Cowichan Division of Family Practice

Providing leadership in healthcare innovations, in collaboration with our community.

2017 Program Data Summary Report

Tiffiny Littmann
Executive Administrator

2016-17
Program Data Summary Report

Table of Contents

Acknowledgements

Thank you to:
Jennifer Berg and Paula Dunford for the FPHSP billing data
Cowichan District Hospital for the raw FPHSP assignment data
Jessica Wilson for the CMC data
Carla Bortoletto for the locum and recruitment data
Mai Bennett for the IT data

2016-17
Program Data Summary Report

Introduction

In 2013, the Cowichan Valley Division of Family Practice (CVDFP) took over the collection and analysis of its program data from Impact BC, with whom a Quality Improvement contract was originally held. The resulting data collection and analysis framework developed by CVDFP now serves to support the organization's strategic priorities, day to day operations and long range planning by documenting progress of its measurable initiatives, analysing performance and functionality, identifying gaps and successes, and highlighting areas of improvement in real time.

This report includes statistical summaries of CVDFP's primary, measurable initiatives for the 2016-17 year; where applicable, the report identifies how the data framework and processes allowed for changes to be made during the year to create improvement; and, where data is available, identifies multi-year trends and provides year over year statistical analysis.

With four years of comparable data now in hand, some longer term trends are beginning to emerge. Any such notable trends have been highlighted throughout the report.

Data Summary

Family Practice Hospital Support Program / Inpatient Care

INITIATIVE OVERVIEW

Developed by CVDFP in 2010, and put in place to replace the original Doctor of the Day program at Cowichan District Hospital, the Family Practice Hospital Support Program (FPHSP) provides support to GPs who provide inpatient care to patients admitted to Cowichan District Hospital without a family doctor. FPHSP is structured so that unattached patients are assigned one at a time to participating physicians, on a rotating basis.

Funding for care delivery is provided by the Ministry of Health, but administered and distributed by CVDFP. FPHSP physicians are provided $150 per assigned patient, plus a quarterly network incentive (an annual amount of $219,000 - $54,750 per quarter - divided evenly among the FPHSP participants).

DATA COLLECTION PROCESS

Data for the Family Practice Hospital Support Program (FPHSP) is collected from several sources:

Cowichan District Hospital (CDH) provides copies of patient assignment rosters from both the emergency department and administration (surgical pre-admits), including patient Medical Health Record (MHR) number, date of assignment, and name of the GP assigned to the patient. This offers absolute data on overall FPHSP patient volumes and, once analyzed, provides a record of how many patients are referred to the respective GPs and how often. The CDH information also offers sufficient data to identify repeat admissions through the ER.

The CVDFP Finance Department provides a summary of GP billings, including patient Personal Health Number (PHN), patient category, and whether the patient is known to have been attached. These records provide information on billing trends, patient attachment levels, and the types of unattached patients seen.

Individual GP clinics – during the 2016-17 year, 34 GPs in 5 different clinics provided reports on the number of patients attached to their practices, including patients first encountered through the FPHSP program, plus ER referrals and those referred by the GP for Me call line.

Data from clinical reports is cross referenced with other attachment reporting mechanisms, such as GP FPHSP billing sheets, to eliminate duplication. Although every reasonable effort is made to ensure accuracy of reported data, a margin of error should be expected. Based on anecdotal feedback and billing trends, it is likely that patient attachment through the various CVDFP programs, including the Family Practice Hospital Support Program, is under-reported.

All incoming data and data formulas are reviewed for accuracy prior to being extracted for inclusion in the CVDFP master data sheets.

Protection of personal information

- *Patient names are not included in any of CVDFP's data collection processes; CDH information is provided in the form of MHRs, CVDFP billing data in the form of PHN.*
- *Patient identifiers such as PHN and MHRs are held in raw data form only, and are not included in any data summaries or other publicized reports.*
- *All data is stored securely and is used only by authorized CVDFP staff.*
- *Raw data is shared only as necessary for data assessment purposes or in specific instances where troubleshooting is required.*

FPHSP TRENDS & COMPARISONS

PARTICIPANT NUMBERS

- As of November 2016, 64 full service family physicians held privileges at Cowichan District Hospital, comprising 75% of all full service GPs within the Division boundaries, comparable to the previous year.
    - Narrowing the parameters to focus on the Duncan region showed that 92% (45 of 49) of Duncan-based full service GPs held privileges at CDH, as of November 2016.
    - By the end of the 2016-17 fiscal year, the number of GPs providing inpatient care had decreased by at least two, with further departures expected in coming months, due either to retirements or changes in practice.
- Of the 64 GPs with privileges, an average of 42% of those participated in the FPHSP program during the 2016-17 year, a significant decrease over the 56% participation in 2015-16, and 53% in 2014-15.
    - In 2016-17, FPHSP averaged 27 GP participants over the course of the year, compared to the average of 32 participants during 2015-16.
    - 2016-17 participant numbers peaked at 29 in January 2017, and saw lows of 26 in both November and December 2016. The 2016-17 year ended with 27 GPs on the roster.
    - Over the 2016-17 year, there were 4 new GP participants added to the roster, 3 of whom were new to the area, one of which decided to expand their level of hospital work.
    - Simultaneously, there were 5 GPs who departed the roster, 2 for personal reasons, while the remaining 3 were from a single clinic that encountered recruitment difficulties and whose GPs withdrew almost completely from hospital work.
    - **Notable trend**: CVDFP noted the downward trend in FPHSP participation last year. Despite concerted efforts to stabilize the program through the 2016-17 year, with particular focus on recruitment, engagement, and development of a mentorship program, participant numbers continue to trend downward.
    - **Implications**: After several years of operation, it has been found that a minimum participant number of 30 is needed to keep the FPHSP program sustainable. With increasing patient volumes due to the withdrawal of several GPs from both FPHSP participation and hospital work, and decreased GP participation, the FPHSP program has reached a tenuous state, which continued to worsen as the 2017-18 year opened.
        - CVDFP has been troubleshooting and working hard to stabilize the FPHSP program for several years but has no means by which to address several key issues – most significantly, the growing patient volume, now comprised primarily of patients who have a family doctor who does not work in hospital. *See stats on the following page.*
        - At time of writing, several meetings had been held with Island Health to look at ways in which inpatient care might be made more appealing and less burdensome to family doctors.
        - The majority of current FPHSP participants have indicated, by way of email polling, that they will remain with the program for the short term on the basis that positive changes will be made in the near future. If these are not realized, there is high likelihood that the program will be discontinued.
        - At time of writing, the FPHSP roster had further diminished to 20 participants, clearly indicating the need for timely interventions.

PATIENT VOLUMES

- In total, the FPHSP program saw 1825 admitted patients, an average of 152 per month; 5 per day.
  - 1488 of these patients were admitted through the ER (46% increase over 2015-16)
  - 337 of these patients were admitted through surgical pre-admits (10% increase over 2015-16)
  - This represents an overall increase of 38% over the 2015-16 combined volume.
- On average, 124 patients per month were assigned to the FPHSP program through ER admissions, a significant increase over the 85 patients per month in 2015-16.
  - **Notable variance:** There was a low of 105 ER patients in April 2016 – this is one patient higher than the highest number of ER patients seen in one month during the previous year.
  - There was a high of 146 ER patients in December 2016.
- On average, 28 patients per month were assigned to the FPHSP program through surgical pre-admits, a slight increase over the 25 patients per month in 2015-16.
  - There was a low of 14 pre-admit patients in August 2016 and a high of 45 patients in November 2016. *See charts below for year to year comparison*
- There was an average of 5.5 patients per month assigned to each FPHSP GP over the course of the year; 4.5 attributable to ER admits, 1 attributable to surgical pre-admits.
  - This volume is a significant increase over the 3.5 patients per GP per month assigned during the 2015-16 year (ER 2.7, and admitting .8 patients per month).
  - Statistically, participating GPs received, on average, 1 patient assignment every 6.5 days through the ER, and 1 patient assignment every 30 days through surgical pre-admits.
    - Again, this is a significant increase over the 1 ER patient per every 11 days, and 1 pre-admit patient every 38 days seen in 2015-16.
  - Highest average per-GP patient assignments from the ER occurred in November and December 2016 at an average 5.6 patients per GP per month.
    - The peak number of assignments, by individual GP, occurred in December, where 7 ER patients were assigned to one individual GP.
  - Highest average per-GP patient assignments from surgical pre-admits occurred in November 2016 at 1.7 per GP per month.
    - The peak number of assignments, by individual GP, occurred in November, where 3 pre-admit patients were assigned to five individual GPs.

2016-17
FPHSP PATIENT VOLUMES

	Cumulative Total	Monthly Maximum	Monthly Average
Total no. of FPHSP patients	*Patient volumes*		
Pt. totals - ER	1488	146	124.0
Pt. totals - surgical admits	337	45	28.1
Total FPHSP patients - ER & admin	1825	190	152.1
Pt volume - daily average (ER & admin)	--	6.3	5.0

12 months (April 2016 to February 2017)

No. FPHSP patients per GP, per month	*Patient volumes*
Average pts per GP - ER	4.5
Max. assigned patients per GP - ER	7
Average pts per GP - surgical admits	1.0
Max. assigned pts per GP - surgical	3
Total number of patients per GP per month, on average	5.5

2015-16
FPHSP PATIENT VOLUMES

	Cumulative Total	Monthly Maximum	Monthly Average
No. of FPHSP patients	*Patient volumes*		
Pt. totals - ER	1016	104	84.7
Pt. totals - surgical admits	305	36	25.4
Total FPHSP patients - ER & admin	1321	122	110.1
Pt volume - daily average (ER & admin)	--	4.1	3.6

12 months (April 2015 to March 2016)

No. FPHSP patients per GP, per month	*Patient volumes*
Average pts per GP - ER	2.7
Max. assigned patients per GP - ER	5
Average pts per GP - surgical admits	0.8
Max. assigned pts per GP - surgical	2
Total number of patients per GP per month, on average	3.5

PATIENT CATEGORIES

- **Notable variance:** Over the year, 2% of assignments reported to CVDFP did not specify the patient category, a notable decrease over the 6% in 2015-16, a positive development.
- As such variance would skew the patient category breakdown, percentages have been recalculated using only those encounters for which a patient category was recorded. See below.

	2013-14		2014-15		2015-16		2016-17	
PATIENT CATEGORY	Total reported encounters	**Percentage of coded encounters**	Total reported encounters	**Percentage of coded encounters**	Total reported encounters	**Percentage of coded encounters**	Total reported encounters	**Percentage of coded encounters**
No family doctor (14081)	98	**12%**	94	**12%**	109	**13%**	123	**11%**
GP with no privileges (14082)	338	**42%**	328	**41%**	304	**37%**	553	**48%**
GP who is out of town (14083)	378	**46%**	385	**48%**	410	**50%**	487	**42%**
Total coded encounters	814	100%	807	100%	823	100%	1162	100%
No category provided	5		20		48		28	
Total reported encounters	819		827		871		1191	

- As this table demonstrates, based upon the reported, categorized FPHSP encounters, patient volumes have shown the following trends:
  - The volume of truly unattached patients has remained relatively constant, with a 2% decrease in the past year
  - **Notable variance:** The percentage of patients who have a family doctor without hospital privileges has increased by 11% in just the past year
  - The percentage of patients who have a family doctor outside of the Cowichan region has decreased 8% over the 2015-16 year

ADMISSION FREQUENCY

- There were 74 patients over the course of the year who had two or more ER admits in a given month. *See chart on the following page for year over year comparisons.*
- There were 198 patients who had two or more ER admits over the course of the year. Of those, there were:
  - 139 patients with 2 admits during the year
  - 37 patients with 3 admits
  - 9 patients with 4 admits
  - 8 patients with 5 admits
  - 1 patient with 6 admits
  - 4 patients with 7 or more admits.
- Overall, there was significant growth in the number of patients with multiple admissions:
  - Collectively, over all categories, there was a 75% increase (113 to 198 patients) over 2015-16, a considerably higher rate of growth than the 46% increase seen in total ER admissions.

Admission frequency, multi-year comparison

Multiple admissions, further breakdown	2013-14	2014-15	2015-16	2016-17
2 visits / year	69	80	86	139
3 visits / year	19	19	16	37
4 visits / year	2	7	5	9
5 visits / year	3	0	5	8
6 visits / year	3	1	1	1
7+ visits / year	0	0	0	4
	96	*107*	*113*	*198*

BILLING TRENDS

- On average, 65% of assigned patients were reported to CVDFP and 64% of assigned patients were billed, compared to 66% and 62% respectively in 2015-16.
    - Reporting levels have been relatively consistent over all four years that this data has been collected, averaging between 62%-66%; with billing levels ranging from 60-64%.
    - The majority of surgical pre-admit patients do not actually require care from the assigned GP - with surgical pre-admits comprising 18.5% of all patient assignments, this likely accounts for a portion of the unreported/unbilled patient assignments.

PATIENT ATTACHMENT

- There was an average of 4.7 patients attached via the FPHSP program each month, for a total of 56 over the year, or 46% of the truly unattached.
- The percentage of patients attached each year has remained relatively constant, ranging from 42% to a high of 49%.

PHYSICIAN SURVEY RESULTS

Total of 39 respondents; 19 of 27 FPHSP participants (70%)

Participation and satisfaction:

- Responses from FPHSP participants increased by 28% over 2015-16 when 42% of participants submit a completed survey, compared to this year's 70%.
- Of the 18 who responded, 44% indicated they were satisfied or very satisfied with the FPHSP program. 56% indicated they were dissatisfied or very dissatisfied.
    - These numbers are consistent with results of the 2015-16 survey, where 43% of participants fell into the satisfied category, and 57% fell into the dissatisfied category.
    - Notwithstanding the above, it should be noted that a number of FPHSP participants who were dissatisfied with the program have resigned since last year's survey.
- 72% of 18 respondents indicated that participating in the FPHSP program has a negative impact upon their regular practice; 6% felt it had a positive influence, while 22% felt it had no significant impact.
    - **Notable variance**: This is a 13% increase over 2015-16, when 59% felt the program negatively impacted upon their practice; in 2014-15, only 10% felt participating in the FPHSP program had a negative impact on their practice.

- **Notable variance**: 73% of 18 respondents are part of a clinic where all GPs participate, compared to 63% in 2015-16, and 40% in 2014-15.
- Seven different respondents indicated they would consider joining FPHSP in future.
- **Notable variance**: 65% of 17 responding FPHSP participants indicated they take on unattached patients, consistent with the 64% in 2015-16, but notably lower than the 90% in 2014-15 and 100% in 2013-14.

The 2016-17 survey asked a number of new questions, not raised in previous surveys:

Value of work:

- When asked how much they personally value their hospital work, using a scale of 1 to 10, no respondents indicated that the work held no value (rating of 1), while 35% indicated the work was highly valued (rating of 10). Of 37 responses:
  - 5% responded with ratings between 1 and 3 (low value)
  - 22% responded with ratings between 4 and 7
  - 73% responded with ratings between 8 and 10 (high value)
- When asked how important inpatient care is in the overall delivery of Family Practice care in the local community, using a scale of 1 to 10, no respondents indicated that it held no value (rating of 1), while 49% indicated it was extremely important (rating of 10). Of 39 responses:
  - 3% responded with ratings between 1 and 3 (low value)
  - 26% responded with ratings between 4 and 7
  - 72% responded with ratings between 8 and 10 (high value)

Influence of colleagues:

- When asked how much is their decision to participate in FPHSP was influenced by whether other GPs in their clinic were also on the roster, using a scale of 1 to 10, 34% indicated they were not at all influenced (rating of 1), while 29% indicated they were highly influenced (rating of 10). Of 38 responses:
  - 42% responded with ratings between 1 and 3 (not highly influenced)
  - 13% responded with ratings between 4 and 7
  - 45% responded with ratings between 8 and 10 (highly influenced)
- Conversely, when asked how much is their decision to provide inpatient care was influenced by whether other GPs in their clinic were also providing inpatient care, using a scale of 1 to 10, 13% indicated they were not at all influenced (rating of 1), while 21% indicated they were highly influenced (rating of 10). Of 39 responses:
  - 26% responded with ratings between 1 and 3 (not highly influenced)
  - 38% responded with ratings between 4 and 7
  - 36% responded with ratings between 8 and 10 (highly influenced)

FPHSP format:

- When asked if the current compensation was reasonable for the FPHSP work, 51% of the 37 respondents indicated it was, while 49% indicated it was not.
  - Of 20 respondents who are not currently on the FPHSP program, 40% indicated they would consider joining FPHSP if the compensation was considerably higher; 60% indicated they would not.

- When asked what number of patient assignments per month would be manageable, assuming they were on the FPHSP roster, the 29 respondents indicated:
    - 1 patient per month: 3%
    - 2 patients per month: 31%
    - 3 patients per month: 17%
    - 4 patients per month: 28%
    - 5 patients per month: 14%
    - 6 to 8 patients per month: 6%
- Four different respondents indicated they would be willing to take two spaces on the FPHSP roster on a short term basis in order to support the continuation of the FPHSP program

Mentorship Program:

In 2016-17, CVDFP developed an inpatient care mentorship program which matches new grads, new recruits, long term locums, and doctors already working in the local community who are new to or are returning to inpatient care, with an experienced full-service physician who provides education, training and support to encourage mentees to take on hospital work and provide full service care to patients in the community.

- Of 38 respondents, 79% felt the mentorship program would strengthen community recruitment efforts.
- Of 38 respondents, only 1 indicated that the addition of the mentorship program would make them more likely to provide inpatient care; 5 felt it would not, and 32 of the respondents already provide inpatient care.
- Of 31 respondents, 3 indicated that the addition of the mentorship program would make them more likely to participate in FPHSP; 13 felt it would not, and 15 of the respondents are already on the FPHSP roster.

ROLE OF COWICHAN MATERNITY CLINIC

The Cowichan Maternity Clinic, although not formally included on the FPHSP roster, serves a specific role in providing care to pregnant unattached patients admitted to Cowichan District Hospital. When such patients are admitted, they are not assigned a GP through the FPHSP roster; rather, they are assigned to the maternity clinic. These patients are then found a permanent family doctor through the CMC's attachment efforts. Specific details can be found under the Maternity Clinic section of this report *(see page 12)*.

YEAR OVER YEAR TRENDS

Statistics around the Family Practice Hospital Support Program had remained remarkably consistent year to year until 2016-17 when several notable changes occurred:

- Patient volumes increased by 38%
- FPHSP participant levels dropped by 14%
- The proportion of FPHSP patients who do have a local family doctor, but one who opts out of hospital work, increased by 11% to a total of 48% of all FPHSP patients

Multiple admission patients have also jumped considerably this past year, potentially in correlation with the increase in overall patient volumes.

FPHSP SUMMARY

The FPHSP / inpatient care data collection mechanisms are well established and have operated smoothly throughout the 2016-17 year, despite staffing changes at Cowichan District Hospital. Data collection and statistical analysis of FPHSP and inpatient care have been sufficiently comprehensive to provide an effective appraisal of program operation, and to support CVDFP in achieving certain strategic priorities for the FPHSP program; specifically, monitoring the level of success of certain interventions, identifying gaps, and highlighting areas for improvement.

Over the past year, the program data has proven particularly meaningful by clearly illustrating the strains on the current system and the gaps that have occurred as a result. This hard data, combined with robust consultative surveying of community GPs, has been invaluable in assessing current state and discussing potential solutions with stakeholders.

Efforts to stabilize the FPHSP program in the short term remain ongoing, but with new physicians disinclined to do hospital work and with several established physicians withdrawing from inpatient care to focus on their clinic work, longer term solutions are needed.

Although the issues remain ongoing, the conversations have been well-informed with robust, real time program data.

Data Summary

Cowichan Maternity Clinic

INITIATIVE OVERVIEW

Opened in March 2011, the Cowichan Maternity Clinic (CMC) was developed to fill a growing void in the community, with a steadily decreasing number of family doctors providing obstetric care. Located in the Cowichan District Hospital, CMC provides maternity care to pregnant women up to 6 weeks post-partum.

One of the clinic's goals is to help close the care gap faced by First Nations women, who face unique cultural, socioeconomic and medical needs during pregnancy. This population comprises approximately 30% of CMC patients. The clinic's mandate also includes attaching patients who did not previously have a family doctor.

The CMC is staffed by family physicians, an RN, a contracted part-time dietician and an MOA.

DATA COLLECTION PROCESS

The Cowichan Maternity Clinic (CMC) data is collected directly from CMC staff as raw data. Although some manual records are used, the majority of data is extracted from the clinic's Electronic Medical Record (EMR).

All incoming data and data formulas are reviewed for accuracy prior to being extracted for inclusion in the CVDFP master data sheets.

Protection of personal information

- *No patient identifiers are included in the data exchange.*

CMC TRENDS & COMPARISONS

PATIENT VOLUMES

- Total patients cared for by the CMC in the 6 years since opening stands at 3,457.
    - This cumulative number of CMC patients, a number including moms and the babies delivered, grew by 487 patients during 2015-16 year, 18 patients more than in the previous year.

  Note: returning patients are not re-counted; the total number of patients cared for equals the total number of patient charts held by CMC.
- There was an average of 148 active patients each month, a decrease of 3 patients per month over the 2015-16 average.
- There was an average of 214 different patients seen each month (the same as in 2015-16), with an average of 410 total appointments booked per month (up from the average of 396 in 2015-16).
- There was an average of 41 postpartum mothers being seen by CMC each month, the same monthly average as in 2015-16.
- There was an average of 26 new patients each month, 56% of whom were referred by GPs.
    - **Notable trend**: although the average number of new patients arriving at the CMC each month has remained relatively constant, the proportion of new patients who are self-referred has continually increased since 2012-13:

REFERRALS TO COWICHAN MATERNITY CLINIC

	Year 1 (2011-12)	Year 2 (2012-13)	Year 3 (2013-14)	Year 4 (2014-15)	Year 5 (2015-16)	Year 6 (2016-17)
Self-referred	15%	13%	14%	20%	29%	44%
GP referred	85%	87%	86%	80%	71%	56%

FIRST NATIONS PATIENTS

- First Nations patients comprised 34% of active patients, up slightly from the 33% in 2015-16.
- During 2016-17, there were a total of 61 new Aboriginal patients (average of 5 per month), a decrease over the 84 new First Nations patients (average of 7 per month) in 2015-16.
- **Notable variance:** Of the Aboriginal patients, an average of 9% lives on Penelakut Island, down from 16% in 2015-16.

The Cowichan Maternity Clinic has attached a total of

638 patients

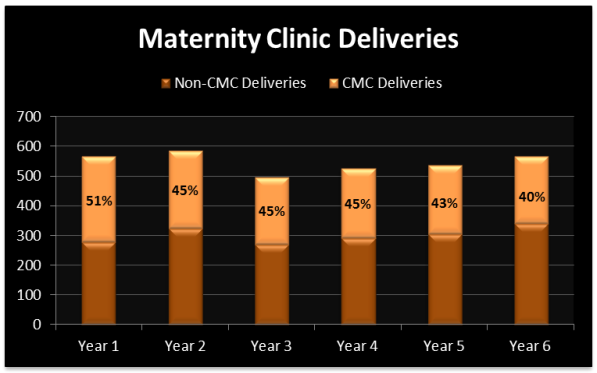
Since opening in 2011

PATIENT ATTACHMENT

- Over the year, the clinic saw an average of 6 unattached patients per month, double the number seen in 2015-16.
- CMC attached a total of 98 patients to a family doctor during 2016-17 (59 CMC patients and 39 family members), 2 more than in 2015-16.
- During the 2016-17 year, CMC reported receiving 7 unattached patients from the CDH ER, patients who, if not pregnant, would have been assigned to a physician on the FPHSP roster. Of these 7 patients:
  - 2 had a local GP who does not have hospital privileges
  - 3 had family doctors outside the Cowichan area
  - The remaining 2 patients had no category indicated

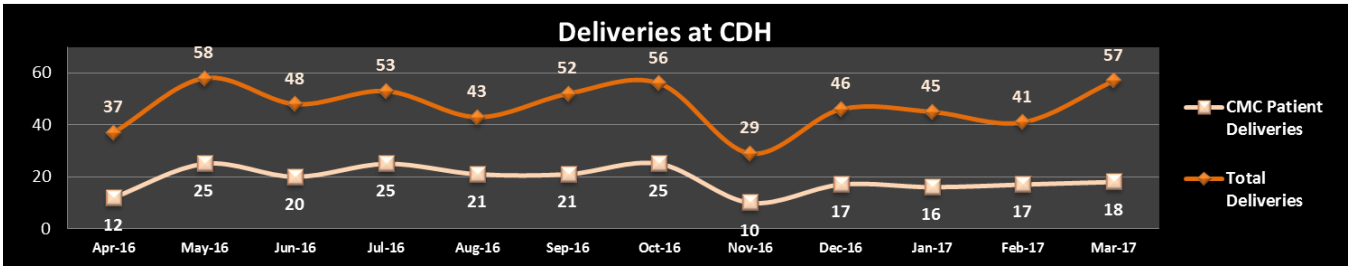
DELIVERY VOLUMES

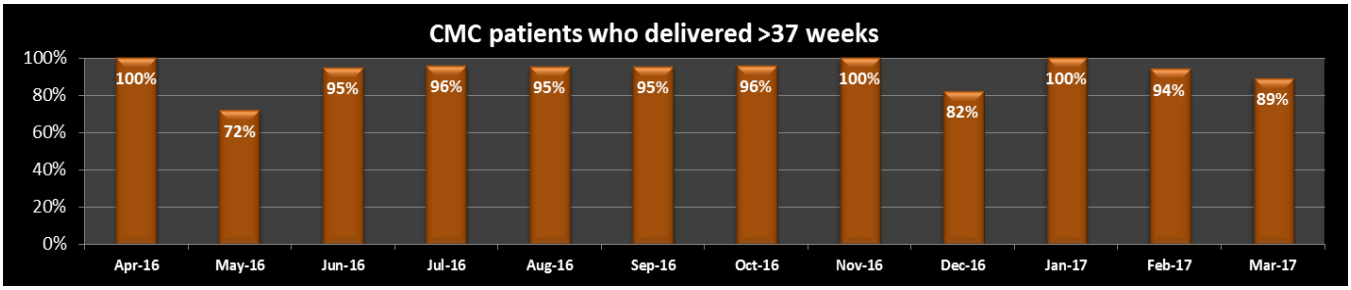
- There was an average of 19 CMC patients per month who delivered at Cowichan District Hospital, for a total of 227 deliveries over the year, levels similar to 2015-16 (231 deliveries).
- Delivery levels peaked at 25 in both May and October 2016, and were lowest in November 2016 at 10.
- The CMC accounted for an average of 40% of all CDH deliveries, down 3% from 2015-16.
- There were a total of 55 patients who delivered by C-section, a decrease over the 64 in 2015-16.
  - Of the 64 C-Sections, 23 were elective, compared to 24 elective in 2015-16.
  - **Notable variance:** Of the 64 C-Sections, 32 were non-elective, versus 40 in 2015-16.
  - See table on page 16 for C-sections expressed as a *percentage* of total deliveries.



- 92% of patients delivered at or over 37 weeks, 8% delivered at less than 37 weeks.
- There were a total of 10 patients who transferred out for delivery elsewhere over the year, a slight decrease over the 11 patients in 2015-16.

2016-17 DELIVERIES

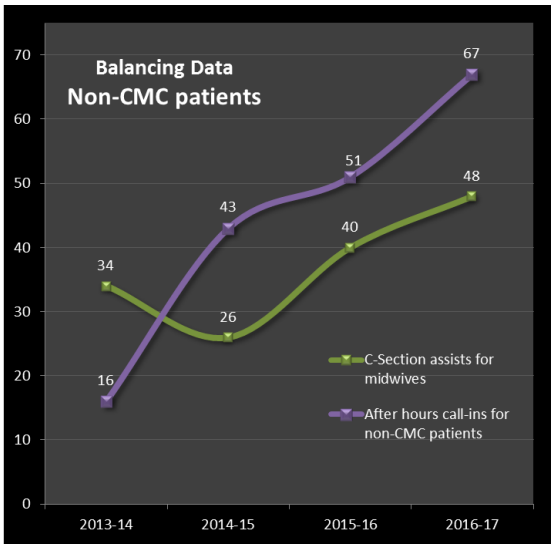


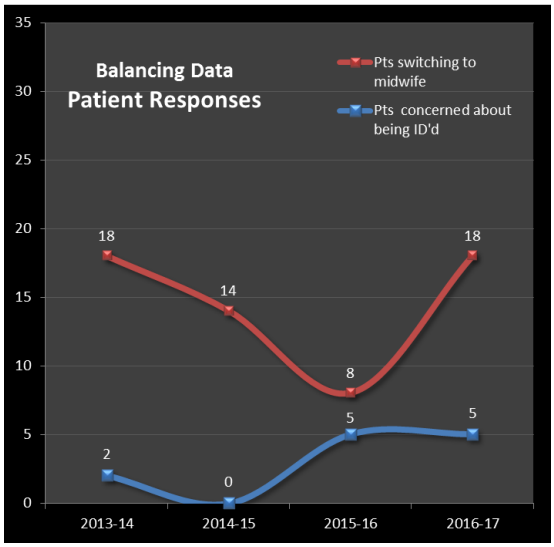


BALANCING DATA

- There were 5 patients over the course of the 2016-17 year who expressed concerns about being identified as pregnant for having attended the maternity clinic, the same number as in 2015-16.
- **Notable variance**: There were a total of 18 patients over the course of the year who switched to the care of a midwife, up from the 8 who transferred care in 2015-16.
- **Notable variance**: There were 48 C-Section assists performed for midwives, an increase over the 40 performed in 2015-16.
- **Notable variance**: There were a total of 67 after-hours call-ins logged for non-CMC patients, an increase over the 51 logged in 2015-16.
- The CMC roster was comprised of 8 family doctors throughout 2016-17, the same as in 2015-16.
    - With 10 GPs being the ideal number for the CMC roster, recruitment remains a priority for the stability and long term sustainability of the maternity clinic.

MULTI-YEAR COMPARISONS
Balancing Data





YEAR OVER YEAR COMPARISONS, 2011-12 to 2016-17

Measure	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Average number of active patients per month (antenatal)	168	165	142	157	151	148
Total number of patients *Expressed as running total and net new for the given year; includes charts for babies delivered **	979	1525 *Increase: 546*	2003 *Increase: 478*	2501 *Increase: 498*	2970 *Increase: 469*	3457 *Increase: 487*
New patients *Monthly average*	357 *(30/mo)*	319 *(26/mo)*	297 *(25/mo)*	325 *(27/mo)*	328 *(27/mo)*	311 *(26/mo)*
Percentage of new patients GP-referred	85%	87%	86%	80%	71%	56%
Total number of different patients seen each month	235	238	208	222	214	214
Average number of patient visits per month	*Stats not avail*	*Stats not avail*	372	404	396	410
Average number of unattached patients per month	3	3	4	3	3	6
Total number of patients attached	112	118	84	130	96	98
Percentage of active patients who are First Nations	23%	34%	32%	33%	33%	34%
Percentage of First Nations patients from Penelakut	11%	10%	19%	17%	16%	9%
Total number of CMC deliveries	289	262	225	234	231	227
Percentage of deliveries at CDH	51%	45%	45%	44%	44%	40%
C-sections, elective *Expressed as percentage of total CMC deliveries*	6%	12%	6%	7%	10%	10%
C-sections, non-elective *Expressed as percentage of total CMC deliveries*	18%	18%	13%	11.5%	17%	14%
Deliveries at less than 37 weeks *Expressed as percentage of total CMC deliveries*	11%	13%	8%	8%	7%	8%
No. of patients who switched to midwife *Expressed as total yearly number and as percentage of total new patients for the year*	22 (6%)	24 (8%)	18 (6%)	14 (4%)	8 (2%)	18 (6%)
No. of C-section assists for mid-wives	15	14	34	26	40	48
After hours call outs, non CMC patients	n/a	n/a	64 *Extrapolated*	43	51	67

** The total number of patients will reflect the number of patient charts held by the Cowichan Maternity Clinic – repeat patients will not be counted twice, which therefore skews year one higher than subsequent years.*

CMC SUMMARY

The CMC data and data collection processes are well established and have operated smoothly throughout the 2016-17 year. The resulting statistical analysis has been sufficiently comprehensive to provide an effective summary of clinic operations, and to support CVDFP in achieving certain strategic priorities for the Cowichan Maternity Clinic; specifically, documenting outcomes and program trends, and supporting discussions around operational models and clinic sustainability.

Overall trends and variances have been highlighted on the preceding pages, and can be observed in comparison table found on page 14. Cumulative data shows generally consistent overall volumes and outcomes; however, a few areas have been identified that show more significant changes over the 4-year period between April 1-2013 to March 31-2017*:

- Percentage of GP referrals:
  - The proportion of new patients who are referred by GPs has continued to trend downward.
  - This number has declined from a high of 87% in 2012-13 to 56% in 2016-17.
- Unattached Patients:
  - The number of unattached patients arriving at CMC has been relatively constant since the clinic opened, until 2016-17, when the average number per month doubled. This potentially correlates with the increase in number of self-referred patients.
- First Nations Patients
  - While the percentage of active patients who are First Nations has remained remarkably constant since year 2 of operation, the percentage of First Nations patients who are from Penelakut Island decreased significantly in 2016-17 from 16% to a 6-year low of 9%.
- Proportion of deliveries
  - While CMC patients have comprised a relatively constant percentage of total CDH deliveries through years 2 to 5, at either 44 or 45%, 2016-17 saw this percentage drop to 40%.
- Non-elective C-sections
  - Having increased significantly from 11.5 to 17% in 2015-16, non-elective C-sections decreased to 14% in 2016-17.
- C-section assists provided to mid-wives
  - This number continues to trend upward, peaking this year at a 6-year high of 48, a notable increase over the 40 in 2015-16.
  - Similarly, after-hours call outs peaked this year at a 6-year high of 67, a significant increase over the 51 in 2015-16.
- Transfer to midwives
  - The number of CMC patients who transferred care to a midwife has shown a notable increase this year, jumping from 8% in 2015-16 to 18% in 2016-17.

** In 2015-16, a review of early data compiled by Impact BC identified some potential inconsistencies in the data analysis between years one and two. Accordingly, a number of the multi-year trends are summarized using the past 4 years only, starting 2013-14.*

Data Summary

Recruitment & Retention Program

INITIATIVE OVERVIEW

The R&R portfolio is comprised of two main components: physician recruitment and the locum program. While the main focus of this initiative is to fill vacancies in full service family practices, and to secure locum physicians for the region, the portfolio incorporates several inter-connected aspects, including: promotion of the Cowichan region; participation in Island-wide recruitment activities; proactive engagement of Residents and medical students; recruitment supports for clinics actively seeking to fill vacancies; resources for physicians seeking locum coverage; and other general supports that keep Cowichan an appealing place for full service family doctors to practice.

DATA COLLECTION PROCESS

Recruitment and locum data is collected from the Recruitment & Retention Project Manager who receives the bulk of incoming communications from inquiring parties, including local physicians, out-of-town physicians looking to relocate, medical residents, and recruitment associates at other divisions of family practice and Island Health.

Some recruitment advertising directs inquiries to the CVDFP admin team, allowing a portion of the recruitment data to be received directly by the QI manager, where it is documented and entered into the master data sheets.

All incoming data and data formulas are reviewed for accuracy prior to being extracted for inclusion in the CVDFP master data sheets.

Protection of personal information

- *No patient identifiers are included in the locum or recruitment data processes; physician names are removed from statistical summaries and any publicized reports.*

R&R TRENDS & COMPARISONS

LOCUM PROGRAM

Program format:

At the end of 2015-16, with GP for Me funding drawing to a close, CVDFP began focusing on long term sustainability plans for a number of its programs, including the Locum Coordinator Program. Following a thorough review of program functionality and outcomes, the decision was made to substantially restructure the Locum Program in a way that would offer a more streamlined, sustainable service.

The original locum program ended on March 31-2016. In its place, a process was established whereby CVDFP maintains a current list of active locum physicians available to provide coverage in Cowichan, including locums' contact information, scheduling availability and other pertinent information. This internal and confidential list is provided to CVDFP members upon request; physicians then contact locums directly to arrange coverage.

As part of this restructuring, the Locum Coordinator position was eliminated, the guaranteed daily minimums were discontinued, as were policies relating to minimum overhead split, maximum coverage entitlement, and other booking restrictions.

Although no formal assessment of the new system has been carried out to-date, the modified program uses minimal staff time and has required considerably fewer CVDFP resources. Anecdotally, although not every GP has been successful in securing coverage through the CVDFP list, most inquiring parties have responded positively to the new process that offers them direct contact with locums, with minimal policies and restrictions.

Restructuring of the program also allowed for a more thorough review of the available locums in the region, a number considerably lower than originally reported: 2015-16 reported an average of 15 locums on the roster, compared to an average of 6 in 2016-17.

Locum program volumes

- The initial Locum List, developed in May 2016, started with 5 participating locum physicians, but grew to 7 locums by August of 2016.
    - Although the composition changed slightly, with one locum departing the list and another joining, the list held at 7 locum physicians to the end of the 2016-17 year.
    - Under the previous Locum Coordinator Program, the locum pool was comprised of an average of 15 physicians; however, anecdotally, it is known that a number of these participants did not actively engage with the Coordinator in addressing coverage needs.
- In 2016-17 there were 12 different GPs who inquired about the locum list, from 10 different GP clinics.
    - With an average of 20 GP clinics in the region, this shows that 50% of clinics have connected with CVDFP about the locum list.
    - The highest demand occurred in June, with 6 requests; this likely relates to promotion around the new program.

Locum program satisfaction

- There were no satisfaction surveys conducted during the 2016-17 year – see summary comments on page 20 for further reporting.

RETENTION & RECRUITMENT

Program format:

As part of the restructuring of the Locum Program in 2016-17, focus for the R&R portfolio was shifted more to recruitment efforts for both full service GPs and locum physicians for the region. With the addition of a dedicated Project Manager, and a reinvigorated Retention & Recruitment committee, this portfolio has shown positive growth over the past year.

CVDFP has continued to engage its partners in locally identified work to address the unique challenges in the Cowichan Region. But 2016-17 has also seen CVDFP participating more fully in regional and provincial level recruitment work, contributing to the development of a collaborative Island-wide network, and a cohesive, regional approach to recruitment.

Recruitment volumes

- Physician openings for full service family practices fluctuated from 4 to 6 at various points during the year, ending with 6 available positions, and averaging 5 for the year, the same as in 2015-16.
    - Of these, 4 carried forward from the previous year; 2 new opportunities arose.
    - During the year, 2 clinics reached out to CVDFP for support in their recruitment efforts.

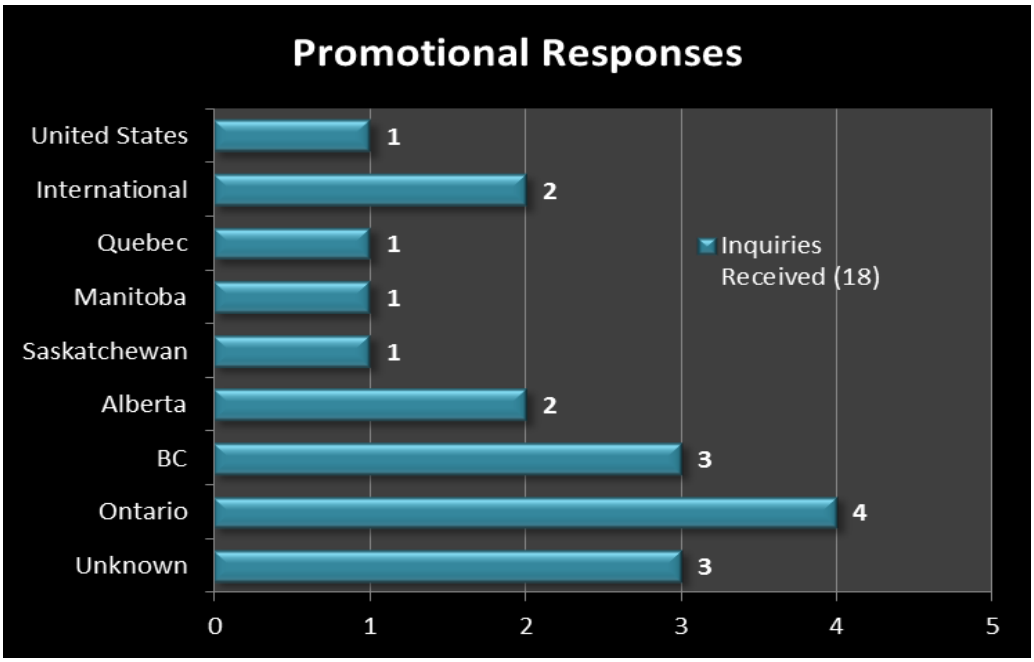
- **Notable variance:** The Cowichan region saw 11 GPs successfully recruited during the year, a 120% increase over the five recruited during 2015-16.
- **Notable variance:** Of these 11 recruits, CVDFP played a role in securing 5 for the region, a 400% increase over the 1 physician CVDFP helped recruit in 2015-16.
- Of the 11 recruits, 3 were International Medical Graduates, 1 was a Resident transitioning to full service practice with a 1-year commitment to the region, and the remaining 7 were full service family doctors relocating to Cowichan.
- Of the 11 new GPs:
    - 3 assumed vacated full service family practices from previous years.
    - 3 joined developing, blended model practices (full service family practice plus walk-in services)
    - 1 joined a developing care team at a First Nations health centre
    - 1 has begun practicing in an adjacent town, providing occasional coverage in Cowichan at a blended model practice
    - 3 others have not yet begun practicing in Cowichan – two have not yet settled in the community; the other is unable to practice at present due to personal circumstances
- The region saw several additional changes in GP practices through the 2016-17 year:
    - One full service GP retired from practice; his patients were absorbed by the multi-GP, blended model practice he had transitioned to just prior to retiring.
    - One full service GP left regular practice and shifted to locum work; this practice remained vacant at the end of 2016-17.
    - One full service GP retired from regular practice and shifted to locum and urgent care work; this practice remained vacant at the end of 2016-17.
    - One family practice locum and maternity care physician retired; this vacancy on the CMC roster remained unfilled at the end of 2016-17.
    - One full service GP transitioned to part time and shifted to long distance locuming; this practice remained vacant at the end of 2016-17.
    - Two different GP clinics reported their plans to close completely during the 2017-18 year, due to the inability to recruit new physicians to replace outgoing GPs.

Promotional activities

- There were no recruitment events or conferences attended by CVDFP over the 2016-17 year; however, the community was represented by the Vancouver Island regional team at 2 different BC-based events: the Family Medical Forum, November 2016 in Vancouver and the Rural Locum Forum, February 2017 in Nanaimo.
    - The CVDFP team received names of several potential locum physicians as an outcome of these events.
- CVDFP joined the regional recruitment team in developing a web portal to collectively promote Vancouver Island and direct visitors to individual community resources.
- A promotional video was developed for the Cowichan region; once finalized (anticipated for the 2017-18 year), the video will be included on the CVDFP website and regional web portal.
- CVDFP placed four print ads during the 2016-17 year, including the BC Medical Journal; the Canadian Medical Journal; the Ontario Medical Review; and American Medical Journal.
    - Response to print ads continues to be positive, particularly from the Ontario region and US.

- **Notable variance:** There were a total of 18 inquiries received from GPs potentially interested in moving to Cowichan, compared to 7 received during 2015-16.
- Of the inquiries received, 10 were inquiries received directly by CVDFP; 8 were referred to CVDFP by Island Health or other third parties.
- Of the 18 inquiries received:
    - 10 were interested in full service positions
    - 2 were interested only in locuming
    - 2 were interested in locuming or part-time family practice positions
    - 2 were interested in locum work, leading to a permanent family practice position
    - 2 were interested in acute care and were referred elsewhere

  See the graph on the following page for a regional breakdown of inquiries.
- The CVDFP recruitment team hosted 5 different GPs for site visits, 3 of whom ultimately decided to relocate to Cowichan.
- CVDFP partnered with the Nanaimo Division of Family Practice to host a Retirement Planning workshop for local GPs.
    - This event, held in Nanaimo, was attended by 8 Cowichan GPs, approximately 20% of attendees.
- Total cost for Retention & Recruitment promotional activities for 2016-17 was $10,406.54, a 90% increase over the $5,475 spent in 2015-16.



It should be noted that the US advertisement was taken out late in the fiscal year and responsiveness continued to grow in the early part of the 2017-18 year; those inquiries are not included in this report.

YEAR OVER YEAR TRENDS

Locum Program

With the significant overhaul of the Locum Program during the 2016-17 year, there are no comparable numbers available for this report beyond the generalities reported in the preceding pages.

Recruitment

Recruitment activity has grown notably during the past year, as highlighted on the preceding pages. The addition of a dedicated Project Manager for this portfolio has bolstered recruitment efforts by offering a more comprehensive, hands-on approach that has generated positive results, as demonstrated by the notable increases in the number of inquiries received, the number of site visits conducted, and the number of GPs recruited. Additionally, certain regions of Canada and the US have shown a growing number of physicians who are interested in relocating, providing specific targets for advertising and other marketing efforts.

Comparable data for 2015-16 to 2016-17 is included in the overall program summary on the previous pages, with areas of note highlighted. Multi-year comparisons and long term trends have not been developed for this report as, until 2016-17, recruitment related volumes had been low, and data sources somewhat anecdotal. The dedicated efforts of the Project Manager and greater engagement of GPs has generated more consistent reporting and greater volumes, which should allow for more effective analysis in future years.

R&R SUMMARY

Locum Program

Data associated with the new Locum Program is minimal, and user numbers are easily monitored. While the current measurement framework provides evidence of program usage, it offers no insight into the overall effectiveness of the program, nor user satisfaction.

Ideally, the program would look to track the number of successful locum engagements; however, it is recognized that the time requirements to communicate regularly with GPs and to document the outcomes would be prohibitive. Instead, it is recommended that surveying of the program users – both full service GPs and participating locums – be carried out during the 2017-18 year to gather insight into the effectiveness of, and user satisfaction with, the Locum Program in its current format.

Recruitment Program

Although meaningful multi-year trends are not yet available for this initiative, the Retention & Recruitment statistics for 2016-17 have been sufficiently comprehensive to provide a basic appraisal of program operation for the year. The resulting statistical analysis has supported CVDFP in achieving certain strategic priorities for this program; specifically, documenting and assessing program successes and monitoring for potential areas for improvement.

Several elements are noted to have contributed to strengthening the R&R initiative over the past year, resulting in the positive outcomes highlighted in the preceding pages. These include:

- Dedicated project manager and an active R&R committee
- Greater immersion in local and regional efforts
- An integrated, cohesive regional recruitment strategy
- Expanded and targeted marketing efforts
- Interpersonal efforts generating greater connectivity to local physicians

In an effort to provide greater alignment of Recruitment and Quality Improvement efforts, the Recruitment & Retention Project Manager has implemented a tracking mechanism that will more closely monitor incoming recruitment-related communications and subsequent interactions. This will further strengthen the data collection processes, offer more quality data, and allow for more effective analysis in future years.

Data Summary

Patient Attachment

INITIATIVE OVERVIEW

CVDFP Patient Attachment efforts are embedded in number of initiatives, including the programs identified earlier in this report: FPHSP, CMC, Recruitment & Retention, along with ER referrals, and via GP practice supports, the latter of which are intended to increase capacity within individual clinics.

In addition to these program-specific attachment mechanisms, in 2015-16, CVDFP implemented a public-facing, dedicated attachment service, the GP Referral Line. This toll-free number offers a resource for patients in need of a family doctor who would not be captured through one of CVDFP's other programs.

The answering service screens callers to ensure they are truly unattached, then provides those who meet the criteria with the names of two GP clinics closest to their geographic area who are currently accepting new patients. Referred callers are also provided a basic health survey, to be filled out and provided directly to the GP clinic – CVDFP does not collect any completed questionnaires or patient information.

DATA COLLECTION PROCESS

Data on the number of patients attached is collected through the established data frameworks described throughout this report and via reports submitted to CVDFP by individual GP offices. Reports collected from GP clinics include:

- Patients attached through the Family Practice Hospital Support Program. In these instances, the data is cross referenced with the attachment reporting included on the FPHSP billing sheets, with any duplication removed. This ensures that CVDFP systems capture as many attached patients as possible.
- Patients attached through the ER Referral Program. This program involves providing to the CDH Emergency Department a roster of GPs willing to accept referrals from ER physicians. Focusing on the higher needs patients, ERPs will use the roster to try and connect a patient in need with an available family physician, in a matching geographic area.
- Patients attached through net-new GP practices. In instances where CVDFP played a role in recruiting a new GP to the area and that GP opens a net-new practice, the unattached patients taken on by that practice (per their monthly attachment reports) are attributed to the recruitment program for first 6 months after the clinic opens.
- GP Referral Service. Data from this program is collected directly from the call service as raw call logs. The information must be reformatted, sorted, extracted and entered into a mechanism that allows the data to be effectively analyzed.

All incoming data and data formulas are reviewed for accuracy prior to being extracted for inclusion in the CVDFP master data sheets.

Protection of personal information

- *Although PHN and MRNs are included in several of the data collection instruments, patient names are not included in any of CVDFP's data collection processes.*
- *Patient identifiers such as PHN and MRNs are held in raw data form only and are not included in any data summaries or other publicized reports.*
- *Referral Line data does include caller names, and in some cases, email addresses, which are provided at callers' discretion. This information is held securely in raw data form only and is not included in any data summaries or publicized reports.*
- *All data is stored securely and is used only by authorized CVDFP staff.*
- *Data is shared only as necessary for data assessment purposes or in specific instances where troubleshooting is required.*

TRENDS & COMPARISONS

CLINICAL ATTACHMENT REPORTING

- In 2013-14, 10 of 17 clinics (59%) and 49 of 75 GPs (65%) provided attachment reports.
- In 2014-15, 12 of 19 clinics (63%) and 54 of 78 GPs (69%) provided attachment reports.
- In 2015-16, 12 of 19 clinics (63%) and 44 of 81 GPs (54%) provided attachment reports.
- In 2016-17, 5 of 20 clinics (20%) and 34 of 86 GPs (40%) provided attachment reports.

GP REFERRAL SERVICE

Patient Attachment

Confirmation of attachment is collected via monthly clinic reports; however, with no specific EMR identifier to assign to such patients, few offices are able to separate these particular individuals from the overall list of new patients. As such, there has been no attachment reported via this service for 2016-17. Overall volumes of calls and referrals do however provide a good indication of the usage of, and need for, this service.

GP Participation

- **Notable variance:** At the start of the fiscal year, there were 6 clinics or GPs on the GP referral service roster; however, this number diminished steadily over subsequent months, ending the 2016-17 year at 2.
    - This number peaked at 7 participating practices in May 2016.
    - This number decreased to only 1 clinic during December 2016 and January 2017.

Call Volumes

- The Referral Line received a total of 766 calls over the year; an average of 64 calls per month, higher than the average of 59 calls per month received during the 2015-16 year.

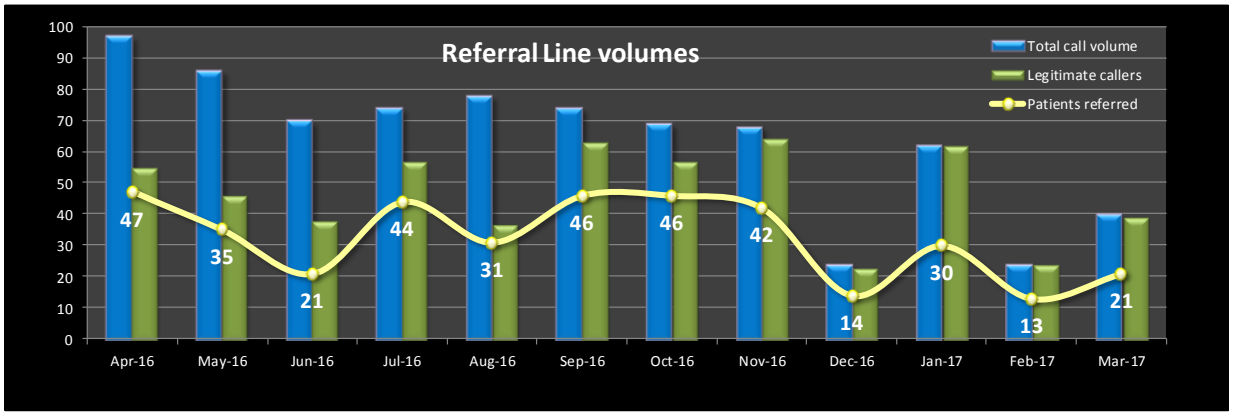
The first 8 months of calls included numerous anomalous calls and irregular call trends – potentially telemarketers or phone scams – these calls have been removed from the calculations so as not to skew program statistics.

- Of the 766 incoming calls, 201 were repeat or otherwise anomalous calls; filtering these from the calculations reduces the number of legitimate individual callers to 565.
    - Of the 565 callers, 390 (69%) were truly unattached and were offered referrals to available clinics, the same as in 2015-16.
- Peak volumes occurred in April 2017 at 97 calls; lowest call volumes were seen in December 2016 and February 2017, both at 24 calls.

Call service performance

Incoming calls to the GP Referral Line are handled in a standardized way, with a specific script provided to operators to follow. However, several significant weaknesses in other areas of the call service have been identified, including: a lack of timely reporting of call statistics to CVDFP; inability to troubleshoot irregular calls and call trends; lack of familiarity with regional geography; generally poor communications at an administrative level. Additionally, organizing the raw data collected from the service into a format that can be readily analyzed is labour intensive.

These areas of deficiency were raised with the CVDFP Board of Directors during the 2016-17 year and the decision was made to transition the GP Referral Service in-house, to be managed and monitored by division staff. This transition will take place at the second quarter of 2017-18.



REFERRAL LINE VOLUMES	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total call volume	97	86	70	74	78	74	69	68	24	62	24	40
Legitimate callers	55	46	38	57	37	63	57	64	23	62	24	39
Patients referred	47	35	21	44	31	46	46	42	14	30	13	21
Percentage unattached	85%	76%	55%	77%	84%	73%	81%	66%	61%	48%	54%	54%

Total	Max	Average
766	97	63.8
565	64	47.1
390	47	32.5
--	85%	68%

YEAR OVER YEAR TRENDS

Clinical attachment reporting

Collection and reporting of individual clinic attachment data has proven challenging, particularly for clinic staff who find the additional work difficult to fit into their already busy schedules. The number of clinics regularly reporting has diminished over time, as shown on the preceding page.

There are some larger clinics with established processes who continue to submit regular reports, and these numbers are included with the overall patient attachment count found on the following page.

GP Referral Service

Although only 9 months of data was available from year 1 of the referral service, by using averages it can be seen that 2016-17 call volumes and patient referrals were comparable with the previous year, with the percentage of truly unattached patients calling the service holding at 69%. There appears to be no correlation in the high-low call volumes when compared to the previous year.

GP participation in the referral serve has continued to decline over both years. At the outset of the program in 2015, 12 practices signed on to the GP Referral Service roster. As of March 2017 this number sat at only 2. This continually diminishing participation raises concerns regarding the sustainability of the service – further promotional efforts and targeted communications should be undertaken as the program moves in-house. Repeat and/or anomalous calls rose significantly in the past year, with 201 repeat calls made by 62 different individuals, compared to 27 repeat calls recorded in the 9 months of 2015-16 (the number of different callers making those repeat calls was not recorded at that time).

ATTACHMENT SUMMARY

Clinical attachment reporting

With GP for Me funding at an end, it has become unrealistic to expect that clinics will continue to submit monthly attachment reports. Information will continue to be collected from those clinics still reporting, and will be included in CVDFP statistical summaries, but there will be no specific expectation that clinics continue to submit reports. Because of the low numbers of reports received, patient attachment for individual GP practices will be understated.

GP Referral Service

Plans to transition the GP Referral Service in-house will not only allow CVDFP to develop a more customized, more effective service, with a greater level of engagement with community physicians, it will provide more meaningful data capture, effective troubleshooting, and the potential to grow the service to support other related programs.

Areas to monitor over the coming fiscal year include the GP participation rate and effectiveness of the new data collection mechanisms. Additional measures will be added to track the outcome of the patient referrals by way of a 60 day check-in with individual callers, and to identifying where callers learned of the service.

Conclusions

The majority of the patient attachment data sources have been sufficiently comprehensive to provide an effective appraisal of the various attachment efforts. The data and data collection process have supported CVDFP in achieving strategic priorities for the patient attachment programs; specifically, assessing of program successes as it looks to maximize attachment opportunities and, specifically in 2016-17, in assessing effectiveness of the GP Referral Service and highlighting the need for intervention.

PATIENT ATTACHMENT TOTALS

PRIMARY PROGRAMS	*To Mar 31-2013*	*2013-14*	*2014-15*	*2015-16*	*2016-17*	*Cumulative totals*
Maternity Clinic	230	84	130	96	98	638
FPHSP	56	42	42	53	56	249
ER Referral Program	n/a	n/a	16	12	0	28
Locum Program [1]	421	0	0	0	0	421
Recruitment [2]	0	0	80	0	0	80
Toll free referral line	n/a	n/a	n/a	4	0	4
Sub-total	**707**	**126**	**268**	**165**	**154**	**1420**
GP SUPPORTS						
Lake Cowichan closure	500	n/a	n/a	n/a	n/a	500
Ind. Clinic submissions [3]	n/a	1338	1543	1132	815	4828
Sub-total	**500**	**1338**	**1543**	**1132**	**815**	**5328**
TOTALS	**1207**	**1464**	**1811**	**1297**	**969**	**6748**

[1] Attachment achieved via a locum physician deciding to stay on in Cowichan and open a new full service practice

[2] Achieved via recruitment of 2 new GPs for the Lake Cowichan Community in which CVDFP played a role

[3] As of March 31-2017, 34 GPs from 5 different clinics had contributed data for the current fiscal year

Data Summary

Information Technology Program

INITIATIVE OVERVIEW

Under the Information Technology banner, CVDFP has developed the Prevalence Data Dashboard Project. The Dashboard is an EMR-based tool used to collect anonymized practice-level data from the EMRs of participating family doctors, and to collate that data into a community-level overview of target populations.

Divisions have few mechanisms available to obtain accurate statistical data on its own patient population, and this project aims to fill that void by creating a centralized, division-owned database of aggregated, regional population data, starting with the frail seniors population. The data collected by the dashboard project can be used in future to support project proposals and will provide opportunities to measure quality-improvement initiatives.

At the practice level, the dashboard will support management of common chronic diseases, improve access to billing incentives and, by standardizing data entry, create improvements in the quality of data within physician EMRs. Administration and implementation of the Prevalence Dashboard is done with the assistance of the Practice Support Program.

DATA COLLECTION PROCESS

Statistics on the Data Dashboard project are collected from the Practice Support Program Coordinators who are supporting GPs to review and organize their patient panels, and implement the dashboard.

All incoming data and data formulas are reviewed for accuracy prior to being extracted for inclusion in the CVDFP master data sheets.

Protection of personal information

- *No patient identifiers are included in the IT data collection processes; physician names are removed from statistical summaries and any publicized reports.*

IT TRENDS & COMPARISONS

With this program still in the implementation phase, there is no QI framework in place and no statistical comparisons available; however, certain stats have been collected to demonstrate engagement levels and participation levels, which will be essential to the success of this project.

GP Participation

- At the end of 2016-17, 35 individual GPs had shared their EMR data with the Dashboard, representing 44% of the 80 full service family doctors in the region at that time who had compatible EMRs.
    - Of these 35, between 8 and 10 shared data without receiving support from the PSP team.

Patient levels

- With 35 GPs sharing EMR data, the dashboard shows 182 patients across the region that are categorized as frail – rated 4 or above on the frailty scale.

IT SUMMARY

Still in its implementation phase, success of the Prevalence Data Dashboard Project will be measured initially by the level of GP participation. The greater the number of physicians sharing EMR data, the more accurate and more meaningful the data will be in creating a regional profile. Additionally, standardization of data entry will ensure the quality of data contributed to the Dashboard. Accordingly, both the participation levels and the numbers of GPs who engage with the Practice Support Team will be areas to watch for the coming year. Once implementation has concluded, additional measures and an overall data framework can be considered.

As of early 2017-18, some new functionality had been added to the Dashboard, including the ability to filter patients by geographical area, and to filter data by individual clinic. Both features will improve usability of the data for both the individual GPs and CVDFP.