A GP for Me Evaluation Report

Fraser Northwest Division of Family Practice

June 30, 2016

Figures

A GP for Me Background

The Fraser Northwest Division of Family Practice participated in **A GP for Me**, a provincial initiative of the Government of BC and Doctors of BC to improve access to primary care and help more British Columbians who want a family doctor to find one. Research shows continuous doctor-patient relationships lead to better health outcomes for patients.

A GP for Me was implemented across the province by 33 local **Divisions of Family Practice**, including the **Fraser Northwest Division of Family Practice.** The Division is a non-profit community-based group of physicians committed to improving primary care for people in their communities. The Division was comprised of 301 members as of March 2016, and includes full practice GPs, locums, hospitalists, GPs with special interests, and emergency department doctors. The Division works collaboratively with community partners to enhance local patient care and improve professional satisfaction for physicians.

Evaluation

The Fraser Northwest Division of Family Practice undertook an evaluation of the A GP for Me initiative to help understand both process and outcomes. The evaluation supports the division to learn from the experience of A GP for Me: What worked? What didn't work?

The evaluation process involved reaching out to partners to secure a broad perspective of the work, and support further learning. The Division evaluation also contributes to a larger evaluation of changes in primary care related to A GP for Me at the provincial level.

Evaluation Goals

1. Provide evidence to understand and articulate the process and outcomes of A GP for Me initiatives
2. Incorporate learning from the experience of A GP for Me into the Fraser Northwest Division of Family Practice and into member practices
3. Provide input into the provincial evaluation of A GP for Me to better understand primary care in BC

Evaluation Questions

1. To what extent have A GP for Me goals been achieved?
2. To what extent have patients, physicians, and the Division of Family practice been impacted over the course of A GP for Me?

3. How did A GP for Me impact primary health care systems integration and transformation?
4. What factors supported or hindered a culture of innovation as part of A GP for Me?
5. What are the most significant changes and key lessons that resulted from A GP for Me?

Methodology

The evaluation included three key methods:

1. Data collection from Division and partners
    a. Community Data Fraser Northwest Division of Family Practice (Reported January 2014)
    b. A GP for Me Attachment Hub Survey (2014)
    c. A GP for Me Practice Visit Profile
    d. Innovation Case Study Documentation
    e. Sunshiner Reporting – Referrals, Assessments, GP Updates, Case Status
    f. Simplified Links Report (May 2016)
    g. Attachment Hub Database
    h. Attachment suite of fees – MOH data
    i. Pharmacist Initiative Data
    j. Psychiatry Allied Health Data
    k. A GP for Me Quarterly Reports

2. Core physician survey (administered in March 2016)
    a. 92 respondents

3. Most Significant Change (in the domains of Quality of Care and Partnership)
    a. 3 Patients
    b. 4 Partners
    c. 4 Health Care Providers

Context

About our Communities

During the assessment and planning phase in 2014, the Division gathered information about the community and the health care context in the region. The following provides an introduction to the Fraser Northwest communities at the time of the assessment and planning:

- Coquitlam Local Health Area (LHA) (Coquitlam, Port Coquitlam, Port Moody, Anmore and Belcarra) and New Westminster are communities served by Fraser Northwest Division
- The total population of these communities was 303,519
- The population of the region continues to grow, it was expected that the Coquitlam LHA will grow 19% and New Westminster will grow 17% over the next 10 years
- With this population growth over the next 10 years, the senior population in the region was expected to increase from 26,475 to 45,255
- There were 182 family physicians providing primary care services in the Fraser Northwest region, with 140 practicing in the Coquitlam LHA and 42 practicing in New Westminster
- 45% of physicians who responded to the physician practice profile survey were between the ages of 46 and 60 while 16% were over the age of 65

Division membership

Figure 1: Division membership by year

December 31, 2011	137
December 31, 2012	174
December 31, 2013	207
December 31, 2014	241
December 31, 2015	282
Current numbers as of March 31, 2016	301

Membership includes ongoing practicing physicians, new physicians to the area and retiring physicians who keep their memberships.

A GP for Me Strategies

The Fraser Northwest Division of Family Practice created 5 projects to address the needs of vulnerable populations in the community, to improve the quality of attachment for existing patients and, to create more practice capacity to attach the unattached.

Attachment Hub

The aim of this strategy was to partner with division members and health authority stakeholders to identify unattached, high-needs patients and attach them to a family physician. Through this, the Fraser Northwest Division aimed to coordinate patient access to a family physician via an appropriate patient-GP matching process, particularly for mothers and babies.

Protoclinic

The focus of this strategy was to create a practice environment that has a low barrier for physicians starting a longitudinal practice, a culture of teaching and mentorship, and a model that encourages medical students and residents who are learning in the community to stay and practice in the community. The intent was to support family medicine students and residents by improving the teaching and mentoring environment in the division. The clinic was also a testing site for sharing patient care with allied health care professionals. To enable this environment, the division partnered with the University of British Columbia's (UBC) Faculty of Medicine to establish a clinic within close proximity to Royal Columbian Hospital's medical teaching program.

Recruitment and Retention

The Fraser Northwest Division aimed to resolve attachment issues in our division through an extensive recruitment and retention campaign. Though establishing partnerships to share patient care and investing in office efficiency methods and practice supports for physicians who are new to practice is important, the reality is that the division must recruit new physicians to replace those that are retiring in addition to creating net new physician opportunities in the region. Thus, the purpose of this strategy was to invest in local and national recruitment campaigns, while concomitantly working with division members to create opportunities that will enable them to remain in practice longer.

Sunshiner's Network

The Fraser Northwest Division physician members indicated in their practice profile survey and during consultation sessions that they wanted to improve health care services for frail and homebound patients. The purpose of this strategy was to facilitate and improve ongoing continuity of care for patients classified at a *frailty level of 5 or higher*, improve access to health care services for Level 5 and higher frail patients by

eliminating certain barriers (e.g. information, assessments, costs, etc.), support family physicians providing in-home care for homebound patients, leverage the skills of nurse practitioners and other allied health care professionals by enabling them to work with their full scope of practice, and encourage and enable patients to access multi-disciplinary care and service providers via a response, assessment and navigation service.

Integration of Allied Health Care Professionals

Partnering family physicians with allied health care professionals enables optimal provision of patient care. While permanent co-location of multi-disciplinary teams serves the needs of geographically clustered, high-needs populations, its costs are often high and it can result in inequity of resource distribution. Through this strategy the division intended to invest in allied health care professional models to increase physician capacity, while not requiring a substantial, long-term investment.

Seventy-three per cent of physicians indicated they have unused space in their offices and would be interested in intermittent visits by an allied health care professional to provide specific services such as counseling and medication reviews. The division acted as a coordinator[1] for the equitable distribution of allied health resources to the population. The division partnered with the CMHA and UBC's Faculty of Pharmaceutical Sciences to provide improved patient care in the areas of cognitive behavioral therapy and comprehensive medication reviews.

[1] The Triple Aim: Care, Health, And Cost
Donald M. Berwick, Thomas W. Nolan and John Whittington *Health Affairs*, 27, no.3 (2008):759-769

A GP for Me Strategy Findings

Attachment Hub

Overview of results for the Attachment Hub

Overall, 62% of referrals made through the Attachment Hub were for mother and babies. 38% of referrals were for all other types of patients.

Figure 2: Overview of Attachment Hub Results

Referral Information	Count
Total Patients Referred	**376**
Total Referrals Stopped	*101*
Forwarded (out of area- sent to another division or provided GP info from division website)	*41*
Discontinued (patient found GP on their own, already had GP, was not interested in the service)	*46*
Unreachable (tried calling on several occasions with no reply)	*14*
Pending Referrals	*80*
Referrals proceeding to attachment	*195*
Average Days in Process (all except mother and baby) (from day referral received to day confirmation of attachment is received)	**34.4**
Average Days in Process (mother and baby*) (from day referral received to day confirmation of attachment is received)	**42**

Figure x: Overall Referrals from Attachment Hub

*The average days in process for mother and baby referrals is longer due to visits to maternity clinics, etc. before attaching to a regular GP.

Attachment Hub Outcomes

Figure 3: Attachment Hub numbers by referral source

Referral Source	Total Referrals	Stopped	Pending	Baby	Dyads	Attachment	Start date
Primary Care OB Clinic	52	14	2	2	34	70	May 2015
Community Maternity Centre	69	10	5	1	53	107	May 2015
Public Health Service	41	8	11	1	21	43	Jan 2016
RCH - Care Clinic (NPs)	9	2	2			5	Sep 2015
Eagle Ridge Hospital	38	11	11			16	Oct 2015
Royal Columbian Hospital	73	31	19		2	25	Oct 2015
GP Direct	10	3	2		4	9	n/a
Home Health	8	2				6	Nov 2015
Other (Specialists)	48	14	13	1	2	23	Feb 2016
ERH-Emergency	22	5	11			6	Nov 2015
RCH-Emergency	6	1	4			1	Apr 2016
Total	**376**	**101**	**80**	**5**	**116**	**311**	

Mother and Baby Referrals (detail)

Figure 4: Mother and Baby Referrals from Attachment Hub

Total # referrals (mother and baby)	**121**
Total # mother/baby patients attached	**237**
# babies attached (with mother at same practice)	116
# babies only attached (with mother at different practice or GP only accepted baby)	5
# mothers attached (with baby at same practice)	116

Reason for Referrals

Figure 5: Reasons for Patient Referrals

Referral Reasons	
Recently moved	104
GP retired	82
Never had regular GP	150
GP moved	2
Transfer of care	6
Other (e.g. Specialist or other divisions)	24

Patient Attachment Mechanism

Physicians were surveyed during the planning process to see how many would be interested in participating in the Attachment Hub. Their responses are shown here to describe their capacity to take on new patients.

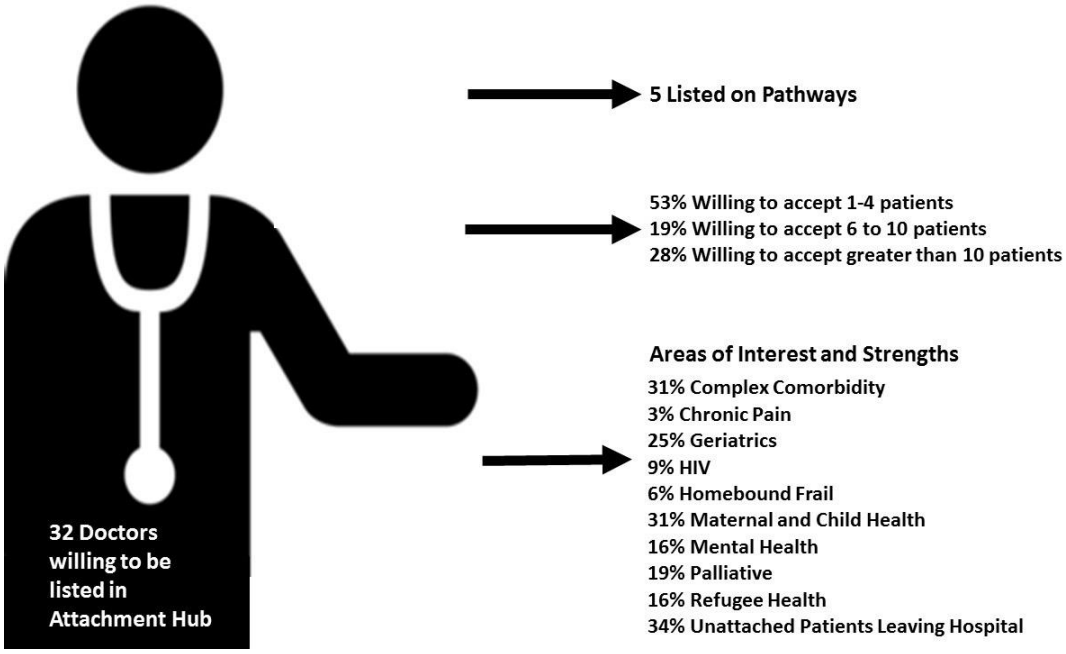
Figure 6: Patient Attachment Mechanism Survey Results (Of 8 respondents (4 Family Practice and 4 Family Practice with Walk-In) who said in October 2015 that they were willing to participate in the Attachment Hub.

5 of 7 physicians said they are accepting unattached patients
Of those who responded, they would take:
• 5-6 per month • No limit (new practice) • 1000 • 600 over time • less than 10
Of those who responded, they would take patients in the following circumstances:
• Family of current patients, attachment hub, from specialists • Referred if from a previous practice, no long-term controlled substances, no active ongoing or legal • Excluding chronic pain, short acting narcotics, patients involved in litigation
4 of 7 said they have space for more physicians
Of those who responded, they have space for the following:
• 1 clinic has space for 1 full-time physician • 1 clinic has space for 1 part-time physician • 1 clinic has space for a physician 3 days per week • 1 clinic has space for 2 physicians

Source: A GP for Me Practice Visit Profile

32 physicians agreed to be included in the Attachment Hub.

Figure 7: Summary of 2014 GP Assessment and Planning Survey Results



Additionally, 4 separate clinics from the practice visit profile summary reported they were willing to accept homebound frail patients. The 32 doctors above are in addition to these 4 clinics and are not listed as practicing at these clinics.

Protoclinic

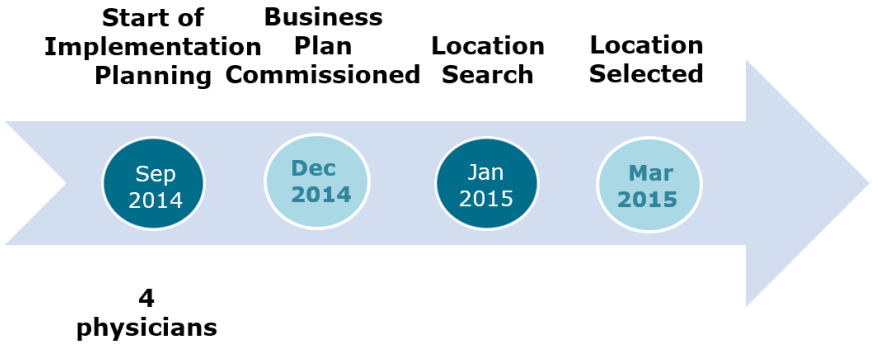
Planning for the protoclinic began in September 2014. As of May 2016, there were:

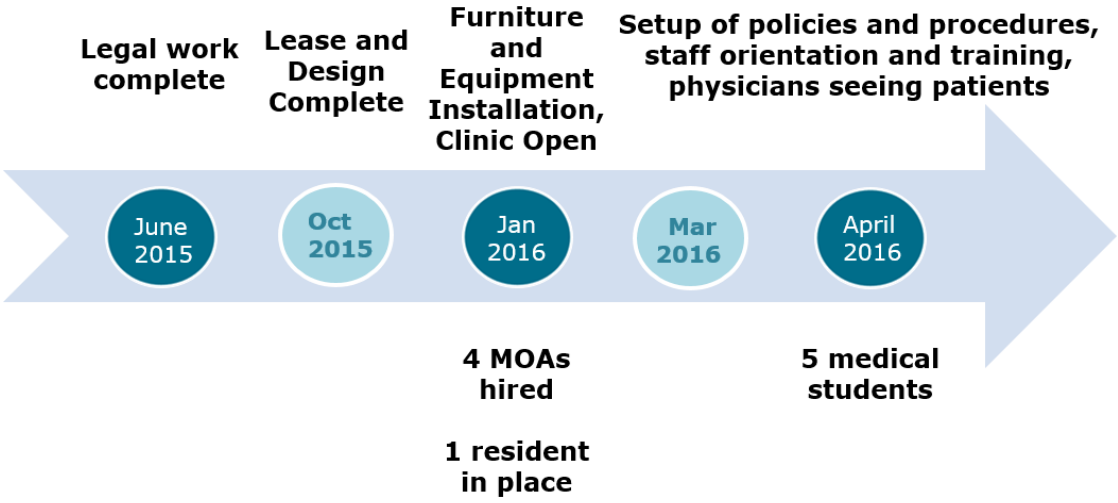
- 4 physicians
- 4 MOAs
- 1 regular resident
- 5 medical students

The protoclinic facilities include:

- 11 exam rooms
- 1 large multi-purpose room (teaching, group medical visits, allied health consultations)

Once the planning phase was complete, establishing events occurred on the following timeline:





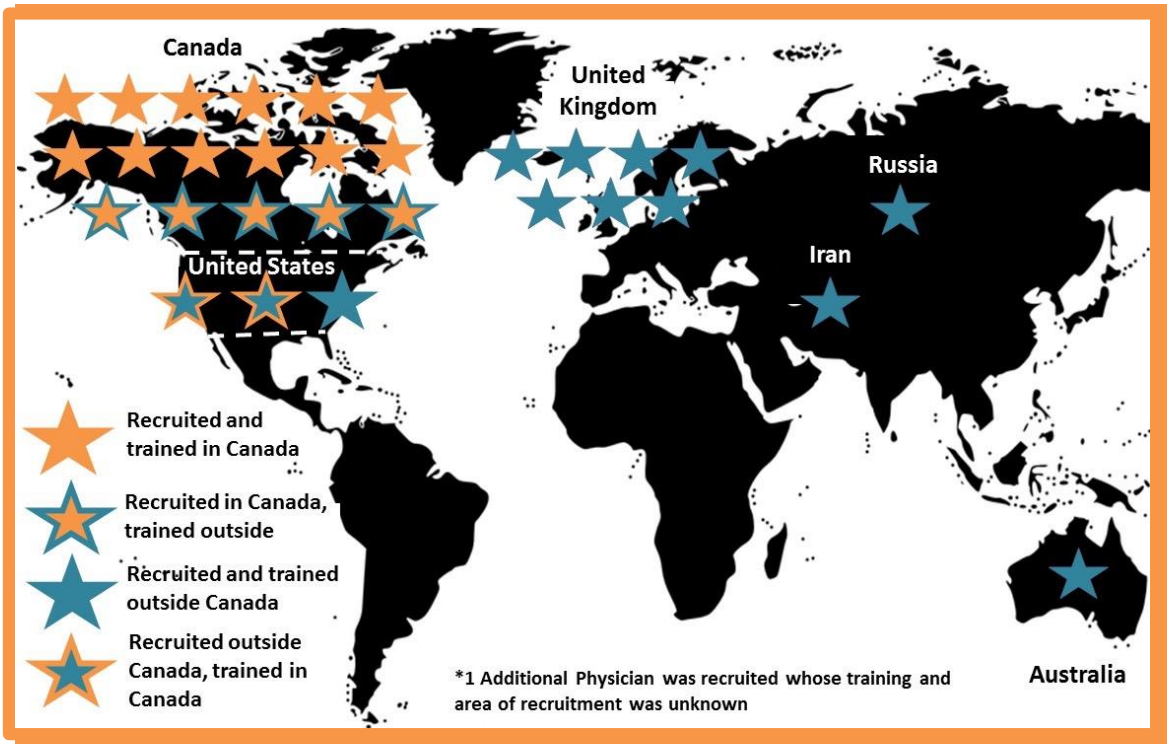
The protoclinic was featured in an Innovation Case Study conducted on behalf of the provincial evaluation team. The case study is also a valuable resource documenting the process of developing the protoclinic.

Recruitment and Retention

31 Physicians were recruited part of A GP for Me.

Recruitment source locations

Figure 8: Location and training of physicians recruited



A number of sources referred physicians who were eventually recruited to Fraser Northwest.

Figure 9: Referral sources for recruited physicians

Referral source	Number of physicians recruited
Health Match	11
Friend/family of local GP	8
Family Medicine Forum	3
Website	3
Friend of UBC Resident	2
Return of service IMG FHA	2
Locum	1
Foremed	1
Resident at Hospital in FNW	1

Physicians in the Division were asked in the Physician Practice Survey reported in January 2014 how important recruitment was from their perspective.

72% of physicians responding said that recruiting new physicians is very important or somewhat important to them. Friends and family were the second biggest source of referrals for new physicians after Health Match, demonstrating a commitment on the part of physicians within the division to support recruitment.

Figure 10: Responses from the Physician Practice Survey (Reported January 2014)

	Very important	**Somewhat important**	**Neutral**	**Unimportant**	**Unsure**	**Total Responses**
Recruiting new physicians to this area	**53 (43%)**	**35 (29%)**	23 (19%)	9 (7%)	2 (2%)	122
"Exit planning" (i.e.to retire or find a replacement)	**34 (28%)**	**25 (21%)**	**29 (24%)**	**29 (24%)**	4 (3%)	121

Sunshiner Frail Elderly Network

Overview

Three pillars of the Sunshiner network were articulated as part of A GP for Me. These were:

- modelling an inter-practice population-specific nurse who can deliver health services in the home and work in a directly collaborative way with physicians
- exploring and defining the space of the non-medical needs and services for vulnerable populations in the community and how that relates to patients, physicians and the health care system
- building a physician-interfacing IT infrastructure to enable team-based caseload management and shared clinical record and care planning

The Sunshiner network is made up of a structured group of physicians committed to caring for the frail homebound populations, supported by a team of allied health supports. At this time, the network does not formally include after-hours support, but the participating GPs still have after-hours coverage obligations.

Prior to implementing A GP for Me, the Division gathered data from physicians about care and services related to elderly patients. The results are presented here.

Assessment and Planning: Physician Practice Survey Results

(reported Jan 2014)

Figure 11: Physician interest in working with allied health care professionals

Please rate your level of interest in some form of increased access to allied health professional support for any of the following:

	Interested	Not interested	Happy with allied support currently in place	Unsure	Total Responses

Geriatric community services coordination (e.g. access for your patients to someone who knows all the public, private and volunteer services & activities)	**87 (93%)**	1 (1%)	1 (1%)	5 (5%)	94
Advanced care planning (e.g. counselor /advisor to do some detailed discussion with family)	**75 (80%)**	9 (10%)	5 (5%)	5 (5%)	94
Palliative care	**57 (62%)**	4 (4%)	**21 (23%)**	10 (11%)	92

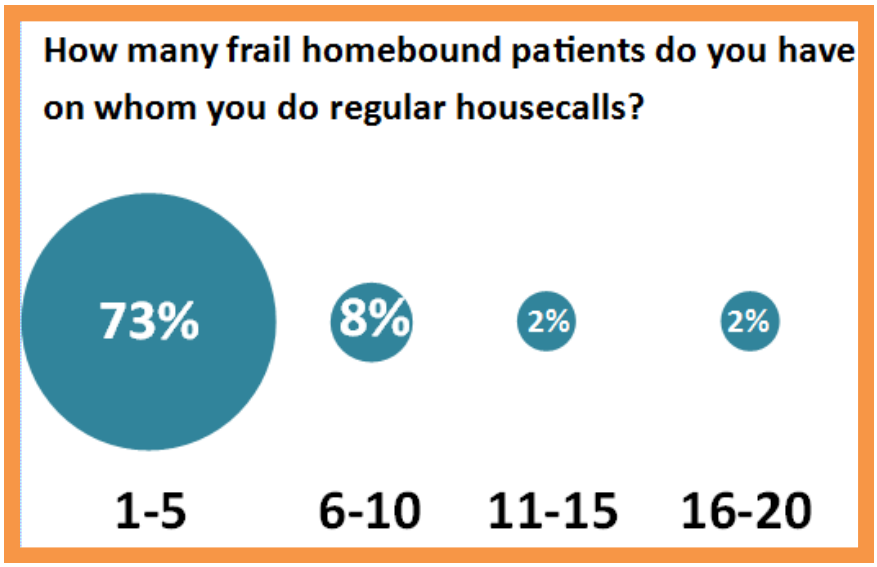
Figure 12: Physician perception of capacity to meet needs for elderly-related concerns

Describe your experience with trying to meet your patients' needs in the following situations (Check as many issues as apply)

	Never enough time	**Not confident in my skills**	**Inadequate access to resources and/or supports**	**I don't see this as part of my job**	**None of these issues apply**	**Total Responses**
Advanced care planning	**53 (56%)**	14 (15%)	19 (20%)	2 (2%)	**25 (27%)**	94
Housecalls to frail homebound elderly	**45 (51%)**	1 (1%)	16 (18%)	10 (11%)	**28 (32%)**	88

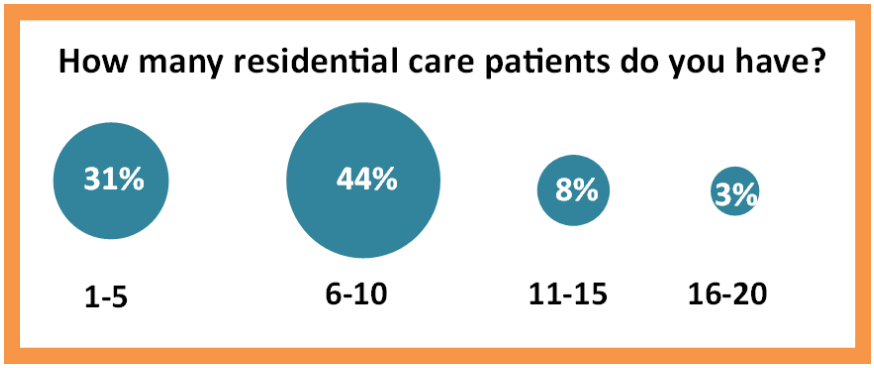
Connecting high needs patients with the community services that might benefit them (e.g. public, private and volunteer)	**31 (34%)**	12 (13%)	**57 (63%)**	3 (3%)	15 (16%)	91
Palliative care	18 (20%)	**27 (31%)**	9 (10%)	5 (6%)	**37 (42%)**	88

Figure 13: Number of frail homebound patients with regular housecalls



*Among 52 of 132 respondents, 8 responded not applicable

Figure 14: Number of residential care patients



*Among 55 of 132 respondents, 2 responded not applicable

Figure 15: Physician interest in working with elderly patients

Please rate your level of interest in participating in ANY of the following:

	I would be interested in joining a team like this as part of my regular work	I would consider participating intermittently	Not interested	Unsure	Total Responses
FRAIL HOMEBOUND PATIENT ON-CALL SUPPORT NETWORK: Team to cover daytime and after hours routine medical needs of STABLE frail homebound patients	10 (8%)	19 (16%)	**79 (65%)**	14 (11%)	122
HOSPITAL AT HOME: Multidisciplinary care for ACUTELY ILL homebound frail patients. (e.g. home IV, nursing, and physician support.)	8 (7%)	18 (15%)	**78 (64%)**	18 (15%)	122
NURSING HOME NETWORK: Team to cover daytime and after hours nursing home calls	5 (4%)	16 (13%)	**84 (69%)**	16 (13%)	121
HOSPICE AT HOME: Multidisciplinary home based care for the terminally ill	6 (5%)	16 (13%)	**81 (68%)**	17 (14%)	120

Figure 16: Number of frail patients seen in last 3 months who could have been safely and effectively managed without admission, OR been discharged sooner, if there was a hospital at home service as an alternative to in-hospital care

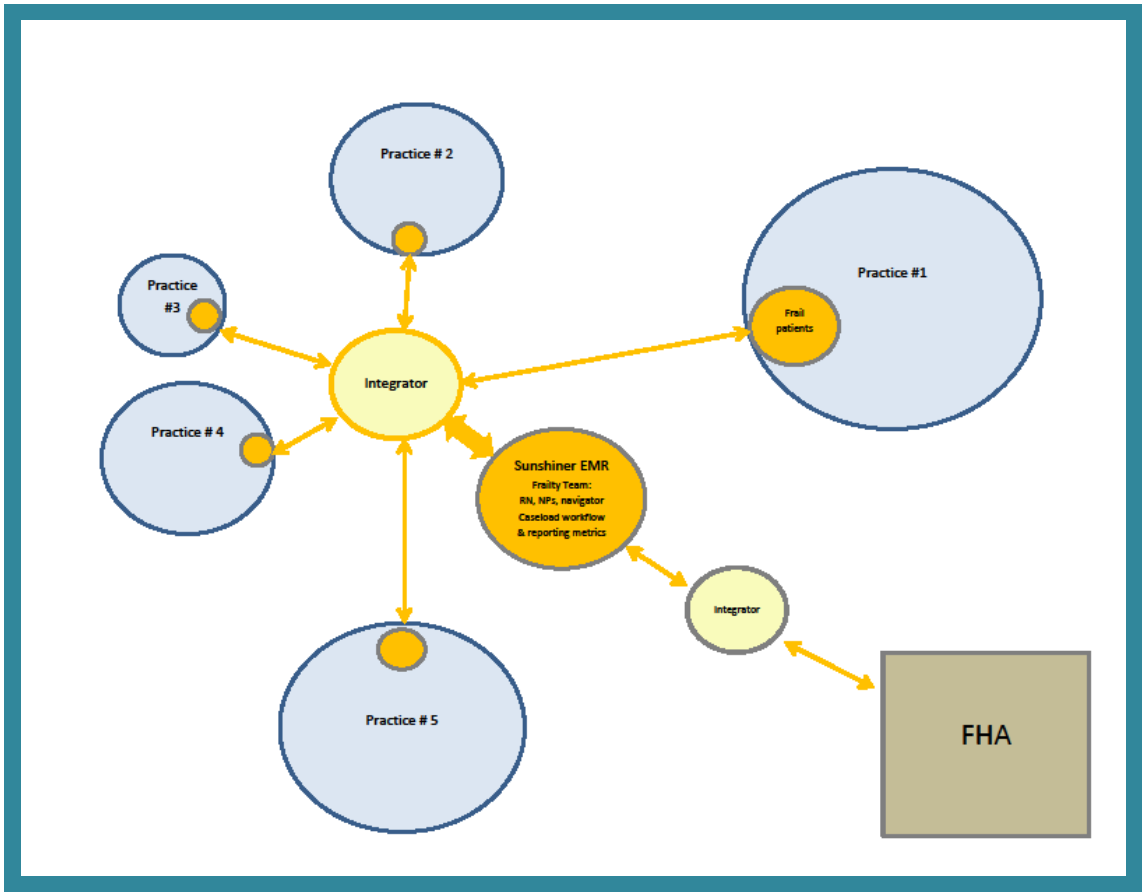
FNW HOSPITALISTS were asked:	
Number of frail patients seen in last 3 months who could have been safely and effectively managed without admission, OR been discharged sooner, if there was a hospital at home service as an alternative to in-hospital care	Number of Physicians
0	0 (0%)
1-2	2 (11%)
3-4	1 (5%)
5-6	2 (11%)
7-8	3 (16%)
9-10	2 (11%)
>10	6 (32%)
Unsure	3 (16%)
Total Responses	**19 Hospitalists**

Responses suggest that for these 19 hospitalists, over 100 frail patients over a 3 month interval could have been discharged sooner or never admitted if there was a hospital at home service.

Sunshiner Network Model

The Sunshiner network model was designed using a hub and spoke model.

Figure 17: Sunshiner network model



Sunshiner Network Patients

A total of 152 patients participated in the Sunshiner Network, with reports from June 15 2015 to April 30, 2016.

80 patients:	Registered Nurse only
46 patients:	Simplified Links social worker navigator only
26 patients:	Both Simplified Links social worker navigator and Registered Nurse

Two key services were provided through the Sunshiner network: access to a Registered Nurse, and access to a social worker navigator through Simplified Links.

This report contains data from two different time periods:

Registered Nurse (4.5 months): January 1, 2016 to May 20, 2016

Simplified Links (9.5 months): June 15, 2015 to April 30, 2016

Registered Nurse

Figure 18: Sunshiner Frailty Network Report of 105 Patients who received RN services between January 1st 2016 to May 20th 2016

PATIENT DEMOGRAPHICS	
Aged 60-69	6 (6%)
Aged 70-79	9 (9%)
Age 80+	**90 (85%)**
Total Home Visits	**105**
HOME VISITS	
General Home Visits Patients aged (60-69)	9 (3%)
General Home Visits Patients aged (70-79)	23 (7%)
General Home Visits Patients aged (Age 80+)	**285 (90%)**
Total Home Visits	**317**
HOME PROCEDURES	
Injections	18
Ear syringe	17
TELEPHONE CALLS & CONFERENCING & CASE MANAGEMENT	
Telephone calls to patient or their representative	210
Telephone contact with another care provider	11
Telephone discussion with a GP	85
In person Case conference with GP	34

Series of telephone calls on same day for purpose of patient case management	15
Family conference	19

Simplified Links Program: Social Worker Navigator

More than 24 doctors have made referrals to the Simplified Links Program.

Figure 19: Number of physicians reporting referrals and assessment for Simplified Links by patient number (from June 2015 to April 2016)

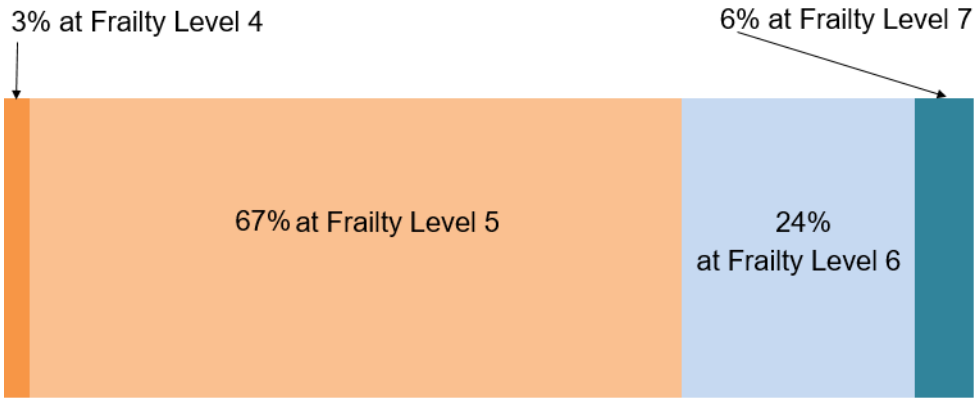
Number of Patients	**Number of Physicians**
1-5	**21 (85%)**
6-10	2 (10%)
11-15	1 (5%)

*Note that patient numbers may be under-reported

Frailty Levels

Frailty Levels of Patients served by Simplified Links during reporting period (71 patients between December 2015 to February 2016)

Figure 20: Frailty Levels of Patients served by Simplified Links



Results from 71 patients who were referred through the Sunshiner Network. Note that an additional 13 patients declined service or did not participate.

Among 71 patients, the following unmet needs were identified through in-home visits by the social worker or gerontologist navigator. Once needs were identified the navigator worked directly with patients and families to make service referral requests and to assist in the implementation of recommended services. In some cases, the services recommended had been previously recommended by home health or patient's family or patient's physician or by telephone navigation such as 811/healthlink. For example, emergency response systems had often been recommended previously but had never been put in place until the navigator assisted the patients and families to implement the recommendations.

The discrepancy between recommendations and implementation rates highlight the challenge of implementing supports that help patients to remain independent. This initiative carefully tracked and reported the rates of implementation of navigator recommendations

Figure 21: Rates of navigator service identification and patient service implementation

Service	Navigator identified unmet need and assisted in making request for service	Patient service implemented
Emergency Response Systems	35	22
Social/Recreational	28	14
Equipment	28	14
Private Home Support (not Simplified Home Care)	24	8
Mental Health/dementia care	24	21
Foot Care	17	16
Housing	15	4
Meal Prep	12	5
Volunteer Visitor	10	10
Housekeeping	10	3
Personal Care	9	5

Adult Day Care	7	7
Transportation	6	6
Financial	5	?
Blood Pressure Check	4	4
Respite Services	3	3
Discharge Planning (To enable early hospital D/C)	3	3
Disability Application	3	3
Purchase of medical supplies	3	4
Pharmacy Outreach	2	2
Hearing Test	2	2
Task Management	1	1
Abuse/Neglect	1	1

During the reporting period, between June 2015 to April 2016, the following was noted among 71 unique patients:

Figure 22: Home health access and patient hospitalizations

Question	**Total (N=71)**
Connected to HH via Links Program?	29
Already connected to Home Health?	20
Patient hospitalized during reporting period?	8
Patient visit to ER during reporting period?	6

Simplified Links Navigator Feedback for Simplified Links

Challenges

Comments from the social worker navigator about challenges are grouped below:

Limited services for those who English is not their primary language:

- Insufficiencies were revealed in programs for East Indian, Chinese, and Italian speaking seniors. This made it difficult to match patients with these backgrounds to suitable community services.

Long wait time to access services:

- Clients often require follow-up and reminders to access the services that have been recommended. Some services take time to commence due to wait lists and referral processes.
- Services and programs with significant wait times include mental health assessments, adult day care admissions, Fraser Home Health assessments, and volunteer based alternatives.

Patient's primary contact declines service for patient:

- Periodically a contact name is given other than the patient. The patient may clearly say that they want to access a service but the contact person says "no".

Success

Comments from the social worker navigator about successes are grouped below:

Increased independence:

- The majority of clients have felt that the Links Program has helped them remain independent with increased confidence.

Access to alternative services:

- Getting to and from the doctor's office can be difficult for many Links patients, navigation helps extend the arms of the G.P.s out into the community setting.

- The Simplified Links team has been able to fill in the gaps for Fraser Home Health by arranging alternative services and programs.
- Services include the following: dementia care, pet therapy, art therapy, transfer of narcotic prescriptions to another pharmacy, cost of prescription delivery, hazards of MOW, removal of ice from the driveway, cleaning of hearing aids, etc.
- The Simplified Links team was able to help and advise several patients concerning the very important issue of housing. They were assisted with applying for and/or arranging SAFER grants, BC Housing, Home Adaptation Grants, movers, decorators, contractors, etc.

Improved patient health and quality of life:

- The Links social worker/navigator was a big help during discharge planning for Link's patients. Hospital O.T.s have community based O.T.s to work with, but the hospital social workers do not have the same arrangement.
- Several Link's patients live in assisted living facilities. The navigator was able to assist these clients in many ways including arranging a daily blood pressure check for one senior and organizing an in-house emergency response system for another.
- Doctors who made referrals to Simplified Links made themselves available for phone calls from the navigator. These calls helped both the doctor and the navigator identify the patients' issues, helping to streamline the navigation action plans.
- Several patients that were assisted through the Simplified Links Program have expressed thanks for keeping them from being admitted to the hospital.
- The Simplified Links team was effective in helping patients develop their coping skills. The navigator was able to assist them as a "life coach" and mentor. Some families have required mediation sessions with the navigator to help them understand their own family dynamics and the benefits of sharing in the caregiving role of their parents.
- One of the most rewarding aspects of the Links program for the navigator was the ability to give ongoing support and check-ins for isolated patients. For many Links patients, the family was not available to help them with their issues. Sometimes the family members were simply not interested or they have been experiencing burnout and frustration.

Improved collaboration between care providers

- Relationships built by the Links team throughout the community over the past year have been strengthening daily. The Links team has corresponded regularly with Fraser Home Health and non-profit groups like Century House Seniors Centre, Burnaby Citizen Support Services, Burnaby Neighbourhood House, and the Seniors Services Society.
- The Links team was able to assist patients and doctors with making referrals to important agencies and programs in the community. These referrals included those for Fraser Home Health, the Alzheimer Society First Link Program, The Parkinson Society, CNIB, MOW equipment, volunteer shopping programs, the M.S. support group, Red Cross Equipment Rental, HandyDART, the Let's Do Lunch program and more.

<u>Quotes from clients and family members</u>

- "I did not know how to safely eject my medication from the blister packs until the navigator washed my black backing sheet with edges and explained by emptying my pills on the sheet I could prevent them from spilling them on the floor".
- "It's been helpful to T. to discuss all the possible options with someone who understands the problems faced by the elderly and in our case, the added difficulty of children living a distance from Mum".
- "As we age, the ongoing visits to BC are increasingly demanding on both my and my sister's time and finances. Fewer trips to BC would make life easier for us both. It is possible that my brother will now join us in Mother's care but this information surfaced only a few days ago and needs to be demonstrated to be believed. However, this possible change makes It timely to review Mother's care in light of our diminishing energy levels and bank balances".
- "Life is sweet but complicated. We do know how lucky we are; but also know we have had a certain 'overwhelmedness' of late. Between family, work and health demands (our son had a brain tumour about a year ago) we feel as if we are often dancing as fast as we can. Your information, insights and support have been invaluable".

Most Significant Change resulting from the Sunshiner Network: Registered Nurse and Simplified Links

Stories about changes resulting from A GP for Me were collected using the Most Significant Change method. A number of the stories were about the Sunshiner Network, and the following story excepts and summaries provide a variety of perspectives on the project.

Key Changes

Patient/Patient's Family:

- **Reduction in emergency room visits** -My mom is doing so much better, both mentally and physically, and I'm less stressed just knowing that she's getting appropriate care without having to move out of her home. I can't count the number of times we would have had to go to the emergency room if it weren't for this program.
- **Access to RN, physiotherapy, and social worker** - **Within a week** we had some of the home supports in, an RN visiting my mom at home, and a physiotherapy assessment. We even had a social worker contact us, which for me, was probably the most valuable piece.
- My mom seems to have support for everything now, and I think she's **feeling a lot more comfortable about staying in her own apartment**.
- So now anytime mom gets sick, Debbie can go over and check on her and if her GP thinks she needs to see her as well she will.

Registered Nurse:

- By **communicating with the patient** about the recent changes in her life and **consulting with her doctor** through picture messages, **we diverted an ER visit**

GP:

- The sharing of the workload is what will allow us to **take on more patients** while **keeping up with our existing frail patients**.

- Now I know that I can **refer patients to this service for assessment** that I'm unable to do, and know that they will follow through.

What is most significant about the change?

Patient/Patient's Family:

- Now, she's less agitated, and probably doesn't suffer the anxiety that I would expect would come with hauling her out of the house a lot. It's allowed her to **stay in her environment** and have the support, and I think that's tremendously **valuable for both her physical and mental health**. My mom also lives with bipolar disorder, and I'm the only one in the family who can manage her with her mental health, so having these supports coming in has kept her much calmer. If these supports weren't in place, the stress of everything would exacerbate her condition even more. I think that is very significant.
- I've seen my mom's **stress levels diminish** significantly since she started getting this support but for me, it's peace of mind knowing that someone is there helping her all the time, and I don't have to be running over there every week.

Registered Nurse:

- The most significant change I've seen from this program is how much of a difference **effective communication** can make in caring for these patients

GP:

That is the key thing: having a **call group that has the skill set to look after these patients and sharing that workload**. In my mind that would be the biggest improvement that I'm looking forward to

GP and Division selection group:

- Great example of the **pinch points in the system**, where the issues are and where the help is coming from
- Significance of **partnerships and communications**
- **Closed gaps between waiting periods**

- **GP and nurse coming together** at a collaborative level to solve problems, Elderly Care, Quick referrals
- **Right kind of care at the right time**
- Many resources, **finding the right resource for the right person** that can make a big difference
- Having an **umbrella over the patient's care** is vital to making the health system work
- High needs patients care- **addressing the difficulty in accessing services** for frail elderly patients

Integration of Allied Health Care Professionals

Physicians were asked in 2014 about their interest in working with Allied Health Professionals. Their responses are below.

Figure 23 : Physician capacity to integrate allied health professionals

If you could have increased access to allied health professional support for patient care (e.g. pharmacist, RN, dietitian, etc.), which approaches listed below would work for you?

Response	Count
DAILY ON-SITE presence of allied health provider in your office	24 (27%)
INTERMITTENT AS-NEEDED ON-SITE visits of an allied health provider to your office (e.g. pharmacist to do "brown bag" medication reviews and case conference with you thereafter)	56 (62%)
OFF SITE referral to allied health provider	**70 (78%)**
Total Responses	**90**

Two allied health professionals were integrated as part of A GP for Me: a pharmacist and a psychiatrist. The pharmacist provided medication reviews with patients in physician offices, and the psychiatrist provided rapid assessment consultations in physician offices.

The following tables detail the number of clinic and GPs participating, the number of patients who received care through this project, and the size of clinics where the allied health professionals worked. For the psychiatrist, wait times are also provided below.

Pharmacist Report

November 1, 2015 to May 31, 2016

(visits 30-45 minutes)

Figure 24: Pharmacist report summary

# clinics participating	9
# GPs participating	25
# patients seen	81
# appointments total	113
Number of clinics with 1 GP participating	4
Number of clinics with 2 GPs participating	2
Number of clinics with 3 GPs participating	1
Number of clinics with 4 GPs participating	0
Number of clinics with 5 GPs participating	0
Number of clinics with 6 GPs participating	1

Number of clinics with 7 GPs participating	1

Psychiatry Report

November 1, 2015 to May 31, 2016

Figure 25: Psychiatry Report Summary

# clinics participating	7
# GPs participating	18
# patients seen	46
# appointments total	72
Number of clinics with 1 GP participating	3
Number of clinics with 2 GPs participating	0
Number of clinics with 3 GPs participating	2
Number of clinics with 4 GPs participating	2
Wait Times (by time period)	
First 3 months	1-2 weeks
3-6 months	3-4 weeks
6 months to current	5-6 weeks

Incentive Fee Utilization

Physicians were provided with access to incentive fees to support the attachment of complex care patients, via the Attachment suite of fees.

The fees were utilized within the Division as follows.

Figure 26: Incentive Fee Utilization by year

	2014		2015	
Fee Code	**# of distinct GPs**	**# of distinct Patients**	**# of distinct GPs**	**# of distinct Patients**
14070 - GP Attachment Participation	125	n/a	119	n/a
14071 - GP Locum Attachment Participation	13	n/a	17	n/a
14074 – GP Unattached Complex/High Needs Patient Attachment	57	2,009	69	1,797
14075 - GP Attachment Complex Care Management Fee	60	382	46	390
14076 - GP Attachment Telephone Management Fee	132	13,329	113	12,543
14077 - GP Attachment Patient Conference Fee	100	1,491	86	1,653

Physician Experience

A survey of Division members was conducted in March 2016 to better understand several key aspects of physician experience: 1. Care, 2. Relationships/Collaboration, and 3. Work-life balance and professional satisfaction

Survey Results: Care

Figure 27: Summary of care survey results

	Very dissatisfied	Somewhat dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
The time I have available to spend with each patient	4 (5%)	**23 (29%)**	**23 (29%)**	**24 (30%)**	5 (6%)
Your ability to provide comprehensive care	2 (3%)	**17 (23%)**	**46 (61%)**	9 (12%)	1 (1%)
Your ability to provide longitudinal care	4 (6%)	**14 (19%)**	**46 (64%)**	7 (10%)	1 (1%)

Survey Results: Relationships/Collaboration

Figure 28: Summary of relationships/collaboration survey results

	Very dissatisfied	Somewhat dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
Collaboration with social services or other community providers	2 (3%)	14 (18%)	**48 (63%)**	12 (16%)	0 (0%)
Collaboration with other family doctors	3 (4%)	15 (20%)	**52 (69%)**	3 (4%)	0 (0%)
Your relationship with family physicians	1 (1%)	3 (4%)	7 (9%)	**33 (42%)**	**34 (44%)**

Collaboration with other health care providers such as allied health professionals	5 (7%)	5 (7%)	**63 (82%)**	3 (4%)	0 (0%)

Survey Results: Work-life Balance and Professional Satisfaction

Figure 29: Summary of work-life balance and professional satisfaction

	Very dissatisfied	**Somewhat dissatisfied**	**Neutral**	**Somewhat Satisfied**	**Very Satisfied**
The balance between your personal and professional commitments	2 (3%)	**18 (23%)**	**15 (19%)**	**33 (43%)**	9 (12%)
Work-life balance	2 (3%)	11 (14%)	**46 (61%)**	**17 (22%)**	0 (0%)
Overall professional satisfaction	3 (4%)	**15 (20%)**	**47 (62%)**	8 (10%)	3 (4%)

Most Significant Change

Impact of A GP for Me in Our Community

To what extent have the provincial goals of A GP for Me been achieved in our Division?

The provincial goals are:

- *enable patients who want a family physician to find one*
- *increase the capacity of the primary health care system*
- *confirm and strengthen the continuous doctor-patient relationship, including better support for the needs of vulnerable patients*

To what extent have patients, physicians, and the Divisions of Family Practice been impacted over the course of A GP for Me?

Logic Model Outcome (Select from list) (if choosing "other" please describe below)	**Impact to patients, physicians, and the Divisions of Family Practice over the course of A GP for Me**
Increased Access To A GP	The recruitment of 31 new physicians and increased support for division members to take on new patients, including through the Attachment suite of fees meant that patients in the community had increased access to GPs.
Effective Engagement	A GP for Me projects have supported division members to support high needs patients, by increasing access to support services via referrals (Sunshiner network), improved wrap-around care via access to allied health professionals for GPs and their patients across the Sunshiner network, via access to pharmacy and psychiatry in clinics, and through the protoclinic teaching environment.

Improved Health Equity	The Sunshiner Network and Allied Health Professional (pharmacy and psychiatry) projects tested new models of care that allowed greater access to allied health professionals for clinics, and therefore patients, across the division, through different models of care. These include virtual networks and intermittent co-location. This process led to improved conditions for prioritizing health equity in primary healthcare by recognizing that different populations have different healthcare needs, and, particularly for marginalized populations, their healthcare needs may not always easily be met by conventional models of care.

How did A GP for Me impact primary health care systems integration and transformation across the Division?

Logic Model Outcome (Select from list) (if choosing "other" please describe below)	**Impact to primary health care systems integration and transformation across the Division**
Effective Engagement	Funding to support physician participation and trying innovative strategies allowed the division and GP members the opportunity to try things they never could have done otherwise. The funding for physicians recognized the passion and energy they have for innovation, and supported them for the income they gave up to participate and the time away from their personal lives. The funding to support innovation meant that new models could be tested and documented to support overall primary care needs identified by GPs and the broader division community over time.

Strengthened Collaboration	The division shifted the recruitment model to incorporate more direct communication between prospective recruits and local GPs, and emphasized building on relationships with friends and family. As a result, fewer resources were required for recruitment overall and newly recruited physicians were more confident in a move to the community, based on a relationship with GPs in the community and trust in the information about the community from a GP perspective. The willingness of division members to reach out to friends and family to support recruitment as an asset to the efforts of the division. It was also noted that this approach may be more appealing to new GPs who prefer to communicate via email and want unbiased information about the community and the nature of practice in the area.
Increased Service Integration	The ability to engage with allied health professionals in innovative ways was important to building the leadership and capacity of the division in addressing system-level change in health care. This allowed the exploration of processes at the ground level to reduce paperwork and duplication with the health authority, and increase time available for patient care. Experimentation with a variety of models tested the equitable distribution of allied health professionals in different ways. Two models of innovative team based care were implemented to test the equitable distribution of allied health professionals across multiple practices. 1) Intermittently co-located multi-disciplinary care e.g. with pharmacists from UBC 2) Virtual team based care of the frail with the sunshiner network. A central EMR was implemented for charting by RN and NPs and MDs doing housecalls and acted as the hub at the centre of a hub and spoke model of information flow for team based care. The sunshiner EMR had caseload workflow and reporting tools for team based care and functions as a “virtual workplace” for a team to work together across a primary care neighbourhood and to support the

	vulnerable patients across multiple different practices. Joint access to an EMR allowed team members including the nurse, and physician to chart together for patients to support seamless data access and care. However, while the EMR records could be accessed by the team members, the physician's EMR record was still separate and required some double-charting.

What factors supported or hindered a culture of innovation as part of A GP for Me? Please describe.

Logic Model Outcome (Select from list) (if choosing "other" please describe below)	Factors supporting/hindering a culture of innovation as part of A GP for Me
Increased Service Integration	Repeated changes in leadership and staff turnover at Fraser Health meant that the division didn't have regular or consistent contacts until January 2016. This hindered the division's ability to work on collaborative initiatives, particularly with respect to allied health professionals in areas such as primary care, nursing, home health and mental health.
Governance	The maturity of the division contributed to the success of A GP for Me. The relationships with physicians, and external partners such as UBC were key to supporting innovation. The leadership of physicians was essential in supporting the success of A GP for Me. Their leadership shaped the initiative, and their personal commitment also inspired other members to become engaged.

Effective Engagement	Some GPs participating in the A GP for Me initiative, and often GPs in general, have little experience working on committees and it takes time to understand the structure and roles, in order to perform efficiently and quickly.

What are the most significant changes and key lessons that resulted from A GP for Me?

Logic Model Outcome (Select from list) (if choosing "other" please describe below)	Most significant changes and key lessons that resulted from A GP for Me
Increased Service Integration	The improved relationship with Fraser Health once a stable and engaged team took on the role of coordinating with the division was critical to the division. This was a significant change but also an important learning in terms of how to cultivate and strengthen a partnership. The division is very committed to sustaining these strong relationship but also concerned about the time it takes to build relationships and change culture. This is also noted as an issue that hindered the division- because while the relationship is currently strong, the division does not control changes and staff turnover at Fraser Health.
Effective Engagement	When GPs are intimately involved in planning and implementing systems change, they can play an important role in creating useful systems to eliminate duplication and create innovative and simple ways to improve the quality of care for patients.

Unintended Outcomes and their Cause

Through the Attachment Hub and the additional dialogue within the division about attaching patients, particularly those with high needs, it emerged that not all physicians were willing to take on new patients or those with high needs. For example, there were some babies accepted by physicians via the Attachment Hub while the mother was not accepted (less than 5). This was a small measurable number of cases but it was discussed anecdotally that this may also be the case in other situations. Some physicians had practices with specific preferences and were therefore reluctant to take on multiple high-needs patients, especially in a short time-frame. For example, physicians mentioned not wanting to take on patients with chronic pain, on long-term controlled substances, short acting narcotics, or patients involved in litigation.

The addition of allied health professionals also posed a challenge, as the space and time needs required capacity within the clinic, including activities such as scheduling and aligning workflow and culture.

Quarterly Reporting Indicator Definitions

Indicator	How Data Was Collected	Detail (associated strategies / projects used to achieve these indicators for each)	Baseline Total (For All Strategies)	Current Total (For All Strategies)	% Change
 11 members involved	Quarterly reports and meeting minutes	Members were engaged in various ways: -A GP for Me steering committee -Strategy working	n/a	11	n/a

		groups and committees -Evaluation Working Group			
 14 partners	Quarterly reports, Attachment Hub tracking Note: due to restructuring at Fraser Health, some departments changed structure during the implementation phase	Attachment Hub referrals from: Primary Care OB Clinic, Community Maternity Centre, Public Health Service, RCH - Care Clinic (NP'S), Eagle Ridge Hospital (ERH), Royal Columbian Hospital (RCH), Home Health Specialists ERH-Emergency, RCH-Emergency Allied Health project: UBC	3 UBC Faculty of Medicine, Fraser Health Primary Health Care, PSP	14	n/a (while the number of partners increased, it is difficult to measure as a percentage change as some relationships were strengthened while others changed over time.

		Faculty of Pharmaceutical Sciences-Pharmacy Clinic Protoclinic: UBC Faculty of Medicine-Department of Family Practice Sunshiner Frailty Network: Fraser Health Home Health Implementation support: PSP, Fraser Health Primary Health Care			
 10,891 patients attached	Attachment Hub tracking 10,500 in Quarterly report related to recruitment (new associate physicians) 80 new attachments - protoclinic-	311 patients were attached via the Attachment Hub. In addition, 31 new physicians were recruited to the community, attaching a much higher	0	10,891	n/a

	Quarterly report 311 attachments from Attachment Hub (tracking)	number of patients for which figures are not available			
 # prevented unattachments		Data on GPs leaving was not available.			
 152 stronger attachments	Sunshiner Network tracking	152 patients received support via the Sunshiner network that improved the quality of care the patient received, supporting the patient to act on the recommendations of the GP to access community resources.	0	152	n/a
 31 new GPs	Recruitment tracking	31 new physicians were recruited to the community	n/a	31	n/a

 # GPs leaving		Data on GPs leaving was not available.			
 36 GPs newly accepting patients	Attachment Hub Practice Visit Profile Summary	32 physicians agreed to be listed in the Attachment Hub. In addition, 4 additional clinics reported they were willing to accept homebound frail patients.	0	36	n/a
 3 allied health professionals added	Quarterly reports	1 RN, 2 pharmacists, 1 psychiatrist	0	3	n/a
 # days wait for 3rd next-available appt.	N/a	This data was not available.			