ANNUAL REVIEW 2013

Richmond
Division of Family Practice
A GPSC initiative

CONTENTS

REPORT FROM THE CHAIR OF THE BOARD

At this time of reflection and renewal I am pleased to report to our members our successes as we finish our third year. I have been capably supported by my fellow Directors and extend my gratitude for their commitment: Drs. Wendy Amirault (Vice-Chair and Finance Committee), Peter Chee (Chair-Acute Care Committee), Ki-Sun Kim (Treasurer and Shared Care Lead), Michael Myckatyn (Chair-Residential Care Committee) , Robert McKenzie (IPCC Co-Chair and Finance Committee), Manoj Singhal (Chair-Coverage Committee) and Patricia Wong.

Dr. Jack Kliman, Board Chair

On reflecting on the past year I am aware of the increasing role of the Division in giving Richmond physicians a place to come together as colleagues, to share our common experiences and challenges and to contribute our ideas for improving the primary care experience for all involved. One such example is the development of the In Hospital Network group which allows the last remaining group of physicians with privileges at Richmond Hospital to access coverage support from their GP colleagues. Member-completed evaluations, surveys and consultations are at the root of all our efforts and we are constantly refining our plans, priorities and activities to meet member identified needs. Our committee and project work is running full steam ahead; work led by members, driven by members and realising results for our members, our patients and the health system.

Another central theme of our work this year has been to restore the sense of community, continuity and collaboration between Richmond GPs and specialists. Through a range of GP-specialty events such as "Clinical Pearls- What They Didn't Tell You In Medical School" and the ongoing series on Mental Health services and programs in Richmond we have had great response and interest from our members, specialty physicians and community organizations. The "Let's Talk: Orthopaedics" event brought out 70 members, all six Richmond orthopaedic specialists, three rheumatologists and clinical staff from OASIS and sports medicine. We are continuing work in a variety of issues and ideas raised at this event and indeed, by bringing physicians together, we have seen inspiring and rich possibilities that present themselves.

Through the Richmond Division we have increasing opportunities to speak out as leaders in our health care community. We are increasingly involved with VCH-Richmond and are seeing increased success in our efforts to represent member directions and interests as changes and initiatives are launched in Richmond through the CSC and IPCC forums and regionally through the Interdivisional CSC.

As we launch our fourth year the provincial Attachment/A GP for Me initiative will be a major area of work. In early April we will start the assessment phase to understand in greater detail the primary care barriers and issues that face Richmond residents looking for a family physician. We will also be consulting our members to better understand their own practice challenges and future plans as well as their perspective on attachment.

I look forward to the upcoming year and our continued efforts to fulfill our organizational mission to be "A medical community that protects, promotes and expands the role of family physicians in caring for their patients."

Dr. Jack Kliman
Board Chair

REPORT FROM THE EXECUTIVE DIRECTOR

As Executive Director, I have thoroughly enjoyed supporting the Board and our members as we work to fulfill the Division's vision of providing a collective and influential voice for Richmond family physicians. It has been a pleasure to work alongside many of our members in projects, committees, working groups and to connect at Division events and social opportunities such as the picnic.

This year we have experienced record levels of member engagement as our attendance and participation levels increased alongside our expanding total membership, which currently totals 128 members or 90% of physicians eligible for membership. We are particularly proud that our membership is reflective of the entire GP community including community-based family physicians and GPs who work as hospitalists and emergency room physicians.

We continue to make locum coverage a priority and I thank the members for their support as we explore unique solutions; who would have thought that speed dating could prove to be a viable and successful approach to bringing physicians together to explore cross- coverage opportunities? Please continue to advise myself or Annie if you need locum coverage as increasing numbers of available locum physicians are contacting the Division looking for temporary or permanent opportunities.

This past year has seen the addition of new projects: BC Pragmatic Trials Collaborative and new phases of our Shared Care projects, new work at the committee level in our committees on residential care, acute care and coverage as well as innovative events such as the Shared Care series bringing together Richmond family physicians and specialty physicians, a series on Mental Health services, Teledermatology, RACE line, OASIS program and member consultation events on a range of issues. The Division's inaugural member picnic, extended to include medical office staff as well as invitations to Richmond specialists, was a fun event and planning is already underway for this year's.

On behalf of the Board I would like to thank Afsaneh Moradi (Physician Engagement Lead-Divisions provincial office) who has been a great resource and guide. We are grateful to Annie Hobson for her commitment to this organization and its work. Most of our members know Annie from her strong presence at our events but her administrative skills allow myself, the Board and our various committees and working groups to work efficiently and effectively. Through the hard work and persistence of our Project Lead for Shared Care, Carrie Locke, our Shared Care projects and events are developing in leaps and bounds.

Our upcoming year looks to be exciting on a number of fronts: expansion of more committees, launching the assessment phase of our work on the provincial Attachment /A GP for Me initiative in addition to the development of additional Shared Care work, more events and collaborative partnerships. We will continue to reach out to our members and to specialist physicians and make efforts to reinvigorate the connections within the medical community in Richmond. Member priorities and interests remain our priority and I welcome your comments and suggestions for ways to make the Division relevant to your needs.

Denise Ralph
Executive Director

Denise Ralph, Executive Director

MISSION, VISION AND VALUES

VISION

The vision of the Richmond Division of Family Practice is to provide a collective and influential voice for Richmond family physicians.

MISSION

A medical community that protects, promotes and expands the role of family physicians in caring for their patients.

VALUES

We will be guided in our work by the following values:

Beneficial

Striving to be beneficial to our membership and/or our patients, outcomes based

Efficiency

Delivering efficient services to our membership, practicing efficiency as a Board and promoting workflow efficiency in our medical practices

Influential

Shaping how healthcare is designed, delivered and evaluated; having a voice with stakeholders, acting with vision

Innovative

Encouraging new sustainable ways to do our work, using resources and leading and sustaining healthcare improvements

STRATEGIC GOALS

1 **Strategic Objective #1:** To continue to develop a strong, supported, skilled and engaged physician community in Richmond. **Beneficial**

2 **Strategic Objective #2:** To ensure efficiency and sustainability of our work through planning our future by defining key outcomes, establishing deliverables and measuring results; through promoting efficient patient transitions within medical practices and between health care providers, sectors and communities. **Efficiency**

3 **Strategic Objective #3:** To influence and shape health care delivery at the practice, community and regional levels as a recognized and valuable voice for our members about the issues they face. **Influential**

4 **Strategic Objective #4:** To promote the use of innovative practices and enabling technologies as an organization and to our members in their medical practices. **Innovative**

INITIATIVES

1. ACUTE CARE COMMITTEE REPORT

I am pleased to update the members on the work of the newest Division Committee launched January 2014 on Acute Care Issues. I have been honoured to be joined in this work by fellow committee members Dr. Ki-Sun Kim (community GP), Dr. Francis Mondor (Emergency Department-RH), Dr. Jack Kliman (community GP), Dr. William Wong (Department Head-Family Practice- RH) and myself, an RH Hospitalist and Committee Chair.

In October 2013, the Division hosted a member consultation meeting and invited all members with opinions on acute care in Richmond to attend. Around thirty people participated and there was a robust discussion regarding acute care issues from a range of GP perspectives. From this initial consultation meeting a committee was struck with the first meeting in January and monthly thereafter.

The purpose of the Acute Care Committee is to assess the problems identified by the membership on acute care issues in Richmond Hospital and where possible, to implement corrective solutions. The following is taken from our Terms of Reference regarding the functions of the Acute Care Committee:

The Acute Care Committee will work collaboratively to:

- **Develop ideas, recommendations and solutions related to acute care** that will improve physician participation and satisfaction
- **Engage Richmond family physicians in the identification of key issues and implementation of solutions** to address acute care issues at Richmond Hospital
- **Provide regular communication to community GPs, hospitalists and Emergency Department physicians and the general membership** to update them on acute care issues and the committee's initiatives and priorities
- **Develop strategy and approach, ensure appropriate guidance and oversight** throughout the life span of the committee; oversee the work of the working groups and project supports and provide communication links to the Board, funders and key stakeholders

One challenge facing the committee has been to understand the significant numbers of existing projects, committees, working groups, management and individuals tasked with working on a range of acute care issues. We have no interest in creating duplicate or parallel efforts and in developing strategy are trying to understand how physicians' voices can best be utilized within this complex environment.

Our first effort has been to develop a working group tasked with looking at communications issues between the Emergency Department and GPs with Hospital Privileges. We are also working to develop an evening dinner event bringing together physicians from the Emergency Department at Richmond Hospital with community-based physicians to discuss a range of issues.

We invite the participation of anyone interested in working on acute care issues and encourage any member with an interest or idea to contact myself or any Committee member. Minutes from our meetings can be found on the Division's website under Committees and we will provide regular updates in the Division Newsletter.

Dr. Peter Chee
Acute Care Committee Chair

2. COVERAGE COMMITTEE REPORT

Committee Members: Drs. Francis Chu, Violet Foo, Stan Hurwitz, Charles Jiang, Manoj Singhal (Chair)

The committee will be wrapping up its efforts as this work will continue to be developed through our work on the provincial Attachment/A GP for Me initiative and I thank my fellow committee members for their efforts. I would like to remind members of the resources and efforts that have been developed for members to assist in providing more coverage:

A Locum Group for Richmond: One of our earliest efforts was to develop a group of physicians committed to working in Richmond. Their individual emails can be found in each newsletter and biographies of these locums can be found on the website.

Support for Physicians When They Acquire a Locum:

1. **Contract Templates**
   On our website you will also find short- and long-form contract templates to assist you with the business details in retaining a locum. These have been reviewed and approved and meet all current legal standards. We are always looking to expand the locum pool and suggestions are welcome.
2. **Overview Document on Community, Accessing Specialists, Home and Community Care**
   We also developed a "Welcome to Richmond" document which overviews the community and provides details on how to access specialists and VCH services for physicians unfamiliar to Richmond.

Soloists Resource Group: Spearheaded by Stan Hurwitz, the Soloist Resource Group uses a listserv through Google Groups to place and respond to requests from the group's members for coverage when a soloist is unavailable or on vacation without locum coverage. Information is posted under Committees > Coverage – Soloists Resource Group in the members-only area of the website; new soloist members are always welcome.

Exploring "Cross Coverage Partnerships": At the Speed Dating for Professional Coverage event held in January 2014, we took a light-hearted approach to an important issue: helping physicians acquire more coverage support. Through a series of focussed conversations or speed dates, physicians discussed the possibility of cross covering each other's practices, sharing locums or developing their own arrangements. We were happy that a number of physicians made connections that have led to increased coverage as well as physicians who are partnering to share a locum physician. We are happy to repeat this event to give other physicians an opportunity to participate.

Efforts to Connect with PG2's: We have managed to link with the provincial medical students' organization and post regular invitations to Division events and activities in an effort to promote Richmond to the new graduates. We have also seen an increase in physicians paired with medical students in Richmond.

The Search for Elusive Locums: We have continued our efforts to advertise on behalf of our members on the locums.ca website as well as Healthmatch BC. We are finding increased contacts from locum physicians as Divisions are increasingly serving as centralised hubs by which locum physicians can contact

INITIATIVES CONT'D

Speed Dating for Practice Coverage poster.

Speed daters Drs. Kazem Khazamipour and Don Faulkner discussing coverage needs.

and learn about available opportunities. I encourage all our members to complete and submit a "Locum Wanted" form and send it in to Annie. If we have your locum request on file we will share it with a "matching" locum candidate and are pleased to report that last year these efforts yielded many weeks of locum coverage for our members. This service is open to all members of the Division and we encourage you to make contact with the Division to share your specific locum needs.

Regards,
Manoj Singhal
Coverage Committee Chair

3. RESIDENTIAL CARE COMMITTEE

Members: Drs. Adam Chang, Morton David, W. Ken Kan, Gary Koss, Beverley Lee-Chen, Michael Myckatyn (Chair), Cheryl Nagle and William Wong

The Residential Care Committee of the Richmond Division met four times in addition to two meetings with the Directors of Care and sub-working group meetings on specific issues. The Committee's work has focussed on:

GEOGRAPHICAL ALIGNMENT PROGRAM

This initiative aims to geographically align physicians to their preferred facilities based on proximity to office or home. We currently have fifty one physicians who provide residential care in Richmond, the majority of whom have a couple of patients in each facility. By optimizing geography we can improve the provision of care and satisfaction for both physicians and patients. Please contact myself or Denise if you wish to see the list of physicians who are willing to "trade" patients or take on new patients in certain facilities.

TRIAL OF ON CALL GROUP

From November 2013 through February 2014, we launched a "third call" group/ resource team of physicians who provided coverage when facilities were unable to make contact with the patient's physician of their designation. We greatly appreciate the efforts of those physicians who volunteered their time in providing this coverage: Drs. Adam Chang, Morton David, Gary Koss, Chee Ling, Henry Ngai, Michael Myckatyn, Cheryl Nagle and William Wong. We are currently reviewing the data from VCH to see if this back-up group was able to decrease the numbers of patients transferred to the Emergency Department due to challenges in accessing a physician.

ONGOING COMMUNICATION WITH RICHMOND DIRECTORS OF CARE

There have been two meetings with the Directors of Care from the six VCH-supported care facilities. to discuss shared issues and efforts have proved to be both useful and helpful for the committee. We will continue to meet quarterly.

INCREASED COMMUNICATION AND SUPPORT TO RESIDENTIAL CARE PHYSICIANS

Efforts to connect and communicate with the physician group in Richmond have included the creation of a Residential Care Billing 101 document to remind physicians of the fee structure, communiqués on the need to update and regularly review DOIs and the challenges of using APRS to provide coverage to residential care facilities due to the inadequate coverage provided by this physician service.

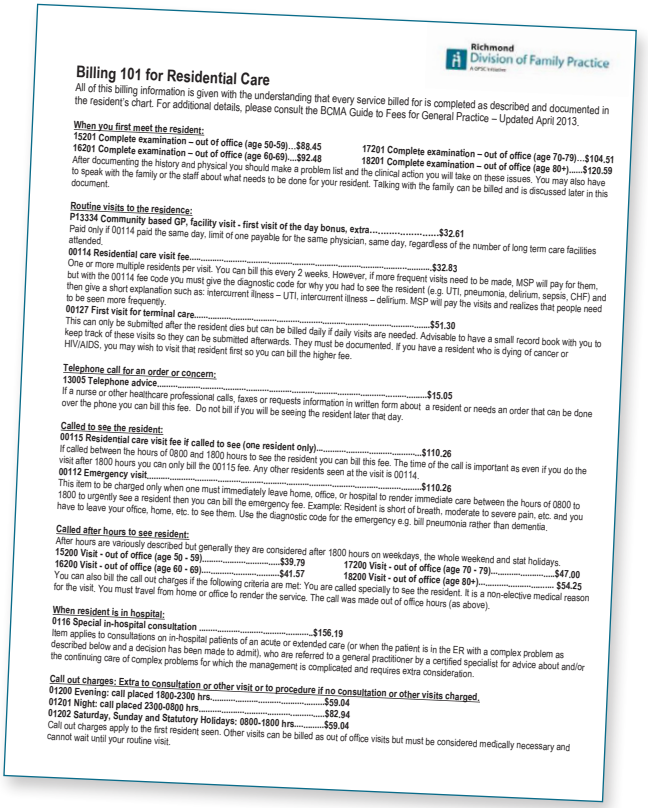
INITIATIVES CONT'D

OUR PLANS FOR WORK IN 2014–2015

- **Polypharmacy project for Richmond** Through the Shared Care Committee we have an opportunity to work on medication optimization and reduction using a circle of care approach involving family physicians and specialists, pharmacists, Directors of Care and nursing staff, patients and their families.
- **Focussed CMEs** on subjects identified by members to enhance their skills in caring for residential care clients.
- As the physician population in Richmond inches closer to becoming residential care residents instead of providers, we are keenly aware of the need to **recruit younger physicians** into this richly rewarding area of general practice.

Dr. Michael Myckatyn
Residential Care Committee Chair

Billing 101 for Residential Care Form



Richmond Division of Family Practice

Billing 101 for Residential Care

All of this billing information is given with the understanding that every service billed for is completed as described and documented in the resident's chart. For additional details, please consult the BCMA Guide to Fees for General Practice – Updated April 2013.

When you first meet the resident:

15201 Complete examination – out of office (age 50-59)...$88.45
16201 Complete examination – out of office (age 60-69)....$92.48
17201 Complete examination – out of office (age 70-79)...$104.51
18201 Complete examination – out of office (age 80+).....$120.59

After documenting the history and physical you should make a problem list and the clinical action you will take on these issues. You may also have to speak with the family or the staff about what needs to be done for your resident. Talking with the family can be billed and is discussed later in this document.

Routine visits to the residence:

P13334 Community based GP, facility visit - first visit of the day bonus, extra.....$32.61

Paid only if 00114 paid the same day, limit of one payable for the same physician, same day, regardless of the number of long term care facilities attended.

00114 Residential care visit fee.....$32.83

One or more multiple residents per visit. You can bill this every 2 weeks. However, if more frequent visits need to be made, MSP will pay for them, but with the 00114 fee code you must give the diagnostic code for why you had to see the resident (e.g. UTI, pneumonia, delirium, sepsis, CHF) and then give a short explanation such as: intercurrent illness – UTI, intercurrent illness – delirium. MSP will pay the visits and realizes that people need to be seen more frequently.

00127 First visit for terminal care.....$51.30

This can only be submitted after the resident dies but can be billed daily if daily visits are needed. Advisable to have a small record book with you to keep track of these visits so they can be submitted afterwards. They must be documented. If you have a resident who is dying of cancer or HIV/AIDS, you may wish to visit that resident first so you can bill the higher fee.

Telephone call for an order or concern:

13005 Telephone advice.....$15.05

If a nurse or other healthcare professional calls, faxes or requests information in written form about a resident or needs an order that can be done over the phone you can bill this fee. Do not bill if you will be seeing the resident later that day.

Called to see the resident:

00115 Residential care visit fee if called to see (one resident only).....$110.26

If called between the hours of 0800 and 1800 hours to see the resident you can bill this fee. The time of the call is important as even if you do the visit after 1800 hours you can only bill the 00115 fee. Any other residents seen at the visit is 00114.

00112 Emergency visit.....$110.26

This item to be charged only when one must immediately leave home, office, or hospital to render immediate care between the hours of 0800 to 1800 to urgently see a resident then you can bill the emergency fee. Example: Resident is short of breath, moderate to severe pain, etc. and you have to leave your office, home, etc. to see them. Use the diagnostic code for the emergency e.g. bill pneumonia rather than dementia.

Called after hours to see resident:

After hours are variously described but generally they are considered after 1800 hours on weekdays, the whole weekend and stat holidays.

15200 Visit - out of office (age 50 - 59).....$39.79
16200 Visit - out of office (age 60 - 69).....$41.57
17200 Visit - out of office (age 70 - 79).....$47.00
18200 Visit - out of office (age 80+).....$54.25

You can also bill the call out charges if the following criteria are met: You are called specially to see the resident. It is a non-elective medical reason for the visit. You must travel from home or office to render the service. The call was made out of office hours (as above).

When resident is in hospital:

0116 Special in-hospital consultation $156.19

Item applies to consultations on in-hospital patients of an acute or extended care (or when the patient is in the ER with a complex problem as described below and a decision has been made to admit), who are referred to a general practitioner by a certified specialist for advice about and/or the continuing care of complex problems for which the management is complicated and requires extra consideration.

Call out charges: Extra to consultation or other visit or to procedure if no consultation or other visits charged.

01200 Evening: call placed 1800-2300 hrs.....$59.04
01201 Night: call placed 2300-0800 hrs.....$82.94
01202 Saturday, Sunday and Statutory Holidays: 0800-1800 hrs.....$59.04

Call out charges apply to the first resident seen. Other visits can be billed as out of office visits but must be considered medically necessary and cannot wait until your routine visit.

PROJECTS

1. SHARED CARE

Overall Purpose: Family physicians and specialist physicians in Richmond — working together to improve health outcomes and the patient journey throughout the health care system.

SharedCare
Partners for Patients

KEY MILESTONES

- **Strong governance:** Re-formed and strengthened the Shared Care Steering Committee; solid reporting and governance structures in place
- **Project expansion:** Expansion in project scope and depth of the initial orthopaedics project; addition of a second-phase project with rheumatology; exploratory discussions and project scoping around transitions into, through and out of acute, ED andmaternity care as well as opportunities for improvements in Polypharmacy, Child and Youth Mental Health and ON TRAC Youth Transitions
- **Enhanced specialist participation:** Addition of new specialists to the Steering Committee/working groups as well as interest from other specialists to engage in Shared Care opportunities; successful engagements with previously unengaged specialists; participation from highly valued specialists in engagement events
- **GP participation:** Engagement of more GPs as a result of increased specialist interest and enhanced profile of Shared Care within the Division
- **MOA participation:** Addition of MOAs to working groups plus a Division-hosted MOA event
- **Health authority participation:** Re-formed the Steering Committee with Health Authority representation has helped with issues of alignment, strategic direction and oversight; issues brought forth from the Steering Committee meetings are brought forth to the Collaborative Services Committee
- **Enhanced profile of Shared Care:** Within and outside of the Division through formal events, newsletter,informal dialogue and working groups
- **Evaluation:** Interim project evaluation completed

Carrie Locke, Project Lead

QUOTES:

"With no Doctors Lounge, changes to the medical community and decreasing numbers of GPs with full hospital privileges there are few opportunities for Richmond GPs and specialists to meet and learn from each other. Shared Care has provided us with a unique opportunity to bring Richmond physicians together to collaborate on a range of work."

— Denise Ralph, Executive Director

"Our collaboration with ortho specialists has been and continues to be instrumental in our efforts to improve the referral and communication process."

— Dr. David Li, GP Lead, Orthopaedics

"Rheumatology remains in the top three specialties that Richmond GPs have told us they need more clinical knowledge and skills in."

— Dr. Ki-Sun Kim, Steering Committee Chair and GP Lead, Rheumatology

PROJECTS CONT'D

STEERING COMMITTEE MEMBERS

- Dr. Ki-Sun Kim, Family Physician (Chair)
- Dr. Barry Koehler, Specialist Physician
- Aman Hundal/Bethina Abrahams (Shared Care Committee)
- JoAnne Douglas, Vancouver Coastal Health
- Denise Ralph, RDFP Executive Director (Vice-Chair)

ORTHOPAEDICS WORKING GROUP MEMBERS

- Dr. David Li, Family Physician (Chair)
- Dr. Richard Kendall, Specialist Physician (Orthopaedics)
- Dr. John Arthur, Specialist Physician (Orthopaedics)
- Dr. Robert Baker, Family Physician
- Dr. Keri Ruthe, Family Physician
- Dr. Manoj Singhal, Family Physician
- Sharon Calvert, Family Physician Office RN
- Kathy Bozanich, Specialist Office MOA
- Pat Gibbs, Specialist Office MOA
- Rachel Duck, Specialist Office MOA

RHEUMATOLOGY WORKING GROUP MEMBERS

- Dr. Ki-Sun Kim, Family Physician (Chair)
- Dr. Barry Koehler, Specialist Physician (Rheumatology)
- Dr. Jerry Vortel, Specialist Physician (Infectious Diseases)
- Dr. James Lu, Richmond Medical Health Officer (Public Health)
- Kim Bourhill, Immunization Program Lead, Richmond Public Health

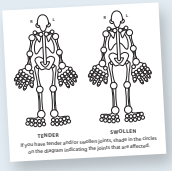
2014–2015 WORK PLANS

As we look ahead, we will continue to work on improving communications and access to orthopaedics; improving referrals, immunization care and clinical education support in rheumatology; identifying and working on other member-identified specialty areas including emergency, maternity and radiology; and bringing more opportunities for GPs and specialists to come together for clinical pearls events.

TIMELINE 2013–14

APRIL

- Launch of the new Enhanced Rheumatology Referral Form (ERRF)



MAY

- Orthopaedic referral process working group meets to review feedback and revisions to the orthopaedic referral process

JUNE

- Exploratory dialogue with public health to coordinate immunization care for rheumatoid arthritis

JULY

- Working group meetings to review feedback and revisions to the ortho referral/appointment confirmation process; survey with membership to determine orthopaedic clinical education needs

AUGUST

- Second pilot of the orthopaedics referral form

SEPTEMBER

- First Shared Care event featuring the RACE telephone line and Richmond OASIS program

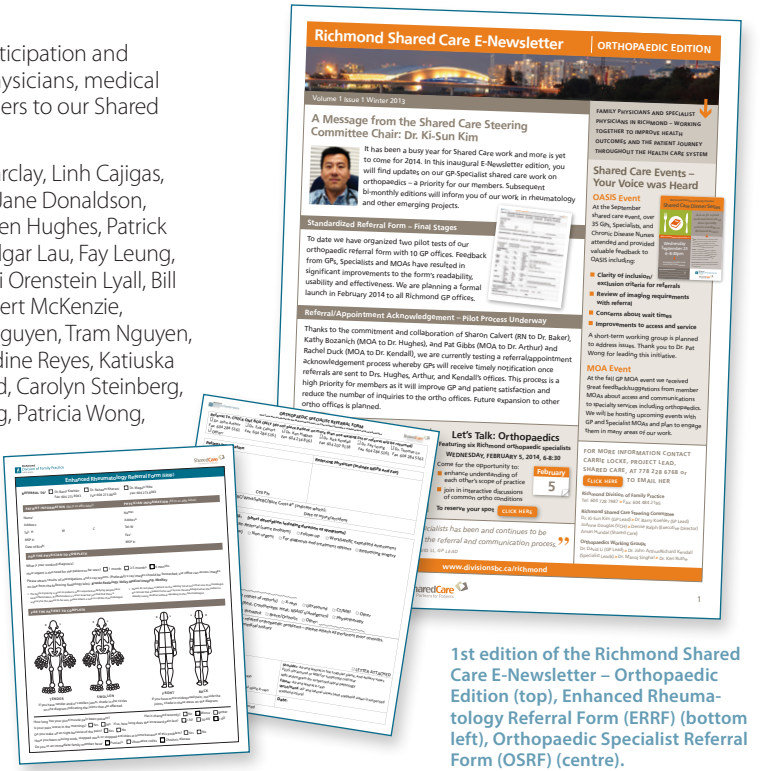
SPECIAL THANKS

We would like to acknowledge the participation and contributions of various Richmond physicians, medical office assistants and community partners to our Shared Care projects:

Wendy Amirault , John Arthur, Shane Barclay, Linh Cajigas, Erik Calvert, Peter Chee, Linda De Luca, Jane Donaldson, Peter Gibson, Megan Hiltz, Allan Horii, Ken Hughes, Patrick Kenny, Raheem Kherani, Jack Kliman, Edgar Lau, Fay Leung, Robert Levy, Thomas Lu, Kelly Luu, Teddi Orenstein Lyall, Bill Mackie, Paul Mah, Suneeta Mangal, Robert McKenzie, Michael Myckatyn, Cheryl Nagle, Nam Nguyen, Tram Nguyen, Susan Rechel, Wingfield Rehmus, Geraldine Reyes, Katiuska Saldana, Louise Sourisseau, Russell Stead, Carolyn Steinberg, Robyn Wells, Margot Wilson, Boon Wong, Patricia Wong, Thomas Wong.

We would like to extend our gratitude to the many community organizations who have contributed to our Shared Care Projects in the past year:

CHIMO, Ministry of Children and Family Development-Richmond, Richmond Addiction Services Society, Richmond Youth Service Agency, Touchstone Family Association.



1st edition of the Richmond Shared Care E-Newsletter – Orthopaedic Edition (top), Enhanced Rheumatology Referral Form (ERRF) (bottom left), Orthopaedic Specialist Referral Form (OSRF) (centre).

OCTOBER

- Richmond represented at the Provincial Shared Care Committee Showcase

NOVEMBER

- First pilot of a referral/ appointment confirmation process; first working group meeting to draft a rheumatoid arthritis immunization protocol; hosted two events: "Teledermatology" and "Child & Youth Mental Health"

DECEMBER

- Launched the inaugural edition of the Shared Care newsletter; consensus reached on the final version of the orthopaedics referral form

JANUARY

- Exploratory discussions to review opportunities for an orthopaedics triage/consult clinic

FEBRUARY

- Hosted two successful events: "Let's Talk: Orthopaedics" as well as "Clinical Pearls: What They Didn't Tell You in Medical School"; launch of the new orthopaedics referral form

MARCH

- Ongoing planning of additional working groups and events

PROJECTS CONT'D

2. BC PRAGMATIC TRIALS COLLABORATIVE

The BC Pragmatic Trials Collaborative is an initiative of the Richmond Division of Family Practice with funding provided by the Innovation Fund, established by the provincial Divisions team.

B.C. Pragmatic Trials Collaborative
Measuring What Matters

therapeutics letter ©

THERAPEUTICS INITIATIVE Evidence Based Drug Therapy

therapeutics letter
July - August 2013

Filling the Evidence Gap
Pragmatic Randomized Controlled Trials in British Columbia

Randomized controlled trials are the cornerstone of medical evidence but there are systematic gaps in this evidence, which need to be filled. This letter discusses some of these gaps, outlines the global need for more pragmatic trials and describes a new British Columbian organization that is attempting to help fill the need.

What is a pragmatic trial?[1]

Most randomized controlled trials (RCTs) are "explanatory" or "efficacy" trials, designed to answer whether a treatment can demonstrate benefit in a select population. Such trials normally compare an intervention to placebo or to another active intervention that may not be standard of care. They also focus on a narrow set of outcomes to which the intervention is targeted. In contrast, "pragmatic" or "effectiveness" trials: 1) examine interventions in a broader population representative of those who will be treated; 2) report outcomes of importance to patients that are intended to capture global benefit and harm; and 3) often compare the intervention in question to standard therapies. Compared to efficacy trials, pragmatic trials are intended to answer the questions that clinicians and patients have regarding therapy.

The need for more representative subjects

Most RCTs use narrow inclusion and exclusion criteria to select the participants most likely to benefit from an intervention and least likely to experience harm (e.g. targeting those at high cardiovascular risk but excluding those with renal insufficiency). This approach maximizes the likelihood of observing benefit. However, this practice also results in many trials excluding subjects similar to the patients most commonly encountered in clinical practice. In a systematic sampling of RCTs published in high impact journals, 38.5% of RCTs excluded older adults, 81.3% excluded individuals with common medical conditions, and 54.1% excluded individuals receiving commonly prescribed medications.[2]

RCT

Pragmatic Trial

Considering the multiple morbidities present in 71% of diabetics, 82% of osteoarthritics, 83% of chronic obstructive pulmonary disease sufferers, and 92% of those with coronary artery disease,[3] such trials are clearly not representative of real world populations.
Of 20,388 US Medicare patients ≥ 65 years of age, **only 1 in 5 patients discharged from an acute care hospital with a diagnosis of congestive heart failure (CHF) met the criteria for enrollment in 3 landmark trials that guide the treatment of all CHF patients.[4]** As a general rule, although older adults and patients with multiple co-morbidities are often the target of clinical practice guidelines, they are poorly represented in the evidence-generating trials upon which clinical guidelines are based. This is especially important for the frail elderly, who fall into both categories. There are observational data raising questions as to the value of lowering blood pressure and blood sugar in the frail elderly.[5, 6] Such studies are only hypothesis generating but clinical trials in this traditionally understudied population are clearly needed.

The need for better assessment of harm

The use of highly selected and generally healthier patients in efficacy trials increases the likelihood such trials will fail to adequately predict harm in a population with a broader spectrum of disease.

Mailing Address: Therapeutics Initiative
The University of British Columbia
Department of Anesthesiology, Pharmacology & Therapeutics
2176 Health Sciences Mall
Vancouver, BC Canada V6T 1Z3

Tel.: 604 822•0700
Fax: 604 822•0701
E-mail: info@ti.ubc.ca
www.ti.ubc.ca

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Led by Richmond Division member Dr. Scott Garrison, the collaborative is a province-wide initiative for family physicians who have come together to answer pivotal health care questions such as "Does reducing polypharmacy in older adults lessen mortality or prolong independence?" The Project has received support and interest from both the Michael Smith Foundation and the Ministry of Health, with both organizations interested in engaging with FPs to work on quality improvement initiatives. The Therapeutics' Initiative newsletter focussed on the project in its summer 2013 edition. There are 130 physicians across the province registered to participate in a collaborative once the Collaborative Trial Network is up and running. Recent efforts have focussed on finding acceptable solutions to billing issues for participating physicians as well as obtaining ethics approval and access to data.

For more information contact:
Scott Garrison MD, PhD
E-mail: BCTrials@DivisionsBC.ca

A YEAR IN REVIEW 2013–2014

2013

APRIL

- Board strategic planning, part 1
- AGM and Membership Event on new fee codes with Dr. Cathy Clelland

MAY

- Coverage Committee meeting
- Member consultation on Attachment
- Bright Idea funding granted to Dr. Allan Horii to research how to link GPs to home bound and residential care patients through technology
- Innovation funding received for BC Pragmatic Trials Collaborative

JUNE

- Meeting of RH GPs with full privileges regarding coverage issues
- Residential Care Committee meeting:
- Billing 101 for residential care
- List of GPs willing to take new or transferred residential care patients

MONTHLY MEETINGS:

- Board
- Integrated Primary and Community Care (IPCC)
- Collaborative Services Committee (CSC)

2014

NOV

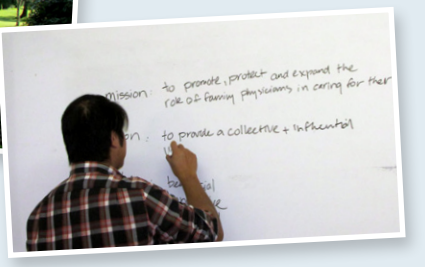
- Finance review of half year spending by Board
- CSC Strategic Planning session of Division and VCH–Richmond
- Launch of 3-month Residential Care Third Call Physician Backup Group
- Shared Care event: Child & Youth Mental Health Services
- Shared Care event: Teledermatology

DEC

- Board completes review of Board organizational policies
- Residential Care meeting with Directors of Care

JAN

- Survey of In Hospital Network group
- Adoption of Strategic Goals for CSC
- First meeting of Acute Care Committee
- Finance Committee meeting
- Speed Dating for Practice Coverage Event



JULY

- Coverage Committee meeting
- In Hospital Network Group for RH launched

AUGUST

- 2012–2013 Audit completed: "clean bill of health" received
- Therapeutics Initiative newsletter highlights BC Pragmatic Trials Collaborative
- Letter of Intent for A GP for Me proposal submitted and approved

SEPT

- Summer Picnic with Richmond medical community and staff
- MOA Dinner Event
- Board strategic planning, part 2
- Shared Care event: RACE phone line/OASIS program

OCT

- Coverage Committee meeting
- Member Consultation Meeting on Acute Care issues
- Residential Care Committee meeting

FEB

- Shared Care Event: Let's Talk: Orthopaedics
- Acute Care Committee meeting
- Residential Care Committee receives presentation on Polypharmacy
- Shared Care Event: Clinical Pearls

MARCH

- In Hospital Network Group renews for 1 year
- Finance Committee end of year review
- Membership increases 16% to 128 active members

COMING AHEAD...

- Launch of A GP for Me/ Attachment assessment phase
- Polypharmacy meeting with Circle of Care
- Ongoing events with GPs and Specialists
- Launch of new committees

UNAUDITED FINANCIAL STATEMENT FOR 2013–2014

BALANCE SHEET

as of March 31, 2014

ASSETS	
Assets	
Chequing/Savings	288,166.08
High Interest Savings	255,015.12
Total Assets	543,181.20
TOTAL ASSETS	543,181.20

LIABILITIES & EQUITY	
Liabilities	
Accounts Payable	5,449.50
GST Payable	- 24,131.95
GPSC Deferred Revenue	43,704.50
Shared Care Deferred Revenue	332,027.00
Total Liabilities	357,049.05
Equity	
Unrestricted Net Assets	- 25.68
Net Income	165,172.33
Total Equity	165,146.65
TOTAL LIABILITIES & EQUITY	522,195.70

UNAUDITED FINANCIAL STATEMENT FOR 2013–2014

PROFIT AND LOSS STATEMENT

April 2013 – March 2014

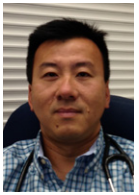
ORDINARY INCOME/EXPENSE	
Income	
GPSC Infrastructure	293,790.00
Shared Care — PiC	0.00
DoFP Innov — BC Pragmatic Trials Collaborative	46,440.20
A GP for Me/Attachment	360,894.50
Bank Interest	3,896.65
Income	705,021.35
GPSC Deferred Revenue	43,704.50
Shared Care Deferred Revenue	332,027.00
TOTAL INCOME	1,080,752.85
Expense	
Administration	14,448.56
Facilities	1,284.49
Human Resources	186,449.79
Supplies & Equipment	2,793.52
Travel	2,389.87
Total Expense	207,366.23
Other Expense: Projects	
Contingencies	8,358.95
Coverage	5,172.91
Residential Care	11,887.67
Acute Care	3,010.55
Membership Events	47,747.45
Specialists — Shared Care	176,846.26
Provincial Data Collaboration	12,107.23
A GP for Me/Attachment	10,485.88
Pragmatic Trials	34,964.32
Bright Ideas	963.07
Total Other Expense: Projects	311,544.29
TOTAL EXPENSES	518,910.52
NET INCOME	561,842.33

ACKNOWLEDGEMENT

The Richmond Division of Family Practice gratefully acknowledges the funding of the General Practice Services Committee, Shared Care Committee and Innovation Fund as well as the support of the Division of Family Practice provincial office and Shared Care central office. We extend our gratitude for the contributions of staff and leadership from Vancouver Coastal Health, the Practice Support Program team in addition to our many community partners and community representatives.

2013 BOARD OF DIRECTORS

Dr. Jack Kliman, Chair & Lead



Dr. Ki-Sun Kim, Treasurer

Dr. Patricia Wong, Secretary

Dr. Wendy Amirault, Director

Dr. Peter Chee, Director

Dr. Robert Mckenzie, Director

Dr. Michael Myckatyn, Director

Dr. Manoj Singhal, Director

SUPPORT TEAM

Denise Ralph, Executive Director

Carrie Locke, Project Lead

Annie Hobson, Administrative Assistant

RICHMOND DIVISION OF FAMILY PRACTICE

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We gratefully acknowledge the funding of the General Practice Services Committee and Shared Care Committee, as well as the support of the Division of Family Practice provincial office.

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The Divisions of Family Practice Initiative is sponsored by the General Practice Services Committee, a joint committee of the BC Ministry of Health and Doctors of BC.

www.divisionsbc.ca/richmond

Richmond
Division of Family Practice
A GPSC initiative

BRITISH COLUMBIA

GPSC
General Practice Services Committee

doctors of bc
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