REICHERT & ASSOCIATES
PROGRAM EVALUATION & RESEARCH

Final Evaluation Report
South Island & Victoria Division Partners in Care

June 2018

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South Island Division of Family Practice
A GPSC initiative

SharedCare
Partners for Patients

Victoria Division of Family Practice
A GPSC initiative

Contents

Abbreviations & Acronyms

AAU	Acute Assessment Unit
BCCA	BC Cancer Agency
ER	Emergency Room
FP	Family Physician
GI	Gastroenterology/Gastrointestinal
IH	Island Health
MOA	Medical Office Assistant
PCP	Primary Care Provider
PHN	Personal Health Number
PMH	Patient Medical Home
PiC	Partners in Care
RACE	Rapid Access to Consultative Expertise
SP	Specialist Physician
SIDFP	South Island Division of Family Practice
TiC	Transitions in Care
VDFP	Victoria Division of Family Practice

Executive Summary

Introduction

Initiated in December 2011, the Partners in Care (PiC) Project was a collaborative undertaking involving a partnership between the South Island and Victoria Divisions of Family Practice (SI/VDFP). This work was funded by the BC Ministry of Health and Doctors of BC through the Provincial Shared Care Committee.

The PiC project aimed to provide physicians with a supportive environment to come together to improve working relationships and communication processes. The core objectives were to:

- Create an environment that encourages and supports the rebuilding of relationships between Family Physicians (FPs) and Specialist Physicians (SPs).
- Facilitate opportunities for FPs and SPs to collaborate on developing practical and sustainable solutions to improve patient care, as well as enhancing their own professional satisfaction.

This report includes evaluation findings from the third and final phase of the project, along with perspectives from phases I and II evaluation efforts.

Key Phase III Project Activities and Associated Evaluation Activities

The SI/VDFP PiC team held bi-monthly Steering Committee and project-specific working group meetings in addition to the key activities outlined below:

Key Project Activity	Evaluation Activities
February 2016 Multi-Stakeholder Oncology/Primary Care Forum	n/a
October 2016 Cross-Project/Program Knowledge Lounge	n/a
October 2016 Multidisciplinary World Café Pearls Event	Post-event survey & follow-up survey
October 2017 Oncology World Café	Post-event survey & follow-up survey
November 2017 Cross-Discipline Engagement Event	Post-event survey & follow-up survey
March 2018 Maternity-Specific World Café	Post-event survey

Post-event surveys assessed the impact of events on participants perspectives/knowledge. **Six-month follow-up surveys** assessed whether event learnings were retained and if they impacted practice changes. In addition to surveys associated with the events above, the **Baseline FP Referral Survey** was distributed in June 2016 to evaluate FP perception and satisfaction with existing referral systems and processes. Additionally, the **RACE FP User Survey** was distributed in September 2016 to assess satisfaction and effectiveness of the app. Finally, questions were added to the **Perinatal Services of BC Survey** to assess reach and uptake of the maternity referral forms and algorithm.

Additional evaluation methods included **interviews** conducted with key stakeholders, a **document review**, and **administrative data review** for the RACE app. Limitations including potential selection and responses biases were mitigated by using multiple lines of evidence. Findings were analysed in the context of the SI/VDFP PiC central objectives and the Shared Care Committee Triple Aim approach.

Evaluation Findings: Operation and Engagement

A Steering Committee (SC) oversaw the implementation of the PiC project and provided guidance to four Phase III working groups/advisory panels: maternity, medical imaging, oncology, and gastroenterology (initiated in Phase I). The SC also supported the work of Phase I/II working groups as they transitioned to a sustainable model (orthopedics, cardiology, neurology, plastics, and gastroenterology).

Key informants noted that SC operations matured over time, and that Phase II represented the project's "peak". Phase III involved challenges such as funding restrictions and fatigue among SC members. The

working groups reported varying levels of success in Phase III; notably Medical Imaging and Oncology had significant challenges operationalizing, whereas Maternity was reported to be the most successful of the working groups. The Maternity group was successful in joining RACE, hosting a World Café, actively participating in the November 2017 Engagement Event, and developing a new referral process.

Evaluation Findings: Project Outcomes

Objective	Evidence of Progress
Building Relationships between FPs and SPs	✓ Key informants reported that Phases I and II unequivocally met the goal of relationship building between family physicians and specialists, most notable through 'Pearls and Dine and Learn' events. ✓ In Phase III, engagement events were reported to promote dialogue and relationship-building, although less so compared to previous phases. ✓ The dialogues initiated in Phase III laid a foundation from which the project could begin to form solutions (e.g. clarifying GI issues, leading to a new referral process). ✓ On Phase III post-event surveys, when asked about the most valuable portion of the event, the most common response centred around the opportunity to build relationships, network, and discuss issues face-to-face.
Developing Practical and Sustainable Solutions to Improve Patient Care and Enhance Professional Satisfaction	***Implementing RACE*** ✓ Key informants reported that the major benefit of RACE is that it makes calling specialists more approachable. ✓ 73 of 78 respondents to the FP RACE User Survey (94%) reported that they were satisfied with the RACE app. 72 of 78 respondents (92%) reported that they were satisfied with their interaction with the specialist. In all cases where the physician was not satisfied with their interaction (n=6), the call was marked as unanswered. ✓ As of May 31, 2018, there are a total of 570 health care providers currently registered to access the RACE app (402 FPs/FP residents and 47 nurse practitioners). There are currently 121 specialists registered with the SI RACE app. ✓ Currently, 12 speciality areas are providing coverage through the local SI RACE line. Eight of these specialities joined the app during Phase II of the PiC project with a further four signing up during Phase III.

	Developing Referral Best Practices and Primary Care Pathways
	✓ A new GI referral process and primary care Pathways were developed as part of the PiC project. Through educational efforts at the November 2017 Engagement Event, participants learned to adopt the new changes. For example:
	  ✓ In the six-month follow up survey, 67% of respondents (10 of 15) had identified that they used at least one GI pathway that they learnt during the session.
	  ✓ 40% of respondents (6 of 15) felt that their GI referrals have been more appropriate.
	✓ Through the PiC project, the Maternity working group developed the new Acute Assessment Unit (AAU) referral system, which has reportedly allowed for more communication and more shared care for maternity care.
	  ✓ In the post-event survey, respondents (n=12) reported several changes they intend to make in their practice, including improving specialist referrals and/or consultations.

Improving Patient Care	✓ In addition to indirect evidence of practice changes that would support improvements in patient care, key informant interviewees told six specific stories of how SI/VDFP PiC initiatives had directly contributed to patient care improvements, notably through RACE coverage, GI primary care Pathways, and the new Maternity Clinic referral process.
Enhancing Professional Satisfaction	✓ RACE GPs reported that RACE made them feel empowered and more confident treating their patients. RACE SPs indicated that RACE has not significantly impacted their workload, and that they are satisfied with the application. ✓ Key informants reported that modifications to referral processes have streamlined processes, giving involved parties more confidence that things will go according to plan.

Promoting Practice Changes	✓ Respondents indicated that, as a result of the various Phase III events, they intend to make several practice changes. For example, 100% of FP respondents to the 2016 Multidisciplinary World Café "agreed" or "strongly agreed" that the Pearls shared at the event were relevant to FPs (83 of 83); 100% also indicated that they will use the Pearls in their practice (83 of 83).

Discussion

Key Strengths and Successes:	Key Challenges:	Lessons Learned:
• Strong leadership from the SIDFP and VDFP project leads • Strong funding support in Phases I and II • Having the right people at the table (FPs and SPs) • Having the data and information to establish objectivity and move forward with productive conversations • Relationship-based events, which support connections, learning, and practice changes	• Funding changes that changed the project direction • Team fatigue/demoralization • Goal clarity across the SC and several working groups • Varying levels of success at the working group level (notable challenges in Medical Imaging and Oncology) • Resistance from key players in operationalizing process changes • RACE uptake from FPs, and insufficient promotional efforts	• The importance of strong project management • The value of engagement events • The importance of objective data • The importance of having all the right voices at the table • The value of adopting provincially led projects • The importance of ongoing education efforts

Key informants noted that sustainability is "to be determined". While some portions of the initiative will be sustainable, such as RACE and the Pathways developed for GI, the outlook on Medical Imaging and Oncology efforts is unclear, as they are not yet at a stage to be discussing sustainability. The Maternity Working Group's collaboration with Growth Health was reported to support sustainability, although there are uncertainties with respect to whether the referral process will be sustained.

In terms of spread of the SI/VDFP PiC initiatives, little is in place currently to spread and share what has been learned. However, key informants indicated that some of the initiatives and efforts from SI/VDFP PiC have already spread to other areas. For example, the project team reported having received calls from a team in Newfoundland that was looking at adopting the SI/VDFP PiC approach. As well, other communities have adopted the Pearls event format (e.g. Northern Interior Rural Division).

Conclusion

The SI/VDFP PiC project reached a mature stage during its third phase, building on the work of Phases I and II. While stakeholders reported that the project was in its prime during the second phase, several key accomplishments were achieved during Phase III and done in the face of challenges such as funding restrictions and burnout among key team players. Key informants highlighted that a major strength of the project was its relationship-based approach, especially the series of World Café/Pearls events that hallmarked Phases I and II of the project. Despite challenges, evaluation findings indicated that Phase III events were successful in promoting the development of relationships between FPs and SPs and promoting practice changes. In addition, evaluation findings reflected progress on the second PiC objective of developing practical and sustainable solutions to improve patient care and enhance professional satisfaction. While outlooks on sustainability varied by initiative, key informants were optimistic about the sustainability of several accomplishments, including RACE coverage in the South Island/Victoria area, gastroenterology primary care Pathways, and Maternity referral improvements. Illustrating the value of the PiC model, several other communities have looked to SI/VDFP to replicate their approach.

About the Project

Partners and Funders

The Partners in Care (PiC) Project was a collaborative undertaking involving a partnership between the South Island and Victoria Divisions of Family Practice (SI/VDFP). The initial phase of the project commenced in December 2011. This work was funded by the BC Ministry of Health and Doctors of BC through the Provincial Shared Care Committee.

Project Aims

The PiC project aimed to provide physicians with a supportive environment to come together to improve working relationships and communication processes, and to offer knowledge transfer opportunities to physicians. A variety of specialties were supported by the project to invite key stakeholders to participate in working groups and discussion panels to guide and develop the project work specific to the strengths and challenges of that specialty area.

The core objectives of the PiC project were to:

- Create an environment that **encourages and supports the rebuilding of relationships** between Family Physicians (FPs) and Specialist Physicians (SPs).
- Facilitate opportunities for FPs and SPs to collaborate on **developing practical and sustainable solutions** to improve patient care, as well as enhancing their own professional satisfaction.

Previous Phases

In working towards meeting these objectives, Phases I and II engaged key stakeholders to promote collaboration across individual specialities. This work was accomplished through completion of PDSA cycles designed to improve referral processes, delivery of care, and communication Pathways within orthopaedics, cardiology, plastic surgery, neurology, and gastroenterology. Phase II also involved establishing a partnership with the Province and Surrey North Delta Rapid Access to Consultative Expertise (RACE) projects, which resulted in the launch of the regional South Island RACE App in December 2015.

Phase III

Phase III of the SI/VDFP PiC project aimed to build on the strengths and successes experienced throughout phases I and II by continuing to support collaborative working relationships with community partners and reinforcing physician engagement. Specifically, Phase III focused on:

- **Continued Support and Development of RACE:** collaboration with the Provincial RACE committee in developing a sustainable support mechanism for the established regional RACE service(s).
- **Expansion of the Phase I & II Initiatives and Learnings to New Specialty Areas:** Oncology, Maternity, and Medical Imaging.
- **Transitioning Phase I & II Specialties to a Sustainable Model:** utilizing PDSA cycles to streamline and standardize the specialty referral/consultation process.

Key Phase III Project Activities

In addition to the key project activities summarized below, the SI/VDFP PiC team held regular (bi-monthly) Steering Committee and project-specific working group meetings.

Multi-Stakeholder Oncology Survivorship and Primary Care Forum

A joint multi-stakeholder event was held in February 2016 in collaboration with the BC Cancer Agency (BCCA) Primary Care and Survivorship program. It provided an opportunity to hear from Primary Care Providers (PCPs), Oncologists, Patients, Caregivers, and community partners in an open forum. Based on barriers and challenges identified by event participants, an oncology process diagram was developed, and four priority discussion topics were set; these were adopted by the oncology working group.

Knowledge Lounge

In October 2016, a cross project/program "Knowledge Lounge" was held to showcase the multiple projects underway throughout the South Island and Victoria Divisions of Family Practice. The purpose of the event was to clarify and solidify partnerships and collaboration among FPs and various community initiatives.

World Café/Pearls Events

Also in October 2016, a multidisciplinary World Café Pearls Event was held. During the event, SPs from various disciplines were invited to share knowledge to support the ability of FPs to provide care within their own practice (*post-event and six-month follow-up surveys are described on page 9*).

An oncology-specific World Café was held the following fall, in October 2017. The event provided an opportunity for Oncology specialists to share knowledge with FPs, increasing their capacity to provide care and to navigate the oncology care system (*post-event and six-month follow-up surveys are described on page 9*).

In March 2018, a Maternity World Café event was hosted to promote information exchange and relationship-building among healthcare providers who play a role in maternity care, including midwives and FPs (*post-event survey is described on page 9*).

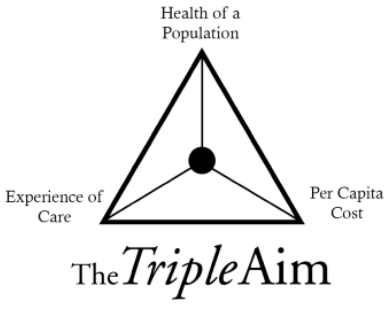
Engagement Event

On November 1st, 2017 a cross-discipline engagement event hosted FPs and SPs from palliative care, gastroenterology, ophthalmology, and maternity. The event was entitled 'Paving a Partnership Pathway – Building the Path to Partnership'. It allowed participants to exchange knowledge across multiple disciplines and provide feedback on various components of the primary care Pathways (*post-event and six-month follow-up surveys are described on page 9).*

About the Evaluation

The evaluation was initiated at the start of the project and operated concurrently with funding cycles. The evaluation was designed to comment on the project's operations and outcomes to support alignment between the program's stated goals and objectives and the Triple Aim approach identified by the Shared Care Committee:

1. Improve the health of the population
2. Enhance patient and physician experience
3. Reduce the per capita cost of healthcare (i.e. system efficiencies)



Evaluation Methodologies

The following is a description of key methodologies used to support evaluation findings, including surveys, key informant interviews, a document review, and an administrative data review.

Surveys

Surveys administered to healthcare providers and their sample sizes are summarized in Table 1 on page 10. The following is a more in-depth description of the survey tools used.

Baseline FP Referral Survey (June 2016): To evaluate FP perception and satisfaction with the existing referral systems and processes, a survey was distributed to all community FPs between April 6 and June 15, 2016. The survey included both categorical and open-ended questions and was designed to capture clarity of the current status of the 3 referral processes associated with Medical Imaging, Oncology, and Maternity. The survey focused on identifying challenges and gaps in care, and satisfaction with existing communication channels between community FPs and SPs. Results from the survey were used to support project planning.

RACE FP User Survey (September 2016): An FP Survey was conducted with physicians registered with RACE to assess satisfaction and effectiveness of the app. The survey included categorical questions and was designed to capture overall satisfaction with the app, the impact of the calls made to specialists, timeliness of contact, and whether the advice provided by the SP had either eliminated an Emergency Room (ER) visit or negated the need for a SP referral.

Post-Event Surveys: To assess the impact of events on participant perspectives and knowledge levels, as well as attendee satisfaction with events, a unique survey was developed for each of the following events:

- October 2016 – Multidisciplinary World Café/Pearl event
- October 2017 – Oncology World Café/Pearl Event
- November 2017 – Physician Engagement Event
- March 2018 – Maternity World Café

Six-month Follow-up Surveys: To assess the extent to which event learnings impacted attendees' practices, and the extent to which attendees retained learnings, additional follow-up surveys were distributed six months following events. Note that a six-month follow-up survey was not completed for the March 2018 Maternity Engagement Event, as six-months did not pass before the project ended.

- April 2017 – Multidisciplinary World Café/Pearl event follow-up survey
- June 2018 – Oncology World Café/Pearl Event follow-up survey
- June 2018 – Physician Engagement Event follow-up survey

Perinatal Services of BC Survey: Two questions were added to a provincial Perinatal Services of BC survey to assess the reach and uptake of the maternity referral forms and algorithm. The survey was sent to 120 primary care providers (FPs and midwives) in June 2018 via Island Health. 45 people opened the survey, and 19 provided a response (Table 1).

Table 1. Sample sizes and response rates for surveys

Instrument	Date	Number of Respondents	Response rate
Baseline FP Referral Survey	April 6 - June 15, 2016	n=59	*unknown*
FP RACE User Survey	December 2015 - September 2016	n=78	82%
Post-event Surveys			
Multidisciplinary World Café/Pearl event	October 2016	n=90	83%
Oncology World Café/Pearl Event	October 2017	n=37	100%
Physician Engagement Event	November 2017	n=53	85%
Maternity Engagement Event	March 2018	n=32	100%
Six-month follow-up surveys			
Multidisciplinary World Café/Pearl event	April 2017	n=37	44%
Oncology World Café/Pearl Event	June 2018	n=8	22%
Physician Engagement Event	June 2018	n=18	51%
Perinatal Services of BC Survey	June 2018	n=19	16%

Key Informant Interviews

Interviews were semi-structured and conducted over the phone. A semi-structured guide included open-ended questions that enabled interviewees to comment on pre-determined issues while providing an opportunity for them to raise previously unidentified issues or to emphasize a given issue in a more flexible, conversational style. All interviewees were identified in collaboration with project staff:

- **Interim interviews:** In May and June 2017, the evaluation team conducted three semi-structured interviews with key informants from: the steering committee, the Medical Imaging project, and the Oncology project. Key informant interviews provided information on gaps and challenges related to the goals and objectives of each project; they also acted as a source of information on the patient experience with respect to the project and its objectives.
- **Final interviews:** In May 2018, 11 interviews were completed as part of the final evaluation process. Interviewees commented on their experience with the project, the project's outcomes, and the sustainability of the project moving forward. Interview respondents included:
    - 3 steering committee members
    - 2 maternity working group members
    - 1 oncology working group member
    - 1 GI working group member
    - 2 frequent FP users of the RACE app
    - 2 covering SPs on the RACE app

    In addition to final interviews completed as part of the SI/VDFP final evaluation. The evaluation accessed data from two interviews conducted as part of the VDFP Transitions in Care (TiC) project evaluation. VDFP interviewees included an FP RACE user, and an SP RACE physician.

Document Review

The evaluation team accessed and reviewed the following project documents:

- The SI/VDFP PiC Proposal
- Community Engagement Working Group summaries
- Working group action items
- Steering committee minutes
- Project Lead's notes

Administrative Data Review

The evaluation accessed analytics from the RACE application via the PiC project lead. Data from the RACE app was collected by the project team on an ongoing basis to track changes in patterns related to use. The monthly tracker collected data on the number of participating FPs, SPs, and nurse practitioners, the

total number of calls made, and the number of calls made to each speciality area. Administrative data provided quantitative information on use of the app, which was analyzed in concert with qualitative data on user experiences with the app.

Analysis

All findings were analysed in the context of the SI/VDFP PiC project's central objectives, and with attention paid to gaps in the referral processes that these objectives were designed to address. The evaluation findings have also been analyzed with attention paid to alignment with the Triple Aim approach identified by the Shared Care Committee.

Limitations

Overall, limitations to the evaluation were minimized through the use of multiple lines of evidence, including project documents, administrative data, interview data, and survey data at multiple time points. The use of different data sources increases the reliability and validity of the evaluation findings.

Survey limitations:

Possible selection bias in the response to surveys could influence results. Although response rates were high for post-event surveys, six-month follow-up surveys tended to have lower response rates. As a result, it is possible that respondents to these surveys were fundamentally different from non-respondents (e.g. more engaged in the project, more likely to make practice changes, etc.). In addition, as participants were asked to self-report certain behaviours on the survey, the potential for social desirability bias could also have served as a limitation.

As noted by survey respondents, and one individual who declined to participate in the survey, recall bias is a strong possibility in six-month follow-up surveys. In an email received in response to a six-month survey link that was sent, a respondent wrote back with the following: *"The fact is I learn the details I need to take care of patients many different ways, and can't remember exactly where I picked up each one…The information gets combined with what I already knew and what I've learned since, from medical school to previous talks to what I've looked up or seen in consults before and after, to create a greater understanding of the disease process and how it's handled in our system at this point in time. I can't go back and figure out what I would know or understand without this presentation, never mind remember specific instances in patient care where that piece of knowledge was key."*

To minimize social desirability bias, participants were assured that surveys were voluntary and confidential; surveys also did not ask any identifying information. Although six-month follow-up surveys have significant limitations, they were designed to act as a supplement to post-event surveys, and results were analyzed within the context of the post-event survey findings. High response rates for the initial post-event surveys add reliability to the results overall.

Key stakeholder interview limitations:

A limitation associated with the use of in-depth interviews with stakeholders who have been closely involved with the project is the potential for a response bias, such as social desirability or recall bias. This may make it challenging for interviewees to provide information that is entirely objective.

To mitigate possible influences of bias, all interviewees were asked similar questions to ensure that each area of interest took into consideration multiple stakeholder perspectives when analyzing response data. Additionally, interviews and analysis of interview data was done by external evaluators.

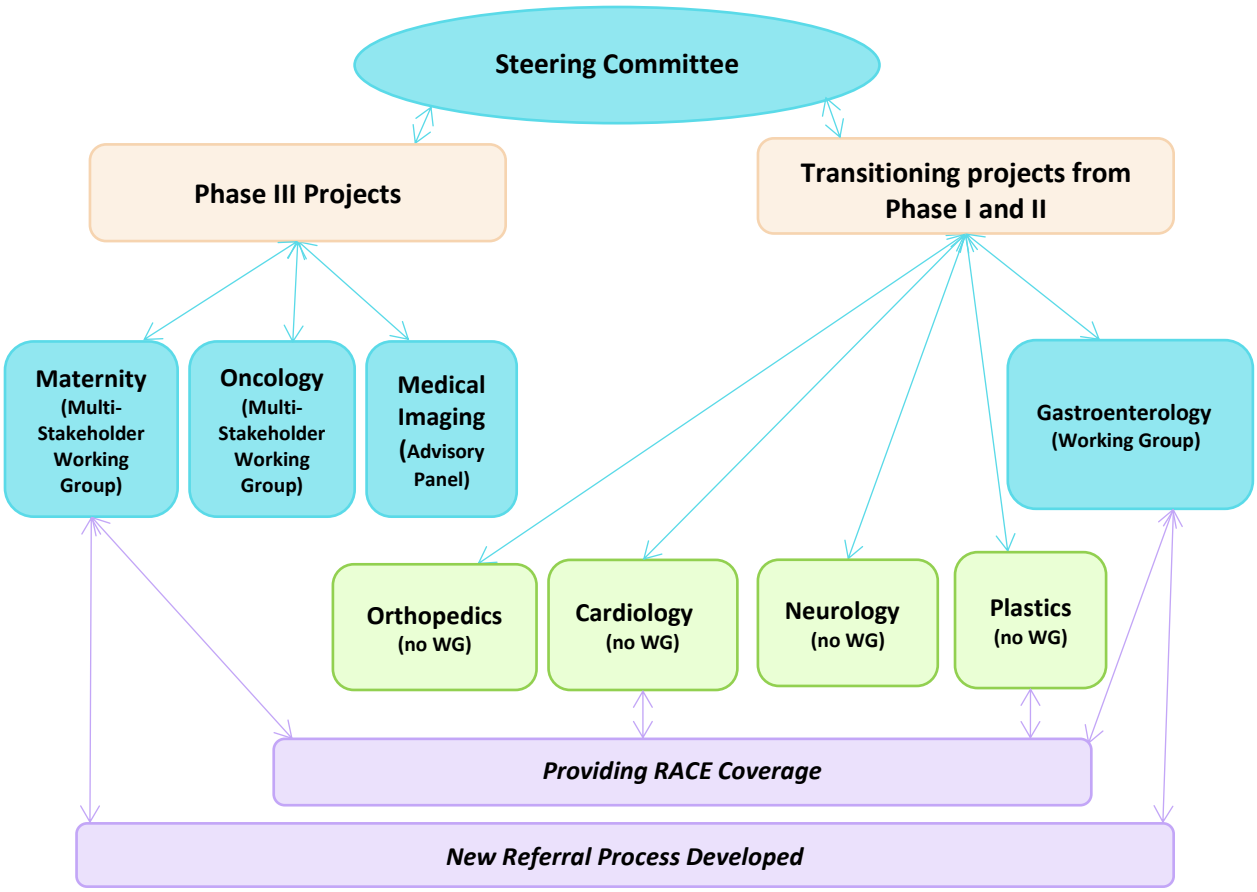
Evaluation Findings: Operation and Engagement

The implementation of the PiC project was overseen by a Steering Committee, which consisted of:

- Family physicians from South Island and Victoria Divisions
- 2 specialist physicians
- Executive Director of the South Island Division
- Shared Care representative from Victoria Division
- Shared Care PiC Project Lead
- Shared Care Initiative Lead
- Island Health representative

The purpose of the committee was to provide oversight to the overall project. Over the course of Phase III of the project, the steering committee provided guidance to four working groups: maternity, medical imaging, oncology, and gastroenterology (Figure 1).

Figure 1. SI/VDFP PiC Organizational Structure: Phase III



Key informants who had been involved in the PiC project since its inception in Phase I noted that the Committee's operations matured over time. They noted that, in the beginning, the Steering Committee members were simply working with the intention of changing relationships. Whereas by the end of the third phase, the project had matured and had concrete outcomes to show. The consensus among interviewees was that the project reached its peak around the end of Phase II, and that during Phase III, challenges began to arise due to funding restrictions and fatigue among committee members (see *Challenges* for further discussion; page 27).

With respect to stakeholder engagement, interview data indicated that, while the majority of key stakeholders were at the table, further collaboration with the Health Authority (e.g. through specialists and FPs involved in hospital work) could have been of benefit to the steering committee.

Among the working groups associated with PiC's Phase III, interviewees reported variable levels of operational success:

Maternity Multi-Stakeholder Working Group

Interviewees reported that the maternity working group made the most progress of all the working groups in Phase III. It was reported to be a very supportive and collaborative. Respondents also noted that it had the right people at the table. Interviewees indicated that these factors, along with strong leadership from the PiC project lead, supported the success of the Maternity initiative.

Key accomplishments of the maternity working group included developing a new Acute Assessment Unit (AAU) process and referral forms, as well as joining RACE, hosting a Maternity World Café, and actively participating in education and engagement efforts at the November 2017 Engagement Event.

Gastroenterology Working Group

The gastroenterology group (initiated in Phase I) was reconvened in Phase III around the reassessment of the GI referral centre and development of new care Pathways for patients being referred to the GI clinic. It was identified by stakeholders that this working group had effective operations to support delivery on their objectives, and that the necessary people were engaged.

Key accomplishments of the gastroenterology working group included developing the new GI Central Referral Triage process (developed in Phase I and enhanced through Phase III efforts), developing 5 primary care Pathways, joining RACE, and actively participating in education and engagement efforts at the November 2017 Engagement Event.

Medical Imaging Advisory Panel

The medical imaging advisory panel also reported having effective operations at the time of their operation, but the panel became largely inactive throughout the second half of Phase III.

While active, the working group was successful in the engagement stage of the project. They determined focus areas and collaborated with key partners to ensure that work was not duplicated, such as the "Choosing Wisely" work being done through Island Health's Quality Assurance portfolio. While the Advisory Panel received confirmation and approval from Respirology and Medical Imaging to implement a Pulmonary Embolism Algorithm, the algorithm was ultimately not implemented due to challenges translating it into the Smart Form format, which would allow it to be compatible with existing processes used within Island Health.

Oncology Multi-Stakeholder Working Group

The oncology working group was not able to operationalize substantially during the project timeline. As a result, the working group is currently pursuing other funding opportunities. Respondents noted that the working group may have benefited from additional stakeholder perspectives (e.g. a community family physician and medical oncologist); although, they noted that they took their approach to maintain the efficiency of a small committee, and that this was appropriate for their stage in development.

The Oncology working group was successful in hosting an Oncology World Café event during Phase III.

Evaluation Findings: Project Outcomes

Building Relationships between FPs and SPs

Evaluation findings indicated that the working groups and events fostered relationship-building between FPs and specialists. However, it was noted that while this goal was well met in the first and second phases, it was less of a key outcome for Phase III. Interviewees indicated that there was a desire for such partnerships between specialists and FPs in all three phases, and that learning each others' needs and wishes was extremely helpful for both parties. By building these relationships and fostering discussions, respondents noted that they were able to identify gaps and challenges and begin a dialogue to form solutions. Interviewees pointed out that the process of relationship-building was an essential step in the Partners in Care project.

On feedback forms following Pearls, World Café, and Engagement events, respondents were asked about the most valuable outcomes of the event. In response to this question, **respondents commonly reported relationship-based or collaboration-based factors as the most valuable event components**:

- October 2016 Pearls/World Café: **Relationship-building and networking** were reported as valuable outcomes of the event. Survey data also shows that **99% of FP respondents (82 of 83) reported improved capacity to provide shared care as a result of attending the event**.
- October 2017 Oncology World Café: When asked about the most valuable part of the event, respondents provided a variety of responses, including **meeting and interacting with specialists and staff (4 of 30), the opportunity to discuss and ask questions (n=7),** and **the small group format** (n=5).
- November 2017 Engagement Event: When asked to comment on the most valuable part of the event, the majority of respondents (24 of 36) mentioned the **opportunity to network, interact with SPs/colleagues,** and/or **have group discussions**.
- March 2018 Maternity World Café: When asked about the most valuable aspect of the event, respondents (n=26) provided a variety of responses, **including the round table/small group format of the event** (n=10), **learning and sharing information in a multidisciplinary setting** (n=3), and **conversing with colleagues** (n=2).

> "**Chance to hear directly from specialists in a multidisciplinary setting** about common problems and come up with consistent approach."
>
> *- Family physician on most valuable aspect of an event*

In the six-month follow up survey to the November 1 Engagement Event, **31% of respondents (5 of 16) indicated having collaborated with a new contact they met at the event in the previous six months**. Respondents at this time again reflected on the networking opportunity that the World Café presented them (n=3), highlighting variously that it was "wonderful," "collegial," and "very helpful." Similarly, **25% of respondents (2 of 8) to the oncology follow-up survey respondents indicated having collaborated with a new contact they met at the event.**

Within each project area, specific comments on relationship-building highlighted how this goal was the foundation to addressing the gaps identified at the outset of the project and meeting the other project objectives. For example, the gastroenterology working group supported GI specialists and FPs to move from blaming one another to developing solutions together. One key informant indicated that they would rate the improvement on the goal of building relationships between FPs and SPs as a transition from *"5% to 60 or 65%"*, and that *"given the challenges, this was a huge improvement."*

Example of misunderstanding between GPs and GI SPs:

"The story that comes to mind is the story of the patient who starts having symptoms with anemia and abdominal pain and it takes months to get in with GI and it turned out the patient has cancer and the patient dies. To the working group, the FP was saying that they referred, but the GI was saying that if the FP had suspected that the patient had cancer, then the FP should have done more testing. But the FP referred to the GI." - key informant

For maternity care providers, the PiC working group was reported to represent the first time specialists and FPs had an opportunity to get together and discuss challenges and solutions in a supportive environment. And thirdly, the RACE app by design provides opportunities for increased connection between SPs and FPs. See *Developing Practical and Sustainable Solutions* below for further discussion on RACE.

Developing Practical and Sustainable Solutions

The second objective of the PiC project was to develop practical and sustainable solutions to improve patient care. This was accomplished through the implementation and expansion of RACE, as well as the development and refinement of referral forms and processes for gastroenterology and maternity.

Implementing RACE

Key informant interviewees were optimistic about the utility of RACE. Indeed, FP and SP users of RACE reported in their interviews that the application was simple to use, and it helped them provide patient care. The biggest impact from the perspective of key informants was that **it makes calling a specialist more approachable**. Key Informant FP users reported feeling comfortable calling RACE, as they know whoever is on the line is ready to accept the call.

Primary uses of RACE reported by key informants included:

- Getting advice about:
  - Investigating/managing patients
  - Treatment options
- Asking non-urgent clinical questions
- Confirming their approach

"I'm really glad it exists. I rely on it; **it's part of my pattern of use.**"

- Frequent GP user of RACE

Key informant interviewees noted that patients also like RACE, as they can get advice from specialists without waiting months and months. Feedback from respondents to the RACE FP User survey and key informant interviewees suggested that the app leads to quicker access to consultation with SPs and fewer referrals to SPs and/or the ER.

Using the example of gastroenterology, interview data indicated that there are other reasons why it can be preferable to use RACE rather than make a referral: *"Often when we see patients its for IBS, it's about*

education and our specialists' offices are not designed for long-term follow up of these issues", making the FP office a more appropriate care setting anyway.

44% of respondents (7 of 16) to the November 2017 Engagement Event 6-month follow-up survey indicated having **used RACE for a patient who, in the past, they would have referred**.

Since December 2015, the number of physicians registered with RACE has grown considerably. **As of May 31, 2018, there are a total of 570 health care providers currently registered to access the RACE app (402 FPs/FP residents and 47 nurse practitioners). There are currently 121 specialists registered with the SI RACE app.** Between December 2015 and May 2018 (30 months), there have been a total of 649 calls to the RACE line, initially averaging 10 calls/month, and now averaging 30+ calls/month, representing over a 150% increase in call volume over the 2.5 years that RACE has been in operation in the South Island/Victoria region.

Currently, 12 speciality areas are providing coverage through the local SI RACE line. Eight of these specialities joined the app during Phase III of the PiC project with a further 4 signing up during Phase II. Two specialities that joined in Phase III (Emergency/ER and Electrophysiology; not included in the total) elected to discontinue coverage due to lack of call volume, however may reconsider future involvement. Efforts to recruit SPs from other areas are ongoing (i.e. Medical Imaging, Rheumatology and Nephrology).

Finally, version 2.0 of the app was launched successfully in late August of 2017, affording users access to a further 13 provincially covered specialties, and also providing covering specialists with the required patient demographics for billing purposes.

In the September 2016 RACE user survey, family physicians using the RACE app reported being satisfied with their experience using the RACE app

- 73 of 78 respondents (94%) reported that they were satisfied with the RACE app.
- 72 of 78 respondents (92%) reported that they were satisfied with their interaction with the specialist. In all cases where the physician was not satisfied (n=6), the call was marked as unanswered.

RACE users indicated in their comments that the app is easy to use, and that they were directly connected to specialists with less hassle than traditional methods (i.e., calling hospital switchboard or connecting to specialists using MOAs).

While users of RACE report a high degree of satisfaction with the application, key informants reported challenges in uptake of the app, lessening its potential impact (see *Challenges* on page 27). Key informants attributed the low uptake of RACE to suboptimal promotional efforts. Physicians at the October 2017 Multidisciplinary Pearls event indicated on their post-event evaluation form that they had not yet signed up for RACE for the following reasons:

- Inadvertent postponement in signing up (forgetful of app, procrastination, etc.) (n=7)
- Unaware of app before the event (n=4)
- Technical difficulties occurred when attempting to join (n=3)
- RACE not perceived as useful in specialised practice (i.e. travel medicine) (n=2)

Developing Referral Processes and Pathways

Gastroenterology

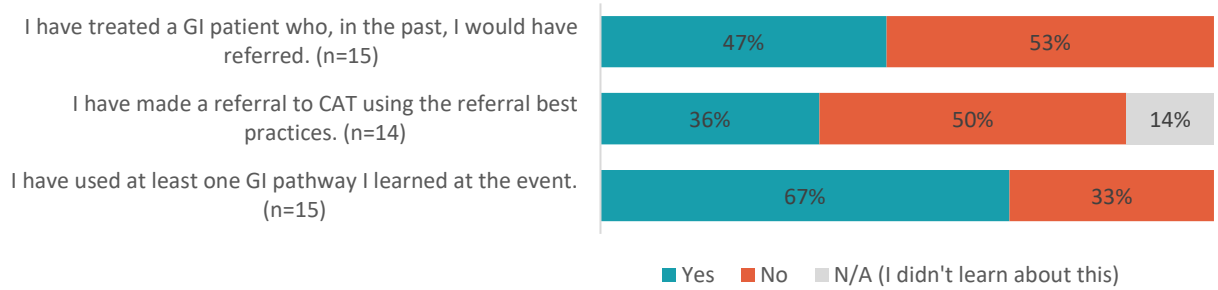
Key informant interviewees noted that, prior to the project, there were significant challenges with the large volume of referrals being received by gastroenterology, and with FPs not filling out forms correctly. Because of these challenges, there was an impetus to modify referral patterns. In Phase I, the SI/VDFP PiC project initiated efforts to improve the completeness and appropriateness of referral forms. Efforts included distributing newsletters, holding evening education sessions, and educating through word of mouth. Phase I also involved the development of the unique **GI Central Referral Triage Process**.

In response to complaints from FPs with respect to the new referral process, the Phase III team initiated efforts to improve the dialogue between FPs and specialists, to maintain relationships, clarify challenges, and establish solutions. With PiC support, the GIs came up with **the Pathway System, involving five guidelines for how FPs can handle certain general cases without referrals,** including calling SPs through RACE. These Pathways were designed to enhance and supplement the Phase I Central Referral Triage Process based on identified gaps. The new process included a mandate that nonurgent referrals are to be reviewed within 14 days, at which time, the triaging staff do one of three things: make suggestions to the FP, reject, or forward them to an enhanced pathway. The aim was to reduce volume of referrals, and especially inappropriate referrals.

Education around these GI referral changes and primary care Pathways was done at the November 2017 Engagement event. In the post-event survey, respondents were asked what, if anything, they intended to do differently in their practice as a result of what they learned. The most common responses after the event included using/modifying their use of GI Pathways, algorithms, and/or referrals. Six months later, in the follow-up survey:

- 67% of respondents (10 of 15) used at least one GI Pathway that they learnt during the session
- 36% (5 of 14) reported to have made a referral to CAT using the referral best practices
- 47% (7 of 15) indicated that they had treated a GI patient who they would have referred before the session (Figure 2).

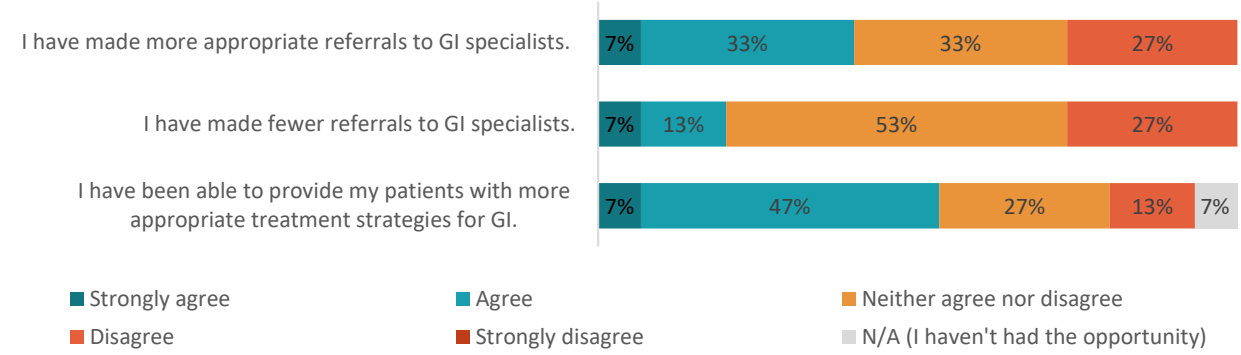
Figure 2. Based on learnings from the November 2017 Engagement Event, have you made any of the following changes in the past 6 months...?



More generally, although only 20% (3 of 15) of respondents reported having made fewer referrals since the November 2017 Engagement Event, 40% of respondents (6 of 15) felt that their referrals were more appropriate (Figure 3). According to key informants, a possible reason for not changing referral patterns

is that FPs do not always have time to sit down and go through the referral system with their patient, and the FP also has to be able to explain to the patient why they can't see a GI, which can be challenging.

Figure 3. Since the GI World Café event...?
(n=15; 6-month follow-up)



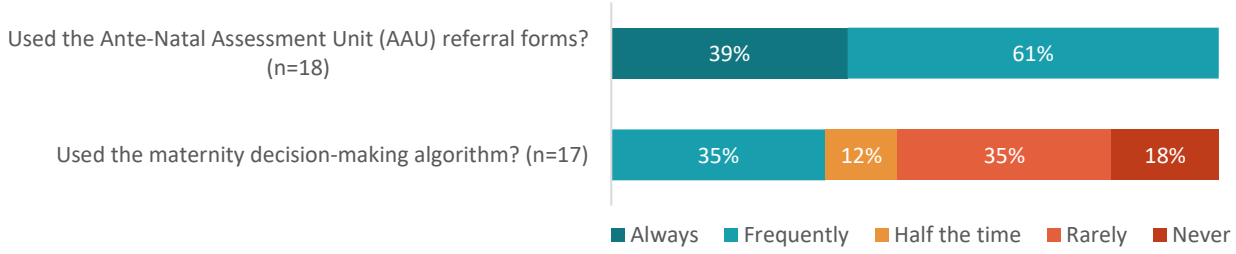
Maternity

For Maternity, interview respondents indicated that the biggest impact of the project was an improved referral process: the new **Acute Assessment Unit (AAU) referral system**. As one respondent shared, the project *"made us figure out what we are actually doing, what the patient was getting"*. Through these discussions, it was clarified that many referrals were being sent back to family care from the clinic, and that some patients were waiting 2-3 days before they were even triaged. Understanding the patient flow allowed them to establish an improved process for referrals. Reportedly, the new referral system has allowed for more communication, more shared care for maternity care, as well as more timely referrals. The new trial process involved the development of care algorithms, and a simplified paper form designed to ensure completeness of information (see Maternity Logic Model in Appendix A). Interviewees from the Grow Health clinic confirmed that the new process allows for fewer, more streamlined consults and better coordination of care.

> "We used to get referrals for twin patients. Sometimes at 8 weeks other times at 28 weeks. It was inconsistent. Now we're seeing pretty much all twins before 16 weeks. **Now it's no longer a scramble to catch-up on info**...and where they're at."
>
> *- Key informant on the benefits of maternity process*

Respondents in a provincial Perinatal Services of BC survey indicated that they have always or frequently used the AAU referral forms (Figure 4). However, the decision-making care algorithm has had lower use, with over half of respondents (9 of 17) never or rarely using it in the past 6 months.

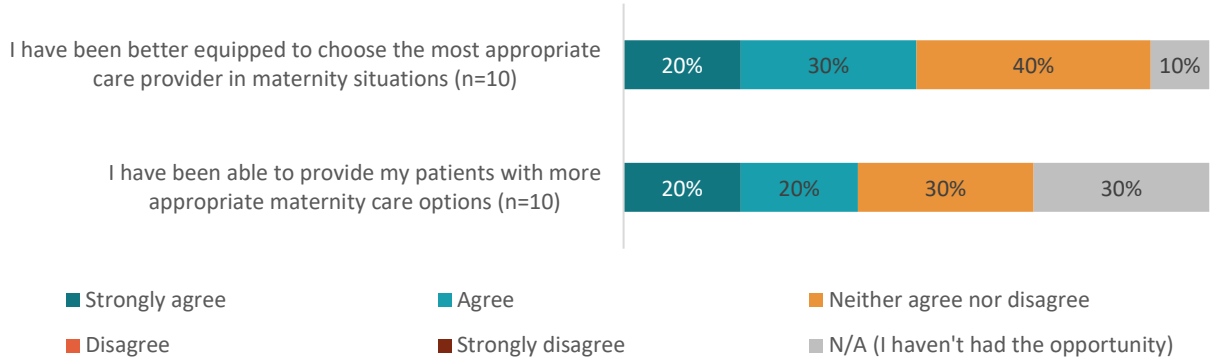
Figure 4. "In the past six months, have you..."
(n=19 FPs/midwives; Perinatal Services of BC Survey)



The March 2018 Maternity World Café event was reported to be useful in supporting FPs to adopt the new referral forms and processes. In the post-event survey, respondents reported several changes they intended to make in their practice as a result of the presentations. Specifically, they indicated **improving specialist referrals and/or consultations** (n=12). Of these respondents, 10 indicated being more aware of when to refer patients or request consults; one indicated that they will use the new referral form; and two indicated that they will follow new referral protocols to streamline the referral process.

Additionally, as Maternity played an active role in the November 1st 2017 Engagement Event, six-month follow-up surveys from this event found that 40% of respondents either "agreed" or "strongly agreed" that they were able to provide more appropriate maternity care options since the engagement event and 50% of respondents either "agreed" or "strongly agreed" that they were better equipped to choose the most appropriate care provider in maternity situations (Figure 5).

Figure 5. Since the November 2017 Engagement Event ...?
(n=14; 6-month follow-up)



Other changes in referral practices

The six-month follow up survey to the November Engagement event indicated that, overall, 56% of respondents (9 of 16) had used Pathways/algorithms (for any speciality) for a patient who, in the past, they would have referred. As another example, 21% or respondents (3 of 14) who learned from an ophthalmologist reported making referrals to ophthalmology using referral form best practices in the six months following the November Engagement event.

Improving Patient Care

The ultimate intention of developing practical and sustainable solutions is to improve patient care. The following diagram outlines six patient examples of how the PiC project made a difference in how patients receive care, and the quality of care that is available to them:

Six Stories of Improved Patient Care

"Ok, we'll go with the GI referrals. You know, they've got their central access referrals and patients normally would have had to see a specialist. Say you get a rejection: being able to reassure a patient that you don't get to see doctor so-and-so, but we have some suggestions for you – **it empowered me to better care for a patient and the patient was reassured because the GI reviewed their case. So, they got excellent care without having to have that referral."** (On RACE).

"Best example would be women who go past their due-date. **Instead of having them wait 41 weeks, we just realize that they would be an overflow and now book them an appointment ahead of time. If they don't end up needing it, no problem, it cancels automatically**. But if they did, great, they don't have to wait 2 hours to see the OB." (On new Maternity clinic processes).

"We had one patient who was quite young, 19-20, with chronic diarrhea. The referral was rejected due to their history of bloodwork and they were told to follow enhanced primary care pathways instead. The GP saw that and ordered more tests. Then they saw drastic changes in the stool sample. **They called us via RACE to find out what to do. They re-submitted the patient and we upgraded their status in triage. We will see her urgently now due to those changes... We can keep up with the urgent people in a more timely manner**." (On enhanced GI primary care pathways and RACE).

"Had a patient waiting for a cardio appointment. There were changes in how they were feeling; I called for advice on meds. The cardio on RACE said this was a great use because they hadn't seen a cardio yet (so they didn't have a connection with a specialist) and I could be the temporary cardio, get advice, and pass that along to the patient. **I got to initiate treatment earlier. The patient started to feel better sooner, less symptomatic. While waiting for a specialist, they could already access care through me.**" (On RACE).

"Child psych: a patient who was borderline, not so ill they needed to go to emerg, but still ill. They were waiting to see a specialist; there are so few child psychologists in Victoria. I was able to call a couple of times to ask about medication management. They were experiencing side effects. I started something, called back, was able to talk about side effects, and changed meds. **It was like they were already connected, but it was through me. This reduced their symptoms.**" (On RACE).

"I used it for investigating questions, when not sure what to do with the patient. E.g. someone listed to see gastro, but they declined the referral because it didn't fit their criteria. I followed the pathway they created, but I had some questions. **They didn't quite fit the pathway, and they recommended calling RACE if I had any questions, so I did. We discussed additional investigations I could do for this patient. It's so useful for those grey area patients – for investigation and medical management**." (On GI primary care Pathways and RACE).

Enhancing professional satisfaction

In line with the Triple Aim approach, the practical and sustainable solutions targeted during the SI/VDFP PiC initiative also aimed to enhance professional satisfaction. As evidenced in patient story #1 above, interview respondents reported feeling empowered by the use of RACE, as it gave them more confidence in the care they provided to their patients. Specialists too reported satisfaction with the use of RACE; they noted that it has not significantly impacted their workload, as FPs have not been using it to a great extent. As one specialist put it, *"it has opened up a pathway of communication between FPs and specialists, which is very important to patient care. The more ways we can communicate with one another, the better."* In the words of another RACE specialist: *"I like RACE, it's very satisfying."*

In terms of the other practical solutions, interview data also indicated that having streamlined referral processes is making a difference in professional satisfaction. For example, respondents indicated having more confidence that what needs to be done will be done in a timely manner, with respect to the maternity referrals and triaging.

> "I don't have to keep checking up on things. **Have created a more efficient system** and much less paperwork for me, which is a bonus."
>
> *- Key informant interviewee*

Promoting Practice Changes

A key outcome of the Partners in Care project has been to promote practice changes that support the Triple Aim. The primary vehicle for promoting practice change among family physicians has been engagement events, including World Cafés.

The practice changes outlined below are intended to:

1. Improve the provider experience of care, by increasing their confidence to provide appropriate care within their own clinic setting and improving their skills.
2. Improve the patient experience of care by reducing unnecessary tests and procedures, improving communication between providers and ultimately improving health outcomes.
3. Reduce cost to the health care system by reducing unnecessary tests and procedures.

The October 2016 Multidisciplinary World Café Physician event provided the opportunity for knowledge sharing among six specialities with the goal of enhancing primary care. SPs provided FPs with tips and tools that they can use within their practice to help reduce the number of referrals made to SPs. **100% of FP respondents "agreed" or "strongly agreed" that the Pearls shared at the event were relevant for family physicians (83 of 83); 100% also indicated that they will use the Pearls in their practice (83 of 83)**.

Six months later, a follow-up survey was administered, offering an indication of the lasting impact of the project's efforts. Physician respondents who completed the six-month follow-up survey indicated that they had incorporated several changes into their practice as a result of what they learned at the event (Table 2).

Table 2. Prospective and Actual Changes in Practice 6 Months post-Multidisciplinary World Café Event

Prospective Changes	Actual Changes
Radiology	
Implement changes on how to treat and prescribe for Chronic Obstructive Pulmonary Disease (COPD), coughs, and asthma.	**85%** of (n=13) respondents who learned from a radiologist tried a new inhaler product with longer lasting bronchodilators.

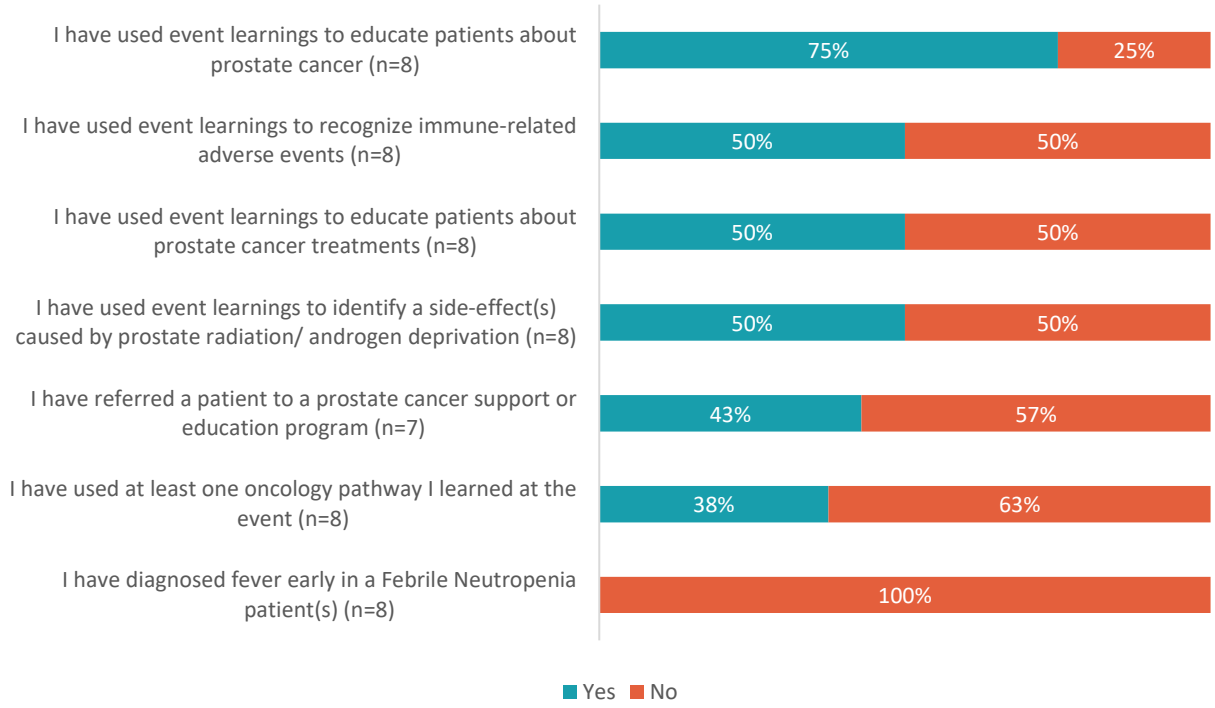
Neurology	
Implement changes regarding headache/migraine treatments.	**8%** of (n=26) respondents who learned from a neurologist increased the frequency that they prescribed intranasal medications to treat migraines. **12%** of (n=26) respondents who learned from a neurologist learned how to inject trigger points for headaches.
Gynecology	
Increase management of vulvodynia treatments and exams.	**39%** of (n=23) respondents who learned from a gynecologist increased the number of referrals they made to pelvic floor physiotherapy.
Gerontology	
Monitor seniors more closely.	**73%** of (n=11) respondents who learned from a gerontologist agreed or strongly agreed that they made an intentional effort to monitor senior patients more closely.
Refer to geriatric specialists less often.	**9%** of (n=11) respondents who learned from a gerontologist decreased the number of referrals they made to a geriatrician.
Use the BC guidelines for endocrine investigations and refer to geriatric specialists more often.	**27%** of (n=11) respondents who learned from an endocrinologist increased the number of times they used the BC guidelines for frailty.
Endocrinology	
Adjust medications for Type II Diabetes/Cardiovascular disease.	**69%** of (n=16) respondents who learned from an endocrinologist made adjustments to medication prescribed to treat Type II Diabetes, and **25%** indicated that they prescribed Jardiance or Victoza for patients with Type II Diabetes to minimize cardiovascular risk.
Gastroenterology	
Use Helicobacter pylori eradication quad therapies.	**35%** of (n=23) respondents who learned from a gastroenterologist increased the number of times they used helicobacter pylori eradication quad therapies.

For the Oncology World Café event in October 2017, respondents were asked in the post-event survey what they would do differently in their practice as a result of the event learnings. Respondents mentioned:

1. Being more aware of how to get in contact with oncologists and the BCCA, and/or calling oncologists more often (n=17)
2. Referring patients to prostate cancer support and education programs (n=8)
3. Having more knowledge of prostate cancer and cancer treatments that they will share with patients (n=7)
4. Being more aware of Febrile Neutropenia and watching more closely for it (n=4)

As illustrated in Figure 6, **most of the respondents (6 of 8) to the six-month follow-up survey indicated that they have used learnings from the World Café to educate patients about prostate cancer**. Half of respondents (4 of 8) reported that they have used event learnings to recognize an immune-related adverse event, to identify a side-effect(s) caused by prostate radiation/androgen deprivation, and to educate patients about prostate cancer treatment. Almost half of respondents (3 of 7) indicating having referred a patient to a prostate cancer support or education program. None of the respondents reported having diagnosed fever early in a Febrile Neutropenia patient.

Figure 6. Based on learnings from the Oncology World Café event, have you made any of the following changes in the past 6 months...?



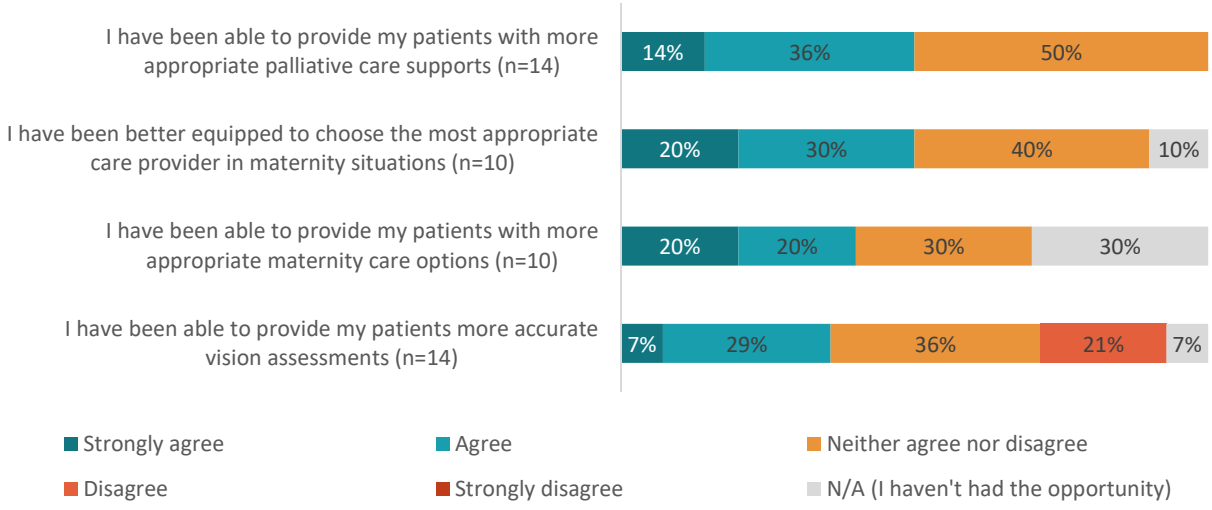
To gauge the November 2017 Engagement Event's impact on FP capacity, respondents were asked what, if anything, they intended to do differently in their work/practice as a result of what they learned. The most common responses included using/modifying their use of GI Pathways, algorithms, and/or referrals (n=7). (Six-month follow-up survey findings for GI practice changes are described under *Gastroenterology* on pages 17-18). Respondents also indicated that they would use RACE (n=5) and Pathways (n=5) more often, use ophthalmology and visual fields learnings from the event (n=3), and, more generally, would modify their approach to referrals (n=6).

Six months following the November 2017 Engagement Event, 50% of respondents indicated that they either "agreed" or "strongly agreed" that they have been able to provide more appropriate palliative care since the World Café (Figure 7). Half of respondents (5 of 10) indicated that they had initiated a pre-pregnancy consultation based on learnings from the World Café, which they may not have done previously. Moreover, as previously noted (see *Maternity* page 18-19), 40% of respondents either "agreed" or "strongly agreed" that they have been able to provide more appropriate maternity care

options since the World Café and 50% of respondents either “agreed” or “strongly agreed” that they have been better equipped to choose the most appropriate care provider in maternity situations (Figure 7).

When asked, 29% of respondents reported having used the learnings from the World Café in the previous 6 months to assess confrontational fields (Figure 7). Additionally, 44% of respondents (4 of 9) who learned about it, indicated that they were able to provide more accurate vision assessments (results not shown).

FIgure 7. Since the November 2017 Engagement Event...?
(n=14; 6-month follow-up)



Summary of Project Outcomes

Objective	Evidence of Progress
Building Relationships between FPs and SPs	✓ Key informants reported that Phases I and II unequivocally met the goal of relationship building between family physicians and specialists, most notable through 'Pearls and Dine and Learn' events. ✓ In Phase III, engagement events were reported to promote dialogue and relationship-building, although less so compared to previous phases. ✓ The dialogues initiated in Phase III laid a foundation from which the project could begin to form solutions (e.g. clarifying GI issues, leading to a new referral process). ✓ On Phase III post-event surveys, when asked about the most valuable portion of the event, the most common response centred around the opportunity to build relationships, network, and discuss issues face-to-face.
Developing Practical and Sustainable Solutions to Improve Patient Care and Enhance Professional Satisfaction	***Implementing RACE*** ✓ Key informants reported that the major benefit of RACE is that it makes calling specialists more approachable. ✓ 73 of 78 respondents to the FP RACE User Survey (94%) reported that they were satisfied with the RACE app. 72 of 78 respondents (92%) reported that they were satisfied with their interaction with the specialist. In all cases where the physician was not satisfied with their interaction (n=6), the call was marked as unanswered. ✓ As of May 31, 2018, there are a total of 570 health care providers currently registered to access the RACE app (402 FPs/FP residents and 47 nurse practitioners). There are currently 121 specialists registered with the SI RACE app. ✓ Currently, 12 speciality areas are providing coverage through the local SI RACE line. Eight of these specialities joined the app during Phase II of the PiC project with a further four signing up during Phase III.

	Developing Referral Best Practices and Primary Care Pathways
	✓ A new GI referral process and primary care Pathways were developed as part of the PiC project. Through educational efforts at the November 2017 Engagement Event, participants learned to adopt the new changes. For example:
	  ✓ In the six-month follow up survey, 67% of respondents (10 of 15) had identified that they used at least one GI pathway that they learnt during the session.
	  ✓ 40% of respondents (6 of 15) felt that their GI referrals have been more appropriate.
	✓ Through the PiC project, the Maternity working group developed the new Acute Assessment Unit (AAU) referral system, which has reportedly allowed for more communication and more shared care for maternity care.
	  ✓ In the post-event survey, respondents (n=12) reported several changes they intend to make in their practice, including improving specialist referrals and/or consultations.

Improving Patient Care	✓ In addition to indirect evidence of practice changes that would support improvements in patient care, key informant interviewees told six specific stories of how SI/VDFP PiC initiatives had directly contributed to patient care improvements, notably through RACE coverage, GI primary care Pathways, and the new Maternity Clinic referral process (see page 20).
Enhancing Professional Satisfaction	✓ RACE GPs reported that RACE made them feel empowered and more confident treating their patients. RACE SPs indicated that RACE has not significantly impacted their workload, and that they are satisfied with the application. ✓ Key informants reported that modifications to referral processes have streamlined processes, giving involved parties more confidence that things will go according to plan.
Promoting Practice Changes	✓ Respondents indicated that, as a result of the various Phase III events, they intend to make several practice changes. For example, 100% of FP respondents to the 2016 Multidisciplinary World Café "agreed" or "strongly agreed" that the Pearls shared at the event were relevant to FPs (83 of 83); 100% also indicated that they will use the Pearls in their practice (83 of 83).

Discussion

Strengths and Successes

Key Strengths and Successes:

- Strong leadership
- Strong funding support in Phases I and II
- Having the right people at the table
- Having the data and information to establish objectivity
- Relationship-based and networking-based events

Interview data indicated that the steering committee was hard-working and had good follow-through from individuals on their commitments. Key informant interviewees indicated that the primary facilitators of success in the project included good leadership from key individuals (including the SIDFP and VDFP project leads), four years of excellent funding support (in Phases I and II), having engaged specialists and FPs at the committee/working group tables and the engagement events, especially the earlier Pearls events.

> "For the specialties that we got involved, there was no challenges because we had people at the table. **There were assumptions on both sides what the barriers of access were, and to break down those barriers together, that was really excellent**!"
>
> *- key informant interviewee*

For the gastroenterology and maternity working groups, an additional facilitator of success was being "armed" with good information. With respect to this, interview data indicated that the gastroenterology was able to use data and information to gain an objective understanding of their situation and promote more productive dialogue. Previously, it was uncertain how many GI referrals were actually happening, and there were portions of the referral process that key players did not understand. As a result, the working group focused efforts on measuring the problem and opening communications between the referring doctor and receiving doctor. According to key informants, the chance to personally meet most of the GIs, whether through education panels or dinners, was useful; meeting them and talking allowed SPs and FPs hear each other and the unique challenges on each end, then work together on solutions.

The maternity group had a similar experience. Key informants described their previous process as "winging it". After going through the process of saying "what are we actually doing in clinics?" and getting the numbers to look at it objectively, they were able to develop booking algorithms. Key informants also pointed to the PiC project lead as a strong facilitator of success for the Maternity project, as they kept things moving forward.

> "**They had their finger on the pulse to know what the GPs were struggling with** and they knew "these are the areas that people need more information" and finding people and getting them on board, all of those logistics, they were excellent. There is a lot of behind-the-scene, one-on-one engagement; they knew who to talk to. They certainly very well connected. That was a real strength!"
>
> *- Key informant interviewee*

In terms of operationalizing project goals, respondents indicated that the Pearls events in Phases I and II were strong vehicles for change. For example, key informants attributed the GI working group's success largely to the education sessions in the style of a "dine and meet your GI". Interviewees noted that such events were well-received, well-attended, and that they improved patient access to care by supporting learning, promoting practice changes,

and supporting the development of relationships. These events were reported to be crucial for improving collegiality between doctors. The events received positive feedback from FPs who indicated that they learned a lot and were pleased with the opportunity to network and develop relationships (see *Promoting Practice Changes*, page 21). In addition, interviewees and post-event survey respondents indicated that specialists appreciated the events and the collegiality they fostered too.

Challenges

Key Challenges:

- Funding changes
- Team fatigue
- Goal clarity
- Varying levels of success at the working group level
- Resistance from key players in process changes
- RACE uptake

As previously noted, interview data indicated that the SI/VDFP PiC project was most effective during Phase II. Subsequent to that phase, externally mandated changes to the project structure introduced several challenges for Phase III. Key informant interviewees discussed the loss of the capacity to host Pearls events, which they felt was their biggest asset as a project and something they had really fine-tuned from an organizational perspective. Interview data indicated that these events were successful in improving the referral processes, and quality of life for doctors, factors that are directly in line with the project goals.

As a result of the challenges defining the terms of Phase III funding, Steering Committee and project staff reported that a portion of the project timeline was spent clarifying the direction of the project, rather than operationalizing solutions. Interim interview data pointed to the operational challenge of difficulties defining project goals. During final interviews, this challenge and its impacts on the project timelines were reiterated. Key informants indicated during their interviews that such challenges were exacerbated by fatigue and burnout among the steering committee members. As many had been involved since the project's inception, the disappointment from the change in direction influenced team morale negatively.

As previously noted, the various working groups achieved varying levels of success in terms of their capacity to operationalize projects within Phase III. For the Oncology working group, working group and Steering Committee members noted that the limited progress was a result of challenges around goal clarity and physician leadership capacity. There were also personnel and organizational changes at BC Cancer Agency at the beginning of the project that may have influenced their capacity to engage with the project. For the Medical Imaging working group, efforts to implement a Pulmonary Embolism Algorithm were stalled as a result of difficulties translating the algorithm to match existing processes. The project lead indicated that although there was a push to complete this at the final hour, the lack of an internal champion to push for its implementation contributed to this initiative being ultimately abandoned.

Aside from these high-level challenges, some smaller scale challenges were also reported by interviewees. For example, some resistance was reported among specialists with respect to the use of RACE, and resistance from key players in the referral pathways was occasionally an issue. In line with PiC's relationship-based approach, key interviewees indicated that through development of these relationships and establishing clear communication, these barriers were largely overcome.

With respect to RACE, the main challenge reported by interviewees was a lack of uptake and awareness of RACE. Key informant FP and SP users of RACE were largely positive about the application and its ease of use. However, specialists noted that they get calls from the same FPs in Victoria, and none from elsewhere on the Island. Interview data indicated that while the project was strong in engaging SPs, less was done to engage FPs, which may have contributed to low uptake of the RACE app among this user group. A consistent recommendation from interview respondents was for more advertising, education sessions, and seminars as to how easy the RACE service is to use.

> "Previously, I would receive a voice mail or page even if just to provide advice, but it was not that well documented, I didn't have all of the information that's a part of the app, but **if we adopt the RACE line more, it'll make my job a lot easier**."
>
> *- key informant interviewee*

One respondent suggested that another explanation for low RACE uptake could be intergenerational: the younger cohort of doctors is likely more used to texting and apps. It was also noted that low use could be indicative that difficulties that FPs have are not amenable to phone conversations. For example, while RACE is useful for medication questions, it does not solve the issue when an FP needs to make a referral or pass a patient on to a social worker.

Key Informant Comments on RACE uptake:

- "I don't get many calls, which I think is funny because we have a 10 month plus waitlist." – *RACE SP*
- "Volume has picked up a bit, but I would like to see it pick up a lot more." – *RACE SP*
- "When I talk about it, family physicians are like 'oh ya…'" – *RACE SP*
- "My thoughts are that it has not been a success, because of insufficient promotion. Behaviour change takes a lot of effort…Have to make it easy for people, and then remind them, to change their practice pattern. Its not an easy thing to do. The uptake has been very poor." - *RACE GP*

In addition to challenges in uptake, smaller operational challenges were reported with respect to RACE. One FP indicated that they found the application tough to use when they are busy, as the hours are quite limited; the hours have usually already ended for the day by the time this FP is done seeing patients, and if they call during the day, they have to interrupt patient visits to answer the call. On the other hand, another FP RACE user indicated that after hours they can call through the hospital, and so they did not feel that RACE was unavailable when they needed it.

Another challenge reported by key informants was that it can be onerous to type in all the patient information each time they use the application. It is easy to make mistakes on small phone screens, they noted. They recommended that RACE be optimized like an EMR so that it inputs information automatically when you search the patients' Personal Health Numbers (PHN). Similarly, they recommended adding defaults to the selections (e.g. select MSP automatically, then the FP can change this selection if the patient uses another insurer). Lastly, key informants reported that, on occasion, they could not find the specialty looking for (e.g. rheumatology).

Lessons Learned

Key informant interviewees reported key learnings from their involvement in the project, including:

- The importance of strong project management:
  - **"Having someone skilled with that planning piece is key because we all have challenging schedules."** They elaborated that it's really important to have someone from the group on top of things and motivating the team to keep going. They pointed to the SI/VDFP PiC project lead as a good example of this role. Similarly, another respondent noted the importance for physician leads to have project managers to support them, because "**physicians are not project managers"**.
  - Another respondent suggested the lesson of "**Mak[ing] sure you get a lead physician who is absolutely passionate about it**." They noted that if it's something you do because you believe so strongly in it, then "it'll happen".

- The value of engagement events:
  - "**Don't underestimate the value of engagement events**", especially GPs coming together and working on shared problems together. This respondent noted that such events lead to improvements in job satisfaction and in the life of GPs, ultimately leading to better patient care in the long term.

- The importance of objective data:
  - "**If you have a problem, you need to measure the problem**." Respondents were adamant about the need to measure problems objectively in order to start a meaningful dialogue around them.
  - **"Evaluation was a really good thing** – I think you have to do that piece."

- The importance of having all the right voices at the table:
  - **"Having all the players involved so you're not doing something that will negatively affect someone else."**
  - "**Multidisciplinary representation and executive support**." One working group reported having some support, but not substantial support from their executive; they noted the importance of this.

- The value of adopting provincially led projects:
  - **"Projects across the province are a good way of saving money and doing good for the province**." This respondent made note of Pathways and FETCH as examples.

- The importance of ongoing education efforts:
  - "**Once you stop having education sessions, people slip back** and aren't filling in forms correctly". This respondent noted the importance of ongoing engagement and education to ensure sustainability; they recognized the challenge with maintaining such efforts within a project structure where funding ends.

Sustainability and Spread

Key informants noted that for the most part, sustainability of the PiC program is "to be determined" and that it will depend on whether they can keep momentum going. Some portions of the project are more sustainable than others. For example, RACE is self-sustaining now and is gaining traction, as are the Pathways developed for GI. The Provincial RACE Service recently underwent a comprehensive external evaluation, the results of which are currently being discussed internally by the Shared Care Committee with a focus on sustainability of the RACE service and the possibility of future enhancements.

> "I understand that the committee is over, but I hope that the Division is doing work around the sustainability of it because **it would be a shame to have it lost**."
>
> "**It's a shame that the committee didn't spend more time on "how can we sustain this thing."** There was a bit of reacting to what the funder wanted. Maybe people would have paid for those things [events]; they really liked them."
>
> *- Key informant interviewees*

Interview data indicated that the maternity group has potential to sustain itself due to its close connections with Growth Health, which was reported to be a strong community of providers. Interview data indicated that the maternity working group is interested in continuing to act on addressing the deficiencies that were identified through the project. Some degree of optimism was reported surrounding the referral process with the caveat that they needed to ensure the referral form is embedded into the EMR within a reasonable time frame: *"The process, as long as the background protocols remain and are reviewed on a semi-regular process (which I think they will be because the OB's will be using them regularly) and we can get the form into the EMR within a reasonable amount of time, I think people will continue to use them. But if they don't get on EMR, I worry that people will revert to the old forms."*

> "**I wasn't expecting it [GI] to end so abruptly**. I think the thing that was unexpected is how we ramped up our momentum. We get the advanced access referrals and you get all these other specialties that want to be there. It wasn't pulling teeth; we were on a roll."
>
> *- key informant interviewee*

The sustainability of other working group areas was less clear. For gastroenterology, key informants indicated that they felt the project was cut off short and are uncertain what will happen. They reported that it would be beneficial to their sustainability outlook if they received ongoing support to keep relationships going.

Medical Imaging and Oncology working groups were reported not to be at a stage where they were ready to talk about sustainability. Interview data indicated that the oncology working group has developed collaborations and partnerships with the patient voices network, and the BC Cancer Agency. They have also begun to pursue further funding options; if funding is not received, the project lead indicated that the project will still go forward, but slowly off the side of a desk. See the Oncology Logic Model (Appendix B) and Process Diagram (Appendix C) for insight into future directions.

More generally, outlooks regarding sustainability related to the funding available to continue the PiC project. Respondents noted that without the World Café and Pearls events, it will be challenging to sustain the practical learnings component: *"The relationships that were built tend to fade again. They need to be fostered."*

In terms of spread of the SI/VDFP PiC initiatives, little is in place currently to spread and share what has been learned. However, key informants indicated that some of the initiatives and efforts from the PiC project have already spread to other areas. For one, the orthopedics work done in Phase I has spread to other communities and it continues in the SI/VDFP community too. *"It's just a thing now. It runs now and it's just a given to our community, but that wasn't always the case"*, as one interviewee put it. Additionally, the project team reported having received calls from a team in Newfoundland that was looking at adopting the SI/VDFP PiC approach. Finally, other communities were reported to have picked up the Pearls events (e.g. Northern Interior Rural Division), the format for which was developed by the SI/VDFP PiC team.

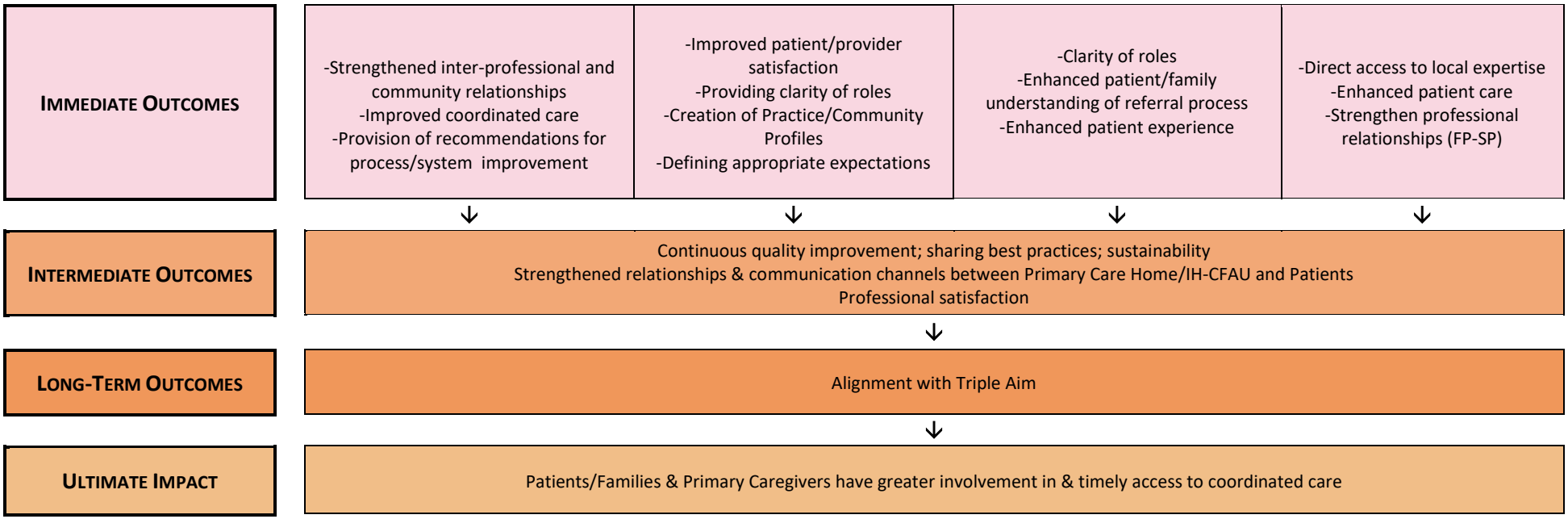
Conclusion

The SI/VDFP PiC project reached a mature stage during its third phase, building on the work of Phases I and II. While stakeholders reported that the project was in its prime during the second phase, several key accomplishments were achieved during Phase III and done in the face of challenges such as funding restrictions and burnout among key team players. Key informants highlighted that a major strength of the project was its relationship-based approach, especially the series of World Café/Pearls events that hallmarked Phases I and II of the project. Despite challenges, evaluation findings indicated that Phase III events were successful in promoting the development of relationships between FPs and SPs and promoting practice changes. In addition, evaluation findings reflected progress on the second PiC objective of developing practical and sustainable solutions to improve patient care and enhance professional satisfaction. While outlooks on sustainability varied by initiative, key informants were optimistic about the sustainability of several accomplishments, including RACE coverage in the South Island/Victoria area, gastroenterology primary care Pathways, and Maternity referral improvements. Illustrating the value of the PiC model, several other communities have looked to SI/VDFP to replicate their approach.

Appendices

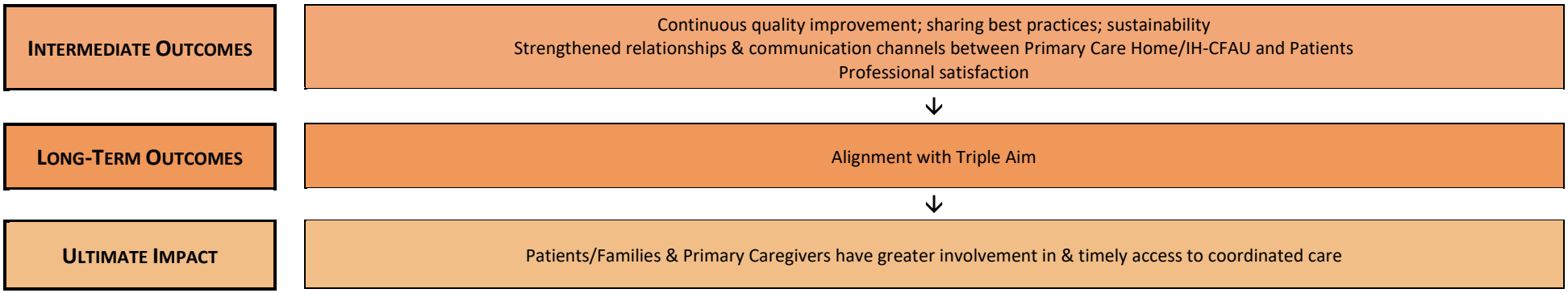
Appendix A. Maternity Logic Model

	ESTABLISH ADVISORY/WORKING GROUP PANEL	STANDARDIZE AAU REFERRAL PROCESS	INCREASE PATIENT/FAMILY AWARENESS OF AAU PROCESS	RAPID ACCESS TO OBS & MAT. FP EXPERTS
PROJECT ACTIVITIES	-Solicit professional and community interest/participation -Engage multi-disciplinary stakeholders involved in a patient's journey (IH Admin, CFAU, SPs, FPs) -Research best practices/lessons learned (Provincial Maternity SC Project/nationally etc.) -Document current care pathway & impact on patient care -Identify gaps in care/communication -Identify list of priority issues (follow up on Physician Survey: 2016)	-Engage required stakeholders (IH, Community FP/Clinics/SPs) -Solicit FP/Primary Care input (wants, needs, current challenges) -Develop standardized Referral Form based on multi-stakeholders requirements -Pilot Referral form/process (select FPs/Clinics) -Provide educational forum (World Café) to launch standardized referral form	-Engage stakeholders (IH, Patient Voice/Allied Health/Primary & Maternity Care) to determine needs -Develop localized patient resources -Determine appropriate channels for distribution (sustainability/spread) -Provide accessibility to patients/community	-Solicit interest of Local Mat/Fetal Specialists, Pediatricians/Gynecologists providing coverage for local RACE service
EVALUATION ACTIVITIES	-Assessment of quality/utility of tracking referral flow -Interview stakeholders/document relevant stories -Identify current successes, challenges providing recommendations for improvement	-Surveys/Interviews: Assessment of quality/utility of summaries -Document Impact on patient care -Identify successes, challenges providing recommendations for improvement	-Interviews: Solicit feedback from patients/families regarding the Impact on improved patient understanding of journey (interviews/surveys) -Identify successes, challenges providing recommendations for improvement	-Track # of calls, -Track appropriateness of calls - Survey users (satisfaction levels)


IMMEDIATE OUTCOMES
-Strengthened inter-professional and community relationships
-Improved coordinated care
-Provision of recommendations for process/system improvement
-Improved patient/provider satisfaction
-Providing clarity of roles
-Creation of Practice/Community Profiles
-Defining appropriate expectations
-Clarity of roles
-Enhanced patient/family understanding of referral process
-Enhanced patient experience
-Direct access to local expertise
-Enhanced patient care
-Strengthen professional relationships (FP-SP)
INTERMEDIATE OUTCOMES
Continuous quality improvement; sharing best practices; sustainability
Strengthened relationships & communication channels between Primary Care Home/IH-CFAU and Patients
Professional satisfaction
LONG-TERM OUTCOMES
Alignment with Triple Aim
ULTIMATE IMPACT
Patients/Families & Primary Caregivers have greater involvement in & timely access to coordinated care

Appendix B. Oncology Logic Model

	PATIENT HELD RECORDS	STANDARDIZE FOLLOW-UP SUMMARIES	INCREASE PATIENT AWARENESS	RAPID ACCESS TO ONCOLOGISTS/FP EXPERTS
PROJECT ACTIVITIES	-Engage multi-disciplinary stakeholders involved in a patient's journey (PCH, IH, VICC, PVN) -Complete comprehensive literature review -Research best practices/lessons learned (provincially/nationally etc.) -Develop localized PHR template -Pilot PHR process (select Pt./FP group) -Determine appropriate channels for distribution (sustainability/spread	-Engage required stakeholders (Community FP/Clinics/SPs) -Solicit FP/Primary Care input (wants, needs, current challenges) -Develop standardized summary based on multi-stakeholders requirements -Pilot Summary process (select FPs) -Determine appropriate channels for distribution (sustainability/spread)	-Engage stakeholders (Patient Voice/Allied Health/Primary/Palliative & Oncology Care) -Research/Lit Reviews – investigate lessons learned other regions -Develop localized patient resources/brochures -Determine appropriate channels for distribution (sustainability/spread)	-Solicit interest of Radiation and Medical Oncologists providing coverage for local RACE service -Solicit interest of local FP Oncology Network providing coverage for local RACE
EVALUATION ACTIVITIES	-Assessment of quality/utility of charts -Impact on patient care & understanding of journey -Identify challenges & provide recommendations for improvement	-Stakeholder Surveys/Interviews -Assessment of quality/utility of summaries -Impact on patient care -Identify challenges & provide recommendations for improvement	-Solicit feedback from patients/families re: Impact of improved patient understanding of journey (interviews/surveys) -Identify challenges & provide recommendations for improvement	-Track # of calls, -Track appropriateness of calls -Survey users (satisfaction levels)
IMMEDIATE OUTCOMES	-Patient/caregivers taking ownership of their own cancer journey -Improved coordinated care -Improved patient/provider satisfaction (i.e, clarity of role; patient understanding of journey)	-Improved patient/provider satisfaction -enhanced continuity of care - improved efficiencies with delivery of care -clarity of roles (Professional/Community Practice Profiles) -defining appropriate expectations	- Clarity of roles -Patient/caregiver awareness of available community support networks -Enhanced patient/family understanding of referral process -Enhanced patient and caregiver experience	-Direct access to local expertise -Enhanced patient care -Strengthened professional relationships and communications channels


INTERMEDIATE OUTCOMES
Continuous quality improvement; sharing best practices; sustainability
Strengthened relationships & communication channels between Primary Care Home/IH-CFAU and Patients
Professional satisfaction
LONG-TERM OUTCOMES
Alignment with Triple Aim
ULTIMATE IMPACT
Patients/Families & Primary Caregivers have greater involvement in & timely access to coordinated care

Appendix C. Oncology Process Diagram

- A significant amount of effort has been spent (1.5 yr) establishing and stewarding a strong partnership with the Vancouver Island Cancer Centre/BCCA
- A joint multi-stakeholder event held in Feb 2016 in collaboration with the BCCA Primary Care and Survivorship program provided an opportunity to hear from Primary Care Providers, Oncologists, Patients, Caregivers, and community partners in an open forum format.
- Four priority discussion topics were identified as potential areas where the SIVDFP Shared Care Project could focus attention

OUR AIM : STRENGTHEN RELATIONSHIP BETWEEN SPECIALISTS & THE PATIENT MEDICAL HOME and ENHANCE PATIENT EXPERIENCE THROUGH THEIR CANCER JOURNEY

CURRENT STATE
WHAT IS WORKING

- Ability to relegate follow up to Primary Care Provider
- Discharge letters provided to PCP include FU protocols
- PCP able to review Care Plans via access to BCCA notes
- New PCP Pt. Care Incentive available
- Systematic screening programs available
- Use of full service specialized GP model for delivery of care
- Timely reports

BARRIERS
WHAT ARE CHALLENGES

- Not enough FPs
- Lack of fee code for FP Cancer Follow Up
- Inconsistent FU between Patient and FP
- Inconsistent surgical info flow SP – VICC
- Lack of Primary Care Provider education re: Cancer Screening/FU
- Patients do not receive FU Care Plans
- Lack of clarity re: who is "Leading" Patient Care
- Inconsistent communications to Pts. re: responsibilities of each care provider
- Multiple Oncologists per patient
- Complexities of Follow Up protocols to guide management
- Dissociation between FP-SPs -VICC

FUTURE STATE
WHAT CAN WE DO

- Empower patients by providing a Patient Held Records (PHR)
- Standardize Summaries of FU Care Plans
- Increase awareness for FPs/PCP of available Patient Resources
- Introduce Complex Care Code
- Centralized recall system
- Closing communication loop
- Incorporate Patient Care Plans into EMR
- Implement collaborative discharge planning
- FP/PCP Rapid Access to Oncology Specialists
- FU Care Clinic for Survivors
- Create a list of FP/PCP accepting unattached cancer patients