Evaluation of the Multidisciplinary Care Provider Grants in White Rock-South Surrey

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

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Executive Summary

Overview of the Program

The Multidisciplinary Care Provider Grant Initiative (MDCP) is one of the programs implemented under the Attachment Initiative of the White Rock-South Surrey (WRSS) Division of Family Practice. The grants allowed practices to hire registered nurses (RN) or licensed practical nurses (LPN) or increase the hours of those already working in the practices. The RNs and LPNs provided complementary care including blood pressure checks, education, dressings, sutures, injections and vaccinations, lab work, and chronic disease management. In total, the initiative allocated $316,773 over a three year period. Fourteen practices received funding which ranged from $5,000 to $26,600 per year.

Purpose of the Evaluation

The evaluation of the MDCP Grant Initiative was undertaken to document its implementation, determine its impact, and surface lessons learned. The Division wants to use this information to make decisions about future programming in the midst of Attachment funding changes.

The following questions are addressed in the evaluation:

1. How does the initiative contribute to the goals of the Attachment Initiative?
2. To what extent is the initiative contributing to the achievement of Attachment goals?
3. What is working well, what are the challenges, and how can the initiative be improved?
4. Is there a continuing need for this initiative?
5. How can the initiative be sustained?

Evaluation Approach

A mixed method design was used to explore the implementation, effectiveness, and lessons learned. The findings draw on document reviews, qualitative data from interviews and focus groups with physicians, Division staff, and the Attachment Initiative Working Group. In total, sixteen people participated in the interviews or focus groups which were conducted during the summer of 2014. A clicker survey was also conducted with physicians attending a Division All Members meeting in May 2014. Thirty-four practicing physicians attended the Division All Members meeting. This represents about 50% of Division practicing physicians. The evaluation was guided by a steering committee composed of Division staff and members.

Findings

How does the initiative contribute to the goals of the Attachment Initiative?

The MDCP grants could contribute to all three Attachment goals. They could improve support for patients by opening opportunities for them to spend more time with alternative care providers and allowing physicians to use their freed-up time to support other patients that required their specialized care. The additional time could also enable practices to increase the size of their rosters thereby enabling those wanting a family doctor to find one. Lastly, the grants could increase the capacity of the primary health care system by increasing inter-professional

practice, improving physician satisfaction with their practice environments, and increasing the efficiency of the practices.

Achievement of Attachment Goals

To what extent does the initiative confirm and strengthen the GP-Patient relationship – including supporting vulnerable patients?

The MDCP grants 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 increased in opportunities for patient education, chronic and complex care management. Overall, it was felt the initiative had increased the ability of the primary health care system to meet patient needs.

The RNs and LPNs provided a range of services including patient education and support, especially concerning chronic disease management (e.g., diabetes), vaccinations, and mental health support. They also supported the practice by organizing charts and patient information. Physicians reported that these services 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.

To what extent does the initiative enable patients that want to family doctor to find one?

By supporting multidisciplinary providers to do tasks previously done by physicians, the MDCP grants allowed doctors to accept new patients. While it is clear that the funded clinics accepted new patients, the exact number of new patients added is difficult to determine due to challenges with the available data. Nonetheless, it is estimated that over 1,800 patients were accepted by funded practices because of this initiative. In addition, one practice accepted 2,000 patients from 2 doctors who left their practices, however, the role of the MDCP grants in facilitating this roster increase is not clear.

To what extent does the initiative increase the capacity of the primary care system?

The initiative was able to increase the capacity of the primary health care system in a number of ways. First, according to the practice reports submitted by the funded practices, 80% of the practices reported increased efficiency (able to see more patients on a weekly basis). The initiative also increased the capacity of the primary health care system by increasing physician satisfaction. The majority of physicians participating in the clicker survey (74%) considered their practices to be more satisfying to them because of the initiative. Lastly, capacity of the primary health care system was increased through improved inter-professional practice. The program had a beneficial influence on the ability of the healthcare professionals to work as a team in the supported practices.

What is working well, what are the challenges, and how can the initiative be improved?

Physicians reported that the MDCP grants were well managed and easy to access. The only substantive challenge mentioned was in integrating the new professionals into the practices. In some cases, there was a learning curve of how to use the skills of the nurses to best support patients and what tasks can be taken over by them.

Is there a continuing need for this initiative?

There does appear to be a continuing need for this program. The majority of physicians participating in the clicker survey believe there is a continuing need for this initiative (69% of physicians). The initiative was ranked as the second most valuable program implemented under the Attachment Initiative in White Rock-South Surrey.

How can the initiative be sustained?

Some of the practices anticipate being able to sustain the multidisciplinary provider in the practice even without Division funds, while others, especially smaller ones, acknowledged they may need to reduce the service without Division funding. Suggestions for sustaining the initiative included using different funding mechanisms such as adjustments to MSP or incentive billing, reducing the provider's hours and providing fee for service vaccines (e.g., Zotavax, Twin Rix, Gardasil, Menactra, Dukoral) as a way to generate the income necessary to support these practitioners.

Conclusions

The MDCP grants were successful in supporting Attachment goals. The initiative was able 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. The grants enabled the practices to attach more patients and the grants contributed 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.

The main challenge with the initiative was in determining how to integrate RNs and LPNs into community-based practices and for smaller practices, finding ways to continue the service when funding ends. It was also difficult to determine the exact number of patients attached through this initiative.

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1. Overview of Initiative

The White Rock-South Surrey (WRSS) Division of Family Practice was one of three provincial prototype Divisions that was funded to develop and implement an Attachment Initiative. The goals of the Attachment Initiative were:

1. To confirm and strengthen the GP-patient continuous relationship – including better support for the needs of vulnerable patients,
2. To enable patients that want a family doctor to find one, and
3. To increase the capacity of the primary care system.

As a prototype community for Attachment funding, members of the WRSS Division developed innovative strategies to support the Attachment goals. They looked for ideas from physicians working in the community. A survey of all doctors in the WRSS Division conducted between September 2011 and April 2012 revealed that the physicians believed they could achieve Attachment goals by incorporating nurses into their practices. This type of shared care is common in other jurisdictions, notably the National Health Service in England. The survey further revealed that the hours of physician service that could potentially be re-allocated to an alternate care provider added up to the equivalent of four full-time physicians. The WRSS Division of Family Practice therefore, through its Attachment Funding, awarded Multidisciplinary Care Provider (MDCP) grants to qualifying practices.

As a prototype community for Attachment funding, physicians had access to a payment made by the Ministry of Health based on the number of attached patients per practice. The Division offered to match the $7 per patient attachment fee available through Medical Services Plan (MSP) funding to support the hiring of the multidisciplinary professional. The costs for these professions would be covered in equal parts by Attachment funding and Division Funds (through the MDCP grants).

Grants were made available to practices that chose to pool or contribute a portion, or all of their practice's attachment funds for new or enhanced clinician services within the practice. Practices had the option of hiring any type of professional. In the first two rounds of funding, matching funds were available for grant applications up to a maximum of $10,000 per practice, for one and two physician practices and up to a maximum of $25,000 for each group practice (defined as three or more physicians in a practice). It was expected that in accepting the funding, the physicians would add new patients to their rosters.

In total, the initiative provided $316,773 to 14 practices over three years. Funding ranged from $5,000 to $26,600 per practice per year (see Appendix A for the allocation of funding per practice per year). All practices chose to hire RNs and LPNs. In the first year three practices used the grants to hire new MDC providers while seven sustained existing registered nurses (RN) and licensed practical nurses (LPN).

Funded practices were to submit quarterly reports describing the impact of the initiative. In these reports as well as in interviews conducted for this evaluation, physicians provided many examples of the range of services the RNs and LPNs were able to provide to the patients. These included administrative support (organizing charts and patient information) as well as patient education and support, especially concerning chronic disease management (e.g., diabetes), vaccinations, and mental health support.

2. Purpose of Evaluation

This evaluation is part of a WRSS Division-wide evaluation of programs that fall under its Attachment Initiative. The information from the evaluations will help the Division make decisions about how to continue to support Attachment goals in the midst of funding changes (i.e., which programs should continue to be funded, change or ended).

The following questions are addressed in the evaluation:

1. How does the initiative contribute to the goals of the Attachment Initiative?
2. To what extent is the initiative contributing to the achievement of Attachment goals?
3. What is working well, what are the challenges, and how can the initiative be improved?
4. Is there a continuing need for this initiative? and
5. How can the initiative be sustained?

3. Methods

A mixed method design was used to explore the implementation, effectiveness and lessons learned from the MDCP grants. The findings draw on document reviews (e.g. practice reports), quantitative data collected through a physician clicker survey, and qualitative data from interviews and focus groups with physicians and Division staff.

Through a review of the initiative's documents and conversations with Division staff and members, a program logic model was created to provide an overview of the initiative and support the development of evaluation questions and indicators (see Appendix B). Evaluation plans were drafted and reviewed by the Division Steering Committee.

Thirty-four practicing physicians participated in the clicker survey administered during the May 2014 Division All Members meeting. Sixteen people participated in the interviews or focus groups which were conducted during the summer of 2014. An overview of the data collection methods, the analysis undertaken, and limitations of the data is provided in Appendix C.

It should be noted that we were unable to obtain the full set of quarterly reports submitted by the funded practices. The most complete set represents only the first two quarters of the first year of the grants. Even among this set of reports, we were only able to extract a limited amount of information because of missing or unreadable responses (responses were handwritten). In the fall of 2014 we received eight reports for the second year (April-September 2013). The format of these reports differed from the first year of reports and did permit a greater amount of data extraction. However, we were unable to determine the total number of new patients accepted over the three years. A more extensive description of these limitations is provided in Appendix C.

4. Findings

This section presents the evaluation findings in order of evaluation question.

4.1 How does the initiative support the goals of the Attachment Initiative?

> *"In terms of Attachment I think the nurses were the most successful, if you look at Attachment in the narrow (sense), in terms of attaching patients . . . In the broader sense, supporting doctors, they did that."* (FG with Attachment Working Group)

The MDCP grants were designed to support all three Attachment goals. The MDCP grants could improve support for patients by opening opportunities for them to spend more time with alternative care providers. Further, the freed-up physician time could then be re-allocated to patients that required their specialized care. By freeing up physician time, doctors could spend more time with complex patients and strengthen the GP-patient relationship, especially for vulnerable patients. The additional time also enabled doctors to increase the size of their rosters, enabling those wanting a family doctor to find one. Lastly, the grants could increase the capacity of the primary health care system by increasing, inter-professional practice, improving physician satisfaction with their practice environments, and increasing the efficiency of the practices.

The following quote fully captures the benefits of this program:

> *"We hired an LPN with the grant. She is able to bring a different skillset but is really able to extend the kind of practice that I have with my patients. With the chronic disease patients she was able to monitor them to ensure they were following regularly with their blood work and she would also coach them to change their lifestyle to reach the target for their various conditions. She would also monitor their blood sugar and their cholesterol and give them guidelines about lifestyle. She also helped with billing, generating a list of patients with special codes. She also did immunizations as well as parent counseling about diet and general developmental concerns with babies. That was really useful for me because I had quite a few young couples with babies, and first time moms need a lot of counselling. If I was doing that on my own it would take a lot of time. Whereas a regular visit would take 10-15 minutes, one of these meetings would easily take 20-30 minutes to go through all the questions and then do the vaccinations. Having the nurse freed me up to be able to see other people."* (Interview with Physician)

4.2 To what extent did the MDCP grants achieve Attachment goals?

Confirm and strengthen the GP-patient continuous relationship, including better support for the needs of vulnerable patients

The MDCP grants have increased support for vulnerable patients by enabling patients to spend more time with a care provider and access a greater range of services.

The following table shows the different services provided by the MDC providers. This data is based on the reports submitted by the practices funded in Year 2.

FIGURE 1: ACTIVITIES THAT THE MDC PROVIDER WAS INVOLVED IN

Not only did the grants result in increasing support for vulnerable patients through increased access to care providers and a greater range of services, according to physicians, the MDCP Grants allowed them to spend more time with patients, especially those dealing with complex conditions. In this way the grants also strengthened the relationship between the physician and the patient. Patients with chronic diseases were monitored and followed up by the MDC provider with reminders for appointments and lab work as well as education and then saw the doctor for additional examinations. The interviews and practice reports were filled with examples

that speak to the additional time patients were able to spend with the nurses and the expanded services, including patient education, self-management, and prevention.

> *"We have a lot of elderly frail patients in our practice so 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 all aspects of their care. In the end they feel very well cared for."* (Interview with Physician)

> *"the nurse has time to ensure 'details' of complex care/chronic disease patients' routine are in place, with more complete education and time to teach patients self-management."* (October 2012 practice report)

All practices reported improved quality of care for patients who had seen the RN or LPN. However, the reports do not provide a detailed descriptions or definitions of what constituted 'improved quality of care'. Nonetheless, physicians were able to describe many benefits to patients including 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:

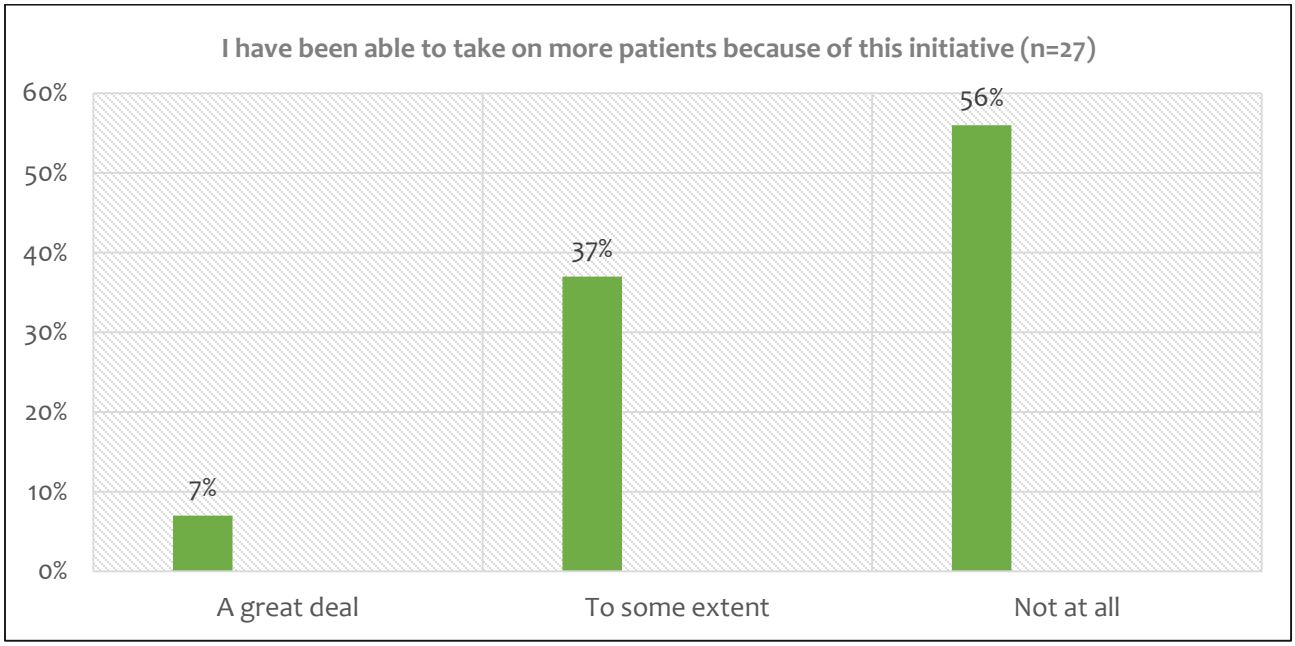
> *"I've seen lots cases of patients' lives turning their lives around, losing significant weight, improving their overall health. And (the nurse) is not just dealing with diabetes and heart disease, she is also a counselor for them as well, almost as in a therapeutic relationship. It's been the most bang for the buck."* (Interview with Physician)

Enable patients who want a family doctor to find one

While it is clear that the clinics accepted new patients, the exact number of new patients added is difficult to determine due to challenges with the data submitted. According to the second quarter reports submitted in Year 2 by the funded practices, 70% of funded practices were able to add more patients to their patient panels. It can be estimated that over 1,800 patients were accepted by funded practices over the three years. About 993 new patients were added during Year 1 and over 975 patients were accepted by the funded practices in Year 2.

When asked directly whether or not the initiative had enabled an increase in patients attached, 44% of the physicians participating in the clicker survey indicated it had to "some extent" or "a great deal," as shown below in Figure 2, and 56% responded that it had no impact on attachment.

FIGURE 2: IMPACT OF INITIATIVE ON SIZE OF PATIENT ROSTER



The findings based on the clicker survey reflect a more modest impact of the initiative on rosters. Reconciling this seeming discrepancy is complicated for a number of reasons. First, some of the physicians who responded to this question did not receive grants. Therefore it would not be expected that the initiative had any impact on the size of their rosters. Second, while over 1,800 patients attached does seem like a sizable number, we do not know the number of patients added per practice or per physician, so any one physician might have seen their contribution as minimal and selected "to some extent". Third, we do not know if the physicians were aware of the size of the increase in their rosters when responding to the survey.

While it is clear that the practices receiving MDCP grants have accepted new patients and the doctors interviewed believe the MDC provider's work was responsible for freeing up their time and enabling the increases in their rosters, as mentioned, it is not possible to determine the exact number of new patients attached and we are left with the physician perspective that the initiative had only a modest impact on rosters.

Increase the capacity of the primary healthcare system

There is ample evidence that the MDCP grants were successful in increasing the capacity of the primary healthcare system. Physicians participating in the clicker survey indicated that their capacity has been increased through strengthening their ability to provide patient education in their practices (as shown in Figure 3).

Data from Year 2 reports also speaks to the improvement in the management of patients with chronic diseases and other complex conditions (see Figure 4 below).

FIGURE 3: IMPACT ON PATIENT EDUCATION

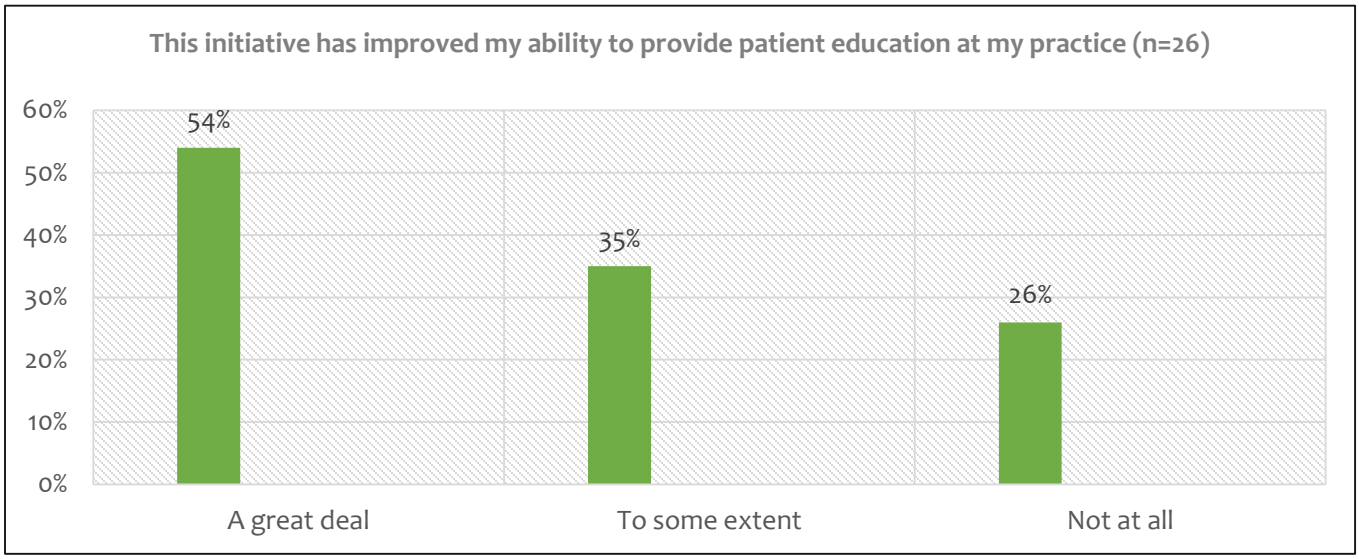
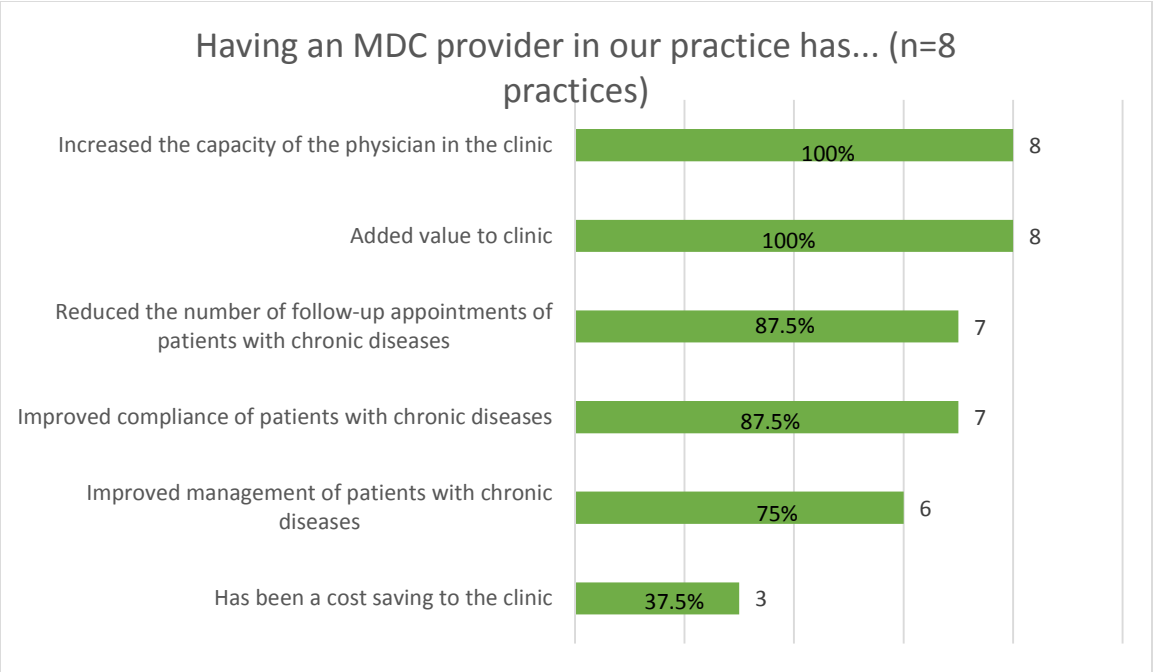


FIGURE 4: IMPACT ON PRACTICE



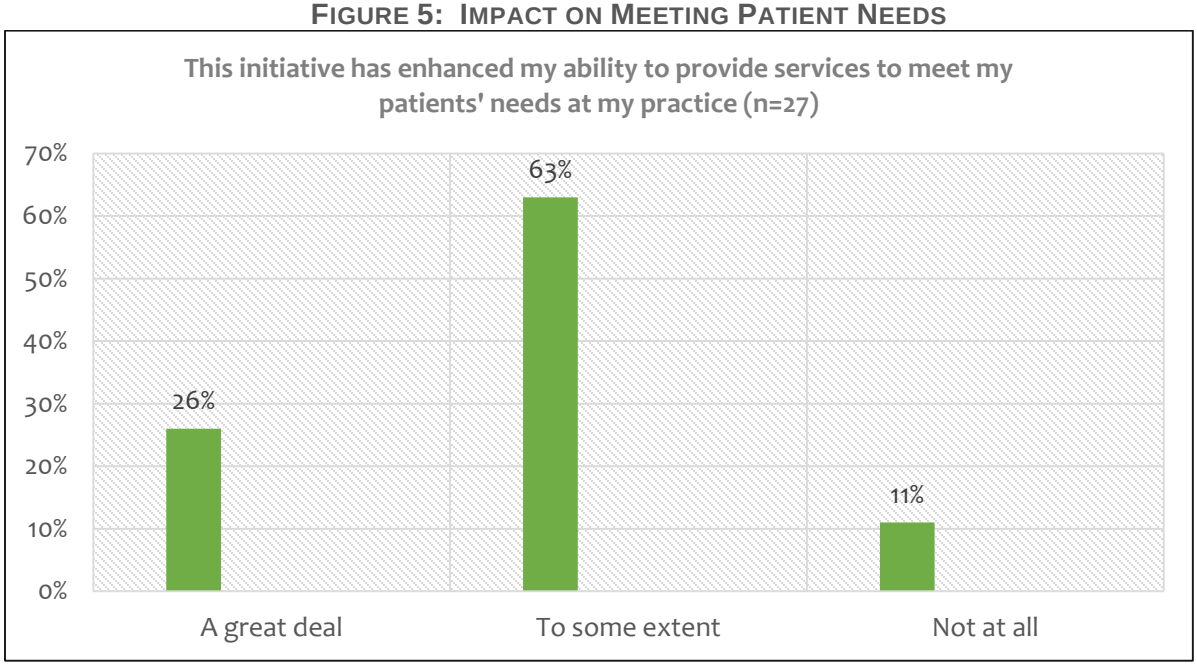
The MDCP grants have also had a positive effect on practice efficiency. Eighty percent of practices reported increased efficiency (seeing more patients on a weekly basis). This increase is directly related to the time that the nurses have freed up by taking responsibility for supporting patients with blood pressure checks, education, dressings, sutures, injections and vaccinations, lab work, and chronic disease management. The nurses also helped with charting and organization in the office.

> *"It's been delightful to have somebody overseeing those educational aspects for diabetes and cardiac care. Making sure that we were looking after our patients effectively. As GPs we don't have the time to do in the busy day what she does. She meets them for ½ hour to 1 hour. She goes through thorough assessments. Especially with those groups of patients I can see the benefits from having her. I can see people with better control, making sure we are getting them to the appropriate specialists, making sure that we are doing the proper examinations and all the follow ups being done. That is the impact of having that grant so we can continue to employ her."* (Interview with Physician)

> *"There's a lot to diabetes education. It's impossible to discuss it in a 10 or 15 minute appointment or half an hour for that matter. And those new type 1 or type 2 insulin starts, they can be quite lengthy and there's a lot of different products out there right now, and I am sure you can rack your brain and try to put it all together and plan for them together, but you know, ASA bolus dosing, single dosing, multiple dosing, different types of insulin, it's so nice to have a nurse that can provide that care."* (FG w attachment WG)

Overall, physicians believed that the grants had enhanced their capacity to meet their patient's needs, as shown below.

FIGURE 5: IMPACT ON MEETING PATIENT NEEDS



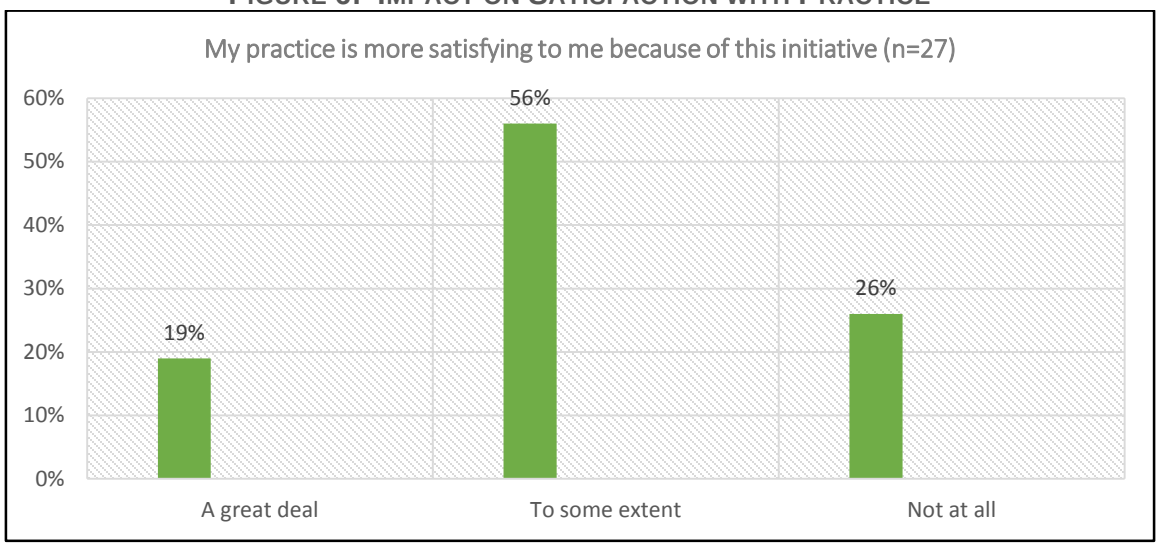
This finding was also confirmed through the practice reports, interviews and focus groups. Division staff agreed that the MDC grants worked *"exceptionally well."* They gave examples of doctors who are setting up practices on their own and have decided to hire a nurse part-time to support them, even without a Division grant because it was a way to stay 'sane.'

One physician commented that the addition of another care provider increased his or her level of accountability which can also result in improvements in care:

> "*Having the additional support and another person that you are accountable to makes a difference."* (Interview with Physician)

Given all these improvements, it is not surprising that the initiative appeared to increase physician satisfaction with their practices. In the practice reports, 70% of physicians (recipients of the grant) reported improved quality of work life. Likewise, 74% of physicians attending the Division All Members meeting reported increased satisfaction to "a great deal" or to "some extent" as seen in Figure 6 below.

FIGURE 6: IMPACT ON SATISFACTION WITH PRACTICE



Lastly, the grants increased the capacity of the primary health care system by enhancing inter-professional practice. As described by the Attachment Working Group, the practices developed a team-based primary care model that, according to the group, was new to many physicians, as illustrated in the following quote:

> *"The multidisciplinary provider in the office and the mental health program really opened the door to a team-based primary care model, which was kind of foreign for a lot of people, especially in smaller practices because they never really worked with nurses or LPN's. So now we see the benefit of actually sharing the workload and that really does allow us to be able to do a bit more and probably provide more comprehensive service to the patients."* (Focus Group with Attachment Working Group)

This view was also shared by physicians in the interviews who described the RN or LPN as part of the team: "*It is having a team of care which is a lot better. It works well."*

Summary

In sum, the MDCP grants have contributed to all three Attachment goals. The grants were successful in providing enhanced services to patients, especially the more vulnerable ones. The time freed by the nurses enabled doctors to add more patients to their practices resulting in an estimated 1,800 plus new patients attached. Lastly, the primary care system's capacity was increased through increased ability to provide patient education, chronic disease management and services to meet patient's needs. Practices reported increased efficiencies; improvements in administration, charting and record keeping; and inter-professional practice. Overall these changes led to physicians reporting increased satisfaction with their practices and in one case, an increase in accountability.

5. What has worked well, what have been the challenges, and what can be improved?

Respondents mentioned a number of program elements that worked well and others that were challenging. These are described below.

Application, adjudication and reporting

The physicians interviewed agreed that the application and reporting processes were simple and easy to follow. They did not raise any challenge with the different steps involved. They described it as a *"pretty straight forward process."*

Division staff and the Attachment Working Group pointed to challenges in reporting. They found that getting reports back from funded practices and having them completed was a big challenge requiring individual follow up. The forms used in the first year, which included mostly open ended questions, were hand written, contained multiple abbreviations and provided very little detail, and as a result, provided little information. In the second year the forms were revised and included more close-ended questions with categories that required checks. The revised forms d allowed for easier tabulation and comparison across funded practices, however, submission of the forms continued to be a challenge.

When asked what would they recommend to other Divisions that are interested in implementing a similar program, Division staff spoke to a need for engaging in a thorough process of agreeing to guidelines and evaluation criteria before starting the program so that expectation for reporting are clear, understood, and agreed to.

Engaging physicians in the process

The MDCP grants initiative was shaped by the needs of the physicians. The survey of physicians was the starting point and according to the Attachment Working Group, it "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)

Another element that resulted in engaging physicians was the requirement that they contribute matching funds to support the multidisciplinary positions. The grant only contributed part of what was required to cover the salaries. In that way physicians had a stake in the program, they were committed because they were contributing their own funds.

> *(I)incentivizing with accountability was the biggest (issue) in the whole thing. All of a sudden people said "Yeah, we'd like to work with the nurse and it would be great if I got some money for that," and "Okay, I'll accept a new patient." And then once you started doing that all of a sudden it wasn't a big deal anymore because it was a cultural thing that (they) 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, but once you started*

*taking on new patients you saw that you could open up and just take on a few at a time. (*Focus Group with Attachment Working Group)

Nurses' skill set and personal commitment

In the interviews and focus groups, the physicians described the skills of the nurses employed in their practices. They worked educating patients, doing blood pressure checks, dressings, sutures, injections and vaccinations, lab work, chronic disease management, following up with medication, and updating charts and contact information, among other tasks. In some cases, the nurse took it upon herself to train in new skills that were a good fit with the practice. It is clear from their words that the talent of the nurses involved is key to the success of the initiative.

Interprofessional practice

Despite the overall success of team-based care, some practices experienced challenges in integrating the RN or LPN into the practice. Deciding what tasks could be done by the nurse was not a simple task. One doctor shared her practice's struggle to make the implementation of the initiative a success:

> *"We had some problems. We had to learn how to incorporate a nurse into our practice. It didn't come naturally to us. The second person wasn't getting the right input from us. As physicians we are always busy like hamsters on our wheels. This time we had to stop and think about what work we could direct to her. It wasn't automatic: injection, syringes in the ears, maintain paperwork. We had to identify as a group of physicians the areas where we could ask for help. We had to actually devote time to think about the best way to integrate her into the practice. She came back after a while and it is going very well. On our third attempt we were successful."* (Interview with Physician)

This challenge may have been exacerbated by the RNs' and LPNs' training, as their practical training takes place in hospitals, not in family practices. To be successful, they need to learn how to work in this new practice environment, transfer their skills, and work with physicians to determine the best way to support the practices.

Now that some of the nurses have established their practices, they are in a position to mentor other nurses. The Division has asked the nurses what kind of support they wanted. Rather than educational modules, the nurses chose to "*get together and share their knowledge."* The Division has received a grant to support the nurses through a community of practice for sharing their learning with each other.

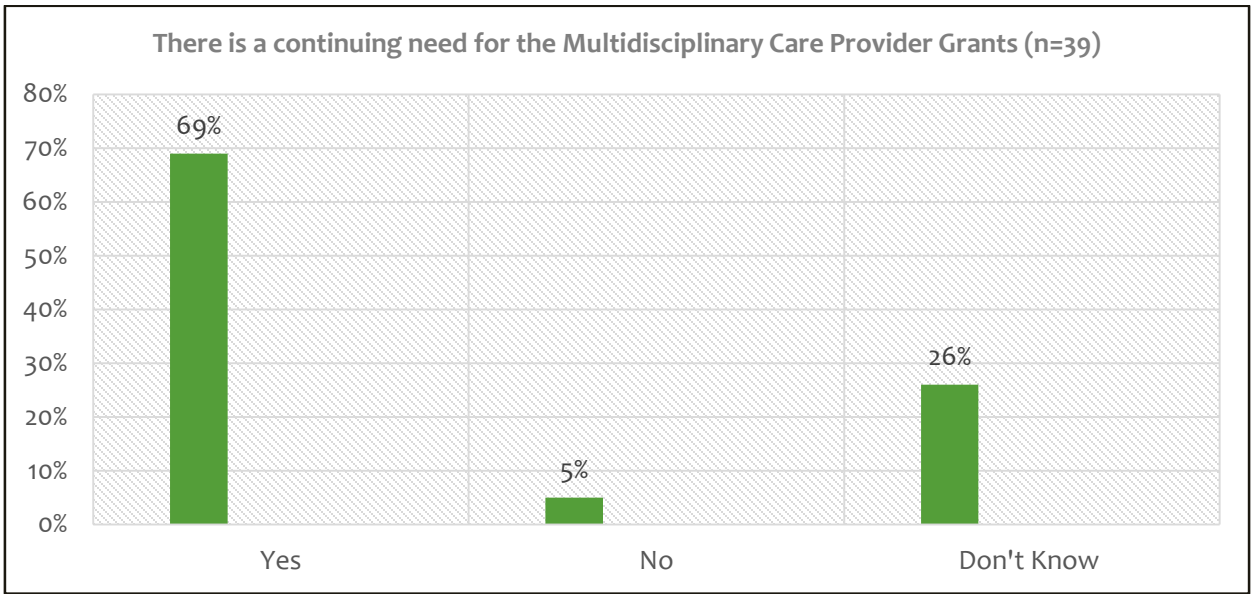
One physician suggested that it would be useful to compile a list of the ways in which a nurse could be used in a family practice environment. This list could also include tips for billing and booking patients to ensure that the RN or LPN is steadily booked at a regular rate and predict the time commitment required from her. This would also help to keep the nurse consistently occupied and would ultimately support the sustainability of the program by generating enough billing fees.

The Attachment Working Group and Division staff as well as one physician agreed that there was a need to share success stories amongst the different practices on how to properly integrate a nurse into their practice. The physicians who have been successful in integrating the nurses can, and some have, become champions.

6. Is there a continuing need for the initiative?

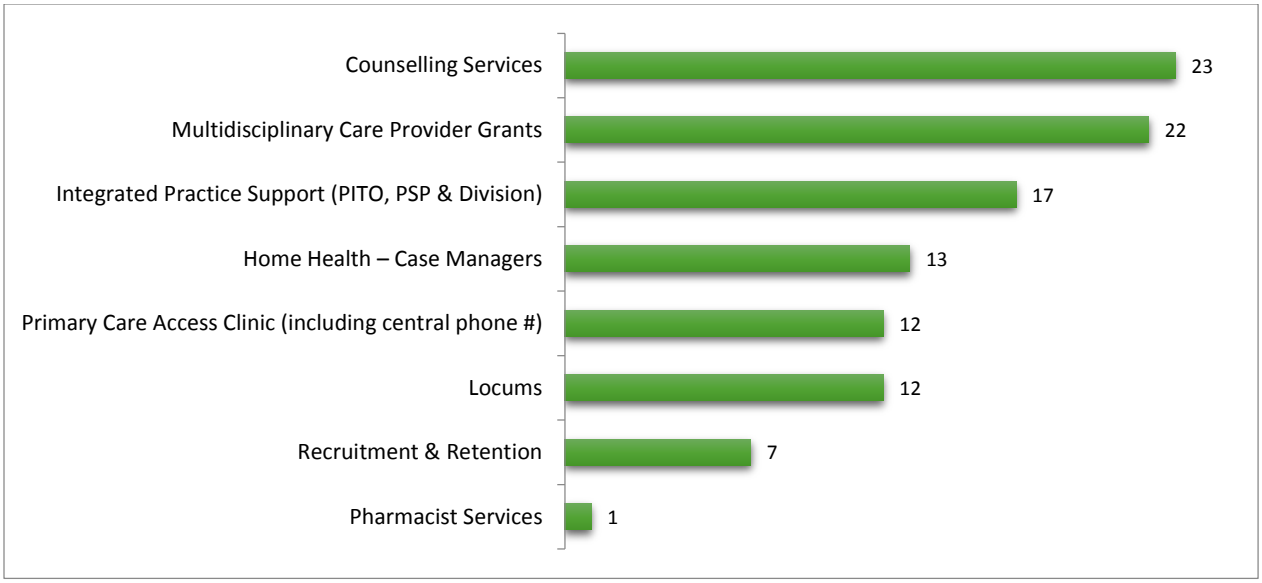
When asked if there is a continuing need for the initiative, 69% of physicians surveyed indicated "yes" compared to only 5% who said "no" and 26% who were not sure (see Figure 7).

FIGURE 7: PERCENTAGE OF PHYSICIANS INDICATING CONTINUING NEED



The MDCP initiative was seen as one of the most valuable programs implemented under the Attachment Initiative. It received the second largest number of votes for "most valuable" initiative with only one vote less than the top initiative, the Counselling Initiative, as shown in Figure 8.

FIGURE 8: MOST VALUABLE ATTACHMENT INITIATIVES



7. How can the initiative be sustained?

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 without the Division's funding. Of the eight practice reports submitted in Year 2, 75% (6 practices) reported they would continue engaging the MDC provider through leftover funds from Attachment, from their MSP and CDM billings, reducing the provider's hours and by providing private vaccines (Zotavax, Twin Rix, Gardasil, Menactra, Dukoral).

In an interview, one doctor said his practice has set aside enough funds to keep the RN for 2 or 3 years. Other physicians may not be able to sustain the practitioners:

> *"We haven't done the figures yet but my sense is that she is costing money to the practice if it wasn't for the grant. It would be nice if it could continue until she was generating enough billing to cover for the cost. We are very small and need to look at it to see if it is viable.*" (Interview with Physician)

> "*Now that the funding stopped we are looking at reducing time. Cut down some days and we are trying to do a booking system. You worry about the morale. We had 2 RNs and 4/5 LPN. Reduced to 2 ½ week."* (Interview with Physician)

The Attachment Working Group acknowledged this was a challenge, especially for smaller practices.

> *"I think especially in the smaller offices, the RN's and LPN's that have been hired wouldn't survive without some support. I don't think a lot of the smaller specialty offices would be able to continue with that."* (Focus Group with Attachment Working Group)

The interviews and focus groups surfaced ideas of how to make the MDCP grants sustainable, suggesting different funding mechanisms such as adjustments to MSP or incentive billing. One physician referred to a similar initiative that was implemented and evaluated in New Brunswick where, instead of providing grants, they adjusted fee codes to support the use of multidisciplinary providers.

8. Limitations

Several limitations of this evaluation are worth noting.

1. While the data does reflect the opinions and experiences of different stakeholders groups, physicians, Attachment Working Group members, and Division staff, not all stakeholders groups were engaged in this evaluation. Notably, no data was collected from the RN's or LPN's, medical office assistants, patients or their families. The information on the impact of this initiative on patient care is based on physician perspectives. We do not know to what extent patients, for example, believe the initiative improved the quality of care, or how LPN's or RN's felt the initiative was working or what challenges they experienced.

2. Triangulation of findings with administrative data was not possible. As mentioned, we obtained the number of patients attached from the reports submitted by the practices (see Appendix B for a further explanation). We were unable to verify the accuracy of this number through a review of office records or verify the basis on which it was calculated by the Division or each practice. Further, no information was available to verify the perceptions that patients were spending more time with care providers or that there had been an increase in range of services provided. These findings are based solely on the perspectives of stakeholders. While the validity of the findings was strengthened through triangulation across multiple stakeholder groups, we were not able to triangulate these findings with administrative data which would further strengthen the robustness of the findings.

3. Findings based on the physician survey data need to be treated with caution as they may under-estimate the impact of the initiative. As mentioned, physicians attending the Division All Members meeting were surveyed through the use of a "clicker" data collection system. This system requires a response from every participant to every question. While participants were instructed to select "not applicable" to questions that did not pertain to them, this did not always happen. Questions that asked about the impact of the program included responses from those who had used the program and those that did not. This created two ways that the true impact could be under-estimated. First, respondents who indicated the initiative had "no effect" likely included both physicians who participated in the program (and believed the initiative was not successful) and those who did not participate in the program (and would therefore not be expected to benefit from the program). So the number of respondents reporting "no effect" is over-estimated, which results in an under-estimate of the effect of the program. Second, because more physicians responded to the impact questions than should have, the denominator for determining the frequency of responses was larger than it should have been. This could have created another under-estimation of the effectiveness of the initiative.

9. Conclusions

Based on the data analysed, the Multidisciplinary Care Provider grants initiative is contributing to the achievement of all three Attachment goals. It has been successful in:

1. Confirming and strengthening the GP-patient continuous relationship through the provision of increased support for vulnerable patients (through patient education, management of patients with chronic and complex diseases) and increasing services that meet patients need).
2. Enabling patients that want a family doctor to find one. It has been estimated that upwards of 1,800 patients have been attached.
3. Increasing the capacity of the primary care system through:
    - Increasing practice efficiency
    - Improving administration, charting and record keeping
    - Increasing accountability,
    - Increasing physician satisfaction with their practices, and
    - Increasing interprofessional practice.

Although we are unable to confirm the magnitude of the impact of this program on the number of patients attached, it was seen as one of the most valuable programs implemented under the Attachment Initiative in WRSS.

APPENDIX A - Multidisciplinary Provider Care Grants – Funding allocated per Practice per Year

Clinic	2012	2013	2014
1.	$16,140	$16,000	$7,800
2.	$10,000	$6,720	$7,800
3.	$9,243		$7,488
4.	$11,760	$12,000	-
5.	$50,000	$26,608	(Separated below)*
	-	-	$25,000
	-	-	$5,327
6.	$15,340	$13,084.50	$10,608
7.	$10,000	$10,000	-
8.	$25,000	$25,000	$25,000
9.	$19,000	$25,000	$5,119
10.	-	-	$5,000
11.	-	-	$25,000
12.	-	-	$25,000
13.	-	-	$8,736
Total Allocated:	**$166,483**	**$134,412.50**	**$157,878**

*Two clinics received combined funding during the first and second year of the initiative. During the third year, the funding was separated

APPENDIX B- Multidisciplinary Provider Care Grants – Logic Model

Target: All practices (Grants were made available to practices that chose to pool/contribute a portion or all of their practice's Attachment funds for new or enhanced clinician services within the practice)
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	Medium Term Outcomes	Long Term Outcomes (Triple Aim)
	Activities	**Participation & Outputs**			
Personnel Division Administrators Physicians MDC Providers Grants Committee Funding from WRSS Up to $10,000 per physician & Up to $25,000 for each group practice	WRSS Advertise Grant opportunity Review and select proposals Disburse funding Collate data and produce reports Practices Hire/sustain existing nurses Support patients Collect data and report	Proposals received Year 1: 10 proposals funded Year 2: 8 proposals funded Reports received 3 new hires and 7 sustained (registered nurses and licensed practical nurses)	Patients: Improved access to care Increased ability to engage in self-care Increased satisfaction with care Care Providers: Increased capacity Improved inter-professional practice Health Care System: Increased attachment	Patients Improved health and well being Care Providers: Improved care provision Increased satisfaction Health Care System: Increased efficiency	Increased patient-centred care Improved experiences of care providers. Improved population health Improved health system sustainability

APPENDIX C – Overview of Methodology and Limitations

This evaluation used a mixed method design. Each method used is described below along with its limitations.

Document Review

The following documents were reviewed:

- Year 1 - Report 1 (July 31, 2012) from 10 practices for period of April 1-June 30 2012
- Year 1 - Report 2 (October 31, 2012) from 9 practices for period July 1-September 30 2012
- Year 1 - Report 3 (January 31, 2013) from 2 practices for period October 1 -December 31 2012
- Year 2 – Report (October 25, 2013) from 8 practices for period April 1-September 30 2013
- Multidisciplinary Care Grant Quarterly Report Summary – December 2012
- Multidisciplinary Care Providers in Practice – Grant - Second Quarter Report Highlights - 2012
- Increasing Primary Care Capacity Through Multidisciplinary Care Providers in Practice – Grant Application and Guidelines – 2012-2013
- Multidisciplinary Care Provider Grants - 2013/2014 Competition Submitted to the Board by the Attachment Working Group/MDC Grant Committee - Recommendations for funding -February 26, 2013

As this list shows, we were unable to obtain the full set of practice reports. The most complete set represents only the first two quarters of the first year of the grants. Even among this set of reports, we were only able to extract a limited amount of information. The reports reviewed were hard to read as the responses were handwritten and not all answers were completed. Because of these limitations, the data in these reports were of limited value.

It was difficult to determine the number of new patients accepted from information contained in the practice reports and Division summary reports. For example, the summary report for the first quarter of 2012 indicates that 1,190 patients were attached, however this figure was noted as being “artificially elevated.” The second quarter summary report for 2012 (April 1st to June 30th) shows that 1,095 patients were attached. The third quarter summary report (July 1st to September 30th) shows that 993 patients were attached. We have chosen to use the 993 figure as the estimate for the number of patients attached in Year 1 which may be an under-estimation.

While the set of reports obtained for Year 2 contained information that could be compared across funded practices, they still posed challenges for determining the number of new patients added:

- One of the practices that submitted the report did not hire an MDC provider and therefore did not use the funds at all. They nonetheless submitted a report and reported that they had added 262 patients. This means that even without the grant they added a

substantial number of patients. However, because they did not have a MDC provider, we have chosen not to include this figure in the calculations.

- Another practice reports 2,022 patients added in the reporting period. The high number of new patients added is explained by the inclusion of the practices of 2 doctors who left to become hospitalists. Although formally, these are new patients to the new clinic, they were previously attached patients. The report does not distinguish how many of these new patients are newly attached patients and how many were added because of the MDC providers.
- Although funded practices were expected to add new patients, one practice did not add any new patients because the practice was "full."
- Most of the practices indicated the number of new patients that were accepted by the clinic during the reported period, however, one clinic reported that they added "1-2 patients per week." For the purposes of estimating total number of patients accepted by the funded practices, this response was calculated as follows: 6 months x 4.3 weeks x 1.5 patients added.

We have estimated that at least 975 new patients were attached based on the data available for Year 2. However, we acknowledge that this, as with the figure from Year 1, may also be an under-estimation.

Physician Survey

Taking advantage of the May 10, 2014 Division All Members meeting, a "clicker" data collection system was used to ask close-ended questions of the approximately 46 physicians in attendance, 34 of whom were practicing physicians. This represents about half of the practicing physicians in the WRSS Division. Because the use of the "clickers" requires a response to every question from each participant, we were not able to filter responses for those who had not participated in some of the Attachment Initiatives. Even though respondents were instructed to select "not applicable" if they were not involved in specific initiatives, this did not happen. As a result the responses on the impact of initiatives contained data from non-participants and this may have diluted the true impact of the initiatives. Respondents who chose the "no impact" option in response to specific questions likely includes both physicians who participated in the program and found it did not make a difference and those who did not participate and accordingly would not be able to report any impact. In addition, the inclusion of non-participants in the responses required that we use a larger dominator to determine the frequency of responses for those who indicated that the initiative made a difference. Together these two problems could have resulted in an under-estimation of the true impact of the initiative.

Interview and Focus Groups

During the summer of 2014 qualitative data was collected through interviews and focus groups with a total of 16 participants. Eight physicians participated in individual phone interviews to share their perspectives and provide information that would provide more insight into the survey results. The physicians were chosen by Division management and were intended to represent a cross-section of physicians within the Division. The representativeness of these physicians is not known and 6 of these physicians also participated in the clicker survey. The interview data was analysed using the recordings and only specific segments were transcribed to use as quotations in this report.

Three focus groups were facilitated, two with the Division's Attachment Working Group and one with Division staff. The Focus Groups recorded conversations were transcribed verbatim and the transcripts were analyzed using content analysis.

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