Divisions of Family Practice
A GPSC initiative

A GP for Me

Final Evaluation & Project Implementation Close-Out Report

WHITE ROCK-SOUTH SURREY DIVISION OF FAMILY PRACTICE

White Rock-South Surrey
Division of Family Practice
A GPSC initiative

Release: Final Version
Date: 20-07-2016

Authors: Eric Chi, Nancy Mathias

Divisions of Family Practice
A GPSC initiative

A note about the A GP for Me Final Evaluation & Project Implementation Close-Out Report

Purpose

This A GP for Me Final Evaluation & Project Implementation Close-Out Report template has been designed, with input from divisions, JCC Evaluation team, and the A GP for Me team, to facilitate the final reporting for divisions' A GP for Me work. The template encompasses both an evaluation component to convey the extent to which a division has achieved its A GP for Me goals and impacts, and a project management close-out component to capture closing considerations from a project oversight perspective for the divisions A GP for Me strategies/projects.

The information captured in this report will enable us to consistently roll-up provincial and local results to help answer the Provincial Evaluation Plan questions:

1. *To what extent have the goals of a GP for Me been achieved?*
2. *To what extent have patients, physicians and local Divisions 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?*
5. *What are the most significant changes and key lessons learned?*

A template for a 2-page Evaluation Summary has also been provided in Appendix 1 for divisions to complete. The Evaluation Summary is intended for internal, quick-reference communication with the GPSC and audiences that do not require the full Evaluation Close-Out Report. Divisions are asked to complete both templates. It is anticipated that the information from these documents can be repurposed for a public-facing version for external audiences. A public version would further answer questions like: How did the projects impact and improve primary care for patients and communities?

Note: If you administered the patient and/or physician survey, please be sure to send this raw data to the provincial JCC evaluation team (plolic@doctorsofbc.ca) by June 31st, 2016 as well.

What will happen with the information provided in this report?

The information provided in divisions' evaluation close-out reports will be used by the funding partners, A GP for Me Program, and JCC Evaluation team in various ways:

- *content will be aggregated to inform communications and reporting about the provincial impact and evaluation of the initiative*
- *lessons learned and close-out recommendations will be extracted and used to inform recommendations to the GPSC regarding governance, structuring, and roll-out of provincial initiatives, and may be used to inform improvements to centralized support for divisions completing provincial initiatives*
- *lessons learned regarding project process, governance, and structure will be summarized in provincial-level reporting*
- *information may potentially be used to facilitate interdivisional information sharing and knowledge management*

- *measurement of outcomes will help to determine the value and impact on the primary health care system overall and in relation to the funds spent*
- *learnings and outcomes will help determine the impact and benefits to patient access and care for development of future models*
- *learnings and outcomes will help determine the impact and benefits for physicians and practices to determine future support and focus*
- *learnings will inform discussions about the spread of successful initiatives*

Who should complete these templates?

Throughout the report there are suggestions as to who should complete each section. Project Managers, Executive Directors, and Division Evaluators should all have input into this report.

Clarifying Questions to Assist You In Completing the Template

Clarifying instructions and questions have been provided in each section to help you to develop your Evaluation Close-Out Report. The clarifying questions provided throughout this template are provided for consideration only; they are not mandatory.

Assistance with these templates:

Please direct questions regarding the completion of these templates to:

Tomas Reyes (treyes@doctorsofbc.ca)

Table of Contents

Divisions of Family Practice
A GPSC initiative

1 Executive Summary

[Suggested completion by Project Lead]
Please provide an executive summary of the overall A GP for Me Final Evaluation and Initiative Close-out Report (1-2 PAGES).

The WRSS Division of Family Practice had the privilege of being one of three prototypes for Attachment (which later became known as A GP for Me). The Division started its Attachment efforts in 2010, shortly after its incorporation in 2009. This meant that the Division "grew up" with Attachment being its central purpose and intertwined in everything that the Division did. Therefore it is difficult to tease out many of the nuances requested in this report.

Through its various initiatives, the WRSS Division of Family Practice was successful in achieving Attachment goals.

> *"We got to a point where were could say that every patient that wants a GP in White Rock had a GP" (WRSS Physician)*

In addition, the Attachment Initiative became a catalyst for furthering the development of the WRSS Division and creating connections between the Division and other partners in the community. The Attachment Goals were achieved in a variety of ways which are highlighted below.

> *"Having done what we've done now is sort of establish that foundation of being able to get a GP for anybody who wants one. We can actually now engage with the community and start talking about optimal use of resources and after hours care and get together as a division talking about which walk-in clinics, need to stay open really, and can we do it as a coordinated effort rather than these one off isolated places that are isolated*." (WRSS Physician speaking about overall impact of Attachment Initiative)

1.1 Increased Attachment - enabling those who want a family physician to have one

The Residential Care Program, Recruitment and Retention, PCAC, Central Registry for Patients, Uptown Medical Clinic and Multidisciplinary Practice Grants have all contributed to increasing the supply of physicians in the community or increasing the efficiency of practices. These programs have enabled patients in WRSS to find a doctor, if they want one. According to data collected through two initiatives (Uptown Medical Clinic and the Multidisciplinary Practice Grants), approximately 12,051 patients have been attached over the course of the Attachment Initiative. This does not mean that these programs were the only contributors to the Attachment numbers, they were however, the only programs that were able to provide this information. When this figure is compared to the initial estimated need (between 8,000 to 14,000 patients needed to be attached), it is fair to say that the WRSS Division has succeeded in meeting its attachment needs.

1.2 Strengthened Relationships between Physicians and Patients - including improved support for the needs of vulnerable patients

Several WRSS Attachment Initiatives were able to demonstrate strengthened relationships between physicians and patients (Pharmacist Initiative and to some extent Counselling and MDP grants). In addition, the PCAC, Pharmacist Initiative, Counselling and MDP grants resulted in improved support for vulnerable patients[1]. A range of improvements were found including:

> *"We have a lot of elderly, frail patients in our practice. I ask the nurse to schedule them for a long complex care review appointment. They [the patients] love it because they get all their questions answered. We discuss every aspect of their care, I think at the end of it they feel very well cared for."* (WRSS Physician speaking about MDP grants)

- Increasing access to a range of health professionals including RNs and LPNs (PCAC and MDP grants), counsellors (Counselling), and a highly skilled clinical pharmacist (Pharmacist Initiative)
- Improved medication management (Pharmacist Initiative)
- Improved chronic disease management (MDP grants)
- Increased assess to physicians in residential care facilities (Residential Care Program)
- Increased time spent with care providers (MDP grants, PCAC, Counselling, and Pharmacist), and
- Increased patient education (Pharmacist and MDP grants)

One of the most dramatic improvements in supporting vulnerable patients was the establishment of the Primary Care Access Clinic where unattached patients who needs cannot be met in a traditional fee for service environment are attached to a Nurse Practitioner and other allied health care providers. In the words of one physician:

> *It is quite amazing the kind of attention these people are getting for the first time ever* (WRSS Physician speaking about PCAC).

1.3 Increased Capacity of the Primary Health Care System

There were numerous ways that the WRSS Attachment Initiatives increased the capacity of the primary health care system. Capacity was increased through:

> *"I think the GPs have a difference sense of practice and being in this community there is a real sense of cohesion, which didn't exist before, and the venue to creatively resolve issues."* (Attachment Working Group Member speaking about the Attachment Initiative)

- Increased interprofessional interactions (Counselling, Pharmacist, MDP grants, and PCAC)
- Increased interprofessional care (Pharmacist, MDP grants)
- Improved practice environments for physicians (Residential Care Program, and MDP grants)
- Increased physician knowledge of medications and community referral sources for mental health issues (Pharmacist, Counselling)
- Increased access to physicians and other health professionals (Uptown, Counselling, Pharmacist, Residential Care, MDP grants)
- Increased practice efficiency (MDP grants)
- Improved administration, charting and record keeping (MDP grants)
- Increased physician satisfaction with their practices (Residential Care Program and MDP grants)

[1] The types of vulnerable patients supported through these initiatives included frail elderly, poly-pharmacy, patients experiencing mental health challenges, and patients with chronic diseases.

- Increased sense of community among physicians
- Increased information sharing within the community (Attachment planning process) and collaboration (Counselling, PCAC, Residential Care, and Pharmacist)
- Increased interest in collectively addressing the needs of the community (all programs).

2 Summary of Our A GP for Me Initiative

2.1 Introduction

[Suggested completion by Evaluator and Project Lead]

The White Rock-South Surrey Division of Family Practice was one of three Divisions selected by the General Practices Service Committee (GPSC) to be a "testing ground" (a prototype) for learning how to support increased attachment between patients and primary care physicians.

A list of the programs is shown below in 2.2. It is important to note that together, these programs touch many of the levers that support Attachment including increasing the supply of physicians in the community, making it easier for patients to find physicians, and increasing the efficiency of practices and range of services offered so more patients can be attached. Some of these programs were already underway with funding from other sources and other programs were purpose-developed with Attachment funds. Although not included here, further support for Attachment Goals was provided through programs like access to Nurse Practitioners (through funding from Fraser Health) and provincial-wide programs (e.g. Attachment fee codes/Attachment Incentives).

2.2 Summary of Strategies / Projects

[Suggested completion by Project Lead]
Please provide, in the table below, a summary of all your A GP for Me projects by Strategy Area. Include a

description of the projects initiated and their objectives. In the next section, we ask you to report how you did in accomplishing the objectives listed herein.

It might be helpful to also describe the "project type" e.g. prototype, or pilot, or improving 'partner collaboration for service delivery', etc.

Project	Brief Description of Project	Objective(s)	Status as of March 31, 2016
Strategy Area: Team-based Care			*e.g. 'Time Extended', 'Sustained through Impact Funding', 'Implementation Complete'*
Primary Care Access Clinic (PCAC)	The PCAC is a full service primary care clinic and offers services that are not generally available from other primary care clinics. Key services include: • Access to a family physician • Access to a Nurse Practitioner • Access to a psychiatrist • Access to a mental health counsellor • Referral to community-based family physicians (for attachment) when appropriate • Referral to FHA services, as required Patients remain attached to the clinic until such time as their needs can be met through a traditional fee for service practice.	Initially established when unattached patients could not get a doctor, the clinic was established to provide follow up care for unattached patients being discharged from hospital. Now that GPs are accepting patients the PCAC serves unattached patients whose needs are not able to be met through a traditional fee for service practice (i.e. those hard to attach).	Sustained through Impact Funding and FH partnership
Multidisciplinary Practice (MDP) Grants	Enabled practices to hire allied health providers (e.g., registered nurses, licensed practical nurses, dieticians, etc.) or increase the hours of those already working in the practices. The practitioners provide complementary care to the care provided by the physician.	To increase support for vulnerable patients by enabling them to spend more time with a care provider and increasing their access to a range of interventions. To attach more patients and contribute to increasing the capacity of the primary health care system through: • increased efficiencies in practices, • improvements in administration, charting and record keeping, • increased physician satisfaction with their practices, and • increased inter-professional practice.	Implementation Completed

Counselling Services	Provided patients who were in need of professional counselling but had no ability to pay with up to 6 short term counselling sessions delivered by a community-based counselling agency.	To provide better support for vulnerable patients and increasing the capacity of the primary care system.	Implementation Complete
Pharmacist Services	Provided a seasoned clinical pharmacist seconded from FHA to be available in GP offices four days per month for GP-requested consultations with their patients who had complex medication needs.	The objectives of the initiative were to: • Optimize therapy • Optimize health outcomes • Reduce drug-related problems • Reduce health care resource utilization • Reduce over-prescribing.	Implementation Completed
Community of Practice for RN/LPN working in practices	Support group for RNs/LPNS with quarterly meetings.	Increase skills and supports for nurses working in practices with GP to increase capacity	Ongoing – with support from Peace Arch Hospital and Community Health Foundation
Home Health – Case Managers	Aligns Home Health Case Managers to physicians to serve all their patients' needs so the GP has only one case manager to work with rather than several.	Increase support to GP to increase capacity.	Ongoing – supported by FH
Residential Care Program	Provides a Site Medical Director (SMD) for all residential care facilities in WRSS who oversees the care needs of all residents. Centralized answering service ensures that facility staff have access to a SMD for immediate care needs 24/7.	To help address the complex needs of the frail elderly living in long term care facilities and support physicians in providing care to residents. To attach those patients that do not have a GP to a GP that goes to the facility	Sustained through Residential Care Initiative
In-hospital Care Program	The In-hospital Care Program provided evening and night coverage to all patients at Peace Arch Hospital, initially was for all hospital patients (attached and unattached), now just for those not under Hospitalist care	Facilitate GPs to follow their patients in hospital (improved continuity of care) by removing the burden of being frequently on call during evenings and nights	Coverage of Community GP patients (attached) sustained through In-patient Care Incentive
Nurse Practitioner (NP) for PATH (Patient Assessment and Transfer Home) Peace Arch Hospital and for Homebound Frail Elderly	NP provides primary care for unattached PATH patients. NPs service homebound frail elderly through Primary Care Access Clinic.	To work with FPs to ensure continuous primary care for homebound frail elderly, and work with patients of the PATH Unit to facilitate early discharge with follow-up in patients' homes for unattached patients.	Sustained through collaboration with FHA and NP4BC funding
Strategy Area: Practice Efficiencies & Support			
Integrated Practice Support (PITO, PSP, & Division)	Provides physicians with support to identify and implement strategies to optimize care for their existing patients and increase capacity in their practices (e.g. by improved EMR use, specific learning opportunities, etc.).	To optimize clinical workflows and efficiencies, improve capacity, optimize EMR use and achieve advanced access through a joint collaboration	Project completed. Support for GPs sustained through PSP working in partnership with Division

		between PSP, PITO and the Division.	
Strategy Area: Attachment Mechanisms			
Central Registry (of physicians accepting patients)	Provides a central phone number for providing information on physicians accepting patients.	To ensure anyone who wanted a FP in WRSS could find one.	Co-located with the PCAC (Sustained by Impact Funding)
Strategy Area: Recruitment & Retention			
Uptown Medical Clinic	The Uptown Medical Clinic was established to offer physician recruits a new, fully operational clinic, as well as business management and financial support for the first two years of practice.	The Uptown Medical Clinic served as a recruitment tool to help meet the community's need for additional family physicians when there was no space in existing clinics to for additional doctors.	At the end of the two years of support, the recruited physicians chose to assume ownership of the clinic from the Division – project completed
Locum Support Program	Recruits physicians to fill community locum opportunities. Provides centralized location for securing locums.	To enable GPs to take holidays and leave of absence from their practices.	Sustained by Impact Funding
Recruitment & Retention	The program involves working with GPs and other partners to recruit new physicians to the community.	To supplement current practices or replace physicians within practices.	Sustained by Impact Funding
Strategy Area: Health Promotion & Education			
Education and Mentoring	Monthly Rounds, and topical education events	To increase skills of GPs, provide mentoring opportunities	Sustained through Infrastructure funds
Right Care Right Place	Public education campaign that directs patients what their choices are for care – GP first, then walk-in, 811 available, pharmacist for urgent medication refill, before going to ER.	To decrease the use of ER for low acuity issues, increase attachment to their GP	Time extended
Medimap	Implementation of a website which shows which walk-in clinics in the community are open and what the wait times are.	To reduce the number of patients going to Emergency for things that can be dealt with by a GP (increase continuity of care)	Complete – website is running.
Fetch	Website to for patients and GPs regarding community health-related resources	To provide resources to both patients and GPs r	Complete – website is running and sustained by partnership with Peace Arch Hospital and Community Health Foundation and Seniors Come Share Society

3 Impact of A GP for Me in Our Community

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

[Suggested completion by Evaluator]

Please detail below your overarching provincial A GP for Me goals and achievements toward those goals. Select applicable outcomes from the provincial logic model (choose from the drop down lists) that best fit your major goals. (If more than one Logic Model Outcome applies please copy the drop-down list.)

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*

Please include both qualitative and quantitative results/findings of the project, and your methods and analysis approach. Please indicate the associated strategies and projects

Be sure to include any relevant quotations from the qualitative data you've collected (e.g. interviews, focus groups, physician comments). Please provide insight into the value created for patients and health care providers.

You can include any relevant charts in the Appendix in your full-length local evaluation report.

A GP for Me Goal	**Increased Attachment - enabling those who want a family physician to have one**
Achievement(s) Toward Our A GP For Me Goal	The suite of programs all contributed to increasing the supply of physicians in the community or increasing the efficiency and therefore the capacity of practices. These programs have enabled patients in WRSS to find a doctor, if they want one. For the past three years, we have always had GPs accepting patients. According to data collected through the evaluation of two initiatives (Uptown Medical Clinic and the MDP Grants), approximately 25,000 patients have been attached over the course of the Attachment Initiative. In addition the Primary Care Access Clinic has over 600 attached to the clinic. This does not mean that these programs were the only contributors to the Attachment numbers, as recruitment of doctors would be included in the numbers reported through the evaluation of the MDP grants. When this figure is compared to the initial estimated need (between 8,000 to 14,000 patients needed to be attached), it is fair to say that the WRSS Division has succeeded in meeting its attachment goal.
Associated Logic Model Outcome(s) (if choosing "other" please describe below)	Select Logic Model Outcome (most relevant) Increased Access To A GP
Other outcome	

Methods and analysis approach applied to assess success	A mixed method design was used to explore the implementation, effectiveness, and lessons learned. The findings draw on document reviews, quantitative data from the programs, quantitative data from 34 practicing physicians attending a Division All Members meeting who participated in a clicker survey, and qualitative data from interviews and focus groups. For each program's methods, please view their respective evaluations (see Appendix 2)
Associated Strategies / Projects	Recruitment and Retention, PCAC, Central Registry for Patients, Uptown Medical Clinic, Integrated Practice Support Program, and MDP Grants

A GP for Me Goal	**Strengthened Relationships between Physicians and Patients - including improved support for the needs of vulnerable patients**
Achievement(s) Toward Our A GP For Me Goal	Several WRSS Attachment Initiatives were able to demonstrate strengthened relationships between physicians and patients (Pharmacist Initiative and Counselling and MDP grants). In addition, the PCAC, Pharmacist Initiative, Counselling and MDP grants resulted in improved support for vulnerable patients. A range of improvements were found including: • Increasing access to a range of health professionals including RNs and LPNs (PCAC and MDP grants), counsellors (Counselling), and a highly skilled clinical pharmacist (Pharmacist Initiative) • Improved medication management (Pharmacist Initiative) • Improved chronic disease management (MDP grants) • Increased assess to physicians in residential care facilities (Residential Care Program) • Increased time spent with care providers (MDP grants, PCAC, Counselling, and Pharmacist), and • Increased patient education (Pharmacist and MDP grants) One of the most dramatic improvements in supporting vulnerable patients was the establishment of the PCAC where unattached patients who needs cannot be met in a traditional fee for service environment are attached to a Nurse Practitioners.
Associated Logic Model Outcome(s) (if choosing "other" please describe below)	Select Logic Model Outcomes (select all that apply, copy drop-down if more are required) Strengthened Patient-Physician Relationship
Other outcome	
Methods and analysis approach applied to assess success	A mixed method design was used to explore the implementation, effectiveness, and lessons learned. The findings draw on document reviews, quantitative data from the programs, quantitative data from 34 practicing physicians attending a Division All Members meeting who participated in a clicker survey, and qualitative data from interviews and focus groups. For each program's methods, please view their respective evaluations (see Appendix 2)
Associated Strategies / Projects	PCAC, Pharmacist Initiative, Counselling Initiative, and MDP grants and education events.

A GP for Me Goal	**Increased Capacity of the Primary Health Care System**
Achievement(s) Toward Our A GP For Me Goal	There were numerous ways that the WRSS Attachment Initiatives increased the capacity of the primary health care system. Capacity was increased through: • Increased interprofessional interactions (Counselling, Pharmacist, MDP grants, and PCAC) • Increased interprofessional care (Pharmacist, MDP grants) • Improved practice environments for physicians (Residential Care Program, and MDP grants) • Increased physician knowledge of medications and community referral sources for mental health issues (Pharmacist, Counselling) • Increased access to physicians and other health professionals (Uptown, Counselling, Pharmacist, Residential Care, MDP grants) • Increased practice efficiency (MDP grants, IPSI, Education) • Improved administration, charting and record keeping (MDP grants) • Increased physician satisfaction with their practices (Residential Care Program, Locum & Recruitment support and MDP grants) • Increased sense of community among physicians • Increased information sharing within the community (Attachment planning process) and collaboration (Counselling, PCAC, Residential Care, and Pharmacist, FETCH) • Increased interest in collectively addressing the needs of the community (all programs)
Associated Logic Model Outcome(s) (if choosing "other" please describe below)	Select Logic Model Outcomes (select all that apply, copy drop-down if more are required) Strengthened Patient-Physician Relationship
Other outcome	Increased Capacity of the Health Care System
Methods and analysis approach applied to assess success	A mixed method design was used to explore the implementation, effectiveness, and lessons learned. The findings draw on document reviews, quantitative data from the programs, quantitative data from 34 practicing physicians attending a Division All Members meeting who participated in a clicker survey, and qualitative data from interviews and focus groups. For each program's methods, please view their respective evaluations (See Appendix 2).
Associated Strategies / Projects	All programs

[For questions 3.2 – 3.5 again choose an outcome from the provincial logic model that is relevant to answering this question. Be sure to include any relevant quotes from the MSC stories. You can include any relevant charts in the Appendix.]

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

[Suggested completion by Evaluator]
Please speak to both positive and negative impacts.
Example: With the new incentive fees in place, physicians are better compensated to provide longitudinal care to complex patients which means that these patients are getting better care.

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	**Patients:** The programs under the A GP for Me initiative have enabled any patient in WRSS to find a doctor, if they want one. **Physicians:** One of the unintended consequences of the increased ability to attach patients to physicians was a reduced demand on walk-in clinics. This, in part, led to the closing of the community-run walk-in clinic as of March 31, 2015. **Division:** The A GP for Me initiative has completely shaped what the Division does; its three goals are integrated into the Division's mission statement.
Strengthened Patient-Physician Relationship	**Patients:** The programs under the A GP for Me initiative have increased support for vulnerable patients by enabling patients to spend more time with a care provider and access a greater range of services at their GP's practice. Greater support was available to patients through increases in opportunities for patient education, and chronic and complex care management. **Physicians:** With the new incentive fees in place, physicians are better compensated to provide longitudinal care to complex patients which means that these patients are getting better care. Various programs allowed physician time to be freed up, thereby doctors could spend more time with complex patients and strengthen the GP-patient relationship, especially for vulnerable patients. For example, MDP grants enable inter-professional practice, improving physician satisfaction with their practice environments.

Other	
Increased Capacity of the Health Care System	**Patients:** The programs under the A GP for Me initiative have enabled any patient in WRSS to find a doctor, if they want one. Greater support was available to patients through increases in opportunities for patient education, and chronic and complex care management, for example through the Counselling Initiative. Physicians reported that the services enabled by the MDP grants resulted in boosting patients' sense of self-worth, encouraging them to be more interested in their health, and enabling a sense of accomplishment when they saw the changes in the tests, or if they lost a bit of weight. **Physicians:** Various programs allowed physician time to be freed up, allowing them to take on more patients or see complex care or vulnerable patients for more significant amounts of time.

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

[Suggested completion by Evaluator]
Please speak to both positive and negative impacts
Example (system integration): Having a social worker available from the health authority to see patients in GPs' clinics in our division has meant that patients are getting the counseling that they need.

Logic Model Outcome (Select from list) (if choosing "other" please describe below)	Impact to primary health care systems integration and transformation across the Division
Increased Service Integration	Having an experienced pharmacist available from FHA to see patients in GPs' clinics has meant that patients with complex medication needs are getting in-depth information and consultation. The pharmacist provides direct service to vulnerable patients and can increase the capacity of the primary care system through increasing physician knowledge of medication management and by increasing opportunities for interprofessional practice. The RNs and LPNs supported to work in GPs' clinics provided a range of services including patient education and support alongside physicians, improving interprofessional practice.
Strengthened Collaboration	Collaboration between the Division and FHA enabled the funding of the PCAC, allowing unattached patients whose needs are not able to be met

	through a traditional fee for service practice access care. The relationships built have allowed several other initiatives to be done in conjunction since. The Division has also built partnerships with other community agencies to sustain some programs.
Choose an item.	
Other Outcome	

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

[Suggested completion by Evaluator]
Example factors could include (but are not limited to): Staff capacity and time available, funding available, partnerships, etc.

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
Effective Engagement	Good engagement with physicians in the Division (through surveys, face-to-face clinic visits, and providing opportunities to be involved in planning, implementation, and oversight). Identification of physician champions/leaders Shared sense of ownership and articulation of common needs allowed all perspectives to be considered Highly qualified Division staff
Other	
Goal Setting/Process Mapping	Setting realistic expectations, trying things out, and learning as you go

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

[Suggested completion by Evaluator]
Key lessons in this case refer to key lessons in attempting to create impact and change for patients and health care providers. Key lessons for the project process beyond these are requested in section 4.2.
Example: Targeted funding helped our CSC members focus and plan toward specific goals

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
Strengthened Collaboration	Work with others in partnership, don't try to do things on your own
Governance	Keep it manageable, don't take on too many projects all at once

Effective Engagement	Take the time to do a good planning process, engaging all physicians so you can identify their needs and strategically allocate Attachment dollars Take the time to do good community outreach, not just to physicians but to other stakeholders in the community
Other Outcome	

3.6 If applicable, please describe any unintended outcomes and their cause.

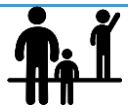
[Suggested completion by Evaluator]
For example, "The mayor of our community announced a child mental health campaign as a result of our school-based attachment program."

One of the unintended consequences of the increased ability to attach patients to physicians was a reduced demand on walk-in clinics. This, in part, led to the closing of the community-run walk-in clinic as of March 31, 2015.

3.7 Quarterly Reporting Indicator Definitions

[Suggested completion by Evaluator]
Please complete the table below. Please feel free to add more description in the Appendix or full-length division evaluation.
Note:
Indicator – refers to the metrics reported in the quarterly reports (i.e. # of patients attached/impacted).
Please define what the indicator is measuring exactly (and, if applicable, over what period of time).
Baseline – what was the original (first) number reported for the corresponding indicator?
Current – what is the current number being measured for this indicator?
*%Change = (Current – Baseline) / (Baseline) * 100%*

Indicator	How Data Was Collected	Detail *Please also indicate the associated strategies / projects used to achieve these indicators for each*	Baseline Total (For All Strategies)	Current Total (For All Strategies)	% Change
 **# members involved**		*Please provide additional, qualitative information / context to describe the result* All members of the Division are impacted by the A GP for Me initiative as it has completely shaped the Division's Mission statement	Baseline unavailable as prototyping started with the start of the Division	132 Division Members 37 participate on Committees 38 participate including Board	
 **# partners**	Went through all projects done in attachment and counted which	1. FHA a. FHA Mental Health and Substance Use	unavailable	19	

Indicator	How Data Was Collected	Detail *Please also indicate the associated strategies / projects used to achieve these indicators for each*	Baseline Total (For All Strategies)	Current Total (For All Strategies)	% Change
	organizations were part of collaboration with Division re: attachment	b. Primary Care c. Hospital administration 2. PITO 3. PSP 4. SOURCES 5. Seniors Come Share Society 6. Residential Care Facilities (9) 7. Peace Arch Hospital and Community Health Foundation 8. BC MoH 9. City of WR			
 **# patients attached**	Uptown Medical Clinic and the Multidisciplinary Practice Grants	*New patient attachments made through: an attachment mechanism and/or a combination of other strategies (indicate which ones) such as new GPs in community; an increase in patient panel size from retiring GP; data collected from/ reported by practices, etc.*	unavailable	25,474	
 **# prevented unattachments**	N/A		unavailable	unavailable	
 **# stronger attachments**	N/A		unavailable	unavailable	
 **# new GPs**	Recruitment and retention numbers	*Please indicate types and roles: e.g.* *• Family practice GP, locum, hospitalist or other; International Medical Grads, graduating residents staying on, etc;* *• Permanent, part-time, starting or taking over a practice; replacing A GP retiring or leaving, etc.*	unavailable	33	

Indicator	How Data Was Collected	Detail *Please also indicate the associated strategies / projects used to achieve these indicators for each*	Baseline Total (For All Strategies)	Current Total (For All Strategies)	% Change
 **# GPs leaving**	Recruitment and retention numbers	*Please provide information about GPs retiring or leaving for other reasons*		Past two years: 5 GPs retired	
 **# GPs newly accepting patients**	N/A		Changes continually		
 **# allied health professionals added**	N/A	*Please indicate types and roles*	unavailable	unavailable	
 **# days wait for 3rd next-available appt.**	N/A		unavailable	unavailable	

3.8 Budget Performance by Strategy

[Suggested completion by Project Lead]
Report your budget and spending by strategy/project. Please provide information on cost performance against your 'final' budget, which is not necessarily that which you provided in the proposal. The line items provided below are 'suggested only' and should be changed to best reflect your approach.

Not sure how to add this up for the years as a prototype – do not have by project

Budget Overview ($)

Strategy 1 *[***Please copy and insert more tables as required***]*

FUNDING	Comment	Budgeted	Actual	Variance
A GP for Me Funding				
In-Kind - DoFP Committees				
In-Kind - Practice Support Program				
In-Kind - Health Authority				
In-Kind - City				
etc.				

Total Funding				

EXPENDITURE	Comment	Budgeted	Actual	Variance
Administration & Overhead Division Staff Operating and Administrative Costs Attachment Working Group Resource Team Staff Implementation Activities etc.				
Sub-total				

Ongoing Operating Costs

ONGOING OPERATING COSTS				Projected (per year)
Administration & Overhead Division Staff Operating and Administrative Costs Attachment Working Group Resource Team Staff Implementation Activities etc.				
Sub-total				

Notes:
The project was over/under budget for the following reasons:

- Reason 1.
- Reason 2.

Total Spending *(of all strategies/projects above)* - ***Not Available by Strategy***

Project/Strategy	Comment	Budgeted	Actual	Variance
Total				

4 Effectiveness of Our A GP for Me Project Implementation

4.1 A GP for Me Governance and Structure

[Suggested completion by Project Lead]
Describe the governance structure and the project structure utilized. Briefly explain how having the governance structure helped with, or hindered the execution of the projects.

Physicians know the ins and outs of what they do better than anybody. In identifying physician champions (i.e., Physician Leads) for various projects under the A GP for Me initiative, the Division ensured that the work done would be physician-led and crafted with a vision that appeals to other physicians. Strong engagement with other physicians within the Division provided opportunities to be involved in the planning, implementation, and oversight of projects. Further supported by skilled Division Staff members, this governance structure allowed for a shared sense of ownership and articulation of common needs within the medical community in WRSS.

There was an Attachment Working Group, which reported to the DoFP Board.

4.2 Project Implementation

[Suggested completion by Evaluator and Project Lead]

Please report on the effectiveness of your project approach/management through: assessment, design, development, and implementation. What were your learnings around organizing for and managing projects in your division? Please see the considerations listed below. This section can be completed for each strategy (or project) if each project approach differed; otherwise complete keeping your division's general project approach in mind.
What are the features, or nuances of the approach to these projects that are lessons learned? What went well? What did not go well? What would you do differently next time?

- Work with others in partnership, don't try to do things on your own
- Take the time to do thorough member engagement, so you can identify their needs and strategically prioritize attachment projects
- According to the Attachment Working Group, surveying the physicians "paid off" because the physicians were engaged from the beginning:
  "We did a survey to find out what the community wanted, the doctor community. And then we identified priorities. So the nurse was the biggest priority. You need to find out from your community of doctors what they want." (Focus Group with Attachment Working Group)
- Keep it manageable, don't take on too many projects all at once
- Take a chance, everything does not have to be perfect
- include community outreach, not just to physicians but to other stakeholders in the community, and
- Recognize that the work of Attachment is never complete; the needs of patients, providers, and communities continuously evolve and require ongoing attention.

Considerations for this section:
***Quality of implementation**: How well was the strategy/project delivered?*
How did the activities or components go? What aspects of the work worked well? Was project implemented properly? What aspects did not work so well?

***Barriers**: What got in the way of your success with design and/or implementation? This section attempts to understand why somethings didn't happen as planned and to identify key environmental variables. Were there*

any challenges to strategy/project participation? What lessons have been learned that might be useful if a similar project was to be undertaken again?

***Reach**: Did you reach the audience you intended to (i.e. physicians, patients, health care professionals)? What proportion of the target group was reached?*

***Satisfaction**: How satisfied were the people involved in the strategy/project? This section seeks feedback from the participants, partner organizations, and strategy/project staff.*
Was the timing appropriate? Were the different parts of the project easy to navigate?

Model that was used for governing this provincial initiative. What worked well? What could be improved?

Division's role in implementing provincial initiatives. What worked well? What could be improved? How well positioned was/is your division to implement provincial initiatives?

Strong physician leadership
Highly trained staff
Strong collaboration with community partners
With 95% of eligible physicians registered as members, strong physician engagement (2010 Annual Review) and interest in participating positioned the Division well to implement provincial initiatives. A huge appetite to take on more initiatives exists in WRSS.

Barriers/hurdles encountered in doing the work, and current positioning to handle same should they arise on the next initiative. Enablers required to implement provincial initiatives.

4.3 Change Management

[Suggested completion by Project Lead]
What changes were established as part of your strategies/projects to increase adoption / acceptance by stakeholders? What change management challenges/considerations were there with stakeholders in the design and implementation of your strategies/projects? Briefly describe the key change management activities undertaken with project stakeholders. This section can be completed by each project if it helps to relay your division's change management effectiveness more clearly.

not available

4.4 Effectiveness of the Provincial Initiative Implementation, Central Teams, and Centralized Supports

[Suggested completion by Project Lead]
Please provide an indication of the effectiveness of the provincial implementation, central teams, and/or central implementation supports e.g. the provincial A GP for Me team, Provincial Division Office (PDO), centralized implementation supports for your division, Practice Support Program (PSP), Provincial Evaluation, etc. to complete your GP for Me strategies / Projects. Please also indicate the extent of support utilized, what worked well, what did not work well, gaps, recommendations for improvements.

not applicable as a prototype community – support was not the same

5 Considerations at the Close of the Project Implementation

5.1 Outstanding Local Objectives by Strategy

[Suggested completion by Evaluator and Project Lead]

Please describe any objectives that were not achieved and the cause. Please note that outstanding "issues" can be captured in Section 5.2.

The following objectives are still outstanding:

Not applicable

5.2 Outstanding Issues

[Suggested completion by Project Lead]
Please indicate any remaining open issues and/or new issues that have surfaced as a result of having completed the Projects in each strategy. Section 5.1 asked for outstanding objectives. List any issues that are contributing to, or resulting from outstanding objectives? What mitigation is being undertaken to address outstanding issues?

Some examples of open issues that you may want to consider:
- policy and regulatory related issues e.g. compensation, privacy
-ongoing resourcing related issues e.g. human resources, financial resources
-issues related to GPSC priorities
-etc.

Example:
TBC Strategy – Attachment clinic - Current provision for compensating health care professionals engaged in team based care is an ongoing open issue for this TBC project in that…. We have taken the following interim steps as a stop gap measure…

Strategy / Project	Open Issues & Mitigation Plans
Counselling Initiative	A mechanism to continue to fund the Counselling Initiative has not yet been found
MDP Grant	Some of the practices anticipate being able to sustain the MDC provider in the practice even without Division funds, while others, especially smaller ones, acknowledged they may need to reduce the service or cancel service without the Division's funding.
	Some members have indicated that they will try to continue engaging the MDP provider from their MSP and CDM billings, reducing the provider's hours, and providing private vaccines (Zotavax, Twin Rix, Gardasil, Menactra, Dukoral). Additional billing practices could help sustain MDP providers.
Strategy/project 3	

Strategy/project 4	
Strategy/project 5	

5.3 Transition to Sustainable Operations

[Suggested completion by Project Lead]
Please indicate expected ongoing benefits and requirements for those operations/changes/activities that were established as part of a GP for Me, that will be sustained (we are not looking for remaining project implementation tasks here).
Some of these sustained operational activities may have been reported as part of the division's request for Impact funding. If information has been provided as part of the Impact funding process, please indicate so in the table below.

Operation/Change/Operational Activity Established As Part of A GP for Me **(that will be sustained)**	**What benefits are expected going forward?**	**Other Considerations What provisions / considerations are required to sustain the gains? What is the source of these provisions? Who is leading the ongoing activity/operation? Other notes?**
Strategy Name		
PCAC	Please refer to Impact Funding request	Evaluation of the clinic is currently underway – this will be used to seek sustainability funding
Strategy Name		
Recruitment and Retention	Please refer to Impact Funding request	Need to be able to retain staff member to continue to support this important activity.

5.4 Knowledge Transfer

[Suggested completion by Project Lead]
Assuming a central repository for divisions' knowledge will not be available at the time of A GP for Me close, what is your plan/process for sharing knowledge/knowledge resources and artifacts with other Divisions and/or GPSC, if requested?
What support do you need to do this? What artifacts would you have? (optional)

(The A GP for Me team can assist with the collection and posting of your A GP for Me knowledge resources on divisionsbc.ca as an interim measure.).

Five complete evaluations have been completed for the A GP for Me initiative in WRSS: 4 individual projects and an overall evaluation of the initiative. These and any future evaluations are posted on the Division website.

5.5 Project Implementation Closure Recommendations

[Suggested completion by Project Lead]
What recommendations would you make to: the GPSC, A GP for Me team, JCC Evaluation Team, A GP for Me Working Group, or Provincial Divisions Office, regarding changes to better support divisions in the strategy development, funding, launch, design, communications, implementation, change management, evaluation, and/or close of provincial initiatives?

Do NOT make it too complicated, trust the Divisions, let them learn as they go, PDSA cycles. Be selective in what you ask the Divisions for, particularly if you want quality answers.

6 Communication to Stakeholders

6.1 Effectiveness of Communication Support throughout the Initiative

[Suggested completion by Project Lead]
Please describe the approach taken for managing communications. What went well? What did not go as well? What could have been done differently? What were the lessons learned?

Please describe the level of support from the Provincial Communications Team throughout the A GP for Me initiative. What went well? What did not go as well? What could have been done differently? What were the lessons learned?

Communication support for the prototypes after implementation of A GP for me became cumbersome to access, and disjointed.

6.2 Closing Communications to Stakeholders

[Suggested completion by Project Lead]
Identify your internal and external stakeholder groups (audiences) that may be impacted by division's close-out/transitioning of A GP for Me projects:

Internal stakeholders(audiences):

- *Division members / doctors*
  - *GPs, specialists, NPs*
- *Clinical partners*
  - *AHPs in clinics?*
- *Health authorities*
  - *FHA*
- *Internal significant partners*
  - *Division staff, contractors*

- *Others?*

External stakeholders (audiences):

- *Patients enrolled in A GP for Me projects who will be impacted*
- *The community at large - general public*
- *Community partners*
  - *Sources*
- *Municipalities*
  - *City of White Rock, City of Surrey*
- *MLAs*
- *Media*
  - *Peace Arch News*
- *Others?*

1. *Did you communicate with stakeholders (audiences) about the close/transition of your initiatives? If so, what information was communicated and how was it communicated?*

Discussed with members at AGM and Members meetings, shared how we will transition activities to other supports, or whether we had to close the project.

2. *Have your initiative results been disseminated to stakeholders /audiences? If so, what information was communicated and how was it communicated?*

Evaluation reports available on websites, shared with partners.

3. *What, if any, plans do you have to share your initiative results with wider audiences?*

No plans.

4. *Have you shared any information about your success with stakeholders/ audiences and if so, how?*

Storyboard at the Quality Forum

5. *What, if any, plans do you have to share information about your success with wider audiences?*

unsure

6. *Were there any media inquiries about the close-out of your A GP for Me projects and if so, what about, and how did you respond? NO*
7. *Are there any ongoing communications challenges that need to be addressed? No*

7 Project Closure Report Approvals

By signing below, you are indicating that you have reviewed the content of this report and have authorized its release to the A GP for Me Team, A GP for Me Working Group, and the GPSC.

Reviewed By:	Date:
Dr. Connie Ruffo, Physician Lead, Division of Family Practice	July 13 /16
Nancy Mathias, Executive Director, Division of Family Practice	July 21 /16
Physician Lead, A GP for Me - Division of Family Practice	July 13 /16 .
N/A Evaluation Lead, A GP for Me Division of Family Practice	
N/A. Project Lead, A GP for Me , Division of Family Practice	

Appendices

Appendix 1: A GP for Me Final Evaluation Summary 2-Page Template- NOT AVAILABLE

Appendix 2: Please see all evaluations on the WRSS website: https://www.divisionsbc.ca/white-rock-south-surrey/annualreviews

Appendix 2 – Full-Length Evaluation Report

Evaluation of the Accomplishments of the Attachment Initiative in White Rock-South Surrey

White Rock-South Surrey
Division of Family Practice
A GPSC initiative

Prepared by
Marla Steinberg, PhD & Associates

Published March 2015

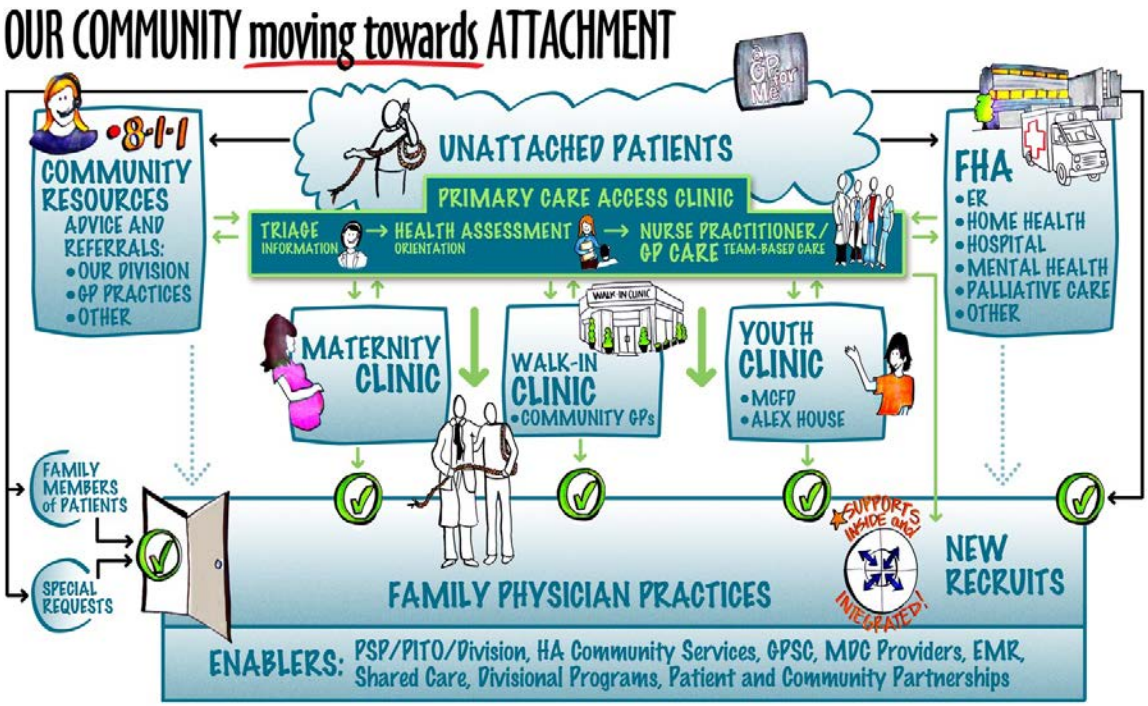

OUR COMMUNITY moving towards ATTACHMENT
8-1-1
COMMUNITY RESOURCES
ADVICE AND REFERRALS:
• OUR DIVISION
• GP PRACTICES
• OTHER
UNATTACHED PATIENTS
PRIMARY CARE ACCESS CLINIC
TRIAGE INFORMATION
HEALTH ASSESSMENT ORIENTATION
NURSE PRACTITIONER/ GP CARE TEAM-BASED CARE
FHA
• ER
• HOME HEALTH
• HOSPITAL
• MENTAL HEALTH
• PALLIATIVE CARE
• OTHER
MATERNITY CLINIC
WALK-IN CLINIC
• COMMUNITY GPs
YOUTH CLINIC
• MCFD
• ALEX HOUSE
FAMILY MEMBERS of PATIENTS
SPECIAL REQUESTS
FAMILY PHYSICIAN PRACTICES
SUPPORTS INSIDE and INTEGRATED!
NEW RECRUITS
ENABLERS: PSP/PITO/Division, HA Community Services, GPSC, MDC Providers, EMR, Shared Care, Divisional Programs, Patient and Community Partnerships

Table of Contents

1 About this Report

From 2011 to 2014, the White Rock-South Surrey (WRSS) Division of Family Practice implemented a variety of initiatives to support attachment within the community. This report presents an overview of the accomplishments. It is based on a synthesis of initiative-specific evaluation reports (see Appendix A for overview of the WRSS Attachment Evaluation) and information collected on the impact of the Attachment Initiative on the WRSS community.

2 Overview of Attachment in White Rock-South Surrey

The White Rock-South Surrey Division of Family Practice was one of three Divisions selected by the General Practices Service Committee (GPSC) to be a "testing ground" (a prototype) for learning how to support increased attachment between patients and primary care physicians.

Goals of the Attachment Initiative:

1. Confirming and strengthening the GP-patient relationship – including better support for the needs of vulnerable patients;
2. Enabling patients that want a family doctor to find one; and
3. Increasing the capacity of the primary care system.

According to data collected by the White Rock-South Surrey Division prior to the start of the initiative, between 5% and 35% of patients in WRSS were unattached. This translates into approximately 8,000 to 14,000 people. Estimates of unattached patients were based on the following:

- 5 to 20% of hospital discharges were for unattached patients
- 10-35% of ER visits were from unattached patients
- the walk in clinics saw 2,842 unattached patients over a 6 month period
- the maternity clinic reported 25% of their patients were unattached, and
- the provincial attachment algorithm showed an unattached rate of 21%.

Figure 1 shows the picture of the community before the Attachment Initiative. Of note is the limited pathways for unattached patients to become attached to physicians.

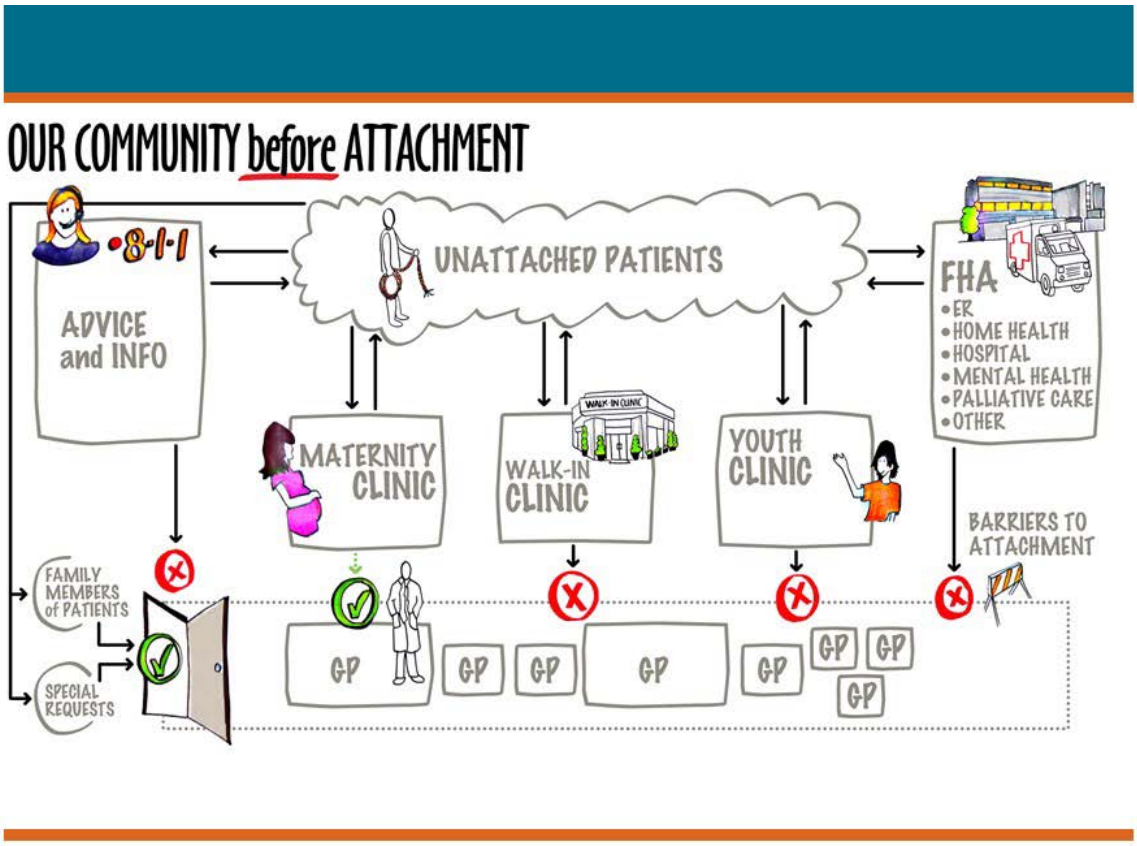


Figure 1: WRSS before Attachment

Like many communities, WRSS needed to find ways to attach patients and strengthen the attachment among existing patients. At the time, none of the physicians in the Division were taking on new patients and none of the existing clinics had the capacity to take on new doctors:

> *"Five years ago you could not get into a doctor no matter what." (WRSS Physician)*

> *"It was a cultural thing that we just didn't accept new patients. You got to know your old patients really well and you kind of keep them really well and did a good job of that" (WRSS Physician)*

In addition, the community was experiencing challenges in caring for patients in the hospital:

> *"We were trying to resolve the hospital issue because that was the (break) platform, and it wasn't that the GPs didn't want to do the hospital work anymore, it was that half the patients came from out of our area, so they were orphan patients…….and there's nobody in the community accepting patients. So it was really very difficult to provide care and assume, you know, that they're going to get continuing care out there, because it wasn't going to happen." (WRSS Physician)*

Further, many practices were aware that they could accept more patients if they were able to increase their efficiency and reallocate tasks to other care providers. A survey of physicians revealed that across the Division, the time equivalent of about 5 full time physicians could be freed up if specific clinical tasks were done by others (e.g. non-physicians or patients themselves). This could result in the attachment of an addition 7,500 into existing practices.

After extensive consultation with its members and in partnership with Fraser Health, the BC Ministry of Health, Peace Arch Hospital Foundation, and the City of White Rock, the WRSS Division developed a comprehensive approach to attachment. In the words of one physician:

> *"The increased resources coming with Attachment felt like the Cavalry had arrived to help us do things that we had been wanting to do." (Attachment Working Group Member)*

> We really wanted to try to have the doctors feel ownership and involvement in what we were doing (Attachment Working Group Member)

A list of the programs is shown below in Table 1. It is important to note that together, these programs touch many of the levers that support Attachment including increasing the supply of physicians in the community, making it easier for patients to find physicians, and increasing the efficiency of practices and range of services offered so more patients can be attached. Some of these programs were already underway with funding from other sources and other programs were purpose-developed with Attachment funds. Although not included here, further support for Attachment Goals was provided through programs like access to Nurse Practitioners (through funding from Fraser Health) and provincial-wide programs (e.g. Attachment fee codes/Attachment Incentives).

Table 1: Programs in White Rock-South Surrey that supported Attachment

NAME OF THE PROGRAM	BRIEF DESCRIPTION
PRIMARY CARE ACCESS CLINIC (PCAC)	The PCAC serves unattached patients whose needs are not able to be met through a traditional fee for service practice. The PCAC is a full service primary care clinic and offers services that are not generally available from other primary care clinics. Key services include: • Access to a family physician. • Access to a Nurse Practitioner. • Access to a psychiatrist through sessional payments from Fraser Health. • Access to a mental health counsellor through Fraser Health Mental Health and Substance Use. • Referral to community-based family physicians (for attachment). • Referral to Fraser Health services, as required. Patients remain attached to the clinic until such time as their needs can be met through a traditional fee for service practice.
UPTOWN MEDICAL CLINIC	The Uptown Medical Clinic was established in December 2011 by the White Rock-South Surrey (WRSS) Division of Family Practice to serve as a recruitment tool to help meet the community's need for additional family physicians. New physician recruits were offered a new, fully operational clinic, as well as business management and financial support for the first two years of practice. At the end of the two years, physicians could choose to assume ownership of the clinic from the Division or take their patients to another practice.

NAME OF THE PROGRAM	BRIEF DESCRIPTION
CENTRAL REGISTRY FOR PATIENTS WHO NEED A PHYSICIAN	Provides a central phone number for providing information on physicians accepting patients.
LOCUMS	Recruits physicians to fill community locum opportunities to enable GPs to take holidays and leave of absence from their practices. Provides centralized location for securing locums.
INTEGRATED PRACTICE SUPPORT (PITO, PSP & DIVISION)	Provides physicians with support to identify and implement strategies to optimize care for their existing patients and increase capacity in their practices (e.g. by improved EMR use, specific learning opportunities, etc.)
MULTIDISCIPLINARY PRACTICE (MDP) GRANTS	Enables practices to hire allied health providers (e.g., registered nurses, licensed practical nurses, dieticians, etc.) or increase the hours of those already working in the practices. The practitioners provide complementary care to the care provided by the physician.
RECRUITMENT & RETENTION	The program involves working with GPs and other partners to recruit new physicians to the community to supplement current practices or replace physicians within practices.
COUNSELLING SERVICES	The program provides patients who are in need of professional counselling but have no ability to pay with up to 6 short term counselling sessions delivered by a community-based counselling agency.
PHARMACIST SERVICES	Provides a seasoned clinical pharmacist seconded from Fraser Health to be available four days per month for General Practitioner (GP) requested consultations with their patients who had complex medication needs. The Pharmacist rotated amongst four GP host clinics, attending one of these weekly. Medical Office Assistants at the four host clinics coordinated patient consultations with the pharmacist, for both patients from their own clinics and patients referred by other clinics in the Division. The pharmacist met with the patients at the host clinics to review their medications and any concerns, and then made recommendations to the patients and/or their physicians, regarding their medication challenges.
HOME HEALTH – CASE MANAGERS	Aligns Home Health Case Managers to physicians to serve all their patients' needs so the GP has only one case manager to work with rather than several.
RESIDENTIAL CARE PROGRAM	Provides a Site Medical Director for each Fraser Health residential care facility in WRSS who oversees the care needs of all residents. The physician ensures that regular physical assessments are completed, documented and integrated into care plans. The physician also attends case conferences between patients, families and facility staff. A centralized answering service ensures that facility staff have access to a Site Medical Director for immediate care needs. Facility physicians attend regularly scheduled educational sessions (nine per year) to gain knowledge, skills and share expertise in the care of the residents and frail elderly. In addition to listening to guest speaker talk about a topic of relevance to the physicians, the physicians use these sessions to trouble shoot and share ideas related to their work within the long-term care facilities.

3 Accomplishments

Through its various initiatives, the WRSS Division of Family Practice was successful in achieving Attachment goals.

> *"We got to a point where were could say that every patient that wants a GP in White Rock had a GP" (WRSS Physician)*

In addition, the Attachment Initiative became a catalyst for furthering the development of the WRSS Division and creating connections between the Division and other partners in the community. The Attachment Goals were achieved in a variety of ways which are highlighted below.

> *"Having done what we've done now is sort of establish that foundation of being able to get a GP for anybody who wants one. We can actually now engage with the community and start talking about optimal use of resources and after hours care and get together as a division talking about which walk-in clinics, need to stay open really, and can we do it as a coordinated effort rather than these one off isolated places that are isolated*." (WRSS Physician speaking about overall impact of Attachment Initiative)

3.1 Increased Attachment - enabling those who want a family physician to have one

The Residential Care Program, Recruitment and Retention, PCAC, Central Registry for Patients, Uptown Medical Clinic and Multidisciplinary Practice Grants have all contributed to increasing the supply of physicians in the community or increasing the efficiency of practices. These programs have enabled patients in WRSS to find a doctor, if they want one. According to data collected through two initiatives (Uptown Medical Clinic and the Multidisciplinary Practice Grants), approximately 12,051 patients have been attached over the course of the Attachment Initiative. This does not mean that these programs were the only contributors to the Attachment numbers, they were however, the only programs that were able to provide this information. When this figure is compared to the initial estimated need (between 8,000 to 14,000 patients needed to be attached), it is fair to say that the WRSS Division has succeeded in meeting its attachment needs.

3.2 Strengthened Relationships between Physicians and Patients - including improved support for the needs of vulnerable patients

Several WRSS Attachment Initiatives were able to demonstrate strengthened relationships between physicians and patients (Pharmacist Initiative and to some extent Counselling and MDP grants). In addition, the PCAC, Pharmacist Initiative, Counselling and MDP grants resulted in improved support for vulnerable patients[1]. A range of improvements were found including:

> *"We have a lot of elderly, frail patients in our practice. I ask the nurse to schedule them for a long complex care review appointment. They [the patients] love it because they get all their questions answered. We discuss every aspect of their care, I think at the end of it they feel very well cared for."* (WRSS Physician speaking about MDP grants)

- Increasing access to a range of health professionals including RNs and LPNs (PCAC and MDP grants), counsellors (Counselling), and a highly skilled clinical pharmacist (Pharmacist Initiative)

[1] The types of vulnerable patients supported through these initiatives included frail elderly, poly-pharmacy, patients experiencing mental health challenges, and patients with chronic diseases.

- Improved medication management (Pharmacist Initiative)
- Improved chronic disease management (MDP grants)
- Increased assess to physicians in residential care facilities (Residential Care Program)
- Increased time spent with care providers (MDP grants, PCAC, Counselling, and Pharmacist), and
- Increased patient education (Pharmacist and MDP grants)

One of the most dramatic improvements in supporting vulnerable patients was the establishment of the Primary Care Access Clinic where unattached patients who needs cannot be met in a traditional fee for service environment are attached to a Nurse Practitioner and other allied health care providers. In the words of one physician:

> *It is quite amazing the kind of attention these people are getting for the first time ever* (WRSS Physician speaking about PCAC).

3.3 Increased Capacity of the Primary Health Care System

There were numerous ways that the WRSS Attachment Initiatives increased the capacity of the primary health care system. Capacity was increased through:

- Increased interprofessional interactions (Counselling, Pharmacist, MDP grants, and PCAC)
- Increased interprofessional care (Pharmacist, MDP grants)
- Improved practice environments for physicians (Residential Care Program, and MDP grants)
- Increased physician knowledge of medications and community referral sources for mental health issues (Pharmacist, Counselling)
- Increased access to physicians and other health professionals (Uptown, Counselling, Pharmacist, Residential Care, MDP grants)
- Increased practice efficiency (MDP grants)
- Improved administration, charting and record keeping (MDP grants)
- Increased physician satisfaction with their practices (Residential Care Program and MDP grants)
- Increased sense of community among physicians
- Increased information sharing within the community (Attachment planning process) and collaboration (Counselling, PCAC, Residential Care, and Pharmacist)
- Increased interest in collectively addressing the needs of the community (all programs).

> *"I think the GPs have a difference sense of practice and being in this community there is a real sense of cohesion, which didn't exist before, and the venue to creatively resolve issues."* (Attachment Working Group Member speaking about the Attachment Initiative)

3.4 Unintended Consequences

One of the unintended consequences of the increased ability to attach patients to physicians was a reduced demand on walk-in clinics. This, in part, led to the closing of the community-run walk-in clinic as of March 31, 2015. The community now needs to determine how best to continue to provide this type of advanced access for patients.

4 Keys to Success

Physicians and Division staff were able to identify a number of elements that facilitated Attachment Initiatives, these included:

- Good engagement with physicians in the Division (through surveys, face-to-face clinic visits, and providing opportunities to be involved in planning, implementation, and oversight)
- Identification of physician champions/leaders
- Shared sense of ownership and articulation of common needs
- Working with partners
- Highly qualified Division staff, and
- Setting realistic expectations, trying things out, and learning as you go.

5 The Legacy of the Attachment Initiative in WRSS

Many of the programs and initiatives that support attachment will be maintained past the prototype funding period. This is important because the need to attach patients does not go away; the needs of the community and the supply and availability of physicians continuously changes and evolves. The following will continue to be available to support Attachment Goals in WRSS:

- Uptown Medical Clinic (now 100% physician financed and managed)
- Residential Care Program (now expanded to a provincial-wide program)
- Primacy Care Access Clinic
- Central Registry (co-located with PCAC)
- Multidisciplinary Care Providers (some of the larger clinics are continuing to fund positions through their own revenues)
- Pharmacist Consultations (available to WRSS physicians through Peace Arch Hospital)

Despite being identified as a highly successful and valuable initiative, a mechanism to continue to fund the Counselling Initiative has not yet been found.

6 Advice to Others

Physicians, Division staff and others offer the following advice to other communities:

- Work with others in partnership, don't try to do things on your own
- Take the time to do a good planning process, engaging all physicians so you can identify their needs and strategically allocate Attachment dollars
- Keep it manageable, don't take on too many projects all at once
- Take the time to do good community outreach, not just to physicians but to other stakeholders in the community, and
- Recognize that the work of Attachment is never complete; the needs of patients, providers, and communities continuously evolve and require ongoing attention.

7 Conclusion

The WRSS Division of Family Practice through Attachment Prototype funding succeeded in implementing a comprehensive suite of programs that addressed the identified needs of the community. The programs enabled the community to recruit and retain physicians, make it easier for patients to find a physician, and improve practice environments so more patients could be attached to existing clinics and receive services that support their health and well-being. While we can estimate that approximately 12,000 patients were attached, success was achieved through the combination of programs and the dedication and commitment of Division physicians, the Attachment Working Group, Division staff and community partners.

Appendix A: Overview of the Attachment Evaluation in WRSS

In order to determine the impact of the Attachment Initiative and surface lessons learned, five of the Attachment programs were selected for evaluation (Residential Care Program, Counselling, Pharmacy, Uptown Medical Clinic, and Multidisciplinary Provider (MDP) Grants) in White-Rock South Surrey.

The evaluation was undertaken to document the programs implemented, determine their impacts, and surface lessons learned so the Division could make decisions about future Attachment programming and share its knowledge with other Divisions and primary health care stakeholders.

Across the programs, a mixed method design was used that included:

- document reviews
- analysis of administrative data (for the Residential Care Evaluation, Emergency Room transfers and patients on 9 or more medications was examined)
- interviews and focus groups with residential care facility staff, physicians, Division staff, program administrators, and
- A physician clicker survey.

The evaluation was guided by a steering committee composed of Division physicians and staff and engaged 77 respondents. Five separate evaluation reports were produced:

1. Evaluation of the Counselling Initiative in WRSS
2. Evaluation of the Multidisciplinary Provider Grants in WRSS
3. Evaluation of the Pharmacy Initiative in WRSS
4. Residential Care Program Evaluation, and
5. Evaluation of the Uptown Medical Clinic in WRSS

Methods

Review of Program Documents

A review of program documents was conducted to gain a comprehensive understanding of the goals of each initiative, activities and intended outcomes. Information from program documents, along with interviews with program staff were used to develop initiative-specific logic models and an overarching Attachment logic model (see Appendix B for copy of Attachment Logic Model). The logic model was used to identify indicators and data collection tools. While indicators were identified for all short and intermediate term outcomes, the evaluation did not involve the collection of data on all indicators.

Review of Administrative Data and Program Records

The evaluation of the Residential Care Program used administrative data from the Resident Assessment Instrument Minimum Data Set 2.0 (RAI – MDS 2.0) and Pathways Data. Quarterly and monthly reports from January 2009 to June 2014 provided data on unscheduled and scheduled Emergency Room (ER) transfers per 100 patients and the percent of patients on nine or more medications per 100 patients (RAI-MDS). A full description of the data and analysis can be found in the Residential Care Evaluation Report and the Report Supplement.

The evaluations of the Counselling Initiative and Pharmacist Initiative were able to use data collected by program administrators. The evaluation of the Multidisciplinary Provider Grants included a review of reports submitted by the funded practices. The evaluation of the Uptown Medical Clinic included a review of financial records.

Interviews and Focus Groups with Program Staff, Physicians, and other Program Stakeholders

Interviews and focus groups were conducted with a variety of stakeholders to explore their perceptions of the specific programs and the Attachment initiatives overall. Respondents were asked to share their perspectives on the impact of the program(s) as well as strengths, challenges and areas for improvement. In total 49 stakeholders participated in interviews or focus groups.

Physician Survey

A clicker survey was administered to physicians attending the Division All Members Meeting in April 2014. The meeting attracted about half of the practicing physicians (34), however, not all respondents had participated in each of the programs. Because the clicker data collection system does not permit the filtering of responses, the findings based on the survey may under-estimate the true impact of the initiative.

An overview of the methods used in each evaluation and the sample sizes is shown below.

Figure 2: Overview of Methods Used Across WRSS Attachment Initiative Evaluations

Program	Interviews or Focus Groups	Survey	Documents Reviewed	Administrative Data
Residential Care	• 9 Site Medical Directors • The lead physician of the WRSS's Residential Care Program • 6 staff members from two residential care facilities • The Program Medical Director, Fraser Health, Total 17	Not applicable	• WRSS Division of Family Practice Residential Care Contract (Term March 2011 to December 2011) • Residential Care Evaluation Report 2011-2012 • Residential Care Program PowerPoint, December 2012, and • WRSS Division of Family Practice website	Unscheduled ER Transfers by quarter per 100 patients Scheduled ER Transfers by month per 100 patients % of patients on nine or more medications
Counselling Initiative	• Sources Manager	Clicker Survey	Sources Annual Report	Outcome Rating System Client satisfaction Surveys Program Statistics
Pharmacist Initiative	• FH Pharmacist	Clicker Survey	Funding agreement	Program Statistics
Uptown Medical Clinic	• 3 Uptown Physicians • Clinic Manager	Clicker Survey	Financial records	None

Program	Interviews or Focus Groups	Survey	Documents Reviewed	Administrative Data
Multidisciplinary Care Provider Grants	See all programs	Clicker Survey	Practice Reports WRSS Division Summary Reports	None
Attachment Initiative Overall	• Attachment Working Group (n= 5) • Division staff (n=3) • Physicians (n=8)	34 practicing physicians	WRSS Division Web Site Various presentations	Not applicable
Total	49 (including 6 physicians who participated in the clicker survey)	34		
Total Number of Respondents	77			

Limitations

The main limitations of the evaluations include:

- Lack of patient/family/resident perspective – Because of timelines, budget, and logistical issues, the perspectives of patients/residents/families were not explored in these evaluations except in the Counselling Initiative where program records on patient reported satisfaction and outcomes were available from the service provider.
- Limited ability to obtain accurate estimates of the number of patients attached. Data on the number of patients attached was obtained from two sources: the size of the patient roster at the Uptown Medical Clinic and the practice reports submitted by practices who received Multidisciplinary Practice Grants. Data for all reporting periods was not available and the reporting requirements changed over the three years. The number of patients attached should, therefore, be considered an estimate.
- Under-estimation of impact of initiatives through physician clicker survey. Because of limitations of the clicker technology, the findings derived from the physician survey may under-estimate the true impact of the initiatives.

Appendix B: Attachment Logic Model

Attachment Objectives: (1) increase attachment; (2) confirm and strengthen GP/patient relationship; (3) increase capacity in primary healthcare system

Inputs	Initiatives and Reach		Short Term Outcomes and Indicators	Medium Term Outcomes and Indicators	Long Term Outcomes (Triple Aim)
	Initiatives *included in evaluation	**Participation & Engagement**			
Personnel Division Staff Physicians Pharmacists PEL Patient Representatives Fraser Health Steering committee members Space Clinic spaces Division space Funding Ministry of Health Fraser Health Doctors of BC (formerly BCMA)	1. Multidisciplinary Shared Providers – Pharmacist Services* 2. Multidisciplinary Shared Providers – Counselling Services* 3. Residential Care Program for Frail Elderly* 4. Primary Care Access Clinic 5. Uptown Medical Clinic* 6. Multidisciplinary Practice Grants* 7. Nurse Practitioners for PATH and Homebound Frail Elderly 8. After Hours Care 9. Recruitment and Retention 10. Night Doctor Program 11. Integrated Practice Support Initiative	# of physicians/% of WRSS physicians engaged # of allied health professionals (pharmacists, counsellors, LNPs, etc.) engaged # of patients/% of patient population in WRSS engaged # of practices/% of practices in WRSS engaged	Patients: 1. Improved access to care 2. Satisfaction with access 3. Increased ability to engage in self-care Care Providers: 4. Increased capacity 5. Improved interprofessional practice Health Care System: 6. Increased attachment	Patients & Families 7. Increased satisfaction with care 8. Improved health and well being Care Providers: 9. Working to scope of practice 10. Improved care provision 11. Increased satisfaction Health Care System: 12. Increased efficiency/appropriate health service utilization	Increased patient-centred care Improved provider experience Improved population health Improved health system sustainability

For further information, please contact:

White Rock-South Surrey Division of Family Practice

Tel. 604.531.1888

Email: wrssdfp@divisionsbc.ca

www.divisionsbc.ca/white-rock-south-surrey