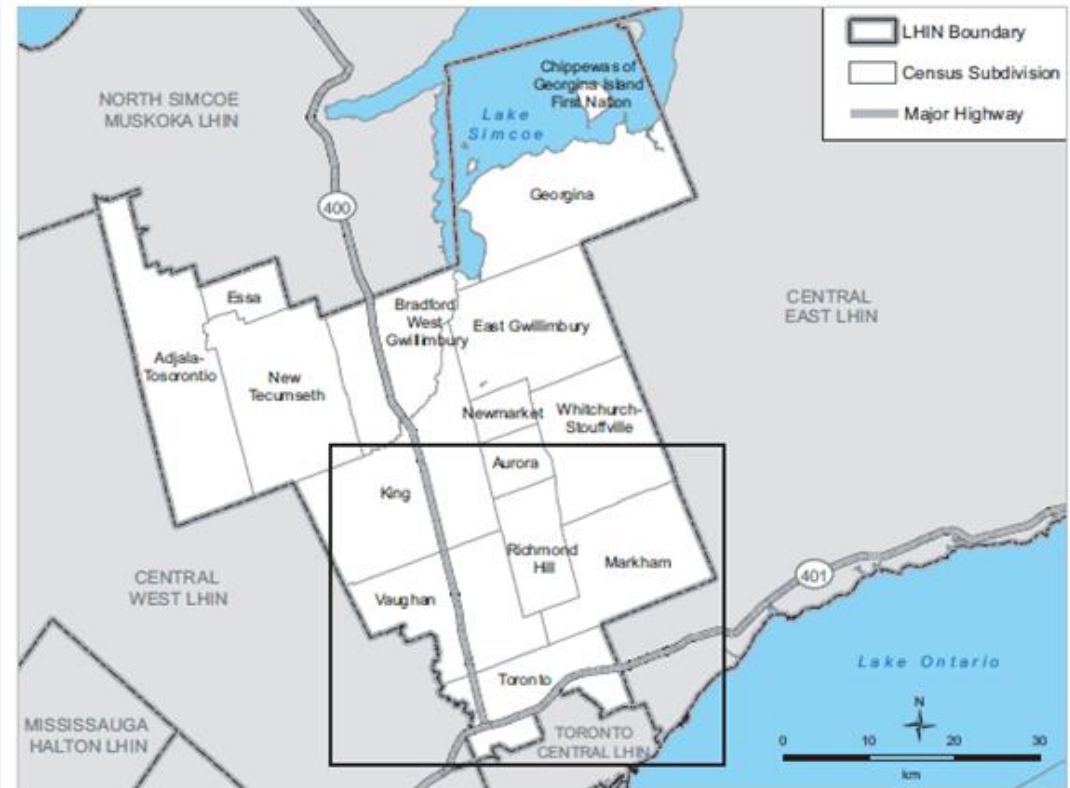


- Georgina Medical Center -1947
- Limited funding model – Primary HC Branch
- Our Plan: Growth and Development of Services for the Community
  - Outreach
  - Chronic DM
  - Mental Health
  - Young Families



# Georgina NPLC History

- Wave 2 - Central LHIN considered 'over served'
- Wave 3 allowed our area to apply!!



# Georgina NPLC History



- Planting the Seed in the Community Members- **Political Action/ Advocacy**
  - Presented to the Town Council on NP practice and the value of NP care
  - Spoke to possible community partners
  - Discussed the model with clients

# Community Needs Assessment



- Characteristics of the population
- The health status of the population
- Local factors affecting health
- Current primary care services
- Local people's views of their health needs and health services
- Local and national priorities

# Community Needs Assessment



- Identifying the Gaps (in our eyes)
  - Elder Care
  - Homeless – 2 local shelters
  - Mental health population- supportive housing
  - Working poor
  - Young families
  - Chippewa's of Georgina Island
  - Shortage of MD's and difficulty recruiting

# Community Needs Assessment



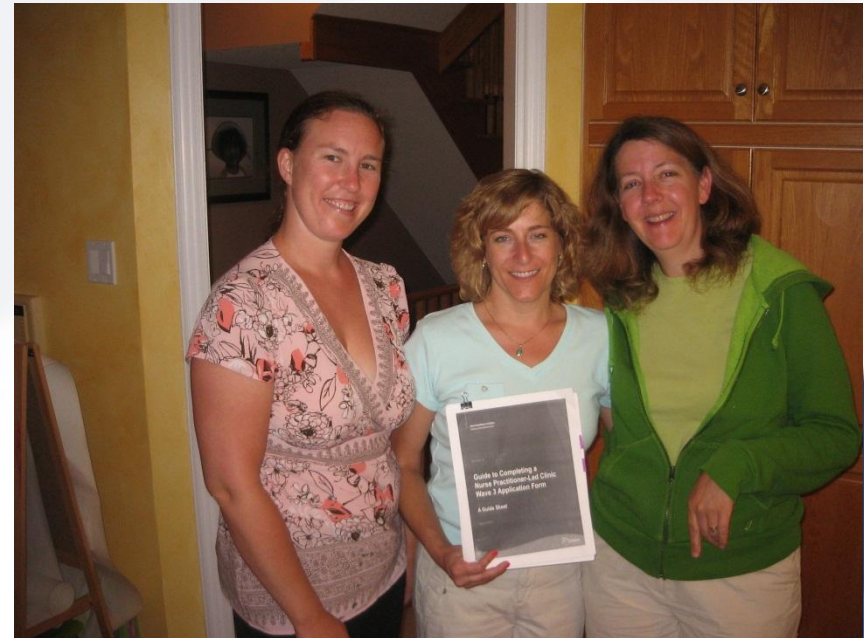
- Got feedback from local stakeholders on our perception of the needs of the community related to their perception
  - Good correlation
- Approximate number of unattached patients is **15,000-20,000**

# The Application – June 25, 2010

## The Tally Express



## Happiness is....



# Awarded GNPLC – Aug 26, 2010

- Now the work on the Bus/OP Plan begins!
- Thank heaven for past lives...



# Business and Operational Planning



- What is a Business Plan?
  - “A business plan is a formal statement of a set of business goals, the reasons why they are believed attainable, and the plan for reaching those goals.” (Wikipedia)
- How can we operationalize our planned programs and services
- MOH 9 Sections outlined

# Business and Operational Planning



- What is an Operational Plan?
  - How are we going to get there
  - Detailed annual resource requirements/budget; and
  - Proposed one-time start up items

# Business and Operational Planning



- Operations Plan
  - Staffing costs
  - Equipment
  - Consumable items
  - IT (huge... hard and software, support...)
  - Overhead (cleaning, heat, hydro....)
  - Insurance (Board, liability, contents..)
  - Benefits (to HOOPP or not to HOOPP)
  - Lease- grounds / maintenance / renos

# Business and Operational Planning



- Bus/Op plan Submission- Dec. 13, 2010.....  
72 Pages
- Georgina NPLC Vision:
  - ***Bridging the gap through collaborative care***
- Core Objective
  - To provide or coordinate comprehensive, interprofessional, full scope nurse practitioner led, primary health care services to the clients registered to the GNPLC

# Business and Operational Planning



- Priority populations for the GNPLC will be:
  - Unattached / transient patients
  - Patients with chronic disease and or risk factors
  - Adolescents and young families
  - Aboriginal People

# Business and Operational Planning

A blue stethoscope is positioned in the top right corner of the slide, partially overlapping the dark blue header area.

- 12 Core Service Providers + Administration
  - NP-PHC (4) and Consulting MD (2-PT)
  - RSW (FT)
  - RD (FT)
  - Health Promoter (PT)
  - RN (PT)
  - RPN (FT)
  - Pharmacist (PT)
    - Lead Administrator (FT)
    - 3 FTE Clerical (mix)

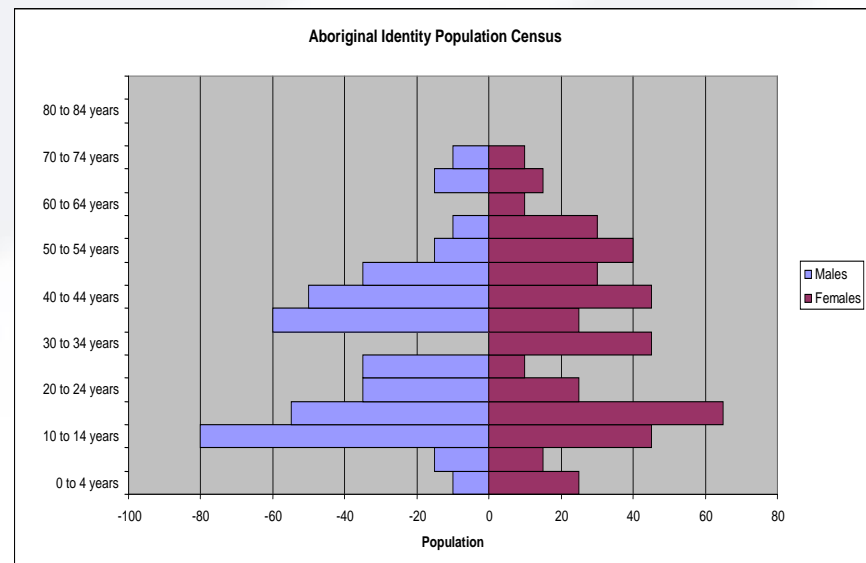
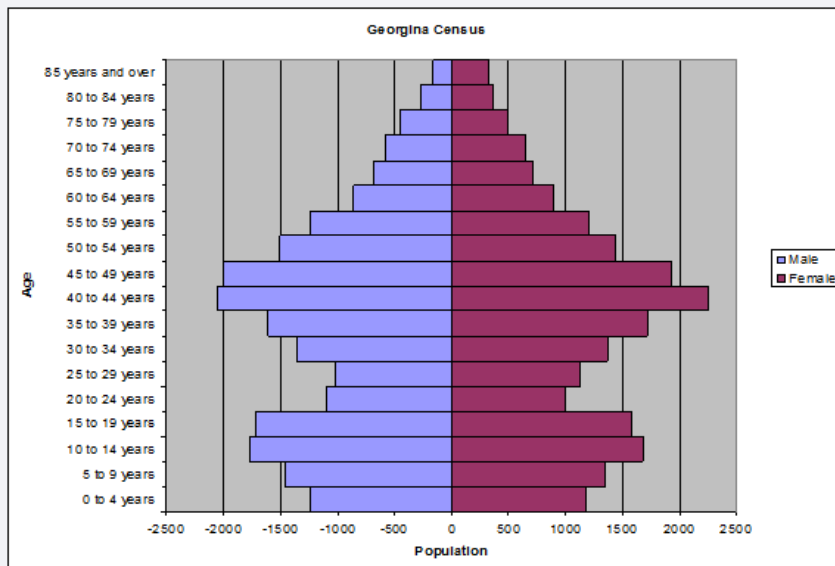
# Business and Operational Planning



Programs	Health Promotion within the Core Programs
<p><b>Core Programs:</b></p> <ul style="list-style-type: none"> <li>• Health assessments, diagnosis and treatment, general health promotion and disease prevention, primary reproductive care, pre and post natal care, primary mental health care, primary palliative care, service coordination and referral</li> <li>• Laboratory services including electrocardiograms, immunization delivery, allergy injections, intake physical assessment, demographic and baseline measurements</li> <li>• Nutrition Services and Education</li> <li>• Mental Health including counselling and addictions support</li> <li>• Pharmacist consultation and links with community pharmacists</li> <li>• Health Promotion and Education including chronic disease management education and support:               <ul style="list-style-type: none"> <li>○ Diabetes</li> <li>○ COPD/Asthma</li> <li>○ Arthritis</li> <li>○ Chronic Pain</li> <li>○ Obesity</li> <li>○ Frail elderly</li> <li>○ Cardiovascular disease / hypertension</li> </ul> </li> <li>• Foot and Wound Care</li> </ul> <p><b>Special Services:</b></p> <ul style="list-style-type: none"> <li>• Palliative Care and Hospice Support</li> <li>• Respiratory Therapy COPD assessments on-site- Guest Service Provider</li> <li>• Audiology Testing Services provided on-site- Guest Service Provider</li> <li>• Outreach program to The Chippewas of Georgina Island</li> <li>• Outreach program for Sexual Health to Keswick and Sutton High Schools</li> <li>• Outreach program to 2 shelters, Sutton Youth Shelter and Sandgate Woman's' Shelter</li> </ul>	<p><b>Women's Health</b></p> <ul style="list-style-type: none"> <li>○ Breast and Cervical Screening</li> <li>○ Osteoporosis</li> <li>○ Menopause</li> <li>○ Heart Health</li> <li>○ Cancer Education</li> </ul> <p><b>Men's Health</b></p> <ul style="list-style-type: none"> <li>○ Prostate Screening</li> <li>○ Heart Health</li> <li>○ Osteoporosis</li> <li>○ Cancer Education</li> </ul> <p><b>Child and Adolescent</b></p> <ul style="list-style-type: none"> <li>○ Nutrition Program</li> <li>○ Healthy Weight</li> <li>○ Exercise</li> <li>○ Counseling</li> </ul> <p><b>General Wellness</b></p> <ul style="list-style-type: none"> <li>○ Education sessions Life Style Changes – Nutrition, Exercise</li> <li>○ Stress Management</li> <li>○ Smoking Cessation</li> <li>○ Heart Health</li> <li>○ Cancer Education</li> </ul> <p><b>Seniors Health</b></p> <ul style="list-style-type: none"> <li>○ Education re chronic disease</li> <li>○ Falls</li> <li>○ Dementia</li> <li>○ Weight and exercise management</li> <li>○ Medication management</li> <li>○ Health Screening</li> </ul>

# Population Demographics

## Stats Canada 2006



# Population Demographics



- **Age:** The Largest percentage of the population for the region is adolescents aged **10-19** and adults aged **35-49**. (Statistics Canada Community Profiles, 2006; Statistics Canada Aboriginal Profile, 2006)
- **Sex :** Equal distribution of females and males in the Town of Georgina and Georgina Island
- **The Chippewas of Georgina Island** First Nation currently have 353 First Nations people living on-reserve on Georgina Island (Statistics Canada, 2010).

# Program Planning



- Focus on programs that will match your demographics
- How do your program needs link in with the Ministry and local LHIN priorities?
  - Access to resources!!!
- Once you have worked out the program types that you require, gear you job posting to highlight the area of interest
  - Right person for the role

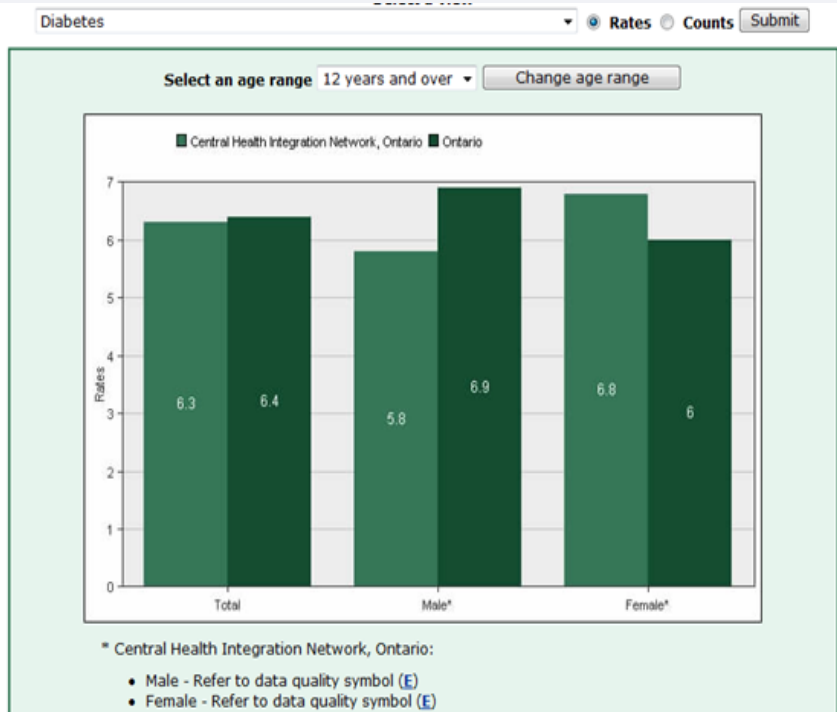
# Program Planning and DM



- Ontario Strategic Plan: Supporting Ontario's Diabetes Strategy
- CLHIN 2010-2013 Planning Priorities: Chronic Disease Management and Prevention
- Diabetes and:
  - Screening: NP
  - Education: RD and HP
  - Diabetes and Foot Care: RN

# Program Planning and DM

## Chronic Disease Prevalence: Diabetes



- Canadian Community Health Survey 2010 Central LHIN profile

# Program Planning and DM



- CLHIN Diabetes statistics are in line with the rest of Ontario
- Diabetes rates among females within the CLHIN are higher than Ontario 6.8% vs. 6.0%
- Statistics on DM are grossly underestimated; many persons living with the disease have not yet been diagnosed (Canadian Diabetes Association)

# Program Planning and DM

- Aboriginal people have a 3 to 5 times greater risk of developing type 2 diabetes than other Canadians, Aboriginal children as young as 5 years of age have been diagnosed with diabetes (Canadian Diabetes Association, 2007)



# Program Planning and DM



- **Psychiatric disorders can be a risk factor for, as well as a complication of, diabetes. Antipsychotic medications, widely used to treat a variety of psychiatric conditions, are also associated with diabetes** (American Diabetes Association, 2011)
- **Screening at 40 or sooner if at risk** (Canadian Family Physicians; Preventive Care Checklist)

# Program Planning and DM



- Diabetes and Foot Care
- Best IHP for the role – RN
- Number of hours needed – 1 day a week
- Resources- Room with an exam table, equipment, consumables, education material, computer for charting, administration support for booking and re-calls

# Program Planning and DM FTE and Workload



- How long are the IHP appointments?
  - NP – 20min regular 40min CPX
  - RSW – 1hr with 15min buffer for charting; group sessions
  - RD – 1hr first visit or depending on counselling needed – 30 min follow up; group work
  - HP – 1hr first visit and hourly groups
  - **RN: Foot and Wound Care – 30 min**
  - Pharm – 1hr initial & 30 min f/u also chart audits

# Program Planning and DM: FTE and Workload

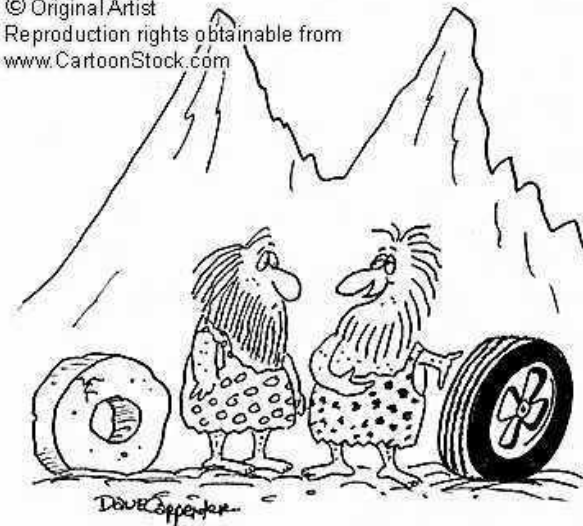


- 1.0 FTE = 10 work days in 2 weeks
- 0.6 FTE = 6
- 0.5 FTE = 5
- 0.4 FTE = 4
- 0.3 FTE = 3
- **0.2 FTE = 2**

# Program Planning and DM

- Utilizing the MOH Guides...
- Program Charts
  - CASE
    - why re-invent the wheel?

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"AND HERE'S OUR NEW AND IMPROVED VERSION."

- Chuck what you don't find useful

# Program Planning and DM



Name	Core Program:
Description	The *** will provide care and services to ***  <i>Objectives:</i>  <i>Population needs:</i>
Needs and Service Gaps	<i>Needs and Gaps:</i>  <i>Location:</i>
Provider(s)	
Collaborating Partnerships	
Key Milestones	<i>Timelines for roll-out:</i>
Evaluation	<i>Success will be measured by:</i>

# Program Planning and DM

Name	Special Program: Foot and Wound Care – <b>Registered Nurse</b>
Description	<p>RN with advanced skills and knowledge in wound and foot care to provide specialized foot care for elderly and clients with Diabetes. On site wound care and related health education.</p> <p><i>Objectives:</i> To provide an enhanced level of foot and wound care to the registrants of the GNPLC.</p> <p>It will address <i>population needs</i> by: providing a service that is usually cost prohibitive for the low income population of the Region.</p>
Needs and Service Gaps	<p><i>Needs and Gaps:</i> Town of Georgina including Georgina Island have high population of smokers, obese individuals, sedentary life, poor diet, high stress, high cholesterol, high blood pressure. We are statistically in line with Ontario for most modifiable risk factors. Our Aboriginal population also faces substantially greater health inequalities relative to the rest of the Canadian population, including lower life expectancy and higher rates of a wide range of illnesses including Diabetes and obesity.</p> <p><i>Location:</i> At the GNPLC location.</p>
Provider	<b>Registered Nurse (1 x 0.2 FTE)</b>
Collaborating Partnerships	Service coordination and collaboration with organizations such as CCAC will be expected. There may be cross over and co-patient planning between the RN, NP, CCAC and Southlake Regional Hospital as needed.
Key Milestones	<i>Timelines for roll-out:</i> The RN position will be posted once the GNPLC is open and when we have reached two thirds (2/3) of our target population volume. Once hired the RN will be expected to establish linkages with other service delivery organizations as previously stated as collaborating partners within the first 6 months of role development.
Evaluation	<p>Measurement will be based on client feedback forms and on MAR data indicating referrals for foot and wound care.</p> <p>Plans for ongoing improvement will include annual needs assessments of the areas provided services by the RN. Annual MAR review of the number of patients treated and number of visits per patient.</p>



# Program Planning - NP



<b>Name</b>	<b>Core Programs: Health assessments, diagnosis and treatment, general health promotion and disease prevention, primary reproductive care, pre and post natal care, primary mental health care, primary palliative care, service coordination and referral - Nurse Practitioners and Consulting MD's</b>
Description	<p>The NP will provide Family Practice, full scope nurse practitioner primary health care to the residents of Georgina as stated above.</p> <p>Patients will have access to NP care 6 days a week with extended hours being provided on 2 evenings.</p> <p><u>Objectives</u> of the core programs are to meet the core objectives of the GNPLC as stated above.</p> <p><u>Population needs</u> will be somewhat addressed as the area is noted as underserved; due to the small number of NP's (4) allocated to this clinic only 3200 of the 15-20,000 unattached patients will have access to the clinic</p>
Needs and Service Gaps & Location	<p><u>Service Gaps</u> for the area include 15,000-20,000 unattached persons, lack of new primary health care providers in Georgina. The closest hospital is 50 km away and many of the residents do not have access to a car. The area is growing in population and will continue to do so with the expansion of the 404. There is a Lack of health education programs to all population demographics, Maternal/Child Care; Closest Breastfeeding clinic in Newmarket has recently closed There is no public laboratory service in The Town of Georgina</p> <p><u>Location:</u> The above stated Core Programs will be delivered within the GNPLC with exterior partnerships sharing in the continuum of care for many of the programs</p>

# Program Planning - NP



<b>Provider</b>	<p><b><u>Nurse Practitioners</u> (4 x 1.0 FTE's) with support from the IHP's and Admin such as:</b> The RPN will assist with physiologic data gathering such as (weights, heights, and laboratory), Secretaries will process and communicate referral appointments.</p> <p><b><u>Collaborating MD's</u> (2 x Consulting MD's) will do advanced assessments, diagnostics, and treatments for NP's patients as needed who are outside the scope of practice of the nurse practitioners. Medical directives will further decrease the requirement for physician services.</b></p>
<b>Collaborating Partnerships</b>	<p>Many of the Core Service programs are in coordination and collaboration with other organizations. The role of the GNPLC is to assess, order diagnostics as needed, diagnose, identify needs, provide therapeutics where appropriate, and supply support as needed in collaboration with the following agencies:</p> <p><b><u>Primary Reproductive care:</u></b> Public Health: provide walk-in access and one on one education</p> <p><b><u>Pre-Post Natal care:</u></b> Southlake Regional Health Center Department of Obstetrics provides care of the pregnant woman from 28 wks gestation to delivery. birth. At one week post-partum the mom and child will return to the GNPLC for assessment and follow up. CCAC provides home visits for newborn, maternal support and breastfeeding support.</p> <p><b><u>Primary Mental health Care:</u></b> York Support Series, Catholic Counselling Service provide individual and group counselling to clients on as needed bases for a maximum of 13 one hour sessions. However, at this time they are overwhelmed with referrals and the wait time is several weeks to a first appointment.</p> <p><b><u>Service Coordination:</u></b> CCAC provides in house assessments, wound care and personal care for patients that are unable to travel and need these supports. The GNPLC will continue to have close relationships and partnerships in care with the CCAC.</p>

# Program Planning and NP



## Key Milestones

**Timelines for roll-out: The core programs within this section will commence on the first day of operations and will continue to grow and develop**

**The GNPLC will continue to establish and foster linkages with other service delivery organizations as listed above**

**Eg: The Board has begun to meet with the Chief Nursing officer of Southlake Regional Health Center to foster and strengthen our relationships with the larger organization. Outcomes of these meetings will be documented within the Clinic policies and referral lines strengthened.**

## Evaluation

Plans to measure success of the service/program have begun at the Board level and will be in collaboration with a research group based in Ryerson University as well as with the Nurse Practitioner Association of Ontario, QIIP and the Central LHIN

Plans for ongoing improvement will be incorporated into our data gathering process through both our EMR and via ongoing Satisfaction Surveys both for patients and staff.

# Professional Associations



- Contact the different associations to better understand the role of the provider in a primary care model:
  - **NPAO** (Nurse Practitioner Association of Ontario)
  - **RNAO** (Registered Nurses Association of Ontario)
  - **RPNAO** (Registered Practical Nurses Association of Ontario)

# Professional Associations

- **OPA** (Ontario Pharmacists Association)
- **DC** (Dieticians of Canada)
- **OASW** (Ontario Association of Social Workers)
- **HPO** (Health Promotion Ontario)



# Group Work.....



- Although there will be individuality
- Look for similarities
- Share ideas
- Find others with:
  - Shared program goal or
  - Shared program delivery (IHP)
- Report back to the larger group

# Participatory Leadership



“The participatory leadership paradigm is based on respect and engagement. It constructively focuses energy in every human to human encounter. A more advanced, more democratic and more effective model of leadership, it harnesses diversity, builds community, and creates shared responsibility for action. It deepens individual and collective learning yielding real development and growth.”

(Torbert & Rook, Seven Transformations of Leadership  
Harvard Business Review)

# Thank You

- For your Time, Attention & Hard Work
- Sharing your work will make a stronger collective group of NPLC's
- Good Luck!!

