Cowichan Valley
Division of Family Practice
A GPSC initiative

KEY FINDINGS and REPORT on DATA

2015 CVDFP Physician Self-Assessment Survey

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Executive Summary

This Key Findings and Final Report highlights the Cowichan Valley Division of Family Practice's (CVDFP's) achievements in the Triple Aim framework of improving the patient and physician experience of care; improving the health of populations; and reducing the per capita cost of health care. The report also includes updated patient and physician demographics, as well as data to aid with physician succession planning.

The results were obtained through the 2015 Physician Self-Assessment Survey, which evaluated the Division's Attachment and GP for Me initiatives through 41 completed physician surveys. Summary results of each survey question can be found in this report.

Improving the Patient and Physician Experience of Care

Physicians reported that the CVDFP's attachment initiatives changed their practices in a number of ways, including accepting new patients and streamlining their office practices. A majority of physicians reported that the Cowichan Maternity Clinic had a positive impact on their ability to provide quality patient care (70%, n=16/23); their relationships with patients (61%, n=11/18); and their overall experience as a family physician (65%, n=13/20). The Family Practice Hospital Support Program attachment initiative had a positive impact on a majority of physicians' ability to provide quality patient care (52%, n=13/25) and their relationships with other family physicians (52%, n=13/25).

A majority of physicians also reported positive impacts for patients and their families as a result of all the attachment initiatives: the Cowichan Maternity Clinic; Family Practice Hospital Support Program; In Practice Attachment; and the Recruitment of New Physicians.

Improving the Health of Populations

- Nearly a third of physicians (31%) report that 1-25 of their patients have three or more visits to the ER per year; 28% report 26-50 ER familiar faces; 17% report 51-75 ER familiar faces; 7% report 76-100 ER familiar faces; 7% report 126-150 ER familiar faces; and one physician (3%) reports 151-175 ER familiar faces.
- Seventy-four per cent of physicians (n=28/38) said "frail elderly" patients had a high impact or priority level, followed by: patients with mental health and substance use issues (73%, n=27/37); patients with chronic conditions (68%, n=25/37); end-of-life care (60%, n=21/35); Aboriginal people (44%, n=15/34); rural and remote populations (26%, n=9/34); and maternal health (15%, n=5/33).
- Physicians reported an average of 165.33 patients in the 60-69-year-old age group, followed by an average of 160.64 patients in the 50-59-year-old age group.
- The average physician has 143.18 active patients with hypertension; 70.88 active patients with diabetes; 69.28 patients with Axis I Mental Health (excluding depression) diagnoses; and 65.44 patients who have been diagnosed with depression.
- Sixty-three per cent of physicians (n=25/40) accept new patients "only in specific circumstances," up from 48% in 2011.
- Twenty-three per cent of physicians are taking on new patients with the intention of becoming their primary care provider, down from 38% in 2011.

Reducing the Per Capita Cost of Health Care

- In 2011, 92% of physicians (n=54/59) said they were interested in trying to increase efficiency in their office. In 2015, 69% of physicians (n=27/29) reported that they had increased efficiency in their office in the past 4 years.
- 48% of physicians (n=28/59) said they were interested in trying to increase capacity in their office in 2011, and 50% of physicians (n=19/38) reported in 2015 that they had succeeded.
- A majority of physicians (86%, n=30/35) had obtained an EMR meaningful use level 3 (MU3) assessment at the time of the 2015 self-assessment survey.
- One-fifth of physicians (21%, n=8/38) are willing and able to coach other physicians.
- Sixty-five per cent of physicians (n=24/37) reported that maintaining a cost-effective practice had a moderate to significant impact on their primary care practice.

Succession Planning and Team Members

- In 2011, 66% of practitioners were planning to retire in 10 or more years, and 22% planned to retire in 5-9 years. Five physicians (9%) were planning retirement in 3-4 years, and two physicians planned to retire by 2013. These numbers were largely unchanged in 2015.
- The number of physicians who are trying to or planning to recruit another physician to work in their office has decreased substantially since 2011, from 47% to 22%.
- More physicians had multi-disciplinary team members associated with their clinic in 2015 (81%) than in 2011 (60%).
- The most in-demand multi-disciplinary team member is a counsellor (2011: 63%; 2015: 79%).

Additional Findings

- Physicians identified a number of changes that would help them manage their patients, including additional staff or locum support, and access to specialists and specialized resources.
- There is a demand from physicians for additional support with billing, EMR, and business management.
- More than half of respondents said they recognized a need to better optimize EMR as a result of this assessment.

1.0 Introduction

The Cowichan Valley Division of Family Practice conducted its first Physician Self-Assessment Survey in 2011. The information from that survey was used extensively between 2011 and 2015 to inform the Division's work on the Attachment/GP for Me initiatives.

The Division exceeded its March 31, 2015 Patient Attachment target of 3,600 patients: by November 2014, the Division had attached more than 3,800 patients. Following the final year of the GP for Me initiative, the Division's focus is shifting toward poorly-attached patients who also lack continuity of care and increase costs to the system.

The 2015 Physician Self-Assessment Survey included 136 questions, many replicated from the 2011 survey, with some additional questions including: information based on accurate patient panel reports; evaluation of the CVDFP's attachment initiatives; and patient populations and health care issues physicians believe are in need of priority attention.

The response rate for the 2015 survey was 48%. Due to unforeseen problems with the initial online survey mechanism, the survey was converted to a hard copy paper version that proved less convenient for members to complete.

The introductory "Highlights" and "Other Trends" sections in this report illustrate the progress that has been made since the 2011 survey. Where appropriate, highlights have been categorized according to the Institute for Healthcare Improvement's Triple Aim framework. Detailed results for the 2015 survey questions are provided following the introductory sections.

2.0 Methodology

The methodology for the 2015 survey is based on a pre/post comparison evaluation model. The 2011 survey serves as the "pre," or baseline, before Attachment/GP for Me initiatives were implemented. The 2015 survey serves as the "post," or outcomes, after a four-year period of measuring Attachment/GP for Me initiatives for improvement.

The completion and analysis of the electronic 2015 Physician Self-Assessment Survey was confidential. The following Privacy Policy (Figure 1) was distributed to physicians. Survey results are presented in an anonymous, aggregated form.

Privacy Policy

The information collected in this survey is intended, first and foremost, for your use in learning about your patient panel, and secondly, for use by the Cowichan Valley Division of Family Practice Society (CVDFPS, the "Division"). The survey can be made anonymous at your discretion, by omitting your name from the document. However, it should be noted that having comprehensive knowledge of its members will benefit the Division in identifying trends, and forming solutions to best fit its members. In addition, being able to link results to individuals will enable the Division to plan for and offer coaching in relevant areas. Any identifying information collected will be kept in a confidential manner, although general trends generated by the data collected may be shared with other interested parties, such as the General Practice Services Committee and/or its initiatives. Shared information on general trends will always be shared in an anonymous and aggregate form.

The survey information will be collected by a Division staff member in a secure database. This database will be for use only within the CVDFP, and almost all data manipulation will, therefore, be anonymous. Only CVDFP members and employees will have access to our databases, and those individuals will only be accessing the information at the direction of the CVDFP Board.

Any names that are provided with surveys will be linked back only to relevant information (such as desire for coaching, degree of EMR engagement, etc.); this information will be used within the Division only for the purpose of coordinating training modules, etc., and will not be shared, except upon specific request of the participant.

Our plan is to provide aggregated data when at all possible, or anonymous data in appropriate cases. For example, "only 10% of GPs work 9 or more half days in their office, whereas 45% work less than 5 half-days per week in their office", or that "75% of physicians use EMR for scheduling, but only 60% download labs directly to EMR". We will not release any individual or identifiable information to other parties.

The results of the survey (again, anonymous and aggregated) will be available to all Division members when analysis is complete.

Consent

By completing the survey, physicians have deemed to have consented to use of the information as described above.

Figure 1 Privacy Policy

3.0 Purpose

The Division's electronic 2015 Physician Self-Assessment survey had three main objectives:

1. To evaluate Attachment and GP for Me initiatives from 2011 to present;
2. To collect data about the current rate of attachment and the poorly attached patient population; and
3. To update the Division's data to enable accurate physician succession planning.

The 2015 survey was also designed to ensure each full-service family practitioner has an accurate patient panel number and can identify the number of patients in their panel who are "familiar faces" at the ER.

4.0 Note

Caveat: This report is based on 41 completed surveys submitted to the Division. Due to the diverse nature of individual physicians' practices, respondents may not have answered each and every question. The total number of respondents for each question is indicated for clarity.

The same physicians may not have responded to the self-assessment survey in both 2011 and 2015. Therefore, the highlights and trends identified do not represent changes amongst the same group of physicians. Nevertheless, viewing the data in aggregate can provide insight into general trends amongst physicians and patients in the Cowichan Valley.

5.0 Key Findings and Triple Aim Framework Highlights

The General Practice Services Committee (GPSC) adopted the Institute for Healthcare Improvement's (IHI's) Triple Aim framework for its attachment initiatives and GP for Me programs. The Triple Aims for system improvements are:

- Improving the patient and physician experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

The information obtained from the CVDFP 2011 physician survey was used to identify areas of focus that would help family physicians in the Cowichan Valley in achieving the Triple Aims, and the 2015 survey shows the progress has been made. Of particular note, the Division exceeded its intended Patient Attachment target of 3,600 patients by March 31, 2015, attaching more than 3,800 patients by November 2014. The 2015 survey results will also inform the Division's work as it looks to make even more improvements.

The following highlights relate to the CVDFP's efforts to achieve the goals of the Triple Aim framework.

5.1 Improving the Patient and Physician Experience of Care

Attachment Evaluation: Maternity Clinic

A majority of respondents reported that the Cowichan Maternity Clinic attachment initiative had a positive or "significant positive impact" on: their ability to provide quality patient care (70%, n=16/23); their relationships with patients (61%, n=11/18); and their overall experience as a family physician (65%, n=13/20).

A majority of physicians reported that the Cowichan Maternity Clinic had a positive or "significant positive impact" for patients and their families in all categories, including: the quality of care for complex patients (86%, n=18/21); access to care for vulnerable patients (78%, n=18/23); ability for unattached patients to find a family physician (73%, n=16/22); patients' relationships with family physicians (65%, n=15/23); and their overall experience as a patient (85%, n=17/20).

Attachment Evaluation: Family Practice Hospital Support Program

Over half of physicians also reported that the Family Practice Hospital Support Program attachment initiative had a positive or "significant positive impact" on: their ability to provide quality patient care (52%, n=13/25); and their relationships with other family physicians (52%, n=13/25).

A majority of physicians reported that the Family Practice Hospital Support Program had positive or significant positive impacts for patients and their families in the following categories: the quality of care for complex patients (70%, n=19/27); access to care for vulnerable patients (70%, n=19/27); and their overall experience as a patient (60%, n=15/25).

Attachment Evaluation: In Practice Attachment

Forty-four per cent of physicians (n=15/34) reported the In Practice Attachment initiative had a positive or "significant positive impact" on their ability to provide quality patient care, and 45% reported a positive or "significant positive impact" on their overall experience as a physician.

A majority of physicians report that In Practice Attachment had a positive or "significant positive impact" for patients and their families in all categories, including: the quality of care for complex patients (63%, n=20/32); access to care for vulnerable patients (70%, n=23/33); ability for unattached patients to find a family physician (64%, n=21/33); patients' relationships with family physicians (69%, n=22/32); and their overall experience as a patient (63%, n=20/32).

Attachment Evaluation: Recruitment of New Physicians

Forty-two per cent of physicians (n=10/24) reported that the Recruitment of New Physicians had a positive or "significant positive impact" on their caseload management and overall experience as a physician. Forty per cent reported positive or significant positive impacts on their work-life balance.

A majority of physicians (56%, n=14/25) reported that the Recruitment of New Physicians had positive or "significant positive impacts" on unattached patients' ability to find a family physician. Forty-five per cent reported positive or significant positive impacts for patients' overall experience.

Changes to Practice from Attachment Initiative

Physicians reported a number of ways in which the attachment initiative has changed their practice over the past two years. Changes related to patient attachment include: accepting new patients at clinic; reduced pressure to accept new patients as other physicians accept them; expanding their practice; taking on new patients through practice attachment; and taking referrals from emergency physicians.

Physicians also reported changes in their office, including: streamlining office and flow efficiencies; reduced office inquiries; improving the quality of their practice and care for patients; and spending more time reviewing new patients' history, thereby increasing their comfort level when taking on complex patients.

Physicians also reported the following results from the attachment initiative: joining the Family Practice Hospital Support Program; assisting the physician in FPHSP and supporting inpatient care; improved management at the hospital; improved physician cooperation; starting the CMC and continuing maternity care for physicians; and stabilizing the FPHSP rotation, with their call group system improving their experience of hospital call.

Additional Resources

Nineteen physicians identified additional resources that would help them manage their patients, including:

- Access to increased psychology resources for adults and children;
- ER and specialist reports coming directly to EMR;

- Easy-to-access patient information handouts in the EMR pre-made medication templates;
- Assistance with patient self-management;
- A personal assistant;
- A paramedical employee in their office;
- Locum support;
- A social worker/counsellor;
- Educators;
- Patient navigator;
- More physicians on electronic fax system to send letters of patients seen in clinic;
- A clinic nurse with a focus on chronic disease management;
- Mental health, obesity, healthy eating, and active lifestyle resources; and
- Improved imaging wait-times.

Additional Learning

Thirteen physicians indicated topics they would like to learn more about, including:

- Billing issues;
- Billing as a locum;
- How other physicians use EMR;
- MSK module and EMR audits;
- Patient access to Med Access;
- Business management of medical practice;
- Setting up a website for medical practice;
- Meditation and mindfulness; and
- Specific medical issues, including: chronic pain management; mental health; palliative care; ADHD; urology; diabetes; COPD; and immunizations.

Physician Insights from Self-Assessment

More than half of respondents (54%, n=13/24) said they recognized a need to better optimize EMR as a result of this assessment. Half of physicians (50%, n=12) said they recognize they need more information to utilize all incentive codes, and one-third (33%, n=8) recognized they needed to improve Chronic Disease Management. One-quarter of respondents (25%, n=6) said they needed to bill more specifically. Individual physicians (4% each) said the self-assessment reminded them of the need to "teach back," and to ask their MOA about their wait times.

5.2 Improving the Health of Populations

Patient Demographics

Physicians reported an average of 165.33 patients in the 60-69-year-old age group, followed by an average of 160.64 patients in the 50-59-year-old age group. Physicians have an average of 604.21 and 442.64 active female and male patients, respectively. The average physician reports having an Aboriginal patient panel of 8%. One-fifth of physicians (21%, n=6/29) report an Aboriginal patient panel between 10-25%.

EMR data from 21 physicians showed an average of 1103 active patients seen in the last five years, ranging between 506 and 1479. The average number of active patients seen in the past three years in EMR records from 24 physicians was 1061 (between 464 and 1719).

Chronic Diseases

The average physician has 143.18 active patients with hypertension; 70.88 active patients with diabetes; 69.28 patients with Axis I Mental Health (excluding depression) diagnoses; and 65.44 patients who have been diagnosed with depression.

Newly Attached Patients

After running an accurate patient panel, twelve physicians report they have attached between 10 and 296 patients since they started tracking, with an average of 106.63 new patients. Five physicians report attaching fewer than 100 patients (42%); 33% have attached 100-150 patients; 8% have attached 150-200 patients; and 17% (n=2) have attached 250-300 new patients.

Taking on New Patients

Less than a quarter (23%) of physicians are taking on new patients with the intention of becoming their primary care provider, down from 38% in 2011. More than three-in-five physicians (63%, n=25/40) accept new patients "only in specific circumstances," up from 48% in 2011. Physicians taking on new patients in 2015, regardless of whether or not they only do so in specific circumstances, reported taking on an average of 2.32 new patients a month.

ER Familiar Faces

Accurate patient panel reports have allowed physicians and the CVDFP to identify the number of patients who are "familiar faces" at the ER for the first time. Nearly a third of physicians (31%) report that 1-25 of their patients have three or more visits to the ER per year; 28% report 26-50 ER familiar faces; 17% report 51-75 ER familiar faces; 7% report 76-100 ER familiar faces; 7% report 126-150 ER familiar faces; and one physician (3%) reports 151-175 ER familiar faces. Two physicians (7%) reported that none of their patients are ER familiar faces.

Future Planning for CVDFP

Physicians were asked to rank the impact or priority of different populations on their practice, to aid with the future planning efforts of the CVDFP. Nearly three-quarters of physicians (74%, n=28/38) said "frail elderly" patients had an impact or priority level of "4" or "5" on a five-point scale.

Patients with mental health and substance use issues were the next largest priority group for most physicians, with a combined total of 73% (n=27/37) saying they were a level "4" or level "5" priority, followed by patients with chronic conditions (68%, n=25/37); end-of-life care (60%, n=21/35); Aboriginal people (44%, n=15/34); rural and remote populations (26%, n=9/34); and maternal health (15%, n=5/33).

5.3 Reducing the Per Capita Cost of Health Care

Increased Attachment and Reduced Per Capita Costs

The Division achieved its March 31, 2015 Patient Attachment target of 3,600 patients, attaching more than 3,800 patients by November 2014. Research has shown that increased attachment

can "reduce health care costs over time and across chronic conditions."[1] Increased patient attachment will reduce system costs.

Increased Efficiency and Capacity

In 2011, 92% of physicians (n=54/59) said they were interested in trying to increase efficiency in their office. In 2015, 69% of physicians (n=27/29) reported that they had increased efficiency in their office in the past 4 years. Similarly, 48% of physicians (n=28/59) said they were interested in trying to increase capacity in their office in 2011, and 50% of physicians (n=19/38) reported in 2015 that they were successful in doing so.

EMR Efficiencies

A majority of physicians (86%, n=30/35) had obtained an EMR meaningful use level 3 (MU3) assessment at the time of the 2015 self-assessment survey. Optimized use of EMR can reduce administrative workloads.

Coaching

One-fifth of physicians (21%, n=8/38) are willing and able to coach other physicians. Of the four physicians who provided additional information, three (75%) indicated that they could provide EMR coaching. Individual physicians also said they could assist with Dragon Dictation software; PSP modules; and mental health.

Personal Challenges

Sixty-five per cent of physicians (n=24/37) reported that maintaining a cost-effective practice had a moderate to significant impact on their primary care practice.

5.4 Other Trends

Retirement Projections

In 2011, 66% of practitioners were planning to retire in 10 or more years, and 22% planned to retire in 5-9 years. Five physicians (9%) were planning retirement in 3-4 years, and two physicians planned to retire by 2013. These numbers were largely unchanged in 2015, with the exception that no physicians reported that they were planning to retire in the next two years. Five physicians (12%) plan to retire in the next 3-4 years, and 20% estimate they will retire in 5-9 years, a slight decrease from 2011. Sixty-eight per cent of physicians plan to retire in 10 or more years, a 2% increase.

Physician Demographics

In 2011, 42% of physicians were between 45 and 54 years old. This age bracket increased to half of physicians (50%) in 2015. While 26% of physicians were 35-44 in 2011, this number has decreased to 21%. The number of physicians aged 25-34 also dropped slightly, from 4% to 3%. The percentage of physicians aged 55 to 64 has decreased, from 25% to 23%, and the number of physicians aged 65 and over increased from 4% to 5%.

The number of physicians practicing between 1 and 10 years has increased, from 13% (n=7/55)

[1] Marcus J Hollander and Helena Kadlec, "Financial Implications of the Continuity of Primary Care," *Permanente Journal* 19.1 (Winter 2015), 4.

to 22% (n=9/41). The average respondent in 2015 had been practicing for 21 years.

Physician Planning

The number of physicians who are trying to or planning to recruit another physician to work in their office has decreased substantially since 2011, from 47% to 22%. A majority of physicians are still attempting to find a short-term locum for coverage for holidays, CME, etc., although this number has decreased from 91% to 82%. Two physicians in both 2011 and 2015 indicated they were planning to merge their practice/office with another practice/office within the next year. No physicians reported they were planning to move or retire within the next year, down from 9% of physicians in 2011.

Multi-Disciplinary Team Members

More physicians had multi-disciplinary team members associated with their clinic in 2015 (81%) than in 2011 (60%). The most common multi-disciplinary team member is still an RN (2011: 44%; 2015: 41%).

Most physicians continue to report that they would benefit from having additional access to multi-disciplinary team members (2011: 87%; 2015: 83%). The most in-demand team member is still a counsellor (2011: 63%; 2015: 79%). Demand for social workers has increased from 29% (n=14) to 59% (n=17). Fifty-two per cent of physicians reported that they would benefit from additional access to a dietician in both 2011 and 2015. A majority of physicians report that they have room in their office to accommodate additional staff, although this number is decreasing (2011: 80%; 2015: 62%).

Inactive Patients

In 2011, seven physicians reported seeing between 100 and 1000 inactive patients in the last 3 years. With more accurate data available in 2015, 11 physicians reported seeing between 0 and 2702 inactive patients in the last 3 years.

Residential Care

The percentage of physicians practicing residential home care is unchanged since 2011, at 88%. The average number of residential home care patients has decreased slightly, from 6 to 4.5. The percentage of physicians accepting new residential care patients has remained relatively stable, rising from 40% to 42%; however, the percentage of physicians who are not interested in accepting new residential care patients has risen from 44% to 56%.

EMR

All physicians report having an EMR, up from 95% (n=58/61) in 2011. The biggest challenge with EMR identified by physicians in 2011 was data entry (32%). In 2015, issues of computer literacy (33%, n=12/36), including difficulties learning the system or typing, had overtaken data entry (28%, n=10/36) as the biggest EMR challenge facing physicians.

6.0 Demographics

6.1 Physician Demographics

6.1.1 Age

Forty physicians responded to physician demographic questions. Over a third of the physicians (35%, n=14) are 50-54 years of age. The next largest groups are 45-49 years (15%, n=6); 35-39 years (13%, n=5); and 55-59 years (13%, n=5). No physicians are in the youngest age group, 25-29 years. Only one physician (3%) is 30-34; 8% (n=3) are 40-44; and 10% (n=4) are 60-64. Two physicians (5%) are 65 or older.

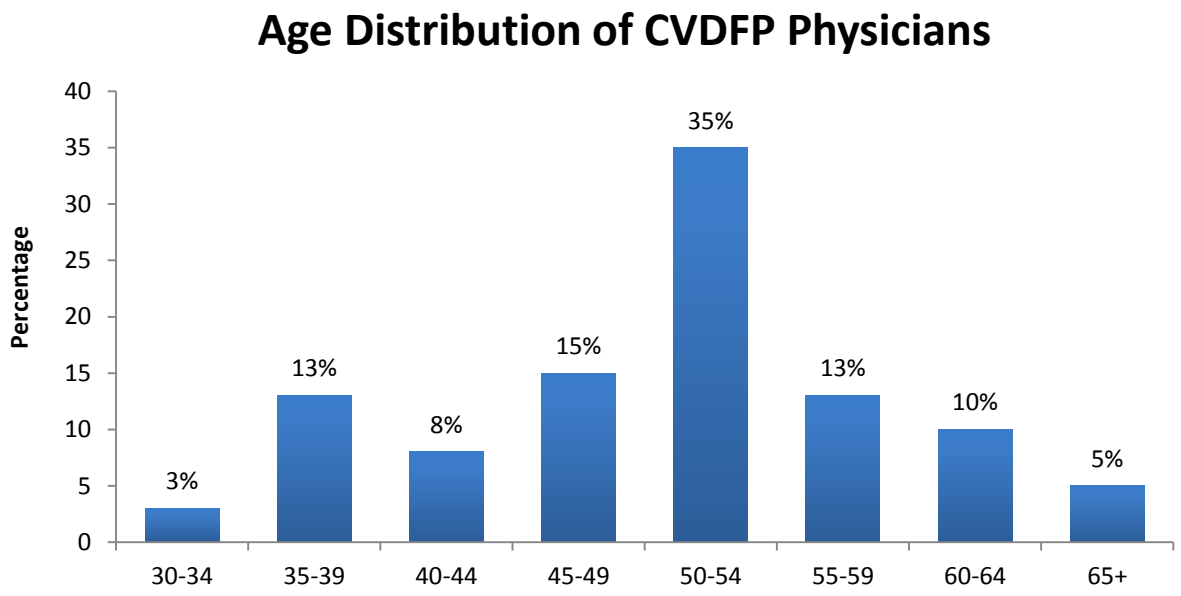

Figure 2 Age Distribution of CVDFP Physicians

6.1.2 Gender

A majority of physician respondents (55%, n=22/40) were female, while 45% (n=18) were male.

6.1.3 Years in Practice

Out of 41 physicians, 44% (n=18) have been practicing for 21-30 years; 22% (n=9) have been practicing between 1 and 10 years; 17% (n=7) have between 11 and 20 years of practice; and 15% (n=6) have been practicing for 31-40 years. One physician (2%) has been practicing for more than 40 years. The average respondent has been practicing for 21 years.

6.1.4 Medical School Attended

The largest number of physicians (34%, n=14/41) attended medical school at the University of British Columbia (UBC). An additional small number of students attended medical school at both UBC and the University of Victoria (5%, n=2). Four physicians (10%) attended the University of Calgary, and an additional 22% (n=9) attended other medical schools across Canada. Three physicians attended medical school in South Africa (7%). Nine physicians (29%) attended medical schools in other overseas locations, including Germany, England, Ukraine, Ireland, Chile, New Zealand.

6.1.5 Place of Residency Training

Most physicians (78%, n=32/41) did at least part of their residency training in Canada. Twelve of those physicians (29%) did at least part of their residency training in British Columbia. Approximately 22% of physicians (n=9) did their residency outside Canada, in countries such as Australia, Ireland, Israel, South Africa, and the United Kingdom.

6.1.6 CCFP Membership

Four-fifths of physicians (80%, n=32/40) are members of the CCFP. A majority of physicians (60%, n=24) have CCFP certification, while 30% (n=12) are CCFP fellows.

6.1.7 Additional Training

More than one-in-five physicians (23%, n=9/40) report having additional training (e.g. CFPC-EM). The most commonly reported additional training is in emergency medicine (8%, n=3).

6.1.8 Retirement

Over two-thirds of physicians (68%, n=28/41) estimate they will retire in 10 or more years. Five physicians (12%) expect to retire in the next 3-4 years. One-fifth of physicians (20%, n=8) estimate they will retire in 5-9 years. No physicians expect to retire in the next two years.

6.1.9 Primary Language

English is the primary language of practice used by all respondents.

6.1.10Secondary Language

Nearly three-in-ten physicians (29%, n=12/41) speak a secondary language fluently enough for patient care, such as Afrikaans, French, German, Hebrew, Russian, and Spanish.

6.2 Patient Demographics

6.2.1 Patient Panel Size

The average size of a patient panel after running an accurate patient panel report is 893 (± 421). Nearly half of physicians (49%, n=18/37) have a patient panel of 1001-1500, and nearly a quarter (24%, n=9) have a patient panel of 501-1000. Nineteen per cent of physicians (n=7) have a patient panel of 1501-2000, and three physicians have a patient panel of 1-500. No physicians had a patient panel over 2000.

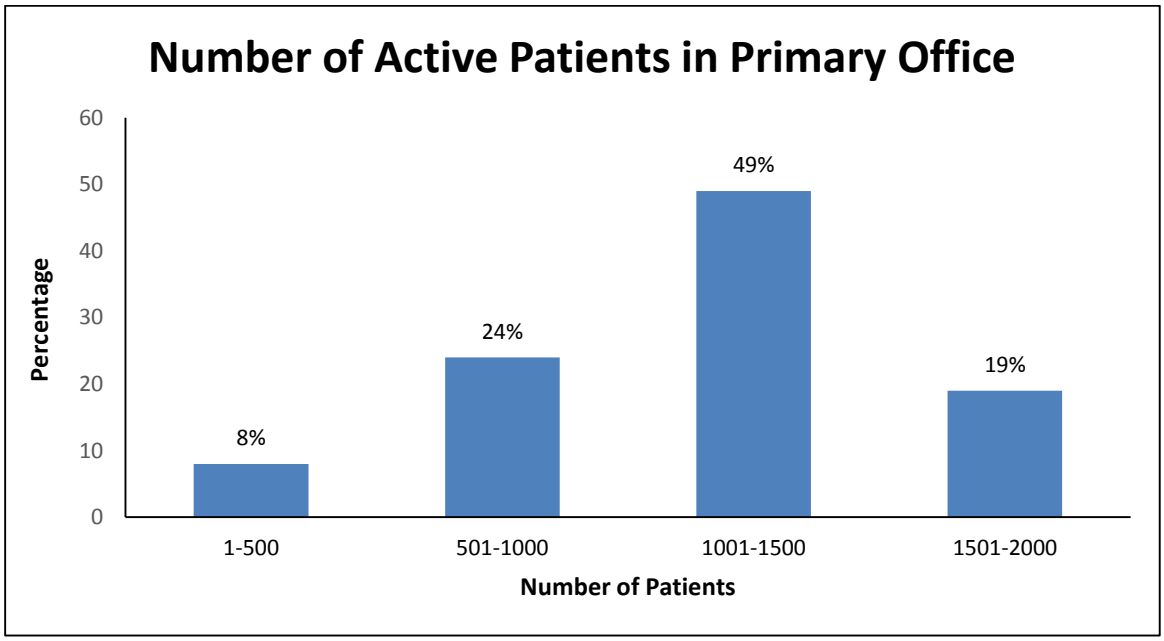

Figure 3 Number of Active Patients in Primary Office

EMR data from 21 physicians showed an average of 1103 active patients seen in the last five years, ranging between 506 and 1479. The average number of active patients seen in the past three years in EMR records from 24 physicians was 1061 (between 464 and 1719). The twenty-six physicians who provided EMR information on the number of active patients seen in the past year saw between 322 and 2300 patients. Of these physicians, 23% (n=6/26) saw 1-500 patients; 46% (n=12) saw 501-1000 patients; 27% (n=7) saw 1001-1500 patients; and 4% (n=1) saw over 2000 patients.

Twelve physicians provided information from their Physician Profile Analysis. Fifty-eight per cent (n=7/12) had seen 1001-1500 patients; 25% (n=3) had seen over 1500 patients, and 17% (n=2) had seen fewer than 1000 patients. The reported average was 1241 patients.

6.2.2 Inactive Patients

The total number of inactive patients (i.e., all patients minus active patients) seen by physicians in the last 3 years was between 0 and 2702. Two physicians (18%, n=2/11) were unable to include prenatal care numbers in their reporting, and two physicians (18%) reported zero inactive patients. Three physicians (not counted in the overall response for this question) were unable to run a report.

6.2.3 Patients Divided by Main Provider

Only two physicians reported having active patients divided by main provider. The average number of active patients were divided amongst three providers as follows: 1523; 1355; and 1261 patients.

6.2.4 Labelling of Patient Charts

Ninety percent (n=34/38) of physicians have consistently applied procedures for labelling charts as active, inactive, deceased, moved away, changed doctors, or transient.

6.2.5 Age

Thirty-three physicians provided data on the number of active patients seen in the last three years by age group. The average number of active patients was highest for patients aged 60-69 years (165.33), followed by 50-59 years (160.64 patients).

Age Group	Avg. Number of Active Patients	Range of Patients
0-9 years	99.66	5-256
10-19 years	102.55	5-217
20-29 years	101.91	23-246
30-39 years	106.79	17-202
40-49 years	117.55	43-230
50-59 years	160.64	42-308
60-69 years	165.33	79-296
70-79 years	98.67	32-215
80-89 years	47.15	8-145
90-100+ years	11.30	0-39

Figure 4 Active Patients by Age Group

6.2.6 Sex

Thirty-four physicians provided data on the number of active patients seen in the last three years by sex. Physicians saw an average of 604.21 female patients and 442.64 male patients. Sixty-five per cent of physicians (n=22/34) have more active female patients than male patients.

Sex	Avg. Number of Active Patients	Range of Patients
Male	442.64	67-810
Female	604.21	76-1214

Figure 5 Active Patients by Sex

6.2.7 Aboriginal Patient Panel

The average physician reports having an Aboriginal patient panel of 8%. Forty-five per cent of physicians (n=13/29) report that Aboriginal patients make up 5-10% of their patient panel. Thirty-one per cent of respondents (n=9) report an Aboriginal patient panel of less than 5%; 21 per cent report that 10-25% of their patients are Aboriginal; and one physician reported that 25-50% of their patients are Aboriginal.

6.2.8 Complex-Care Plan Eligibility

Most physicians (72%, n=18/25) report having fewer than 100 Complex Care Plan-eligible patients. Respondents reported having an average of 64 such patients. Seven physicians (28%) reported having 100-152 Complex Care Plan-eligible patients. On average, physicians saw 77 active Complex Care Plan-eligible patients.

6.2.9 Registry for Recalls/Billing

Most physicians (85%, n=29/34) have a registry, or perform regular audits (at least 2 per year) to ensure recalls/billing.

6.2.10Billing

Nearly a third of physicians (31%, n=10/32) billed 75-99% of patients last year, while 22% (n=7) billed 100% of patients last year. Thirty-four per cent of physicians (n=11) were unsure what percentage of their patients were billed in the previous year.

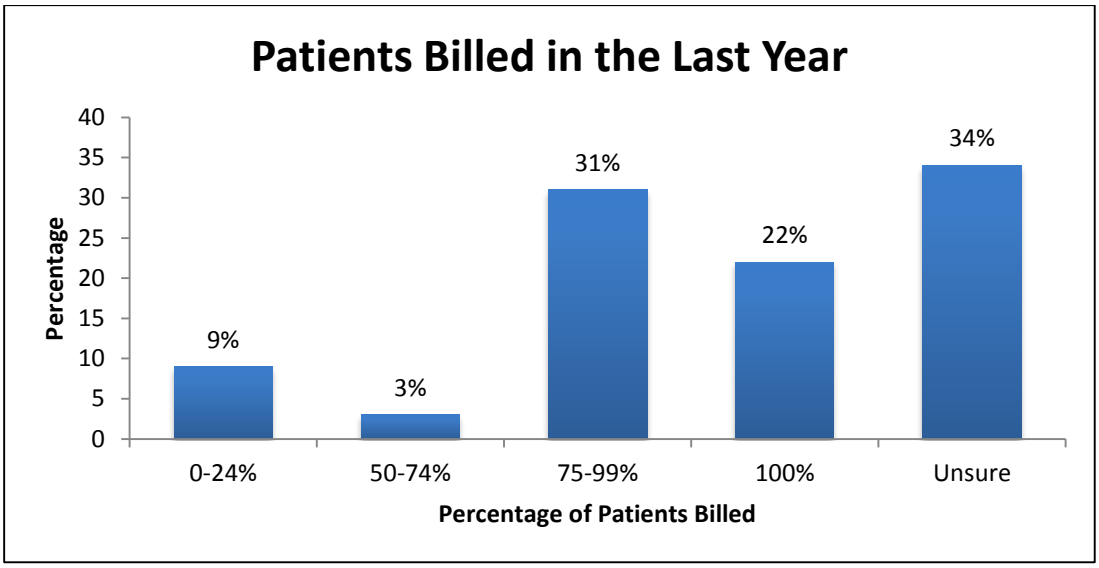

Figure 6 Patients Billed in the Last Year

6.2.11Chronic Diseases

The following table shows the number of physicians who reported seeing patients in their main office within the last three years with the diagnoses indicated below. The average number of active patients seen by those physicians is also listed, along with the range of patients seen with those diagnoses. The average physician has 143.18 active patients with hypertension; 70.88 active patients with diabetes; 69.28 patients with Axis I Mental Health (excluding depression) diagnoses; and 65.44 patients who have been diagnosed with depression.

The table also includes information on whether or not physicians have a registry or perform regular audits (at least two per year) for recalls for those diagnoses. Approximately one-third of physicians (30-33%, n=10) perform regular audits for cerebrovascular disease (CVA, TIA), chronic kidney disease, congestive heart failure, COPD, diabetes, hypertension, and ischemic heart disease. No more than two physicians reported that any patients who were eligible for extra Chronic Disease Management billing codes were billed in the last 12 months for any of

the applicable diagnoses.

Diagnosis	Physicians Reporting Active Patients	Avg. Active Patients Seen by Those Physicians	Range of Active Patients Seen	Have Registry or do Regular Audits	Physicians Reporting CDM Billing in Last 12 months	Avg. Patients for CDM Billing	Range of Patients for CDM Billing
Addictions	1	10	N/A	3	N/A	N/A	N/A
Arthritis	23	42.57	2-165	6	N/A	N/A	N/A
Axis I Mental Health (excluding depression)	18	69.28	2-425	6	1	16	N/A
Cancer	3	17	9-28	4	N/A	N/A	N/A
Cerebrovascular Disease (CVA, TIA)	31	13.03	0-55	10	N/A	N/A	N/A
Chronic Pain	12	26.92	2-78	5	N/A	N/A	N/A
Chronic Kidney Disease	30	22.8	2-91	10	N/A	N/A	N/A
Congestive Heart Failure	30	12.13	1-48	10	2	7	1-13
COPD	31	36.43	1-149	10	2	37	16-42
Depression	32	65.44	2-263	8	N/A	N/A	N/A
Diabetes	33	70.88	3-247	10	2	91.5	34-115
HIV, Hepatitis C	13	7.77	0-21	6	N/A	N/A	N/A
Hypertension	33	143.18	10-408	10	2	167.5	85-250
Ischemic Heart Disease	32	29.03	1-135	10	1	65	N/A
Neurodegenerative Disease (dementia, brain injury, MS, etc.)	10	17.8	1-59	5	N/A	N/A	N/A
Palliative	5	6.8	6-18	3	1	2	N/A

Figure 7 Active Patients with Chronic Diseases; Registry and Audits; CDM Billing

7.0 Services Provided

7.1 Practice Location

A large majority of physicians (93%, n=38/41) practice primary care medicine in their own office. Responses excluded after-hours/walk-in clinic and ER.

7.2 Routine Schedule

Most physicians schedule AM appointments with patients in their offices (n=31, MTWF AM; n=34, Thurs AM). An average of 26 physicians scheduled PM appointments in their offices on any given weekday. The lowest number of physicians (n=25) reported scheduling afternoon bookings on Tuesdays and Fridays. Other locations where physicians held AM appointments included: residential care; clinics (e.g., Brookside or Coleman); family medical offices; surgical offices; the Penelakut Tribe Office; and the physician's locum office. Other locations reported for physicians taking PM patients included: clinics; locum locations; and the Penelakut Tribe Office.

Very few physicians reported non-standard booking patterns for any day of the week. The most common non-standard booking day reported was Friday (n=5), with three physicians practicing on Fridays every other week. A small number of physicians reported non-standard booking patterns for other days of the week.

7.3 After Hours Work

Nearly three-quarters (73%, n=30/41) of physicians report staying in the office after charting their last scheduled patient. Of those respondents, 40% (n=12/30) report staying 1 hour, followed by 37% (n=11) who report staying 2 hours. Three physicians (10%) report staying 3 hours after their last patient, and two physicians (7%) report staying more than 4 hours. Two physicians (7%) reported staying less than 1 additional hour. The average respondent who stays in the office after charting their last patient remains in the office for 1 hour and 40 minutes.

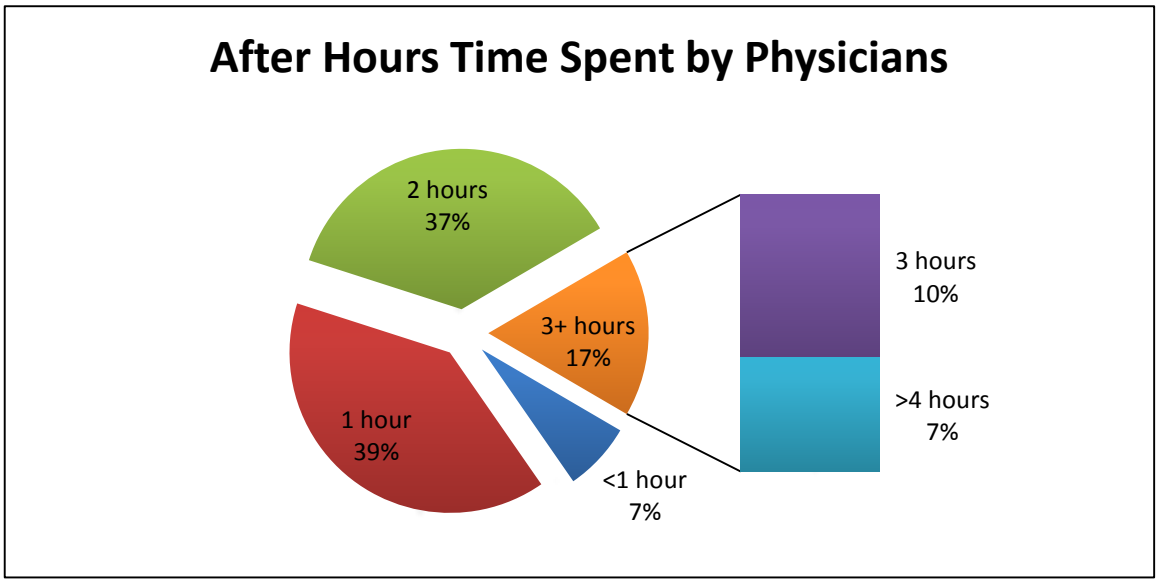

Figure 8 After Hours Time Spent by Physicians

7.4 Practice Hours

In an average week, over half of physicians (56%, n=20/26) practiced primary care at only one site, while 36% (n=13) practiced at two sites, and 8% (n=2) practiced primary care at three sites.

All physicians (n=37) report spending time in direct patient contact (i.e., appointments) at site 1. A majority of physicians spend time on direct patient-related paperwork (89% n=33/37), third party paperwork (89%, n=32/36), and charting (88%, n=29/33) at site 1. The largest number of physicians who spent time at site 2 reported they were working on charting (27%, n=9); in direct patient contact (24%, n=9); and on direct patient-related paperwork (24%, n=9). All physicians (n=19) who report spending time on panel/practice management report doing so at site 1, with 16% (n=3/19) also spending time on panel/practice management at sites 2 or 3.

7.5 Out of Office Hours

Physicians spend an average of three hours per week out of their office on work related to their main practice/patient population. Approximately one quarter of physicians spend 1-3, 3-5, and 5-8 hours out of the office on work related to their main practice (n=10/41, 10/41, and 11/41, respectively). A total of three physicians spent less than 1 hour on related work (7%); and seven physicians (17%) spend more than 8 hours on related work outside of their office.

7.6 Active Hospital Privileges

Most primary care physicians (90%, n=37/41) have active hospital privileges.

7.7 Inpatient Care

Most physicians (85%, n=35/41) provide inpatient care. The same number of physicians (85%, n=35/41) are in a weekend call group. They report receiving as many as 14 and as few as zero weekend calls. The average physician in a weekend call group receives 7 weekend calls.

7.8 Family Practice Hospital Support Program

Half of respondents (50%, n=18/36) are members of the Family Practice Hospital Support Program.

7.9 Residential Care

Most respondents practice residential home care (88%, n=36/41).

Slightly more physicians (46%, n=17/37) set up their weekend call by using a call group than by sharing it with partners (43%, n=16/37). Ten per cent of physicians' weekend call set up (n=4/37) is "solo."

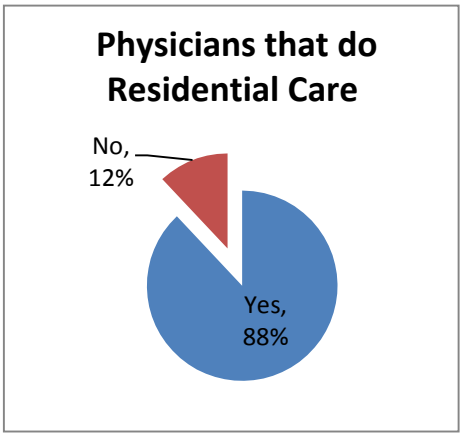

Figure 9 Physicians Practicing Residential Care

Physicians have an average of 4.5 patients (±3 patients) in residential care. One in five physicians (21%, n=8) have 3-5 patients who are currently in residential care, and over a quarter of physicians (28%, n=11/39) currently have 6-10 patients in residential care. Three physicians (8%) have between 11-15 patients currently in residential care, and 6 physicians (15%) have more than 15 patients in residential care.

7.10 Obstetrics

Only 7% of physicians (3/41) practice obstetrics. The call set up for these physicians on weekdays is primarily "call group" (66%, n=2). All respondents who have a call set up for weekends (n=2) report using a call group.

Two-thirds of physicians practicing obstetrics reported 20-29 deliveries (66%, n=2/3), while the remaining physician reported 30-39 deliveries. All three respondents report accepting prenatal/obstetric referrals from other practices.

7.11 Palliative Care

Almost all physicians (98%, n=40/41) report practicing palliative care. Seventy per cent (n=28/40) are confident in supporting all patients and families in end of life care, while the remaining 30% (n=12) said they were "somewhat" confident.

Twenty-four physicians reported needing support in different aspects of end of life care, often in more than one area. Three-quarters of respondents (75%, n=18/24) reported needing support with complex pain and symptom management. Over half (54%, n=13/24) require support in 24-hour residential care support. Thirty-eight per cent (n=9) require support with complex medical problems related to end of life care, and three physicians (13%) require support with counselling regarding expectations of the family. One physician (4%) said there was a need for a hospice.

7.12 Procedures

Most physicians (85%, n=35/41) do procedures such as lumps and bumps and IUD insertions in their own office. Three physicians (7%) perform these procedures using ambulatory care at CDH, and two physicians (5%) perform these procedures in both locations.

7.13 Locums

Nearly a quarter of physicians (23%, n=9/40) do locums to "help out a colleague"; two physicians (5%) do "true locums." The majority of physicians (70%, n=28/40) do neither.

7.14 Walk-In Patients

Over half of physicians (53%, n=21/40) do not accept walk-in patients, while 48% (n=19/40) do. No physicians reported a strictly walk-in practice.

7.15 Fee for Service

Most physicians (90%, n=34/38) report that between 90 and 100% of their primary care office work is fee-for-service. Of the nine physicians who report using an alternative payment plan for any of their primary care office work, 4 physicians (44%, n=4/9) use an alternative payment plan 10% of the time, and one physician (11%, n=1/9) reports using it 25% of the time. Four physicians (44%, n=4/9) report using an alternative payment plan less than 10% of the time.

7.16 Recalls for Patients with Chronic Diseases

Sixty-three per cent of physicians (n=22/35) perform recalls for patients with chronic diseases who have not followed up within their expected timelines and/or need guideline care.

7.17 Recalls for Specific Reasons

Most physicians (90%, n=34/38) perform recalls for any other specific reason (e.g., repeat imaging or labs due, immunization/boosters due, etc.).

7.18 Patient Self-Management

Forty-nine per cent of physicians (n=17/35) use patient self-management strategies in their practice less than half the time. The same number of physicians use patient self-management strategies more than half the time.

Over one-third of physicians (35%, n=13/37) consistently ask patients if they want or need to bring family members, friends, Elders, or other spokespersons to their appointments, especially for appointments concerning diagnosis and treatments. Nearly half of physicians (49%, n=18) engage in this practice, but "could make some improvements." Sixteen per cent of physicians (n=6) are not engaging in this practice.

Only 16% of physicians (n=5/31) consistently use the "teach back" method (i.e., have patients describe to them, in their own words, the instructions they have been given). Over half of physicians (52%, n=16/31) say they engage in this practice but "could make some improvements. Nearly one-third of physicians (32%, n=10/31) are not engaging in this practice.

7.19 Clinical Guidelines

A majority of physicians follow the most recent clinical guidelines for the following conditions: diabetes (97%, n=37/38); HTN (97%, n=37); COPD (92%, n=35); CKD (92%, n=35); CHF (87%, n=33); depression (87%, n=33); and palliative care (68%, n=26).

7.20 Mental Health Conditions

Nearly all physicians are either "confident" (45%, n=17/38) or "somewhat confident" (47%, n=18) in identifying and managing all patients with mental health conditions.

Seven physicians identified areas in which they might need support, including: counselling support; ADHD; acute psychotic break; diagnosis not clear or not responding to treatment; diagnosis by psychiatry; depression with suicide risk; psychotic illness; medication changes; social work; personality disorder; patients in crisis; patients with complex needs and side effects; and patients resistant to treatment.

7.21 Feedback from Patients

The majority of physicians (90%, n=35/39) do not have a method set up in their office to get feedback from patients about any aspect of the patient experience. Only one physician (3%) reported having a feedback method set up, while three physicians (8%) were unsure.

7.22 After-Hours Clinic Visit Reports

Of the twenty-six physicians who reported the estimated number of after-hours clinic visit reports they receive in a week, 80% (n=21/26) estimated they receive 1-10 reports per week, and 8% (n=2) received 11-20 reports per week. One physician (4%) receives more than 20 reports a week. The average amongst respondents was 6 reports per week. Two physicians said that clinics are not sending reports, with one physician indicating that this was due to privacy issues.

Eleven physicians provided audit results for the number of reports they received in the previous week. Three physicians (27%, n=3/11) received no reports in the previous week; six physicians (55%) received 1-10 reports; and two individual physicians (9% each) reported receiving 20 and 41 reports, respectively. An additional three physicians provided yearly audited report totals, ranging from 28 to 57 reports in the previous year.

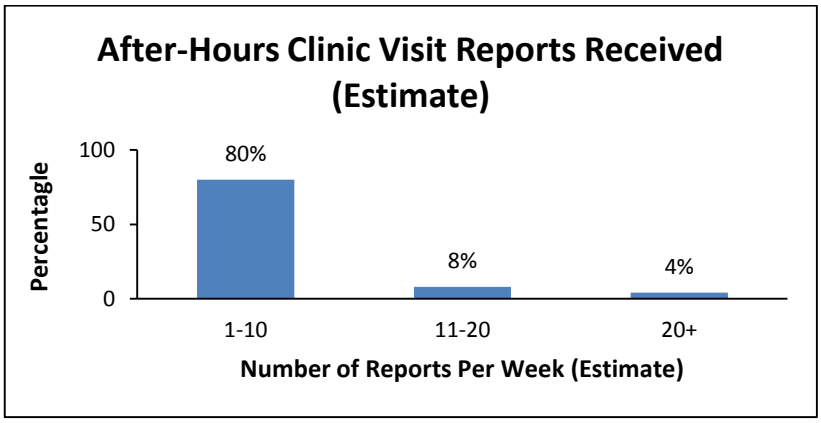

Figure 10 After-Hours Clinic Visit Reports Received (Estimate)

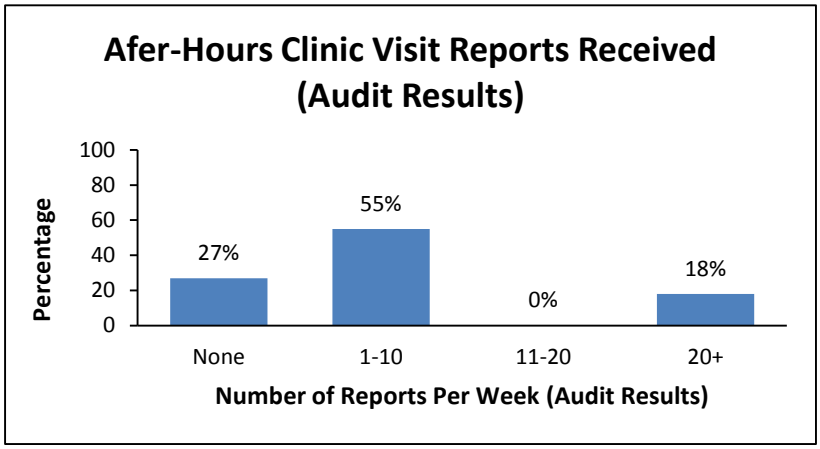

Figure 11 After-Hours Clinic Visit Reports Received (Audit Results)

7.23 ER Familiar Faces

Nearly a third of physicians (31%, n=9/29) report that 1-25 of their patients have three or more visits to the ER per year; 28% (n=8) report 26-50 ER familiar faces; 17% (n=5) report 51-75 ER familiar faces; 7% (n=2) report 76-100 ER familiar faces; two physicians (7%) report 126-150 ER familiar faces; and one physician (3%) reports 151-175 ER familiar faces. Only two physicians (7%) reported that none of their patients are ER familiar faces.

7.24 ER Summary

More than two-fifths of physicians (43%, n=15/35) would like assistance obtaining a summary of how many of their patients attended the ER in the last month, by triage level.

7.25 Specialist Support

More than half of physicians (52%, n=21/40) report having "good" access to emergent specialist support; 42% (n=17) report "good" access to urgent specialist support; and 37% report "good" access to elective specialist support. One third of physicians reported below average (20%, n=8) or "low" (13%, n=5) access to elective specialist support.

8.0 Capacity/Satisfaction

8.1 Regular Absences

Only 5% of physicians (n=2/39) report regularly taking lengthy time away from practicing primary care in the Cowichan region. The physicians who report taking time off report working every other week, with a long-term locum to cover; another reports taking 6-8 weeks for holidays, including blocks of 2-3 weeks in the summer.

8.2 Past Absences

Fifteen per cent (n=6/40) of physicians have taken significant time off in the last three years. Of those respondents, half reported taking time off for maternity leave, and half reported absences due to sabbaticals ranging from 4 to 6.5 months.

8.3 Significant Time off in Next Three Years

Most physicians (88%, n=35/40) do not plan to take significant time off in the next three years. Two physicians (5%) anticipate that they will take significant time off in the next three years, and three (8%) are uncertain.

8.4 Changes in Practice

Most respondents (83%, n=7/40) have no plans to cut back their office work in the next three years. Four physicians (10%) are uncertain, and three physicians (8%) do anticipate reducing their hours of work. Stated plans included: reducing to part-time hours; reducing hours in office; and possible retirement.

8.5 Planning

More than one-in-five physicians (22%, n=6/27) are currently in the process of trying to recruit another physician to work in their office, or are planning to do so within the next year. A majority of physicians (82%, n=22) are attempting to “find a short-term locum for coverage for holidays, CME, etc.” Two physicians (7%) will “merge their practice/office with another existing practice/office”; and one physician will “find a long-term locum (e.g., for a maternity leave, sabbatical).” No physicians were attempting to “find a replacement (e.g., to move or retire)” within the next year. One physician (4%) stated they needed another 1-2 people at urgent care within the next year.

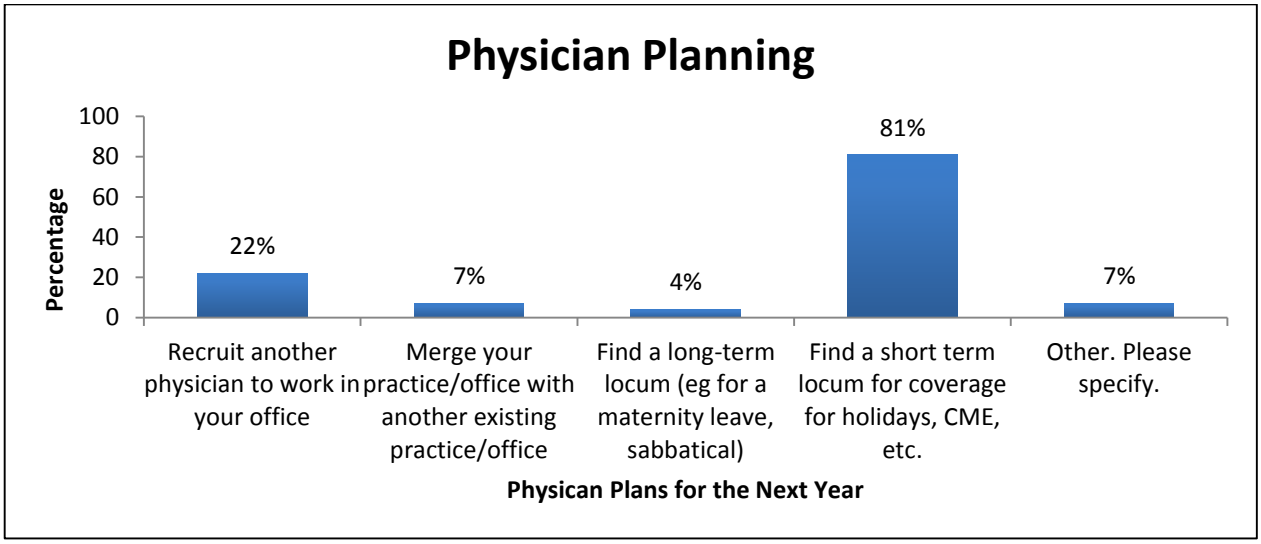

Figure 12 Physician Plans for Next Year

8.6 Increased Capacity

Half of physicians (50%, n=19/38) report that they have increased capacity in their office in the last 4 years. Over a third of physicians (34%, n=13) have not increased capacity in their office in the last 4 years, and 16% (n=6) are unsure.

8.7 Increased Efficiency

Most physicians (69%, n=27/39) report they have increased efficiency in their office in the last 4 years. Seven physicians (18%) reported that they were unsure, and five (13%) stated that they had not increased efficiency in their office.

8.8 Future Vision

Over one-fifth (23%, n=9/40) of physicians have a vision of changing the way they practice primary care medicine in the future, while 20% (n=8) are unsure. Physicians' specific visions include: group visits; stopping group practice in five years to work as a locum; more palliative care; working on a call share for lodge patients for intermittent coverage; a private practice/team-based model; increasing surgical practice of lumps and bumps; incorporating new physicians into the clinic and working with one other healthcare provider (RN, mental health, RT, behaviourists, etc.) within practice; and working sessionally or in a shared practice if the opportunity arises. One physician stated their future vision would depend on how the primary care teams look when rolled out.

8.9 Other Clinical Setting

Less than half (43%, n=17/40) of physicians practice in other clinical settings, including after-hours or walk-in clinics. Physicians were asked to report the number of hours, shifts, or sessions worked in a month, and it is not clear in every instance which measurement they were using. As a result, meaningful data for the amount of time worked is not available. However, seven physicians reported working in the ER; three physicians reported working MOCAP call; two physicians reported working at a maternity clinic; two physicians worked as sessionals; and two physicians worked in walk-in clinics. Single physicians worked surgical assists for patients not in their practice; WCB; Aboriginal health; cosmetic medicine; hospital/DOD; and in residential care.

8.10 Non-Clinical Work

For physicians who reported doing non-clinical work (paid or unpaid) in an average month, the largest number of physicians (n=16) reported spending time in CME lectures, for approximately four hours a month. The second largest number of physicians spent time in unpaid meetings (n=13, avg. 3.35 hours), followed by: teaching (n=11); board positions (n=9); other, e.g. sports team doctor, PARTY program volunteering, GP referrals for vasectomies, etc. (n=6); hospital committees (n=5); PSP – GP Champion (n=4); and administrative positions (n=3, avg. 3.33 hours).

8.11 Learners in Primary Care Office

Nearly all responding physicians (96%, n=23/24) have medical student learners in their primary care office. Forty-six per cent (n=11) have residents, and 8% (n=2) have nurse practitioners in their primary care office.

Eight physicians (62%, n=8/13) report spending one term per year with medical students, while 23% (n=3) spend two terms per year with the students, and 23% (n=3) have elective (i.e., full time) students. Seven physicians report that residents are in their office on “Family Medicine Block,” while two are on elective time, and one is in their office on “Native Health Block.” Physicians with nurse practitioners in their office reported that they were there 2-4 hours at a time; or on a “2 hour longitudinal plus 8 months per year; 2 residents currently with Aboriginal program.”

8.12 Supervising Learners in Other Clinical Locations

Fourteen physicians report supervising learners in other clinical locations, with 86% (n=12/14) supervising medical students and 79% (n=11) supervising residents. No physicians reported supervising nurse practitioners in other clinical locations.

Physicians reported this supervision took place in different locations, including: Cowichan District Hospital; Chemainus Health Care Centre ER; CMC; emergency rooms; the hospital; a maternity clinic; urgent care; diabetes teaching sessions; and the lodge for student with a geriatric interest. The amount of time physicians spent with their learners varied greatly, including 1.5 hours per week; 2 hours per week; 4 hours per session; and 10-20 hours per week when at the site. Other physicians reported monthly totals, including 1-2 shifts a month; 3-4

call days a month; 48 hours per month; one day per month or 48 hours every 8 weeks; and one day every second week.

8.13 Faculty Position

Over a third (35%, n=13/37) of physicians have a faculty position. For respondents who indicated the type of position, the most common position was clinical instructor (60%, n=6/10). Other positions reported were: assistant clinical professor; associate clinical professor; and associate professor.

8.14 Research

Only one physician (3%, n=1/39) reported spending time on research.

8.15 Recreation

The average physician took off five weeks for recreation in the last year. Seventy-nine per cent of physicians (n=25/33) took 2-6 weeks for recreation, and 15% (n=5) took 7-8 weeks. Individual physicians (3% each) took 1 week and 12 weeks off for recreation.

8.16 CME Activities

Twenty physicians report taking an average of seven days off for CME activities in the last year. Forty-per cent of physicians (n=8/20) took 2-5 days off for CME activities; 40% (n=8) took 6-8 days off; and 20% (n=4) took 10-14 days off.

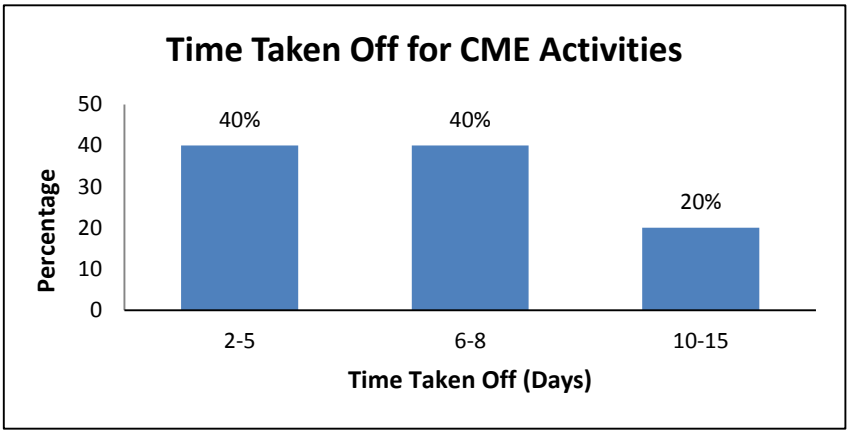

Figure 13 Time Taken Off for CME Activities

On average, 38 physicians had 67% (± 24.2) reimbursement of their CME activities for BCMA. Only 16% (n=6/38) reported 100% reimbursement, while 26% (n=10) reported 0-20% reimbursement.

8.17 Office Space

Physicians report that an average of five physicians work in their office space. Fifteen physicians (38%, n=15/39) report 3-4 physicians working in their office space; 23% (n=9) report 5-6 physicians in their office space; and 28% report 8 physicians in their office space. Only 10% of physicians (n=4) report that they do not share their office space with another physician.

8.18 Sharing Office Space

Twenty-six physicians provided the names of physicians with whom they share space, ranging from two to seven names.

All physicians who report sharing resources report that they share both space and staff (100%, n=34/34). Ninety-seven per cent (n=33) of physicians report sharing common expenses/overhead, and 32% (n=11) share patients.

8.19 Sharing Patients

Of the 30 physicians who share patients, 77% (n=23/30) have an official "main provider" documented in the chart. Four physicians reported that where no official main provider was documented, 0-20% of their patients have an "unofficial" main provider.

Almost all physicians who do not share patients report doing cross-cover for office appointments (97%, n=28/29), while slightly fewer physicians report doing cross-cover for inpatient care (89%, n=24/27).

8.20 Office and Physician Hours

Physicians report an average of 8 hours a day when the patient telephone line is answered. Seventy per cent of physicians (n=16/23) report 8-8.5 telephone hours; 17% (n=4) report 8.5 hours; 17% (n=4) report 7.5 hours; 9% (n=2) have 9 telephone hours a day; and one physician (4%) has 6 telephone hours a day.

Over one quarter of physicians (27%, n=10/37) report that during standard Monday to Friday office hours their offices will close for a lunch break.

Physicians' offices are open for an average of 41 hours per week with one or more physicians seeing patients, with 88% of offices open 33-45 hours per week (n=30/34). Nine per cent are open 46-51 hours per week; and 3% (n=1) are open 30 hours per week.

The average number of physician hours per week is 130, ranging from 35 to 245 hours. Nine physicians' offices (29%, n=9/31) have 35-80 physician hours per week; 32% (n=10) have 105-124 physician hours per week; 10% (n=3) report 180-189 physician hours per week; and 29% of physicians' offices (n=9) report 200-245 physician hours per week. Five physicians report having another primary care provider (i.e., NP), who is available an average of 29 hours per week.

8.21 Administrative Staff

Thirty-seven physicians report an average of 5.4 (± 2.58) administrative staff members in their office. A majority of physicians (51%, n=19/37) have 3-4 administrative staff members. Fourteen per cent (14%, n=5) have 6-7 administrative staff; 16% (n=6) have 7-8 staff; and 11% have 10-11 administrative staff in their office.

Thirty-eight per cent of physicians (n=13/34) have a ratio of 1 MOA FTE: 1 MD FTE. Six physicians (18%) have a ratio of 1.2-1.5 MOA FTE: 1 MD FTE. Five physicians (15%) report a variation of 3 MOA FTE: 7-8 MD FTE, manager, billing clerk, RN, LPN. Three physicians (9%)

report 2 MOA FTE: 1 MD FTE; and two physicians (6%) report 1 MOA FTE: 4 MD FTE. Other reported ratios include: 0.8 MOA FTE: 1 MD FTE; 1 MOA FTE: 1.4 MD FTE; and 3 MOA FTE: 2 MD FTE.

8.22 Multi-disciplinary Team Members

Only 19% of physicians (n=7/37) report having no multi-disciplinary team members associated with their clinic. Forty-one per cent (n=15) have an RN as a multi-disciplinary team member; 30% (n=11) have an LPN; 8% (n=3) have an NP; 8% have a spiritual elder/counsellor; 8% have a cognitive assessment member team member; and 3% (n=1) have a seniors' outreach member. Other reported multi-disciplinary team members include: behavioural therapists; HCA; massage therapists; orthotics; RMT; and working closely with the Lodge.

A majority of physicians (83%, n=30/36) said they would benefit from having additional access to multi-disciplinary care team members in their practice. The largest numbers of physicians said they would benefit from access to: a counsellor (79%, n=23/29); a social worker (59%, n=17); a dietician (52%, n=15); and a behaviourist (31%, n=9). Twenty-four per cent of physicians (n=7) said they would benefit from an LPN or RPN; 17% (n=5) would benefit from access to an NP; and individual physicians (3% each) said they would benefit from access to a navigator and a physiotherapist.

A majority of physicians (62%, n=23/37) said they had room in their office to accommodate additional staff.

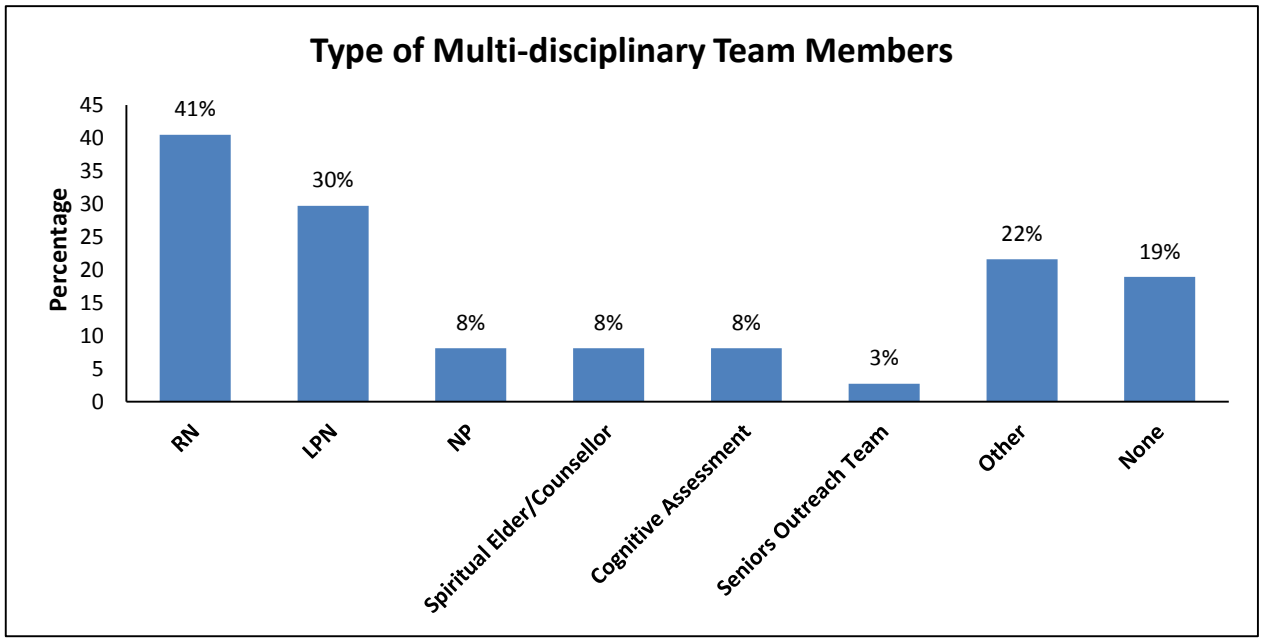

Figure 14 Type of Multi-disciplinary Team Members

8.23 New Patients

Less than a quarter (23%, n=9/40) of physicians are taking on new patients with the intention of becoming their primary care provider (i.e., complete, long-term patient care, not simple transient visits/walk-in clinic follow-ups/obstetrics, etc.). More than three-in-five physicians

(63%, n=25/40) accept new patients "only in specific circumstances (e.g., family of current patients, patients met at walk-in clinic, etc.)."

Physicians who are taking on new patients, including those who take on patients under specific circumstances, take on anywhere from 1 to 4.5 patients a month, for an average of 2.32 (±1.27) new patients a month. Seven physicians responded that they were "busy," had a "full practice," were "overburdened" or did not want to be overworked as reasons that prevented or deterred them from taking on more patients.

8.24 Patient Panel of Newly Attached Patients

After running an accurate patient panel, twelve physicians report they have attached between 10 and 296 patients since they started tracking, with an average of 106.63 new patients. Five physicians report attaching fewer than 100 patients (42%, n=5/12); 33% (n=4) have attached 100-150 patients; 8% (n=1) have attached 150-200 patients; and 17% (n=2) have attached 250-300 new patients. An additional five physicians reported that they were "unsure."

8.25 Unintended Patients

Over half of physicians (54%, n=20/37) see patients in their office with whom they do not intend to take on/begin a primary care relationship. Fifty-five per cent of physicians (n=12/22) said these patients represent 0-1% of their appointments in an average week. Five per cent of physicians (n=1) said these appointments represent 2-3% of their weekly appointments; 9% (n=2) said it was 4-5%; 18% (n=4) said it was between 5 and 10%; 5% (n=1) said it was 10-20%; and for two physicians (9%) these patients make up more than 30% of their weekly appointments.

8.26 Residential Care Patients

Forty-two per cent of physicians (n=17/41) accept new residential care patients, and one physician (2%) indicated they do not currently accept new residential care patients, but they are willing. Over half of respondents (56%, n=23/41) say they are not interested in accepting new residential care patients.

8.27 Professional Life

Seventy-eight per cent of physicians (n=31/40) are either "satisfied" or "very satisfied" with their professional life in their primary care office. Thirteen per cent of physicians (n=5) report that they are neither satisfied nor dissatisfied, and 10% (n=4) are "dissatisfied" with their professional life in their primary care office.

A majority of physicians (60%, n=24/40) are "satisfied" or "very satisfied" with their professional life in medical practice outside the office. Seven physicians (18%) are neither satisfied nor dissatisfied, and seven physicians are "dissatisfied" or "very dissatisfied" with their professional life in medical practice outside the office.

8.28 Patient Care

More than half of physicians (55%, n=22/40) are satisfied with the care they are able to provide to their patients, and an additional 30% (n=12) are "very satisfied." Two physicians (5%) report

that they are dissatisfied with the care they are able to provide their patients.

8.29 Life Outside Work

Nearly a third of physicians (30%, n=12/40) report that they are "satisfied" with the amount of time available to them outside of work, while an additional third (33%, n=13) are "very satisfied." One-fifth of physicians (20%, n=8) are "dissatisfied" or "very dissatisfied" with the amount of time available to them outside of work, and 18% (n=7) are neither satisfied nor dissatisfied.

More than half of physicians (56%, n=22/39) are "satisfied" or "very satisfied" with the quality of time available to them outside of work (e.g., having to have their pager on). Eighteen per cent (n=7) are "dissatisfied" or "very dissatisfied" with the quality of time available outside of work, and one quarter (26%, n=10) are neither satisfied nor dissatisfied.

8.30 Financial Remuneration

Half of physicians (51%, n=19/37) are "satisfied" by the financial remuneration they receive for their office/primary care practice, and an additional 11% (n=4) are "very satisfied." One-fifth of physicians (22%, n=8) are "dissatisfied" by their compensation, and 16% (n=6) are neither satisfied nor dissatisfied.

8.31 Personal Challenges

Physicians were asked to rank how the issues below impacted their primary care practice, on a scale from 1 to 5, with 1 being "no impact" and 5 being a "significant impact." The totals below represent the number of physicians who reported an issue had a moderate (3) to significant (5) impact on their primary care practice.

Physician Challenge Reported	Frequency
Balancing home/family and work life	35 (90%, n=35/39)
Keeping up with new information/guidelines/CME	30 (75%, n=30/40)
Locum coverage/poor locum availability	27 (69%, n=27/39)
Maintaining a cost-effective practice	24 (65%, n=24/37)
Retirement planning	22 (56%, n=22/39)
Learning and using EMR effectively using billing codes	18 (46%, n=18/39)
Staffing issues	15 (38%, n=15/39)

Figure 15 Personal Challenges Faced by Physicians (Moderate to Significant Impact)

8.32 Impact of Work on Family Life

Work causes family conflict/stress for half of physicians (51%, n=20/39). All physicians who specified the source of this stress said it was caused by not having enough time to spend at home or with their family due to long hours and too much work.

8.33 Better Work/Life Balance

Physicians said the Division could provide better locum coverage (n=4), physician recruitment

(n=2), and wellness programs or strategies (n=2) to improve physicians' work/life balance. One physician said a reduced paperwork load would improve both work/life balance and time for patient care.

8.34 Additional Comments

Three physicians provided additional comments on questions 110-112. One physician said they would have to cease hospital work if they did not receive more assistance. Another physician recommended physician health programs, including mindfulness-based stress reduction, and another said that the lack of flexibility, including the need to commit to all sessions, was a barrier to participation in PSP models.

8.35 CVDFP Membership

Almost all respondents (97%, n=36/37) are members of the CVDFP. The one non-member (3%) is not interested in joining at this time.

8.36 Representing Interests

Almost half of physicians (49%, n=19/39) are "very confident" the the CVDFP represents their interests, while 41% (n=16/39) are "somewhat confident." Five per cent of physicians (n=2) are "unsure," and 5% are "not confident" that the CVDFP represents their interests. One physician said the scheduling of evening events and morning rounds does not suit their practice or work/life balance.

8.37 Teaching/Support

Twenty-seven physicians said they would like continued support to find locums, and continued support with initiating or optimizing EMR usage. Twenty-three physicians would like continued support for continuing education for their MOAs, and 21 physicians would like continued support with incentive billing. Thirteen physicians would like support with administrative continuing education, and 12 would like assistance with incorporating a multi-disciplinary team member (SW, LPN, RN, dietician, etc.). Between 8 and 9 physicians requested assistance with: finding a partner; "exit planning"; incorporating a nurse practitioner or physician assistant into their office; or completing the Physician Self-Assessment Report survey.

No physicians requested support with changing from solo to group practice.

8.38 Coaching

One-fifth of physicians (21%, n=8/38) are willing and able to coach other physicians. Of the four physicians who provided additional information, three (75%) indicated that they could provide

EMR coaching. Individual physicians also said they could assist with Dragon Dictation software; PSP modules; and mental health.

8.39 Pride of Practice

Physicians are most proud of the quality of care they provide (82%, n=32/39), followed by: positive, long-term relationships with patients (77%, n=30); full-service comprehensive care

(67%, n=26); patient advocacy and support (62%, n=24); and providing a well-organized and efficient practice (59%, n=23). Physicians who specified additional responses said they were most proud of their compassion; that EMR has become a useful adjunct to their practice; and their welcoming office and happy work environment.

8.40 Insights Gained from Physician Self-Assessment

More than half of respondents (54%, n=13/24) said they recognized a need to better optimize EMR as a result of this assessment. Half of physicians (50%, n=12) said they recognize they need more information to utilize all incentive codes, and one-third (33%, n=8) recognized they needed to improve Chronic Disease Management. One-quarter of respondents (25%, n=6) said they needed to bill more specifically. Individual physicians (4% each) said the self-assessment reminded them of the need to "teach back," and to ask their MOA about their wait times.

8.41 Immediate Change

Nine physicians recognized immediate and obvious changes they could easily make, including:

- Finding time to optimize EMR;
- Increasing their same-day appointment ratio;
- Taking advantage of more PSP modules;
- Finding accurate contact information for available services; and
- Setting dates to run lists for CDM codes/billing.

8.42 Long-term Change

Eighteen physicians said they had identified areas for long-term changes for the next 1-2 years, including:

- Incorporating group visits;
- Familiarizing themselves with complex care fees;
- Centralized lists for community services;
- Working towards team-based care;
- Better organization of EMR;
- Planning for their retirement by finding a replacement;
- Finding a physician to assist in their office;
- More ER shifts;
- More time off;
- Better registries/recalls for CDM;
- Better cooperation between hospital maternity group and other office-based groups; and
- Finding a new office manager.

8.43 Change in Past Six Months

Twenty physicians reported making changes in the past six months. Four physicians (20%, n=4/20) reported improved EMR use. Other physicians reported changes including: better billing practices; charting and immunization improvements; accepting new patients without over-scheduling; using new templates; improvements related to COPD; improvements related

to opioids; making longer appointments with patients; and decreasing workload for better work/life balance.

8.44 Additional Resources

Nineteen physicians identified additional resources that would help them manage their patients, including:

- Access to increased psychology resources for adults and children;
- ER and specialist reports coming directly to EMR;
- Easy-to-access patient information handouts in the EMR pre-made medication templates;
- Assistance with patient self-management;
- A personal assistant;
- A paramedical employee in their office;
- Locum support;
- A social worker/counsellor;
- Educators;
- Patient navigator;
- More physicians on electronic fax system to send letters of patients seen in clinic;
- A clinic nurse with a focus on chronic disease management;
- Mental health, obesity, healthy eating, and active lifestyle resources; and
- Improved imaging wait-times.

8.45 Unique Practice

Twenty physicians provided information on what makes their practice unique, including but not limited to:

- High Aboriginal and elderly client load;
- More complex care and elderly care;
- Visiting patients in ER for follow-up;
- Sharing half-time with another physician;
- Covering other physician's practice entirely on off-days;
- Prioritizing own work/life balance to improve quality of patient care;
- Part-time practice with lots of time devoted to each patient; and
- Group visits.

8.46 Additional Learning

Thirteen physicians indicated topics they would like to learn more about, including:

- Billing issues;
- Billing as a locum;
- How other physicians use EMR;
- MSK module and EMR audits;
- Patient access to Med Access;
- Business management of medical practice;

- Setting up a website for medical practice;
- Meditation and mindfulness; and
- Specific medical issues, including: chronic pain management; mental health; palliative care; ADHD; urology; diabetes; COPD; and immunizations.

9.0 Practice Improvement

9.1 Daily Tasks

Most physicians (81%, n=30/37) think they perform tasks daily that could be done effectively and safely by non-physician staff or patients, including: blood pressure checks; ear syringing; dressing changes; injections; phone calls; paperwork preparation; foot care; liquid nitrogen; and temperatures.

9.2 GPSC Incentive Payment Programs

Most physicians are aware of GPSC incentive programs, including: complex patient care incentive payments (n=28); condition-based incentive payments diabetes, CHF, hypertension, and/or COPD (n=28); prevention incentive payments (n=28); telephone advice with a specialist/GP with specialty training (n=26); mental health patient care incentive (n=25); end of life incentive payments (n=23); and community patient conferencing incentive payments (n=22).

Fewer physicians were familiar with: facility patient conferencing incentive payments (n=21); acute care discharge planning (n=15); family physician obstetrical premium payments (n=15); Maternity Care Network initiative payment (n=14); and Obstetrical Delivery Bonus (n=15).

A majority of physicians routinely bill GPSC incentive payment programs with which they are familiar, with the exception of: facility patient conferencing incentive payments (46%, n=13/28); Obstetrical Delivery Bonus (31%, n=5/16); Maternity Care Network initiative payment (27%, n=4/15); and family physician obstetrical premium payments (25%, n=4/16).

9.3 PharmaNet

Almost half (49%, n=20/41) of physicians subscribe to PharmaNet for access to patient prescription records.

9.4 Patients Seen

Thirty-nine physicians see an average of 15.05 patients (± 3.36) in a three-hour stretch. Three physicians (8%) see 11 patients; 62% (n=24) see 12-16 patients; 26% (n=10) see 17-21 patients; and two physicians (5%) see 22 patients in a three-hour stretch.

9.5 Appointments

Almost half of physicians (45%, n=18/40) book appointments at a frequency of 15 minutes. Eleven physicians (28%, n=11) book appointments at a frequency of 10 minutes; five physicians (13%) book 10-15 minutes; five physicians (13%) book at a frequency of four per hour; and one physician (3%) books 4-5 per hour including fit ins.

Three of the above physicians (8%) who book 10-15 minute or 15 minute appointments also book 30 minute appointments for physicals. Others allow time for fit ins or urgent access.

9.6 Appointment Time Blocks

Over a third of physicians (35%, n=14/40) have 3-4 different types of appointment time blocks in their schedule, while one-third of physicians (33%, n=13) have 7 or more different types of appointment time blocks. Twenty-three per cent of physicians (n=9) have 5-6 time blocks; and 10% (n=4) have 1-2 time blocks in their schedule.

9.7 Advanced Access and Traditional Booking

Most physicians (72%, n=26/36) practice Advanced Access booking (encouraging 40%+ of same-day appointments), while the remainder (28%, n=10) practice traditional booking (appointments booked far in advance).

9.8 Next Available Appointment

If a patient calls at 8:00 am on an average work day, the majority of physicians (59%, n=23/39) report that the third next available appointment they could book with a primary care provider is "today." Eighteen per cent of physicians (n=7) report it would be 1-2 days; 15% (n=6) report 3 days; 5% (n=2) report 4-5 days; and one physician (3%) reports the third next available appointment with a primary care provider would be in 6-10 business days.

9.9 Same Day or Next Day Appointments

Over half of physicians (51%, n=20/39) schedule 21-60% of appointments within 36 hours of the patient phone call. Forty-one per cent of physicians (n=16) schedule 61-100% of appointments within 36 hours.

9.10 Visit Process

Nearly three-quarters of physicians (74%, n=29/39) report that patients complete the visit process (i.e., from the time they come in until they leave) in 30 minutes or less, with slightly more than two-fifths (41%, n=16) reporting that their cycle time is 20 minutes or less. Twenty-three per cent of physicians (n=9) report that their patient cycle time is between 30 and 45 minutes.

9.11 Measuring Patient Cycle Time

Forty-three per cent of physicians (n=17/40) have a process to measure patient cycle time (i.e., the time from patient sign-in to departure). Only 29% of physicians (n=6/21) who have such a process report that they use it regularly.

9.12 Feeling Rushed

Half of physicians report feeling rushed when seeing patients either "frequently" (45%, n=18/40) or "almost always" (5%, n=2). One-fifth of physicians (20%, n=8) report feeling rushed "half the time," while 30% (n=12) report that they "rarely" feel rushed.

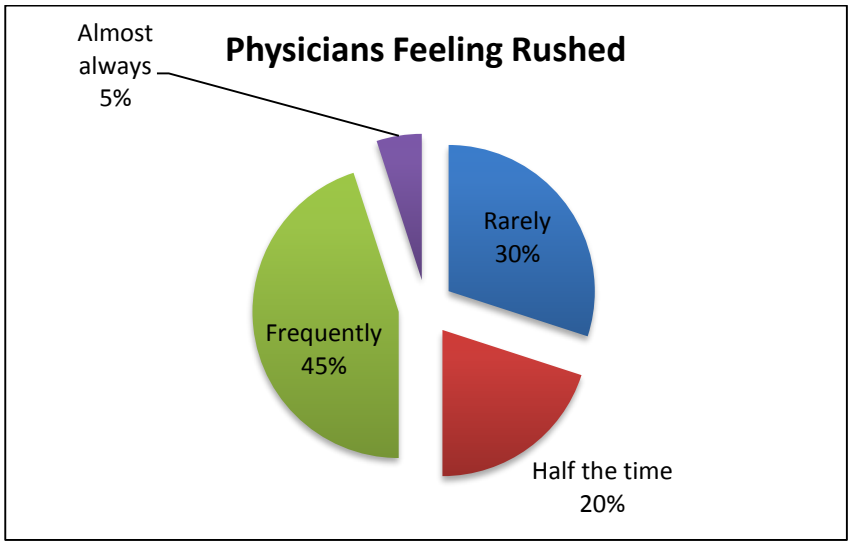

Figure 16 Physicians Feeling Rushed

9.13 Daysheet/Appointment List

Nearly a third of physicians (30%, n=12/40) "almost always" check ahead in their daysheet/appointment list with the intention of preparing for appointments, tracking down results, anticipating difficult visits/patients, etc. Twenty-three per cent of physicians (n=9) "frequently" check ahead, while 35% (n=14) do so "half the time." Only 10% of physicians (n=4) "rarely" check ahead, while 3% (n=1) "never" do so.

9.14 Start and End of Primary Practice Office Workday

Most physicians (81%, n=33/41) generally start their primary practice office on time as scheduled. However, only 44% (n=17/22) generally end work at their primary practice office on time.

9.15 Staff and Physician Feedback

Sixty per cent of physicians (n=24/40) have a mechanism in place to get office staff and physician opinions about patient flow, task distribution, office routines, etc. The most common practice is doctor and/or staff meetings, with 13 physicians (59%, n=13/22) citing "monthly" meetings. Other physicians hold "regular" or as needed meetings. One physician (5%) noted they meet with their scheduler and runner at least once a day.

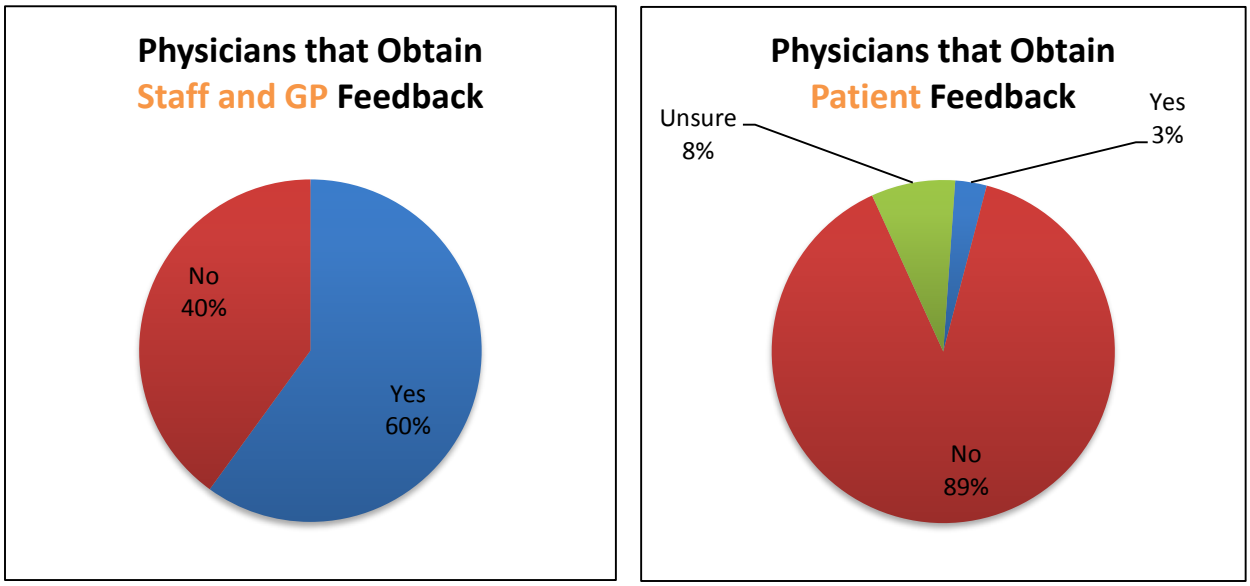

Figure 17 Physicians that Obtain Staff and GP Feedback; Physicians that Obtain Patient Feedback

9.16 Staff Policies

Almost all physicians (92%, n=36/39) have staff policies, procedures, and job descriptions.

9.17 Group Office Visits

One-fifth of physicians (21%, n=8/31) have organized a group office visit. Only 16% of physicians (n=5/31) continue to do group visits, or plan to do group visits in the future, while 71% (n=22) do not, and 13% (n=5) are "unsure." The two physicians who indicated the location of their group visits said they took place in the "office," and that they concerned diabetes; or diabetes, COPD, and mental health. One physician noted the frequency of these visits, which took place every three months.

Physicians were asked whether they used a facilitator from Island Health for group visits. All twelve respondents indicated they did not. A single physician specified that they used an "office nurse" as a facilitator.

9.18 After-Hours Care

More than a third of physicians (38%, n=14/37) provide after-hours care to their patients by referral to an after-hours clinic. Eight per cent of physicians (n=3) provide after-hours care through an after-hours phone line, while 5% of physicians (n=2) use both clinic referrals and an after-hours phone line.

Nearly half of physicians (49%, n=18/37) use an alternative method to provide after-hours care, including referral to the ER (35%, n=13); an urgent care clinic (11%, n=4); a walk-in clinic (11%, n=4); or a combination of the above. One physician noted they run a clinic on Saturdays and statutory holidays.

9.19 EMR

All physicians (n=41) report that their office has an EMR. Respondents who specified the type of EMR report using Med Access (n=30).

9.20 Starting Use of EMR

Nearly half (45%, n=17/38) of physicians started using an EMR in 2010. Eleven physicians (29%) started using an EMR between 2003 and 2009. Six physicians (16%) started using an EMR between 2011 and 2014. Three physicians (8%) started using an EMR in 1996, and one physician (3%) reports that they have "always" used an EMR.

9.21 Physician Challenges with EMR

Most physicians (89%, n=32/36) reported challenges with implementing an EMR. The largest categories of challenges identified related to: computer literacy (33%, n=12), including difficulties learning the system or typing; and data entry (28%, n=10). Other reported challenges related to ease of use (22%, n=8), workflow (17%, n=6), and trying to learn the system while maintaining a connection with patients during their visits (8%, n=3).

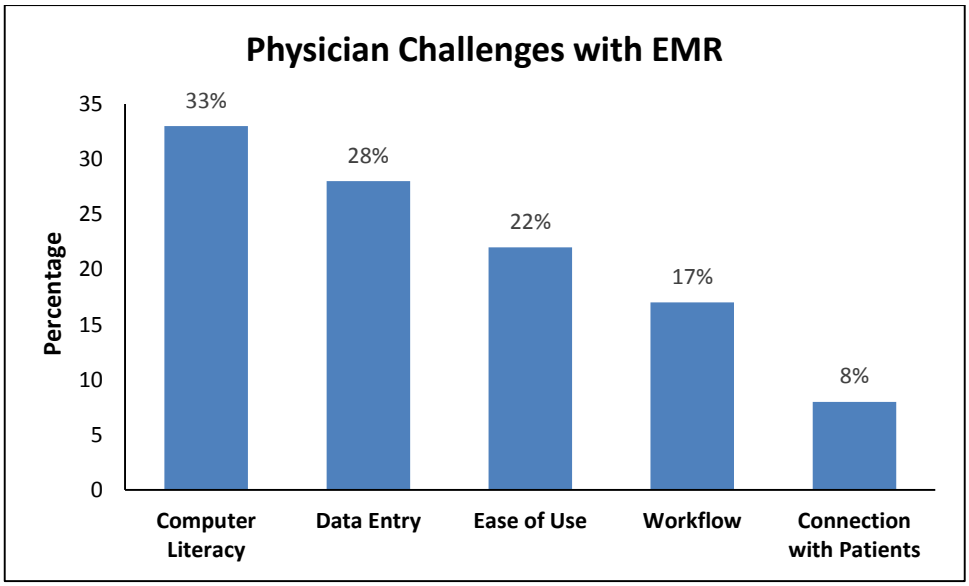

Figure 18 Physician Challenges with EMR

9.22 Staff Challenges with EMR

Twenty-five physicians reported on their staff's biggest challenges implementing an EMR, while three physicians reported the question was not applicable (11%, n=3/28). The most commonly reported challenges related to learning the system (32%, n=9); data entry (32%, n=9), and ease of use (21%, n=6).

9.23 Purpose for Use of EMR

All physicians (n=41) use their EMR for full charting (no paper). Most physicians also use their EMR for scheduling/billing (90%, n=37/41) and patient recall/decision making (88%, n=36).

9.24 EMR MU3 Assessment

A majority of physicians (86%, n=30/35) have obtained an EMR MU3 assessment.

9.25 EMR Usage

All physicians (n=40) report consistently using their EMR for scheduling/daysheet management; storage of lab results; lab interface for direct download of results for LifeLabs/Excelleris; and patient encounter notes. Ninety-eight per cent of physicians (n=39/40) report consistently using their EMR for billing/invoicing; writing consultation letters; maintaining up-to-date problem lists; and maintaining up-to-date chronic medication lists. Ninety-five per cent of physicians (n=36/38) consistently use their EMR for lab interface download of results for Hospital/Cerner; 93% (n=37/40) consistently use their EMR for performing recalls; and 90% (n=36/40) consistently use their EMR for messaging/tasking staff.

Fewer physicians, although still a majority (80% n=32/40) are consistently using their EMR to message colleagues. Only three quarters of physicians (75%, n=30/40) are consistently using their EMR for reporting, with 18% (n=7/40) reporting inconsistent use. Five per cent (n=2/40) are not currently using EMR for reporting, but would like to, and 3% (n=1/40) do not use EMR for reporting and are not interested at this time.

9.26 Issues Affecting Physician Ability to Increase EMR Usage

Training is identified as a limiting factor affecting physicians' ability to increase EMR usage in their office. Half of physicians (50%, n=19/38) reported a need for general training about EMR potential was mildly limiting their EMR usage, while and additional 34% said it was moderately (18%, n=7), significantly (13%, n=5), or very significantly (3%, n=1) affecting their ability to increase EMR usage. A need for specific EMR training was a moderately or significantly limiting factor for 58% of physicians, and a very significantly limiting factor for 5% (n=2). An additional 24% (n=9) reported it was a mildly limiting factor.

Almost half of physicians (48%, n=19/40) say their typing skills limit their ability to increase EMR usage in their office, and 59% of physicians report their computer navigation skills mildly (44%, n=17/39) or moderately (15%, n=6/39) limit their ability to increase EMR usage. A majority of physicians (68%, n=25/40) said anticipated concerns regarding physician workflow were not limiting their ability to increase EMR usage. Time constraints were reported as a limiting factor for one physician.

9.27 Issues Affecting Administrative Staff's Ability to Increase EMR Usage

The largest limiting factors affecting administrative staff's ability to increase EMR capabilities in their offices are a need for general (45%, n=17/38) or specific (46%, n=17/37) EMR training. Nearly a third of physicians (32%, n=12/38) report anticipated concerns regarding physician workflow are a limiting factor. Over a quarter of physicians (26%, n=10/38) report that computer navigation skills limit their staff's ability to increase EMR capabilities. Typing skills are not a limiting factor for the majority of physicians' staff (90%, n=34/38). No physician identified costs and time to develop and train new staff as a limiting factor.

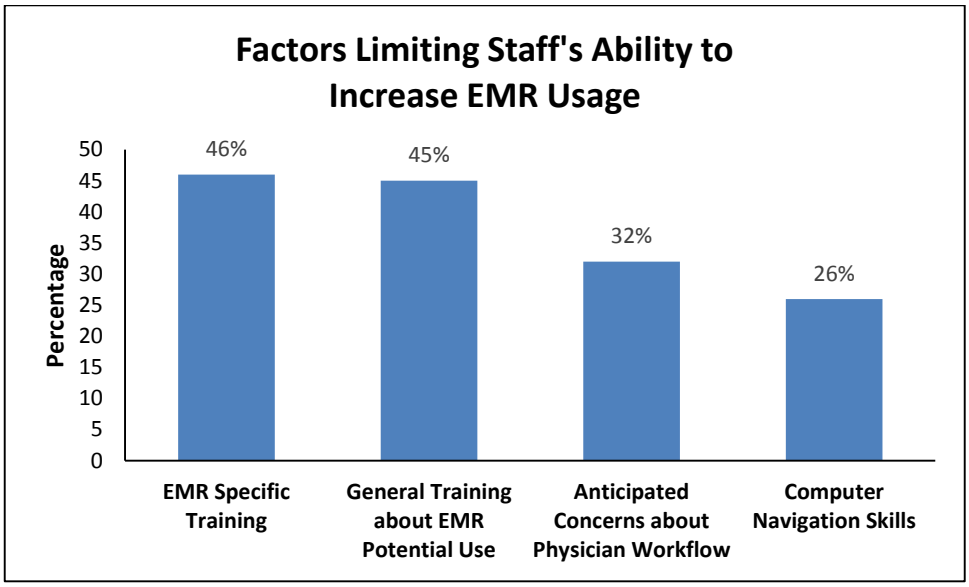

Figure 19 Factors Limiting Staff's Ability to Increase EMR Usage

9.28 Active Paper charts

Nearly two-thirds of physicians (65%, n=24/37) do not have active paper charts in their office. Physicians who still have paper charts report using them for: chart notes (n=1); filing paper copies of current received information (n=2); and filing paper copies of current sent information (n=2). The physicians using paper charts in these ways report that the data is then entered into the EMR by scanning it in. Other physicians reported keeping active paper charts for frequent access to older records (n=4) or other uses (n=13).

9.29 Staff Concerns

Four physicians (57%, n=4/7) reported that staff's concerns about anticipated difficulties in adapting current paper charts to electronic charts had "some effect" or was a "major contributing factor" in their decision to retain paper charts. One physician (14%, n=1/7) reported that time lost due to interruptions to office when initiating EMR use had "some effect" on their decision; another physician identified "cost to store data" as a reason for retaining paper charts. The seven physicians who responded reported the following had "no effect" on their decision to retain paper records: limited staff computer navigation skills; limited staff typing skills; staff concerns regarding additional responsibilities/knowledge base; anticipated concerns regarding office workflow with an EMR in use; anticipated concerns regarding physician workflow with an EMR in use; and physical front desk set up/space constraints.

9.30 Voice Recognition Software

Most respondents (63%, n=25/40) never use voice recognition software, while one-fifth "almost always" use voice recognition software. Three physicians (8%) use voice recognition software "rarely" and four physicians (10%) use it "half the time" or "frequently."

9.31 EMR Coaching

Half of physicians (51%, n=20/39) would like the Division to provide help or coaching in the use of an EMR. Physicians reported a number of different areas where they could use assistance, including: adapting and creating templates; audits; goals; recalls; care plans; proactive care; panel management; and shortcuts to increase speed of patient charting. One physician suggested offering teaching sessions prior to EMR upgrades.

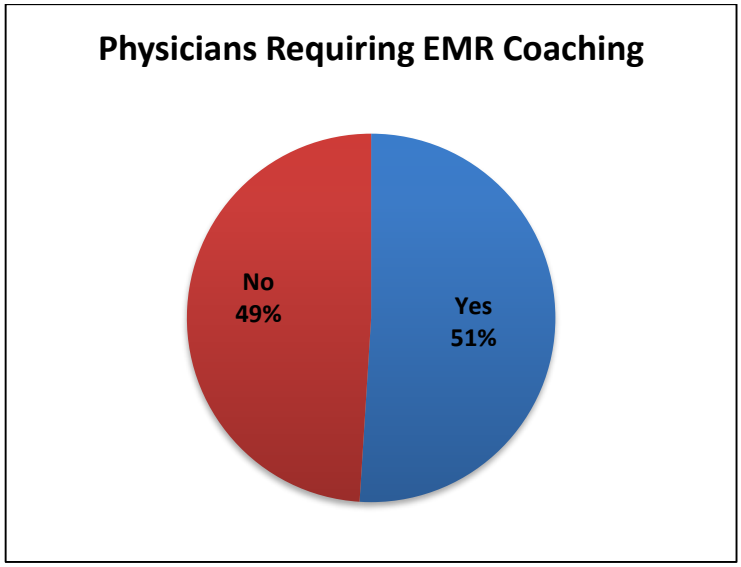

Figure 20 Physicians Requiring EMR Coaching

9.32 PSP Modules

Physicians reported completing PSP modules at the following rates: Advanced Access (n=22); Adult Mental Health (n=22); Child and Youth Mental Health (n=19); Shared Care COPD/HF (n=19); Musculoskeletal (n=18); Palliative Care (n=16); Chronic Disease Management (n=15); and Pain Management (n=15). The modules with the lowest reported completion were Group Medical Visits (n=10) and Patient Self Management (n=5).

Of responding physicians, the modules most consistently applied in their offices are: Advanced Access (72%, n=18/25); Musculoskeletal (71%, n=17/24); Pain Management (68%, n=15/22); Shared Care COPD/HF (63%, n=17/27); Child and Youth Mental Health (62%, n=16/26); Adult Mental Health (56%, n=15/27); and Chronic Disease Management (52%, n=11/21).

The largest number of physicians expressed interest in completing the following modules, or putting them into practice: Patient Self Management (62%, n=8/13); Child and Youth Mental Health (31%, n=8/26); Palliative Care (30%, n=7/23); Adult Mental Health (22%, n=6/27); and Shared Care COPD/HF (22%, n=6/27). Between 3 and 5 physicians expressed future interest in the remaining modules.

9.33 Engaging in Practice Improvement

Almost half of physicians (47%, n=18/38) said their interest in engaging in practice improvement would increase if it were delivered through the Division. Fifty-eight per cent of physicians (n=22/38) said their interest would increase if it were more tailored to their specific practice needs, and 65% (n=24/37) said their interest would increase if practice improvement work were better tailored to their schedule.

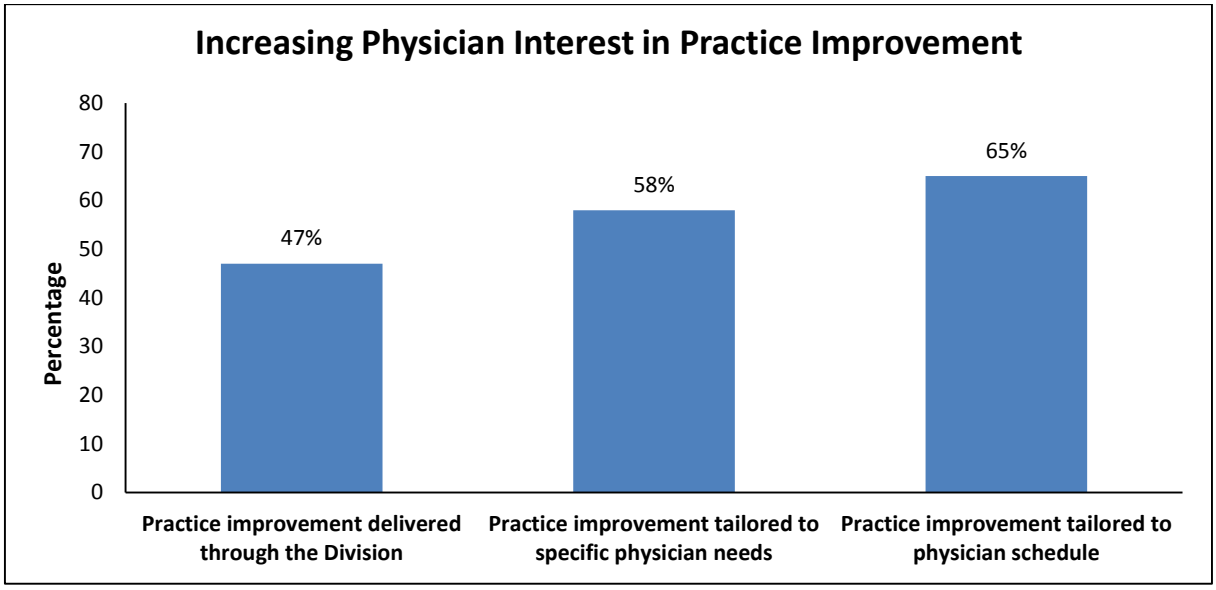

Figure 21 Increasing Physician Interest in Practice Improvement

9.34 PSP Use

Nearly all physicians (89%, n=33/37) report that they have used PSP. Two physicians (5%) have not used PSP, and two (5%) were unsure.

10.0 Attachment Evaluation

10.1 Attachment Initiative Evaluation – Physicians

On a five-point scale, with 1 being "no impact," 3 being a "moderate impact," and 5 being a "significant positive impact," a majority of respondents reported that the Cowichan Maternity Clinic attachment initiative had a positive (4) or "significant positive impact" (5) on: their ability to provide quality patient care (70%, n=16/23); their relationships with patients (61%, n=11/18); and their overall experience as a family physician (65%, n=13/20).

Over half of physicians also reported that the Family Practice Hospital Support Program attachment initiative had a positive or "significant positive impact" on: their ability to provide quality patient care (52%, n=13/25); and their relationships with other family physicians (52%, n=13/25).

Forty-four per cent of physicians (n=15/34) reported the In Practice Attachment initiative had a positive or "significant positive impact" on their ability to provide quality patient care, and 45% reported a positive or "significant positive impact" on their overall experience as a physician.

Forty-two per cent of physicians (n=10/24) reported that the Recruitment of New Physicians had a positive or "significant positive impact" on their caseload management and overall experience as a physician. However, 44% of physicians (n=11/25) reported that it had no impact on their ability to provide quality patient care, and 52% (n=12/23) said it had no impact on their relationships with physicians in other specialties.

	Cowichan Maternity Clinic	Family Practice Hospital Support Program	In Practice Attachment	Recruitment of New Physicians
Your ability to provide quality patient care	70% (n=16/23)	52% (n=13/25)	44% (n=15/34)	32% (n=8/25)
Your work-life balance	44% (n=8/18)	40% (n=10/25)	31% (n=10/32)	40% (n=10/25)
Your caseload management	33% (n=6/18)	44% (n=11/25)	36% (n=12/33)	42% (n=10/24)
Your relationships with patients	61% (n=11/18)	50% (n=12/24)	35% (n=12/34)	22% (n=5/23)
Your relationships with other family physicians	50% (n=10/20)	52% (n=13/25)	35% (n=11/31)	29% (n=7/24)
Your relationships with physicians in other specialties	47% (n=9/19)	33% (n=8/24)	35% (n=11/31)	26% (n=6/23)
Your overall experience as a family physician	65% (n=13/20)	48% (n=12/25)	45% (n=15/33)	42% (n=10/24)

Figure 22 Physicians reporting a positive or "significant positive impact" of attachment initiatives on their work. Excludes "not applicable" responses.

10.2 Attachment Initiative Evaluation – Patients

A majority of physicians report that the Cowichan Maternity Clinic and In Practice Attachment initiatives had a positive or "significant positive impact" for patients and their families in all categories, including: the quality of care for complex patients (86%, n=18/21; 63%, n=20/32); access to care for vulnerable patients (78%, n=18/23; 70%, n=23/33); ability for unattached patients to find a family physician (73%, n=16/22; 64%, n=21/33); patients' relationships with family physicians (65%, n=15/23; 69%, n=22/32); and their overall experience as a patient (85%, n=17/20).

Physicians reported similar positive results for patients and their families from the Family Practice Hospital Support Program attachment initiative. However, only 44% (n=12/27) of physicians reported positive or "significant positive impacts" for unattached patients' ability to find a family physician, and 48% (n=13/27) reported positive or "significant positive impacts" for patients' relationships with family physicians.

A majority of physicians (56%, n=14/25) reported that the Recruitment of New Physicians had positive or "significant positive impacts" on unattached patients' ability to find a family physician, while 16% (n=4/25) reported it had "no impact."

	Cowichan Maternity Clinic	Family Practice Hospital Support Program	In Practice Attachment	Recruitment of New Physicians
Quality of care for complex patients	86% (n=18/21)	70% (n=19/27)	63% (n=20/32)	36% (n=9/25)
Access to care for vulnerable patients	78% (n=18/23)	70% (n=19/27)	70% (n=23/33)	42% (n=10/24)
Ability for unattached patients to find a family physician	73% (n=16/22)	44% (n=12/27)	64% (n=21/33)	56% (n=14/25)
Patients' relationships with family physicians	65% (n=15/23)	48% (n=13/27)	69% (n=22/32)	43% (n=10/23)
Overall experience as a patient	85% (n=17/20)	60% (n=15/25)	63% (n=20/32)	45% (n=10/22)

Figure 23 Physicians reporting a positive or "significant positive impact" for attachment initiatives on patients and their families. Excludes "

10.3 Changes to Practice from Attachment Initiative

Physicians reported a number of ways in which the attachment initiative has changed their practice over the past two years. Changes related to patient attachment include: accepting new patients at clinic; reduced pressure to accept new patients as other physicians accept them; expanding their practice; taking on new patients through practice attachment; and taking

referrals from emergency physicians.

Physicians also reported changes in their office, including: streamlining office and flow efficiencies; reduced office inquiries; improving the quality of their practice and care for patients; and spending more time reviewing new patients' history, thereby increasing their comfort level when taking on complex patients.

Physicians also reported the following results from the attachment initiative: joining the Family Practice Hospital Support Program; assisting the physician in FPHSP and supporting inpatient care; improved management at the hospital; improved physician cooperation; starting the CMC and continuing maternity care for physicians; and stabilizing the FPHSP rotation, with their call group system improving their experience of hospital call.

One quarter of physicians (25%, n=4/16) report that the attachment initiative has resulted in "very little" or no change in their practice over the past two years.

10.4 Future Planning for Cowichan Valley Division of Family Practice

Physicians were asked to rank the impact or priority of different populations on their practice, to aid with the future planning efforts of the CVDFP. Nearly three-quarters of physicians (74%, n=28/38) said "frail elderly" patients had an impact or priority level of "4" or "5" on a five-point scale.

Patients with mental health and substance use issues were the next largest priority group for most physicians, with a combined total of 73% (n=27/37) saying they were a level "4" or level "5" priority, followed by patients with chronic conditions (68%, n=25/37); end-of-life care (60%, n=21/35); Aboriginal people (44%, n=15/34); rural and remote populations (26%, n=9/34); and maternal health (15%, n=5/33).

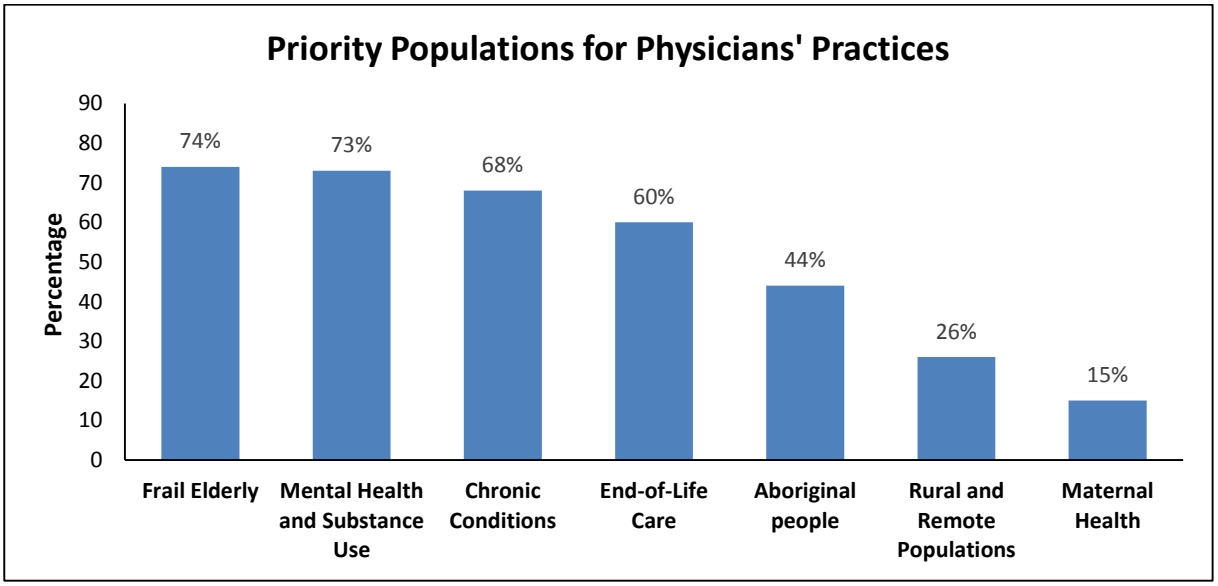

Figure 24 Priority Populations for Physicians' Practices

10.5 Additional Populations Needing Priority Attention

Six physicians (32%, n=6/19) identified children and youth as a group in need of priority attention, in particular for: mental health needs; at risk youth; preventative care; and personality disorders and psychiatric needs.

Three physicians (16%) identified "chronic pain" as a population in need of priority attention. Two physicians (11%) cited substance use and addiction as a population needing priority attention, with one physician citing dual diagnoses of substance abuse and mental health in particular.

Eleven physicians (58%) said there were no additional populations needing priority attention, or that they were unsure.

10.6 Additional Health Care Issues Needing Priority Attention

One quarter of physicians (25%, n=5/20) said obesity and/or lifestyle changes and preventative health are issues in need of priority attention. Three physicians (15%) said palliative beds should be a priority issue, with one physician calling for "a proper hospice" with 24-hour nursing care by nurses trained in palliative care. Two physicians (10%) said addiction needs priority attention, with one physician citing marijuana addiction in particular.

Individual physicians (5% each, n=1/20) said the following health care issues need priority attention: youth and adult mental health; a COPD clinic; a new hospital; immunization rates; and chronic pain, including fitness programs for chronic non-musculoskeletal pain/fibro pain.

Two-fifths of physicians (40%, n=8/20) said there were no additional issues needing priority attention, or that they were unsure.

10.7 Additional Member Services

Two physicians identified additional member services priorities for the Cowichan Valley Division of Family Practice: access to detox; improved mental health services, particularly for children and youth; specialist dine-and-learns; and daytime learning modules.

11.0 Conclusion

Since the May 2010 announcement that the Cowichan Division of Family Practice was to be one of three BC Communities prototyping the Patient Attachment Initiative, the amount of transformational system change in this community has been both substantive and sustainable. The CVDFP is incredibly proud to have exceeded its attachment goal, and to have done so ahead of schedule and under budget.

The CVDFP remains committed to the Triple Aim goals as we move beyond Attachment and A GP for Me to improving care for our Frail Seniors. The incredible amount of thought, effort, creativity, innovation and perseverance that went into the past six years of work has undoubtedly positioned us for success in all of our future endeavours.