

MPH Capstone Project

Equity-focused primary health care: A critical analysis and evaluation framework for the 'A GP for Me' initiative

Erin Carey, MPH Candidate
Faculty of Health Sciences, Simon Fraser University

Senior Supervisor: Dr. Laurie Goldsmith
Second Reader: Dr. Andrew Webb

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Introduction

Recognition of the impact that social and structural factors have on population health is increasing in Canada and around the world. This involves an understanding that one's health behaviors are often shaped by their social context, and that not all people are given an equal opportunity to engage in the kind of decision making that results in positive health outcomes. This awareness is at the heart of health equity, which is defined as the "absence of systemic and potentially remediable differences in one or more characteristics of health" (Browne et al., 2012). As a significant determinant of health, health services play a substantial role in population health, with the potential to improve or exacerbate the gap that exists between those who are socially advantaged and those who are disadvantaged. Primary healthcare in particular has the potential to achieve the greatest gains in redressing inequities. A strong primary healthcare foundation, when paired with structural and policy changes and responsive to the needs of marginalized groups, is one of the strongest predictors of reduced health inequities (Browne et al., 2012; White & Newman, 2015). Primary healthcare that is equity-focused aims to improve not only overall population health outcomes, but also reduce the inequitable distribution of health by addressing the social determinants that are associated with poor health outcomes. Integrating an equity lens into primary healthcare involves tailoring services to meet the unique needs of patients who are marginalized. This benefits not only those who are most vulnerable, but the entire population.

Attachment to a regular source of primary healthcare is associated with multiple benefits, including improved medication adherence, improved health outcomes, and reduced all-cause mortality (Wong et al., 2011; Starfield, Shi & Macinko, 2005).

However, finding and maintaining an attachment to a primary healthcare provider has become more challenging in recent years. The shortage of available providers is a result of British Columbia's rapidly growing and aging population, combined with a shift in the primary care landscape. This is mainly due to the impending influx of retiring doctors, combined with a younger, increasingly female workforce, who, compared with men, are more likely to work fewer hours per week, see fewer patients, and leave the medical profession sooner (Burton & Wong, 2004). This has all contributed to a reduction of the healthcare system's capacity to adequately meet the needs of all patients. Consequently, accessing appropriate, continuous, patient-centered primary care has become increasingly difficult for people in British Columbia. As of 2013, 200,000 British Columbians were in need of attachment to a regular source of primary care – up from 176,000 in 2010 (Statistics Canada, 2014). This is particularly salient for marginalized patients, who are less likely to be attached to a primary care provider (White & Newman, 2015).

It is undeniable that an increased availability of primary care itself is associated with improved health outcomes on a population level. However, this is predicated on the assumption that these services are equally available and appropriate for all people. According to Starfield, Shi & Macinko (2005), one study showed that “the supply of primary care physicians is less closely related to the health of urban African Americans than it is for urban whites or for African Americans in rural areas.” This is likely due to the tendency of physicians to locate their practices in more desirable, affluent areas, and potentially cherry-pick patients they deem less complicated. Positive primary care experiences are associated with reductions in the adverse effects of income inequality on health, suggesting that primary healthcare has the potential to significantly improve

health equity (Starfield, Shi & Macinko, 2005). This may mean focusing not only on increasing the number and availability of providers, but also on how services can be adapted to adequately respond to the needs of those who are most vulnerable and can gain the greatest benefit from high quality primary care.

With the responsibility for providing primary care placed largely on GPs, the capacity to provide ongoing quality care to vulnerable high-needs patients is limited. This could result in a cyclical effect of burden for both patients and providers, with doctors becoming overworked and overburdened and patients experiencing poor health outcomes as a result of unmet healthcare needs. Access to high quality health services is one of the key determinants of health, yet those who are the most marginalized and have the highest healthcare needs face the greatest number of barriers to accessing care. Furthermore, health services that respond to the unique needs of marginalized populations remain under-resourced and under-funded, and significant knowledge gaps exist around how to appropriately respond to the needs of these patients (Browne et al., 2012). Primary healthcare reform must focus not only on an exponential increase in the number of available providers, but also an increase in services that are equity-oriented. Enhancement of services for disadvantaged populations is one of the most effective ways of reducing health inequities. This is associated with an improvement in health outcomes for those who are most at risk, as well as improved population health outcomes overall, including reduced risk of acute and chronic health conditions and lower rates of preventable hospital admissions. (Browne et al., 2012). Inequitable care and access impacts the overall healthcare system, ultimately resulting in health system inefficiency. Lack of access to primary care and inappropriate service provision are indicated by higher

emergency room visits by disadvantaged populations who have greater health needs, resulting in increased acute care costs and a greater use of human and financial resources (Barsanti & Nuti, 2014).

One of the proposed solutions for improving equity in primary care is a move towards multidisciplinary team-based practice. In many ways, this is consistent with an equity-focused approach, with early data in British Columbia showing promising results. Team-based models of care have been linked to improved clinical outcomes for patients, improved access to care, and overall patient satisfaction (BC Ministry of Health, 2015). Research from the United States shows that low-income populations whose usual source of care is a community health center receive more preventative services and report more favorable health outcomes and lower rates of all-cause mortality than those of the same socioeconomic status who receive care in a single-provider setting (Starfield, Shi & Macinko, 2005). Although community health centers differ somewhat in Canada and the United States, with US Community Health Centers associated with a sliding fee scale, the wrap-around approach that is characteristic of team-based care, and recognition of the social and systemic factors that can result in poor health outcomes remain the same.

This paper will explore what the development of a primary healthcare program that clearly prioritizes health equity might look like, and how team-based multidisciplinary care may or may not be associated with this. Through this analysis, comparisons are made between the development and evaluation of a hypothetical equity-focused program and a real multidisciplinary primary care practice in which support for health equity is implied but not specifically articulated. Strategies and recommendations for incorporating an equity lens into the framework that will be used to evaluate this

program are discussed. This critical analysis also explores the current relationship between primary healthcare and the social determinants of health, and why a disconnect remains, despite primary healthcare's longstanding association with health equity. Through this analysis, I outline the dimensions of equity-focused primary healthcare, and how this can be operationalized at the policy, organizational, and individual provider levels.

Health Equity in the Context of Primary Healthcare

Despite the equality of access inherent within the Canadian healthcare system and primary healthcare's potential to reduce inequitable distributions of health, health equity does not spontaneously result from this. These conditions are necessary but not sufficient to ensure equity-focused primary healthcare. In order to achieve this goal, a commitment to health equity must not only be articulated explicitly, but also implemented through conscious actions at the policy, organization, and individual provider-levels. Although the factors associated with equity-focused primary healthcare may not all be applicable to every context, each is reflective of a commitment to reduce differential health outcomes by improving health services and access for those who are most vulnerable.

At the policy level, this is associated with a socially progressive political environment that supports redistributive measures and social programs. Governance structures that support inter-sectoral collaboration is another contributing factor, at both the policy and organizational-level. Other organizational-level factors include alternative physician payment modalities, a commitment to equity in organizational policies and statements, and advocating for structures, policies, and processes that support the

enactment of equity. This may include organizational policies and practices that directly respond to patients' needs, through both the scheduling of services and aspects of the services themselves. Equity-focused primary healthcare also entails addressing inequitable power distributions between providers and system users, as well as among staff members. Actively countering the impact of intersecting oppressions on health and access to care is an obligation for organizations as well as individual providers. Individual providers can also enact equity-focused care through a social understanding of health, tailoring care according to the patient's social context, and facilitating access to resources that address the determinants of health.

The 'A GP for Me' Initiative

'A GP for Me' is an initiative currently underway in British Columbia that has the potential to significantly improve health equity. Recognizing the need to increase the capacity of the healthcare system to meet the needs of the population in BC, the Ministry of Health introduced this plan in 2013, with the multiple aims of enabling patients who want a family doctor to find one, increasing the capacity of the primary healthcare system, and confirming and strengthening the continuous doctor-patient relationship, including better support for the needs of vulnerable patients (General Practitioner Services Committee (GPSC), 2015).

The overarching goal of this program is to increase the capacity of the primary healthcare system to enable access to a family doctor for every person in the province who wants one. Recognizing that there is no "one size fits all" approach to healthcare, this initiative is being implemented differently across the province, according to local

needs and priorities. The ‘A GP for Me’ strategies are developed and implemented in each community by those who are directly involved in healthcare provision. This direct involvement allows for incorporating an understanding of population needs at the local level, which enables innovative approaches and adaptations to existing structures that can change the way that healthcare services are accessed and utilized. The health equity implications of this initiative are interesting to explore. Although ‘A GP for Me’ is attempting to address the issue of lack of attachment to primary care by increasing the number of available providers, many of the approaches to this seem to be inherently equity-oriented. Strategies such as team-based multidisciplinary models and mechanisms that aim to identify and attach those who are members of specific vulnerable populations are reflective of the core principles of equity-focused primary healthcare. While health equity is not explicitly addressed in the program mandate, it is reasonable to expect that improved health equity may be an outcome.

The ‘A GP for Me’ initiative highlights better care for vulnerable patients as a priority, both in its provincial evaluation framework, as well as in the overarching program goals (GPSC, 2015). However, this goal is not well defined, nor are its objectives inherently equity-focused. Objectives of the provincial ‘A GP for Me’ Plan include:

- Strengthened GP communities of practice
- Supportive learning environments for GPs
- Strengthened organizational leadership in primary care
- Supportive GP compensation models
- Stronger networks of support for GPs and allied health providers (GPSC, 2015)

According to the General Practice Services Committee (GPSC), the difficulty that many British Columbians are facing in finding a continuous primary healthcare provider is resulting in increased health inequities, defined as “lack of access to a family doctor.” However, the narrowness of this definition of health equity raises concerns. Attempting to respond to a problem that is resulting in increased health inequities without a fully nuanced understanding of what it means or prioritization of its measurement in the provincial evaluation, puts into question the ability of this initiative to measure potential improvements to health equity, or even address it at all. For instance, the absence of consideration of health equity in the planning of this program is demonstrated by the provider- and more specifically, physician-focused-, rather than patient-centered approach. While these objectives may be associated with positive patient health and system outcomes as a result of increased physician capacity and satisfaction, the connection with improved health equity is tenuous. Although there is a high degree of flexibility in how the Divisions of Family Practice are implementing this program, depending on local needs and priorities, there remains an obligation to adhere to the provincial mandate, in which health equity as a priority is implied but not explicitly stated. Some projects appear to be more equity-focused than others. However, the ability to measure the degree to which the principles of health equity are being advanced is limited by the lack of a clear overall provincial mandate.

Despite the ‘A GP for Me’ goal of providing better care for vulnerable populations, the complex and multi-faceted issue of health equity is largely ignored in its implementation and evaluation plan. The brief mention of health equity in the ‘A GP for Me’ plan speaks to the increased emphasis on social inequities and public health in recent

years, with a move to refocus the field away from the predominantly biomedical model to one that is more patient-centered and reflective of the principles of social justice (Gil, 2006; Rasanathan et al., 2011). However, this brief mention of health equity does not include a guiding framework or clear definition of what health equity looks like in the delivery of healthcare, without which remaining committed to the goal of health equity, especially in an environment with increasing political and financial pressures, can be difficult. These contentions bring to light the question of whether or not a program that incorporates elements of health equity, but without an explicit focus or plan for implementation or measurement, can truly result in improved health equity.

The Fraser Northwest Division of Family Practice, as part of the overall ‘A GP for Me’ initiative, is implementing a virtual multidisciplinary clinic to provide primary healthcare to the frail homebound elderly population. Known as the ‘Sunshiner Network Frailty Clinic’ (hereafter referred to as the ‘Sunshiner Initiative’), this program is building on the importance of the continuous patient-provider relationship and recognizing the unique needs of this patient population. The Sunshiner Initiative aims to step outside of the traditional physician-focused fee-for-service model of care by providing a holistic set of services in the patient’s home, delivered by a team of providers, including nurse practitioners, a registered nurse, a pharmacist, and family doctors. The practice will also include a community service assessment and navigation component as a way to address social or non-medical needs. Should this program prove to be successful, it could result in a number of important public health policy implications, including increased capacity for family doctors- and the primary health care system as a whole - to care for more patients. Increased primary care capacity is associated with improved patient health outcomes,

increased access to care for vulnerable patients, increased provider job satisfaction, and ultimately significant government cost savings (Starfield, Shi & Macinko, 2005).

The Sunshiner Initiative is only one example of how Divisions of Family Practice across the province are implementing ‘A GP for Me.’ Due to variations in local needs and priorities, there is a great deal of flexibility in how the Divisions can achieve the overall program mandate of increasing the capacity of the primary healthcare system. This particular model is aiming to improve primary care for the homebound frail elderly through a unique approach to multidisciplinary team-based care, which will result in not only an increase in GP availability to accept more patients, but also improved care for an identified vulnerable population. I will use the Sunshiner Initiative as a case study to explore what equity-focused primary healthcare looks like in practice, by comparing it with a hypothetical equity-oriented model.

Applying an Equity Lens to Primary Healthcare

Historically, health policy has been reluctant to embrace explicit theories of health equity or social justice. While health inequities are often acknowledged in the provision of health services, this has typically lacked a solid theoretical foundation, instead adopting measures of “distance, access and the lack of resources as the metrics of social (in)justice without critically placing their research in a framework of social justice.” (Garglione & Raviglione, 2009). This dissociation between theory and policy is not unique to this initiative, yet the fact that health equity is rarely explicitly prioritized in healthcare program planning is puzzling, given the degree to which accessible high-quality primary healthcare is associated with improved population health outcomes and

reductions in social inequities (Starfield, Shi & Macinko, 2005; Shadmi et al., 2014). Although some argue that the role of healthcare in explaining and addressing health inequities is small compared to the role of the wider determinants of health, strong evidence pointing to the potential for equity-focused primary healthcare systems to improve population health outcomes is enough to warrant a discussion around what a primary healthcare program prioritizing improved health equity as a goal would look like (Gargione & Raviglione, 2009).

Widely considered to be the foundation of public health, and essential for strengthening the public health care system (Buettner-Schmidt & Lobo 2012), social justice is an appropriate lens through which to situate this analysis, as it enables an acknowledgement of the role that social determinants of health play in the shaping of health outcomes and healthcare access, while allowing for objective policy-driven considerations. The basic principles of social justice in the context of primary health care include health and human rights, personal and community responsibility, empowerment, solidarity, and subsidiarity (Gargione & Raviglione, 2009). One emerging theoretical approach to social justice is idealist theory, which posits that all members of society should have access to as much healthcare as they need, a socially just healthcare system is one in which there are no barriers to accessing health services, healthcare is a publicly funded right for all, and access to healthcare should be achieved in a socially just fashion (Rosenburg, 2014). The rationale for selecting this particular theoretical approach was based on the limited, yet strong data on equity in healthcare service delivery, in which this was the dominant framework. Drawing on principles of social justice idealist theory, I will explore what a primary healthcare program that is explicitly equity-focused might

look like, and how strategies to advance social justice in healthcare can be implemented at the policy, organizational, and individual provider levels.

The determinants of health are the structural factors responsible for health inequities between and within populations. While the health system may be primarily concerned with access to health services as a determinant of health, it has great potential for addressing factors affecting health beyond the realm of healthcare. This concept of responding to non-medical health needs in the improvement of population health is not new. Primary healthcare was originally conceptualized as a means of addressing broader social factors affecting health, but this role was soon disregarded in favor of a more narrow bio-medical approach to health, which was seen to yield greater and more immediate health benefits (Rasanathan et al., 2011). However, the potential for primary healthcare to expand its scope beyond curative medicine and improve health inequities has seen a renewal in recent years. The 2008 World Health Report describes the scope of primary healthcare as including care that is “not just first contact, but instead, comprehensive, integrated and people-centered, coordinated through the entire health system” (Rasanathan et al., 2011). Primary healthcare that is equity-oriented, addressing the healthcare needs of the most disadvantaged, is gaining recognition as one of the most effective ways of reducing health inequities. Equity-oriented primary healthcare can have a tremendous impact on health equity, especially in conjunction with structural and policy changes (Browne et al., 2012). However, despite this potential, incorporating the social determinants of health into primary healthcare may be easier said than done.

Many similarities are shared between primary healthcare and the social determinants of health, making the two approaches highly compatible – at least in theory.

At the core, both approaches focus on health promotion and disease prevention and improving access to care as fundamental priorities. Both also recognize the need for wider societal participation, with social determinants advocating for a whole of society approach to improving health equity, and primary healthcare valuing inter-sectoral action (Rasanathan et al., 2011). However, despite these shared principles, in practice the social determinants and primary healthcare approaches are often incompatible. For example, healthcare providers may overlook addressing other social determinants of health beyond that of the health system, while a focus on primary healthcare that is too broad could result in a weakening of the biomedical aspects of primary healthcare (Rasanathan et al., 2011). Similarly, while the end goal may be the same, the focus of that goal differs between the two approaches. A typical primary healthcare approach to health equity considers how the rest of society can support health systems to reduce inequities, while a social determinants of health approach questions why health inequities exist, viewing primary healthcare as only one of many points of entry for action (Rasanathan et al., 2011). Neither approach is sufficient on its own; the potential for reducing health inequities is strongest when these approaches are integrated. Our understanding of health and healthcare is shaped to fit the dominant discourse by powerful actors, like politicians and medical professionals. With physicians receiving little or no training in concepts of social determinants of health, it is unsurprising that the current medical model aligns with the dominant political discourse of market individualism, with health promotion activities heavily focused on behavior modification and individual responsibility (Baum et al., 2009). Perhaps a more simplistic explanation for the lack of synergy between primary healthcare and social determinants of health is that downstream solutions are easier to

implement, yield more directly measureable results, and thus attract more short-term political support (Baum et al., 2009).

Despite these barriers, there is ample evidence suggesting that an equity lens can and should be incorporated into the planning of primary healthcare programs. As a major determinant of health, access to health services – particularly primary healthcare – is essential in health promotion and disease prevention activities. Primary healthcare has been shown to be more effective in preventing illness and death than specialty care, is associated with more equal distributions of health, and has the potential to positively impact health equity and improve population health outcomes (Starfield, Shi & Macinko, 2005; Baum et al., 2009; Browne et al., 2012). However, although improvements in population health are often equated with improvements in healthcare, this is not always the case. The potential for health systems to reach their potential for improving health equity and population health outcomes is often limited by their lack of acknowledgement of the social determinants of health, their failure to ensure equitable access to care, and limited inter-sectoral action (Baum et al., 2009). In order to make any real improvements to health equity, health systems must explicitly address social determinants of health. Those that do not – which are the majority of health systems in most countries – invariably exacerbate health inequities. This usually does not happen intentionally, but rather through systemic barriers resulting in differential treatment for marginalized populations (Rasanathan et al., 2011). Even with good intentions and a belief in health equity as a core principle, change is unlikely to happen without deliberate action. By not explicitly addressing social determinants of health, there is no motivation or accountability for advancing health equity (Browne et al., 2012).

Understanding Equity-focused Primary Healthcare

Equity-focused primary healthcare is an effective means of responding to social issues affecting health, such as homelessness, systemic discrimination, and chronic mental illness and substance abuse. This impact can be particularly strong when linked with structural and policy changes. Given that the dominant approach to primary healthcare is not equity-focused, it can be difficult to envision what an equity-focused primary healthcare program looks like and how it functions. This section will explore what the development of a hypothetical primary healthcare program (known as the ‘Sunshiner Equity Practice,’ or ‘SEP’) might look like, and how this compares to the Sunshiner Initiative (SI), by highlighting aspects of the SI that are or are not equity-focused. The characteristics of the hypothetical SEP are based on an ideal model of equity-oriented primary healthcare, as described in the literature. For ease of comparison, we will assume that the SEP is also a virtual multidisciplinary primary healthcare program. The only ways in which the SEP differs from the SI is through an explicit focus on equity-oriented care, and care provision that extends beyond that of the frail elderly to include a more diverse range of patient populations. The equity-focused characteristics of the SEP described may be operationalized differently in different situations, and may not be applicable in every primary healthcare context. Therefore, only those that are directly applicable to the Sunshiner Initiative will be expanded upon.

The SEP is a primary healthcare initiative that embodies four key dimensions of equity-focused primary healthcare services, as described by Browne et al. (2012). As a primary care clinic providing care to a number of highly marginalized populations, it practices equity-responsive care by addressing and prioritizing social determinants of

health as a routine aspect of care. The SEP also practices trauma- and violence-informed care, through a profound understanding of the pervasive effects of trauma and violence, and responding to this in a respectful way that goes beyond simply providing ‘trauma treatment.’ Additionally, the SEP exemplifies contextually tailored care. This can be understood as an extension of patient-centered care in which services are tailored to the context and needs of the local population. Finally, the SEP is adept at providing culturally competent care, responding to health needs by recognizing the ways in which racism and systemic discrimination shape health outcomes, opportunities, and quality of life. While contexts and opportunities vary markedly between primary healthcare programs, these dimensions are typically operationalized through four key strategies: community participation, multidisciplinary teams, appropriate technology, and a focus on health promotion and disease prevention, in addition to curative care provision (Baum et al., 2009).

The SI excels in two of these four dimensions by providing inequity-responsive care and contextually tailored care. The Assessment and Navigation component of the SI is an attempt to extend the realm of primary healthcare beyond that of curative medicine by focusing on the social aspects of a patient’s life that impact health. If the GP or NP caring for a patient feels that one or more determinants of health are not being addressed, a referral is made to a social worker who will provide an assessment in the patient’s home and facilitate access to outside resources, such as housing advocacy, assistance with government pensions or benefits, or Home Health services to allow them to thrive independently at home. Given that the SI serves the frail elderly population, the care

provided is contextually-tailored to the needs of this population by responding to patients' differing levels of ability through home visits, thus improving access to care.

Policy Level Factors

As with any healthcare initiative, the development of the SEP begins at the policy level, and is dependent upon a number of political and other external factors. The SEP was developed under ideal policy conditions, which has contributed to its success. The governments in power at the time of its inception were socially liberal and progressive in their understanding of the need for social policy and redistributive measures that support the needs of vulnerable populations. The same cannot be said of the SI, which has managed to grow and develop despite a neoliberal and fiscally conservative political climate.

Health system reform that recognizes the need for equity-focused primary healthcare to address the differential experiences of disadvantaged groups is not possible without recognition of the importance of social determinants of health (Rasanathan et al., 2009). This is achieved through governance structures that enable inter-sectoral action and the understanding that the capacity of health systems to improve health equity is strongly influenced by other sectors, such as housing, transportation, and education (Baum et al., 2009; Rasanathan et al., 2009). Unfortunately, despite evidence linking improved health equity with inter-sectoral collaboration, investments in healthcare are largely limited to curative – and usually acute – services (Baum et al., 2009). Effective inter-sectoral action can be supported by Health in All Policies programs and equity-

focused surveillance systems, which aim to capture population-level data that measure social determinants of health (Baum et al., 2009).

Organizational Level Factors

In developing the SEP, seven factors at the organizational level were considered to ensure that health equity was incorporated throughout the program's service delivery. First, rather than a fee-for-service payment modality, the SEP employs a salary-based model, recognizing that alternative fee structures can be associated with increased population health outcomes and cost reductions (Browne et al., 2012). This was an important consideration for the SEP, as it allows physicians to participate in activities beyond direct patient care, including interdisciplinary team meetings and strategic planning. While the SI operates on a fee-for-service model, the funding structure of this program allows for physician remuneration for non-clinical time spent on the project.

Another way in which the SEP is incorporating health equity into its practice at the organizational level is by addressing inequitable power distributions between providers and system users (Browne et al., 2012). Organizations must practice reflexivity by critically reflecting on how power relations impact relationships with patients, as well as other sectors and the wider community. Fostering an environment that encourages the acknowledgment of one's privilege is an important step in addressing the health effects of stigma, social exclusion, and persistent power imbalances experienced by many marginalized patients.

Recognizing and addressing power differentials among interdisciplinary staff members is also essential for developing an equity-focused primary care practice

(Browne et al., 2012). The SEP aims to achieve this by acknowledging the value and importance of all team members' roles and critically reflecting on how these power imbalances are managed. Responding appropriately to power differentials within the organization is necessary for avoiding destructive power imbalances between patients and staff (Browne et al., 2012). This is also managed appropriately in the SI. Although GPs are responsible for key decision making in the project, this power is leveraged through open dialogue and knowledge sharing with non-physician providers.

The SEP also prioritizes health equity by explicitly articulating a commitment to equity in its organizational and policy statements. Incorporating a commitment to health equity into its mission statement, vision, and goals creates a sense of accountability on the organization to operationalize these statements through actions. This can be reinforced through the advocacy and social justice work of organizational leaders in the community, as well as through hiring practices that reflect this commitment. Conversely, these equity-focused organizational statements have attracted like-minded employees to the SEP, increasing the potential for shared values among staff (Browne et al., 2012). This is an area for improvement for the SI, as the organizational statements of the Fraser Northwest Division of Family Practice do not explicitly address a commitment to health equity. However, should the SI prove to be sustainable and develop into an independent entity after the funding from 'A GP for Me' ends, this would be an opportunity to articulate an intention to prioritize health equity at an organizational level.

Through the development and implementation of the SEP, developing and advocating for structures, policies, and processes to support the enactment of equity has been a consistent focus. This is operationalized as frequent interdisciplinary team

meetings, active participation of all team members in planning services, and organizational leaders advocating for stable funding that supports these activities (Browne et al., 2012). Advocating for flexible, long-term funding structures is particularly important, as this enables the organization to focus on service delivery instead of the constant pressure to secure funding, while allowing the organization to determine its own priorities. The SI is consistent with this aspect in that interdisciplinary meetings between the GPs, NPs, and administrative staff are frequently held, in which all team members participate in the planning and implementation of service delivery. However, long-term stable funding has yet to be secured for the SI, but sustainability plans are being developed to secure sources of continuous funding after the end of A GP for Me in March 2016.

The SEP is also prioritizing equity through organizational policies and practices that respond directly to clients' needs. For instance, the SEP is aiming to meet the needs of various patient populations through creative and flexible scheduling structures (Browne et al., 2012). By allowing for flexible scheduling options, including weekend, evening, and drop-in appointments, the SEP recognizes how patients' individual decisions are often shaped by broader societal contexts. This also reflects an understanding that time is required for active engagement with patients, and seeing changes in health outcomes is often a gradual process. The SI also understands the need for flexible patient scheduling by providing care through both routine appointments as well as on a rapid-response basis. Care is currently available during regular business hours, with the intention of scaling up to 24/7 rapid response care, as the program continues to develop.

In addition to considering patient needs in the scheduling of services, the SEP strives to tailor the services themselves to the context of patients' lives. This approach is an extension of patient-centered care, which includes making adaptations to services that take into account social and cultural contexts (Browne et al., 2012). The SI achieves this by providing care in the patient's home or the provider's office, depending on their ability and level of frailty. According to Browne et al. (2012), team-based care is often necessary to achieve tailored services, as it enables a wrap-around approach to primary care to ensure that all medical and social needs are met.

Finally, the SEP prioritizes equity at the organizational level by actively countering the impact of intersecting oppressions on health and access to care. Part of this entails developing an understanding of structural and systemic intersectional oppression and implementing strategies that counter the barriers associated with access to healthcare. These strategies include the development of policies that support a low-barrier healthcare environment and community-level leadership and education on how to counter systemic oppression. Again, this is most effective through inter-sectoral collaboration (Browne et al., 2012). This is an area of opportunity for the SI. At the organizational level, this would start with the Fraser Northwest Division of Family Practice, which, as a leader in primary healthcare in the community, could have a profound impact on not only the health sector's understanding of intersectional oppression, but also the community as a whole. Expanding the patient base beyond that of the frail elderly to include a more diverse patient population is another strategy to address intersecting levels of marginalization.

Individual-Level Factors

In addition to policy- and organizational-level strategies, the SEP is also taking steps to prioritize equity at the individual provider level. This begins with having a foundational social understanding of health, and a recognition that factors affecting health extend beyond the biomedical realm (Baum et al., 2009). Providers involved with the SI are well versed in social determinants of health. This does not necessarily involve having the capacity or skills to address all social needs presented by patients, but recognizing how these needs can be appropriately responded to, which is facilitated by the SI's team-based approach.

Tailoring care according to social context is a component of equity-focused primary healthcare at the individual provider level as well as the organizational level. The SEP recognizes that tailoring services is an effective means of drawing people in, rather than limiting access. One of the ways that providers of the SEP exhibit this is by understanding that small gestures like greetings or approaches to sensitive topics can vary according to patient populations, and having the ability to respond appropriately (Browne et al., 2012). Actively countering the impact of intersecting oppressions on health and access to care is also important at the individual provider-level. Providers in the SEP understand that patients' experiences of intersectional oppression can be reinforced or alleviated through their interactions with providers. Unconditional positive regard is a simple yet effective strategy for countering oppression (Browne et al., 2012).

Individual providers in the SEP also practice equity-focused care by enhancing access to resources that address the determinants of health. Responding to the determinants of health is an essential component of high quality primary healthcare, and

addressing these issues should be seen as a routine aspect of healthcare (Browne et al., 2012). Knowing how to facilitate access to services like housing, employment, and welfare is a core skill for providers in both the SEP and the SI, and is facilitated by a team-based model of care.

Equity-focused Program Evaluation

Equity-focused primary healthcare not only involves strategies to incorporate equity into service delivery, but should also include evaluation that measures the extent to which health equity is actually being improved, and how health equity indicators are being incorporated into primary healthcare. The following will explore strategies for overlaying an equity lens onto evaluation of a primary healthcare program, and provide recommendations for incorporating equity into the Sunshiner Initiative evaluation framework in Appendix 1.

Strategies for Evaluating Equity

Evaluation of any health-related program begins with effective monitoring systems. Monitoring differs from research in that it is action-oriented, descriptive rather than explanatory, and is typically more useful for short-term policy planning than long-term planning (Braveman, 2003). Monitoring and evaluating equity in healthcare is important for a number of reasons. First, it is associated with ethical implications, as it provides accountability for ensuring that human rights issues and distributive justice are being attended to (Braveman, 2003). Second, the systematic collection of data that separately describes the health of those who are advantaged and disadvantaged allows for

assessment of the differential impacts of policy on these groups (Braveman, 2003).

Finally, there has been a paucity of equity-oriented evaluation in healthcare over the years, with the majority of monitoring and evaluation activities focused solely on service quality (Barsanti & Nuti, 2014). Consistent and rigorous evaluation of equity in primary healthcare is necessary for reducing health inequities at the population level.

When evaluating equity in healthcare, appropriate indicators and targets must be considered. Designing SMART objectives (specific, measurable, attainable, relevant, and time-bound) is important, as it enables progress toward measuring health equity at both regional and national levels, and on a consistent basis (Barsanti & Nuti, 2014).

Additionally, equity targets should be prioritized over overall targets. Overall targets measure goals in terms of averages that combine all groups, while equity targets are stratified by socio-economic measures. This highlights, rather than conceals the needs of vulnerable populations (Barsanti & Nuti, 2014). This is an area in which the SI evaluation framework can be improved upon. As can be seen in Table 1 of the appendix (page 31), the goals and indicators are based on overall population metrics, rather than equity-oriented targets. An evaluation that accounts for socioeconomic differences would provide a better understanding of the true needs of those who are most vulnerable.

When considering disparities in health through program evaluation, vertical equity should be prioritized over horizontal equity. Horizontal equity refers to the allocation of equal resources for equal needs, as in universal healthcare coverage. This understanding of equitable distribution of services is based on illness as the major determinant of resource allocation, with the goal of decreasing the variability of system quality and performance (Barsanti & Nuti, 2014). Vertical equity, on the other hand,

refers to the allocation of different resources for different levels of need, as in many social programs based on income level. Evaluations that incorporate vertical equity are better able to identify poor access for disadvantaged populations, using gap analysis to determine if differences are in fact inequitable. The goal here is health improvement, rather than decreased system variability (Barsanti & Nuti, 2014). This is another area for improvement in the SI evaluation framework. While the purpose is to measure health outcomes and access to services for a recognized vulnerable population, it could go one step further by accounting for different levels of disadvantage within that demographic, rather than assuming that the frail elderly population, while vulnerable, is socioeconomically homogeneous.

Incorporating an Equity Lens into Evaluation

Developing an evaluation framework that incorporates an equity lens typically includes three key stages. The first stage involves measuring and sharing evidence, with the goal of increasing awareness of the social implications of a public health issue and sharing knowledge that often remains at the academic level ((Barsanti & Nuti, 2014).

In the second stage, data are continuously monitored and qualitative targets are established. When implementing measures at this stage, three basic research questions must be addressed: First, considering both absolute and relative disparities, how do levels of health vary across different groups? Second, how do levels of social determinants of health vary across different groups? Addressing this question may not always be within the realm of the health system, but there is a responsibility for promoting awareness of this to other sectors. Lastly, how have levels of health and social determinants across

different groups changed over time? Addressing this question is necessary for determining if policies are on track to meeting the goal of reducing health inequities (Braveman, 2003).

Other strategies include developing incentives to encourage the implementation of equity-promoting strategies among healthcare programs, the sharing of an equity approach in service delivery, and incorporating socioeconomic information into health administrative data and existing data sources (Braveman, 2003; Barsanti & Nuti, 2014). This later point is particularly useful for health professionals, as it enables governments to establish systems to continuously monitor results. However, data gathering alone is insufficient, and must be placed within the context of an overall strategy for reducing health inequities, and situated in an ongoing cyclical process of data gathering and action in order for real impacts to be measured (Braveman, 2003). The use of community-based participatory research techniques is another effective strategy for monitoring data and establishing targets, as efforts are more likely to be sustainable with meaningful engagement from community members who are directly affected by an issue (Braveman, 2003).

Stakeholder engagement is also important at this stage, as this can have a profound impact on the overall course of the evaluation. One method of identifying appropriate stakeholders is through ‘political mapping,’ which is the process of evaluating who currently has and could have the power to influence an issue (Braveman, 2003). Furthermore, recognizing that the role of the health sector should be to stimulate action in other sectors that influence health, appropriate stakeholders outside of the health sector must be identified and engaged with. The evaluation of the SI could be improved

upon by engagement with a more diverse set of stakeholders. Appendix 1a (page 42-43) outlines the stakeholders involved in this program, and does not include any stakeholders from outside the organization or direct funding bodies.

The third stage of incorporating equity into evaluation involves developing a quantitative and systematic approach based on disaggregated indicators. For instance, Barsanti & Nuti (2014) cite an example from Italy in which quantitative targets for reducing equity gaps were incorporated into reward systems for health leaders. While this approach may not be applicable to all contexts, it is an interesting and innovative way of incentivizing health equity.

Moving Toward Equity-focused Primary Healthcare

While the benefits of equity-focused primary healthcare are evident, some question the feasibility of incorporating equity measures into service delivery. It is clear that alternative service delivery strategies are needed when providing primary care to vulnerable populations, and research shows that equity-focused approaches can be more efficient than standard care, and result in improved health outcomes and improved quality of life (Browne et al., 2012). However, these benefits are not limited to marginalized individuals receiving care. Providing equity-competent care for those who are marginalized can bring about improvements in primary healthcare delivery for all populations (Browne et al., 2012). Despite the overwhelming evidence in favor of equity-focused primary healthcare, widely implementing these strategies into the dominant approach will require considerable time and substantial changes to health policy. This

must begin with a radical ideological shift in how we view health and a restructuring of our understanding of what society's role is in responding to health and illness.

BC's current neoliberal political system, which has steadily grown in prominence in Canada and throughout the developed world since the early 1990s, values free market enterprise over social responsibility, through policies that support limited government intervention and welfare state retrenchment (McBride & McNutt, 2007). Through the normalization of neoliberalism, those in power have effectively maintained it as the dominant ideology in Canadian society (Muntaner et al., 2012). Social welfare policies, in general, are less of a priority for neoliberal governments than socially progressive ones, as these policies play no role in advancing the ideals of capitalist enterprise and increasing competition in a global market economy (McBride & McNutt, 2007). Making lip-service to the importance of supporting communities through redistributive measures, while failing to make policy changes, has been noted as common practice in neoliberal states (Coulter, 2009), and detrimental to the advancement of programs that strive to reduce inequities and improve population health outcomes.

Clearly, a society's dominant ideology has a profound impact on social policy. Yet, the perceived apolitical stance taken by neoliberal governments is a political tactic in itself, helping them maintain neutrality in the face of social inequities (Coulter, 2009; Muntaner et al., 2012). Ignoring the political context in which health inequities are situated makes neoliberal governments blind to the lived experiences of its citizens. By ignoring the social factors that contribute to health and illness, people are reduced to service users, tax-payers, or consumers – essentially means of advancing the neoliberal goals of economic competition, commodification, and market growth (Coulter, 2009).

One of the most significant silences on the issue of health equity and social justice is the disregardment of political ideology and the major role that it plays in the health of populations. According to Muntaner et al. (2012), “implicating social injustice as the root of health inequalities is too vague and abstract to be meaningful. What is needed is an interrogation of the political causes of social injustice.” Through carefully enacted political tactics, neoliberal governments have successfully deflected the responsibility of health inequity. This has been artfully achieved through the normalization of neoliberal ideology, presenting an apolitical/non-ideological position, and carefully defining their role in social affairs. However, if we are ever to achieve health equity and social justice for all, it is necessary to interrogate these assumptions, rather than blindly accepting them. Understanding and challenging the political context that shapes health outcomes is the only real way to move towards change.

Although change of this magnitude is often slow and tedious, it begins with incremental changes that over time accumulate into powerful impacts. Reforming the health system to prioritize equity and implement strategies that adequately respond to the needs of diverse populations will not happen overnight. However, change is possible, even within inhospitable policy environments. ‘A GP for Me’ may present many areas for improvement and opportunities for change, but the potential for substantial improvements to health equity is there. However, this cannot be fully realized without an interrogation of the structural forces that give rise to the differential health status of marginalized populations. Critically analyzing the ways in which health equity is being advanced in programs like ‘A GP for Me’ is a step in the right direction.

Critical Reflection

Writing this Capstone paper has been a challenging yet rewarding experience. As a new staff member with the Fraser Northwest Division of Family Practice, I have had the fortunate opportunity of integrating my work with the Sunshiner Initiative into this project. Critically examining the equity focus of this program within ‘A GP for Me’ has provided me with a unique perspective that may not have been possible as solely a staff member or as a student disconnected from the inner workings of the organization. However, this growth and development has not been without challenges. In developing the evaluation framework, I felt somewhat limited by the constraints imposed on me by my professional obligation to adhere to a certain mandate. While I could clearly see how equity could – and should – be integrated into the framework, I was not able to apply this approach directly, as the strategies outlined do not align with the provincial evaluation framework for ‘A GP for Me.’ Furthermore, exploring strategies for incorporating an equity lens into service delivery was equal parts exciting and frustrating.

Despite these limitations, completing this project has been an extremely valuable experience, in that it has provided me with renewed optimism that meaningful change, while difficult and time-consuming, is possible. I feel more confident now in articulating the steps needed to move towards improved health equity, and I look forward to carrying this knowledge forward in my work.

References

- Barsanti, S. & Nuti, S. (2014). The equity lens in the health care performance evaluation system. *International Journal of Health Planning and Management*, 29, e233-e246.
- Baum, F.E., Begin, M., Houweling, T.A.J. & Taylor, S. (2009). Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health*, 99(11), 1967-1973.
- Braveman, P.A. (2003). Monitoring equity in health and healthcare: A conceptual framework. *Journal of Health, Population, and Nutrition*, 21(3), 181-192.
- British Columbia Ministry of Health. (2015). *Primary and Community Care in BC: A Strategic Policy Framework*. [Victoria, B.C.]: Ministry of Health.
- Browne, A.J., Varcoe, C.M., Wong, S.T., Smye, V.L., Lavoie, J., Littlejohn, D., Tu, D., Godwin, O., Krause, M., Khan, K.B., Fridkin, A., Rodney, P., O'Neil, J. & Lennox, S. (2012). Closing the health equity gap: Evidence-based strategies for primary health care organizations. *International Journal for Equity in Health*, 11(59), 1-15.
- Buettner-Schmidt, K. & Lobo, M.L. (2012). Social justice: a concept analysis. *Journal of Advanced Nursing*, 68(4), 948-958.
- Burton, K.R. & Wong, I.K. (2004). A force to contend with: The gender gap closes in Canadian medical schools. *Canadian Medical Association Journal*, 170(9), 1385-1386.
- Coulter, K. (2009). Women, poverty policy, and the production of neoliberal politics in Ontario, Canada. *Journal of Women, Politics & Policy*, 30(23), 23-45.
- Fraser Northwest Division of Family Practice (2013). *Physician Practice Profile Survey* (Unpublished).
- Gargioni, G. & Raviglione, M. (2009). The principles of primary health care and social justice. *Journal of Medicine and the Person*, 7, 103-105.
- General Practice Services Committee. (2015). *A GP for Me/Attachment initiative*. Retrieved from the GPSC website <http://gpscbc.ca/attachment-initiative>.
- General Practice Services Committee, Evaluation Working Group (2015). *A GP for Me Provincial Evaluation Plan*. [Victoria, B.C.]: Ministry of Health.

- Gil, D.G. (2006) Reflections on health and social justice. *Contemporary Justice Review*, 9(1), 39-46.
- Harris, M. (2010) Evaluation Public and Community Health Programs. Jossey-Bass, San Francisco, CA.
- McBride, S. & McNutt, K. (2007). Devolution and neoliberalism in the Canadian welfare state. *Global Social Policy*, 7(2), 177-201.
- Muntaner, C., Chung, H., Murphy, K. & Ng, E. (2012). Barriers to knowledge production, knowledge translation, and urban health policy change: ideological, economic, and political considerations. *Journal of Urban Health*, 89(6), 915-923.
- Preskill, H. & Beer, T. (2012). Evaluating Social Innovation. Guelph, ON: Centre for Evaluation Innovation.
- Rosenburg, M. (2014). Health geography I: Social justice, idealist theory, health and health care. *Progress in Human Geography*, 38(3), 466-475.
- Shadmi et al. (2014). Primary care priorities in addressing health equity: summary of the WONCA 2013 health equity workshop. *International Journal for Equity in Health*, 13(104)
- Starfield, B., Shi, L. & Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank Quarterly*, 83(3), 457-502.
- Statistics Canada (2014). *Canadian Community Health Survey*. Retrieved from the Statistics Canada website <http://www.statcan.gc.ca/pub/82-625-x/2015001/article/14177-eng.htm>.
- White, B.M. & Newman, S.D. (2014). Access to primary care services among the homeless: A synthesis of the literature using the equity of access to medical care framework. *Journal of Primary Care & Community Health*, 6(2), 77-87.
- Wong, S.T., Browne, A.J., Varcoe, C., Lavoie, J., Smye, V., Godwin, O., Littlejohn, D. & Tu, D. (2011). Enhancing measurement of primary health care indicators using an equity lens: An ethnographic study. *International Journal for Equity in Health*, 10(38), 1-12.

Appendix 1: Evaluation Framework

The following describes the Sunshiner Initiative evaluation framework and plan developed for the Fraser Northwest Division of Family Practice, as part of the overall ‘A GP for Me’ evaluation. This framework is a working document that will be further developed and refined as the project and overall ‘A GP for Me’ evaluation plan evolves.

Provincial Overview: A GP for Me

A GP for Me is a province-wide initiative funded jointly by the Government of BC and Doctors of BC to:

- Enable patients who want a family doctor to find one.
- Increase the capacity of the primary health care system.
- Confirm and strengthen the continuous doctor-patient relationship, including better support for the needs of vulnerable patients.

Over time, the supports provided by A GP for Me will:

- Make it easier for doctors to provide and coordinate care for their patients efficiently – so they will be able to accept more patients into their practices; and
- Enable physicians to develop plans at a community level to improve local primary care capacity, including a mechanism for finding doctors locally for patients who are looking for one.

Fraser Northwest Division of Family Practice

The Fraser Northwest Division of Family Practice (FNWDoFP) represents 240 Family Practice doctors serving 6.1 municipalities (New Westminster, Coquitlam, Port Coquitlam, Port Moody, Anmore, Belcarra, and North Burnaby) and working collaboratively to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians, through a variety of initiatives, including 'A GP for Me.' This work is guided by the vision of

“Strive[ing] to be a leader in supporting a healthy and sustainable community of doctors committed to continuity of care, patients participating in managing their health, and primary care which is accessible and relationship based.”

The Fraser Northwest Division received funds to begin implementing 'A GP for Me' in October 2014. Assessment and consultation activities highlighted 3 priority areas, which informed the following five strategies:

- Physician-patient attachment mechanism ('Attachment Hub)
- Sunshiner Frailty Network
- Primary Care Teaching Clinic
- Allied Health Initiative
- Physician recruitment and retention

This document will focus on the evaluation framework for Strategy II, the Sunshiner Frailty Network.

The Sunshiner Frailty Network (Sunshiner Initiative)

The Sunshiner Initiative is a virtual, full-service team-based primary care practice caring for homebound frail patients. Recognizing that many family doctors were spending a great deal of time responding to the needs of frail elderly patients through either home visits or extended in-office appointments, with many patients continuing to fall through the cracks, experiencing repeated avoidable emergency department visits and hospital admissions, the Fraser Northwest Division is aiming to increase GP capacity through this initiative, improve patient health outcomes and access to services, while improving family doctors' professional satisfaction and wellbeing.

Stakeholder Engagement

Stakeholder engagement is essential at every level of evaluation to increase internal ownership of the evaluation process, ensure that all relevant issues and voices are represented, and to maintain accountability to both the Division and its members and the provincial evaluation team. Stakeholders are involved in the evaluation of the Sunshiner Initiative at various levels. See Appendix 1a for an overview of key stakeholder engagement.

Alignment with the Provincial Framework

Key elements of this evaluation framework are informed by the provincial 'A GP for Me' evaluation plan, to maintain consistency in indicators and methods in order to meet GPSC mandated reporting guidelines. In order to achieve this, the Sunshiner

Initiative evaluation framework is largely informed by both the BC Health Quality Matrix and the IHI Triple Aim.

Four goals are highlighted in the provincial implementation of A GP for Me:

- Enable patients who want a family doctor to find one
- Confirm and strengthen the continuous doctor-patient relationship
- Increase the capacity of the primary healthcare system
- Provide better support for vulnerable patients

In accordance with the provincial A GP for Me evaluation, as well as the local needs and priorities specific to the Sunshiner Initiative, the three overarching goals/outcomes for this evaluation are consistent with one or more of the above goals. As the Sunshiner Initiative is only one of 5 projects under the Fraser Northwest Division's implementation of 'A GP for Me', not all of the provincial goals will be adhered to, but will likely be considered in the evaluations of the other four initiatives.

Table 1: Goals, Indicators, and Data Sources

| Goal | Indicators | Data Sources |
|---------------------------------------|---|--|
| Improved patient health outcomes | <ul style="list-style-type: none"> • Number of home visits • Number of at-home assessments (non-medical) • Community services access • Number of ER visits • Number of hospital admissions | <ul style="list-style-type: none"> • Electronic medical record (EMR) data • Assessment and navigation service provider reports • Data from Fraser Health |
| Improved patient access to healthcare | <ul style="list-style-type: none"> • Number of NPs caring for patients • Number of GPs caring for patients • Number of RNs caring for patients | <ul style="list-style-type: none"> • EMR data |
| Increased provider job satisfaction | <ul style="list-style-type: none"> • GP communication • Division member participation • GP capacity • NP capacity • GP/NP satisfaction/wellbeing | <ul style="list-style-type: none"> • Survey of GPs and Home Health case managers • Third next available appointment time • NP self-report logs • Most Significant Change (MSC) stories |

The development of the goals and indicators was based on consultations with key stakeholders, including physician and staff members of the Sunshiner Initiative Core Working Group, with the assumption that the overall plan and framework may evolve as the initiative continues to develop.

Table 2: Outcomes and Indicators – Alignment with Provincial Framework

| ‘A GP for Me’ Goals | | | | |
|------------------------------------|--|---|---|---|
| Evaluation Metrics | Enable patients who want a family doctor to find one | Confirm and strengthen the continuous doctor-patient relationship | Increase the capacity of the primary healthcare system | Better support for vulnerable patients |
| Outcome (short/medium term) | | Improved provider job satisfaction and wellbeing | Increased GP capacity to accept more patients | Improved patient access to primary care |
| Indicator | | Provider experience and satisfaction | Decrease in home visits for frail patients by GPs | Increased number of patients cared for by GPs, NPs, and RNs |
| Source(s) | | MSC stories Physician satisfaction survey | EMR data | EMR data |
| Outcome (short/medium term) | | | Improved communication and information flow between healthcare providers and the health authority | Improved patient health outcomes |
| Indicator(s) | | | Number of connections made through patient referrals between GPs and Home Health case managers Hiring of Fraser Health funded practice nurse | Increased number of home visits by NPs and RNs Increased use of community services, through referrals from at-home assessments Decreased number of ER visits Decreased number of hospital admissions |
| Source(s) | | | Fraser Health data | EMR data Assessment & Navigation service provider monthly reports Data from Fraser Health |
| Outcome (short/medium term) | | | Improved provider job satisfaction and wellbeing | |
| Indicator | | | GP: Decrease in wait times for appointments NP: decrease in time spent documenting/charting | |
| Source(s) | | | GP: Third next available appointment time NP: self-report logs | |

Evaluation Approach and Design

The Sunshiner Initiative evaluation will be a formative outcome evaluation, using an observational pre/post and post-only design. A formative evaluation is appropriate for initiatives that are forming and under refinement, and have not yet been fully implemented or established. This type of evaluation focuses on improving, enhancing, and standardizing key aspects of the program (Preskill & Beer, 2012). Unlike the provincial ‘A GP for Me’ plan, a developmental evaluation approach will not be used for the Sunshiner Initiative. A developmental evaluation is useful for programs that are being developed in a more innovative and exploratory context, in which the outcomes are largely uncertain and the trajectory is unknown. A formative evaluation, on the other hand, is more suited to programs that are less exploratory, where more is known about the expected outcomes. While the Sunshiner Initiative is a rather new and innovative concept in the primary care landscape in BC, it is based on the well-established concept of team-based multidisciplinary care, the effectiveness of which is strongly supported by evidence (Browne et al., 2012).

Measuring the expected as well as unexpected effects of a program, an outcome evaluation is typically carried out after a program has been implemented and expected to have directly measurable effects (Harris, 2010). This evaluation will rely on observational methods to determine the effectiveness of the program, using a pre/post-test design where baseline data is available, and post-test-only measurements, where applicable. The following questions will be answered in the evaluation. (Refer to Appendix 1c for complete evaluation plan).

Table 3: Outcome Evaluation Questions

| Goal | Outcome Evaluation Questions |
|---------------------------------------|---|
| Improved patient health outcomes | <p>To what extent have home visits for frail patients by a NP or RN increased as a result of this program?</p> <p>To what extent have home visits for frail patients by a GP decreased as a result of this program?</p> <p>To what extent are frail patients receiving non-medical assessments as a result of this program?</p> <p>To what extent are frail patients being referred to non-medical community services as a result of this program?</p> <p>To what extent are frail patients utilizing non-medical community services as a result of this program?</p> <p>To what extent have emergency room visits decreased as a result of this program?</p> <p>To what extent have hospital admissions decreased as a result of this program?</p> |
| Improved patient access to healthcare | <p>To what extent has patient access to care improved as a result of this program?</p> |
| Increased provider job satisfaction | <p>How has GP communication with Home Health improved as a result of this program?</p> <p>How has Division member participation in the program increased over time?</p> <p>How has provider (GP/NP) job satisfaction improved as a result of this program?</p> |

Data Collection

Data pertaining to patient home visits, community service utilization by patients, number of ER visits and hospital admissions, numbers of patients cared for by providers, and number of Division members participating in the Sunshiner Initiative will be collected continuously throughout the project. This data will be collected through the

assessment and navigation service provider monthly reports, collaboration with Fraser Health for hospital statistics, and Fraser Northwest Division of Family Practice internal documents. Appendix 1d outlines the plan for continuous data collection throughout the project.

Qualitative methods will be used to determine provider job satisfaction, through a survey administered to physician members of the Division prior to the implementation of the project, and at the completion, allowing for a comparison of post-test data to baseline data (see Appendix 1e). To enhance the quality of data collected, and adhere to provincial evaluation guidelines, professional satisfaction will also be measured through Most Significant Change stories, which will be collected using a structured interview guide (see Appendix 1f). These stories will not only provide a rich source of data for the evaluation, but may also be useful to the Division, and the GPSC for ‘A GP for Me’ promotional or communication materials.

Data Analysis

A specific data analysis approach has not yet been identified, and will be determined through collaboration with the evaluation team. As this evaluation framework follows a mixed methods approach, a combination of quantitative and qualitative data analysis techniques will be employed.

Appendix 1a: Sunshiner Initiative Stakeholder Engagement

| Stakeholder name | How are they involved? | What is their interest? | Barriers to engagement? | How and when will they be involved? |
|---|--|--|--|---|
| <p>Key stakeholder: Fraser Northwest Division of Family Practice (Including members)</p> | <p>Project team is involved in conducting the pre-project community assessment, community engagement, evaluation framework development, implementation and data collection. The core evaluation project team is responsible for driving implementation of the project and conducting the evaluation.</p> | <p>Mandated by the GPSC to ensure the evaluation framework aligns with the provincial A GP for Me evaluation mandate and that the evaluation adheres to ethical guidelines, and takes place within allocated time and budget constraints. Facilitate involvement of other stakeholder groups, including the evaluation advisory committee.</p> | <p>None known.</p> | <p>First group to come together. Will be leading the project planning and implementation process from start to finish.</p> <p><i>Engagement methods:</i> -collaboration with GPs involved with the project -ad-hoc project meetings</p> |
| <p>Key stakeholder: Sunshiner Initiative Core Working Group</p> | <p>Program staff and physicians directly involved in the implementation of the project Working group structure used to share information with key project stakeholders, gain feedback and endorsement for approaches and make decisions. As the project proceeds, may</p> | <p>The success of this project could significantly improve patient health outcomes and quality of work life for GPs who are involved. Results of the evaluation could impact future of this program, as well as funding or expansion opportunities.</p> | <p>Could be difficult to engage all face to face on a consistent basis due to geographic spread and time constraints. Participation may need to be scheduled around physician work commitments</p> | <p>Lead by the core evaluation project team. Involved from the beginning of the project.</p> <p><i>Engagement methods:</i> -evaluation advisory meeting -Quarterly Working Group meetings (or monthly, as needed)</p> |

| | | | | |
|--|---|--|-------------|---|
| | stratify into sub committees or working groups around specific topics. | | | |
| Key stakeholder: Funders: Doctors of BC/Ministry of Health → GPSC | Currently involved in providing funding to the Fraser Northwest Division of Family Practice for the implementation of A GP for Me, over the course of one year. | Funders are interested in ensuring that they are gaining return on funding investment – in this case, an increase in the number of British Columbians attached to a family doctor. | None known. | Responsible for receiving quarterly reports on overall project status and goals. Hosting workshops and providing resources to divisions to assist Divisions with the implementation and evaluation of A GP for Me |
| Key stakeholder: Fraser Health Authority | Providing requested data on patient ER visits and hospital admissions | As a partner in A GP for Me, providing a practice nurse for the Sunshiner Initiative, the successful outcome of this evaluation will allow for more seamless delivery of Home Health services, information sharing, and will provide opportunities for community involvement | None known | Data analyst will provide requested statistics on a quarterly basis throughout the project |

Appendix 1b: Sunshiner Initiative Logic Model

| Inputs | Activities | Outputs | Outcomes (short/medium term) | Outcomes (long term/impact) |
|---|--|---|---|---|
| <p>Program staff</p> <p>Funding</p> <p>Physician partnerships</p> | <p>Providing care to homebound frail elderly</p> | <p>Number of patients cared for by GPs</p> | <p>Improved patient access to primary care</p> | <p>Improved GP and overall primary care capacity</p> <p>Improved population health</p> <p>Improved health equity</p> <p>Government cost savings</p> |
| | | <p>Number of home visits by NPs/RNs</p> | <p>Improved patient health outcomes (including better support for vulnerable patients)</p> | |
| | | <p>Number of at home assessments</p> | | |
| | <p>Assessment & Navigation service provider providing psycho-social assessments and connecting patients with community resources</p> | <p>Number of patients referred to and connected with community services</p> | <p>Improved communication and information flow (short term)</p> <p>Improved provider job satisfaction (medium term)</p> | |
| | <p>Relationship-building with Home Health Case Managers</p> | <p>Number of connections made through patient referrals between GPs and CMs</p> <p>Hiring of FH-funded practice nurse</p> | | |
| | <p>Measuring changes in NP process/efficiency</p> | <p>Records of time spent performing non-patient activities</p> | | |
| | <p>Measuring changes in GP process/efficiency</p> | <p>Third next available appointment time metrics</p> | | |
| <p>Measuring NP quality of work life</p> | <p>Most Significant Change stories</p> | | | |

| | | | | |
|--|--------------------------------------|---------------------------------|--|--|
| | Measuring GP quality of work life | Most Significant Change stories | | |
|--|--------------------------------------|---------------------------------|--|--|

Appendix 1c: Sunshiner Initiative Evaluation Plan

| Evaluation Questions | Indicators | Data Sources | Timeframe | Responsibility |
|---|---|--|-----------|-------------------------|
| <p>To what extent have home visits for frail patients by a NP or RN increased as a result of this program?</p> <p>To what extent have home visits for frail patients by a GP decreased as a result of this program?</p> | <ul style="list-style-type: none"> Percent increase over time in home visits for frail patients by NPs and RNs Percent decrease over time in home visits for frail patients by GPs | | Quarterly | MOA |
| <p>To what extent are frail patients receiving non-medical assessments as a result of this program?</p> | <ul style="list-style-type: none"> Percent increase over time in at-home non-medical assessments for frail patients | Assessment & Navigation service provider monthly reports | Monthly | MOA/Program Coordinator |
| <p>To what extent are frail patients being referred to non-medical community services as a result of this program?</p> <p>To what extent are frail patients utilizing non-medical community services as a result of this program?</p> | <ul style="list-style-type: none"> Number of referrals to community services for frail patients through the assessment and navigation component Number of community services used by frail patients through the assessment and navigation component | Assessment & Navigation service provider monthly reports | Monthly | Program Coordinator |
| <p>To what extent have emergency room visits decreased as a result of this program?</p> | <ul style="list-style-type: none"> Number of emergency room visits for patients of participating Sunshiner Frailty Network GPs | Fraser Health data analyst | Quarterly | Program Coordinator |

| | | | | |
|--|--|---|--------------------------------|--|
| To what extent have hospital admissions decreased as a result of this program? | <ul style="list-style-type: none"> Number of hospital admissions for patients of participating Sunshiner Frailty Network GPs | Fraser Health data analyst | Quarterly | Program Coordinator |
| To what extent has patient access to care improved as a result of this program? | <ul style="list-style-type: none"> Number and percent increase over time in patients cared for by NPs Number and percent increase over time in patients care for by GPs Number and percent increase over time in patients care for by RNs | EMR data | Quarterly | MOA |
| How has GP communication with other healthcare providers, Home Health case managers, and community service organizations improved as a result of this program? | <ul style="list-style-type: none"> Qualitative measure – survey data | <ul style="list-style-type: none"> Physician survey Home Health Case Manager survey | Quarterly | Program Coordinator |
| How has Division member participation in the program increased over time? | <ul style="list-style-type: none"> Number and percent increase over time in FNW Division of Family Practice members participating in the Sunshiner Frailty Network | <ul style="list-style-type: none"> Practice Agreements signed | Quarterly | Program Coordinator |
| How has provider (GP/NP) job satisfaction improved as a result of this program? | <ul style="list-style-type: none"> Quantitative: Improvements in process/efficiency → Changes to third next available appointment time (GPs) → Change in number of hours spent documenting/charting (NPs) Qualitative: Self-reported improved quality of work life | <p>EMR data</p> <p>NP self-report logs</p> <p>Most Significant Change stories (video recordings?)</p> | <p>Quarterly</p> <p>Annual</p> | <p>MOA</p> <p>Program Coordinator</p> <p>Program Coordinator</p> |

Appendix 1d: Sunshiner Initiative Data Collection Plan

| SUNSHINER EVALUATION DATA COLLECTION PLAN | | | | | | | | | | | | | | | |
|---|---|--|--|-----------|---------------------------------------|---------|---------|---------|----------|---------|---------|---------|---------|---------|---------|
| Goal | Metric | Description | Data Source | Frequency | Baseline | Jun./15 | Jul./15 | Aug./15 | Sept./15 | Oct./15 | Nov./15 | Dec./15 | Jan./16 | Feb./16 | Mar./16 |
| Improved patient health outcomes | Home visits | Number and percent increase over time of home visits for frail patients by NPs and RN | EMR Data | Monthly | 60-90 (priority, regular, and urgent) | | | | | | | | | | |
| | | Number percent decrease over time of home visits for frail patients by GPs | EMR Data | Monthly | | | | | | | | | | | |
| | Community services access through assessment and navigation referrals (per patient) | Number of patients referred to community services through the Sunshiner Frailty Practice assessment and navigation component | Assessment/Navigation service provider monthly reports | Monthly | N/A | | | | | | | | | | |
| | | Number of patients using community services as a result of referrals from the Sunshiner Frailty Practice assessment and navigation component | | | | | | | | | | | | | |
| | ER Visit decrease | Number of emergency room visits for patients of participating Sunshiner Frailty Network GPs | Fraser Health data analyst | Quarterly | | | | | | | | | | | |
| | Hospital Admissions decrease | Number of hospital admissions for patients of participating Sunshiner Frailty Network GPs | Fraser Health data analyst | Quarterly | | | | | | | | | | | |
| Improved patient access | Number of patients cared for by NPs | Number and percent increase over time in patients cared for by Nurse Practitioners | EMR Data | Quarterly | 147 | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|---------------------------------------|-----------|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | Number of patients cared for by GPs | Number and percent increase over time in patients cared for by GPs | EMR Data | Quarterly | | | | | | | | | | | | | | | |
| | Number of patients cared for by RNs | Number and percent increase over time in patients cared for by RNs | EMR Data | Quarterly | 0 | | | | | | | | | | | | | | |
| Increased provider job satisfaction | GP communication improved | Improvements in communication between GPs and other healthcare providers, Home Health case managers, and community service organizations | Survey | Quarterly | N/A | | | | | | | | | | | | | | |
| | Division member participation increase | Number of FNW Division of Family Practice members participating in the Sunshiner Frailty Network | Practice Agreement | Quarterly | 5 | | | | | | | | | | | | | | |
| | GP satisfaction improved | 1. Quantitative: Process/efficiency (increased capacity) 2. Qualitative: Self-reported improved quality of work life | Third next available appointment time | Monthly | | | | | | | | | | | | | | | |
| | | | MSC Stories, Physician survey | Annual | Physician survey data | | | | | | | | | | | | | | |
| | NP satisfaction improved | 1. Quantitative: Process/efficiency (increased capacity) --> change in number of hours spent documenting/charting 2. Qualitative: Self-reported improved quality of work life | NP self-report logs | Monthly | | | | | | | | | | | | | | | |
| | | | MSC Stories | Annual | N/A | | | | | | | | | | | | | | |

Appendix 1e: Physician Survey

(Adapted from the Fraser Northwest Division of Family Practice Physician Core Survey, 2013)

1. What is your gender?

- Male
- Female
- Other

2. What age group do you fall into?

- Below 25 years
- 25 to 34 years
- 35 to 44 years
- 45 to 54 years
- 55 to 64 years
- 65 years and older

3. Please indicate which of the following best describes your current role:

- Family physician/general practitioner
- Family physician/general practitioner with a special focus to my practice, *please specify*_____
- Hospitalist
- Emergency physician
- Specialist physician
- Other, *please specify*_____

4. How many years have you been practicing?

- Less than 1 year
- 1 to 3 years
- 4 to 5 years
- 6 to 10 years
- 10 to 15 years
- 15 to 20 years
- 20 to 25 years
- Over 25 years

5. How many years have you been practicing in this community?

- Less than 1 year
- 1 to 3 years
- 4 to 5 years
- 6 to 10 years
- 10 to 15 years
- 15 to 20 years
- 20 to 25 years
- Over 25 years

6. Estimated years until retirement:

- Under 1 year
- 1 to 2 years
- 3 to 4 years
- 5 to 9 years
- 10 + years

7. Which languages do you speak fluently enough for patient care? Check all that apply.

- English
- French
- Mandarin
- Cantonese
- Punjabi
- Spanish
- Japanese
- Other, *please specify* _____

8. Please check ALL that apply to your current situation:

- I am in full-time medical practice
- I am in part-time medical practice or semi-retired from the medical labour force
- I am a locum tenens. (*If you do not have a permanent practice, complete the questionnaire in relation to last practice you served/are currently serving*)
- I am employed in a medical or medically related field
- I am employed in other non-clinical settings (*e.g., administration, teaching, research*)
- I am on a leave of absence or sabbatical from active patient care. (*Complete the questionnaire in relation to your most recent medical practice*)
- I have a faculty appointment
- I have a formal hospital appointment

- I have significant administrative responsibilities
- I have a formal leadership appointment

9. Are you involved in any A GP for Me projects?

- Yes
- No
- I am unaware of A GP for Me

If YES, please answer the following:

As part of A GP for Me you may be contributing to initiatives in several ways. This includes participating in a working group, steering committee, or implementing a project in your clinic. Considering the various roles available, please indicate your level of involvement in the Sunshiner Frailty Network below:

| Level of involvement | | | |
|----------------------|---------------------|-----------------|----------------|
| Somewhat involved | Moderately involved | Highly involved | Not applicable |
| | | | |

10. Are you involved in any quality improvement initiatives in your practice?

- Yes, regularly,
- Yes, infrequently
- No, but plan to be soon
- No

11. Have you signed up for the attachment suite of fees? (14070 – GP Attachment Participation Code and 14071 – GP Locum Attachment Participation Code)

- Yes
- No, but I plan to
- No, and I don't plan to – please specify why _____

If YES, please answer questions 12 and 13.

12. Are you billing any of the attachment suite of fees? (check all that apply)

- 14074 – GP Unattached Complex/High Needs Patient Attachment Fee
- 14075 – GP Attachment Complex Care Management Fee

- 14076 – GP Attachment Telephone Management Fee
- 14077 – GP Attachment Patient Conference Fee

13. What impact have the attachment suite of fees had on the number of your rejected claims?

- The number has decreased
- The number has stayed the same
- The number has increased
- Don't know

14. Who plays a role in billing within your practice? (check all that apply)

- Physician
- MOA
- Office manager
- Billing manager
- Billing consultant
- Other, please specify _____

15. How do you determine which diagnostic code to use? (check all that apply)

- Billing by issue brought up in visit
- Identifying billable diagnostic codes in advance of patient visit
- Identifying billable diagnostic codes after patient visit
- Other

16. Does the Attachment suite of fees provide sufficient support to attach complex patients?

- Yes
- No

If NO, please answer question 17.

17. In addition to the Attachment suite of fees and other complex care related fees, what would support you in providing care for complex patients? (check top 3)

- Clear information about billing
- Simpler billing guidelines
- Administrative support to take care of billing
- Support for integrating billing codes into work flow (e.g. telephone management)

- Working with a multi-disciplinary team
- Access to a mentor
- Recruitment and retention of more physicians
- Other fees, please specify _____
- Other support, please specify _____

18. Does your practice have an arrangement where patients can see a care provider if needed when the practice is closed (after-hours) without going to the hospital emergency room or department?

- Yes
- No

If YES, is this person a:

- Doctor
- Nurse
- Other, please specify _____

19. What proportion of your patients who request a same- or next-day appointment can get one?

- Almost all (>80%)
- Most (60-80%)
- About half (~50%)
- Some (20-40%)
- Few (<20%)
- Don't know

20. EXCLUDING ON-CALL ACTIVITIES, how many HOURS IN AN AVERAGE WEEK do you usually spend on the following activities? Assume each activity is mutually exclusive for reporting purposes (i.e., if an activity spans two categories, please report hours in only one category).

TOTAL hours worked per week _____

- a) Direct patient care without a teaching component, regardless of setting _____ hours
- b) Direct patient care with a teaching component, regardless of setting _____ hours
- c) Teaching/Education without direct patient care (contact with students/residents, preparation, marking, evaluations, etc.) _____ hours
- d) Indirect patient care (charting, reports, phone calls, meeting patients' family, etc.) _____ hours
- e) Health facility committees (academic planning committees) _____ hours

- f) Administration (i.e., management of university program, chief of staff, department head, Ministry of Health, etc.) _____hours
- g) Research (including management of research and publications) _____hours
- h) Managing your practice (staff, facility, equipment, etc.) _____hours
- i) Continuing medical education/professional development (courses, reading, videos, tapes, seminars, etc.) _____hours
- j) Other _____hours

21. How is your MAIN patient care setting organized? Check ONLY ONE.

- Solo practice
- Group practice, please specify the number of physicians _____
- Inter-professional practice, *please specify the type of provider(s) that works with you* _____

22. Does anyone in your practice help manage or provide care in any of the following ways?

| | Yes | No |
|---|-----|----|
| Help manage and coordinate care after hospital discharge | | |
| Coordinate care with social services or other community providers | | |

23. For your more complex patients receiving health care from multiple providers outside your practice, to what extent...

| | Not at all | Not really | Undecided | Some extent | Very great extent |
|--|------------|------------|-----------|-------------|-------------------|
| ...are you able to communicate with the other providers involved in a timely manner to advance the care of the patient? | | | | | |
| ...do all providers caring for these patients have the same information available to them when working with the patient? | | | | | |
| ...do you collaborate with other providers in | | | | | |

| | | | | | |
|---|--|--|--|--|--|
| establishing goals for treatment or management and plans? | | | | | |
|---|--|--|--|--|--|

24. Please indicate with whom you regularly collaborate in providing patient care AND whether your collaboration is part of a formal arrangement. Check ALL that apply

| | I regularly collaborate with the following in providing patient care | I have a formal arrangement for collaborating with the following | I do not collaborate with the following |
|--|--|--|---|
| Family physicians | | | |
| Psychiatric specialists | | | |
| Internal specialists | | | |
| Surgical specialists | | | |
| Other specialists | | | |
| Nurse practitioners | | | |
| Psychiatric nurses | | | |
| Other nurses (RN, LPN, RPN) | | | |
| Physician assistants | | | |
| Dietitians/nutritionists | | | |
| Occupational therapists | | | |
| Physiotherapists | | | |
| Chiropractors | | | |
| Psychologists | | | |
| Mental health counselors | | | |
| Addiction counselors | | | |
| Social workers | | | |
| Pharmacists | | | |
| Speech-language pathologists | | | |
| Complementary/alternative medicine providers | | | |

25. To what extent are you able to coordinate with service organizations in the community concerning planning and providing care for your most complex patients (for example, those with multiple chronic conditions or significant social issues impacting their health)?

- Unable to
- Infrequently able to
- Usually able to
- Able to always or almost always when necessary

26. Please rate your satisfaction with each of the following

| | Very satisfied | Somewhat satisfied | Neutral | Somewhat dissatisfied | Very dissatisfied | Not applicable |
|--|----------------|--------------------|---------|-----------------------|-------------------|----------------|
| Your current professional life | | | | | | |
| The balance between your personal and professional commitments | | | | | | |
| Your relationship with your patients | | | | | | |
| Your relationship with family physicians | | | | | | |
| Your relationship with physicians in other specialties | | | | | | |

27. Indicate your level of satisfaction with the following aspects of your primary care practice

| | Very satisfied | Somewhat satisfied | Neutral | Not very satisfied | Not at all satisfied |
|---|----------------|--------------------|---------|--------------------|----------------------|
| My ability to remain knowledgeable and current with the latest developments in my field of practice | | | | | |
| The freedom I have to make clinical decisions that meet my patients' needs | | | | | |
| The time I have available to spend with each patient | | | | | |

| | | | | | |
|--|--|--|--|--|--|
| My income from clinical practice | | | | | |
| Overall experience with practicing my profession | | | | | |

28. How have the following areas of your practice changed over the past 12 months?

| | Much worse | Slightly worse | About the same | Slightly better | Much better | Not applicable |
|--|------------|----------------|----------------|-----------------|-------------|----------------|
| Your patients' access to after-hours care | | | | | | |
| Your patients' access to timely care, such as a same or next-day appointment | | | | | | |
| The amount of time you have available for clinical care | | | | | | |
| Efficiency of your billing processes | | | | | | |
| Your clinical quality improvement processes | | | | | | |
| Coordination with hospitals | | | | | | |
| Collaboration with social services or other community providers | | | | | | |
| Collaboration with other family doctors | | | | | | |
| Collaboration with other health care providers such as allied health professionals | | | | | | |
| Your ability to provide comprehensive care | | | | | | |
| Your ability to provide longitudinal care | | | | | | |
| Work/life balance | | | | | | |
| Overall professional satisfaction | | | | | | |

Appendix 1f: MSC Interview Guide

A GP for Me – Sunshiner Initiative MSC STORY COLLECTION TEMPLATE (TO USE IN: FACE TO FACE, PHONE/SKYPE) FOR HEALTH CARE PROVIDERS: PHYSICIANS/NURSE PRACTITIONERS

1. Introduction and Background

A GP for Me is a province-wide initiative jointly funded by the Government of BC and Doctors of BC, created through the General Practice Services Committee (GPSC) to improve health care in BC.

Over time, the supports provided by A GP for Me are intended to:

- make it easier for doctors to provide and coordinate care for their patients efficiently – so they will be able to accept more patients into their practices; and
- enable physicians to develop plans at a community level to improve local primary care capacity, including a mechanism for finding doctors locally for patients who are looking for one.

The purpose of using the most significant change methodology (MSC) in the A GP for Me Initiative is to collect and analyse descriptive data in the form of stories which represent the perceptions and experiences of those connected with A GP for Me. Interviews using this template are undertaken to document, word-for-word, short stories told by people who may have benefited or been touched in some way by A GP for Me. These stories will enable the program to be designed and implemented in ways that reflect the views and concerns of people they it intends to benefit.

2. Respondent Demographics

| | |
|--|--|
| Storyteller name¹ (if consent has been provided) | |
| Interviewer Name | |
| Type of interview (i.e: face to face, phone/skype) | |
| Location of interview | |
| Years in Practice (please specify your number of years in practice: 0-5; 5- | |

¹ If respondent wishes to remain anonymous, don't record his/her name or contact details.

Probing questions:

Could you please tell me the story of what happened??

What were things like before the change?

Then what happened... what changed?

Why? Why did the change occur?

How did it occur/is it still occurring?

Who began doing things differently as part of this change?

Who else was involved?

How did you feel when this change occurred?

How did people react to this change?

From your point of view, is this a positive or negative change?

If you were telling this story of change to an audience, what title would you give it?

4- What makes this change important?

5- Do you want to add anything else?

Comments from data collector : (summarise the most significant change and why this change is important for the respondent):

5. Close interview

Thank the respondent for his/her availability and the time spent on the interview. Mention that his/her participation is vital to improve the primary health care system and access to services in BC. The people served by the 'A GP for Me' initiative will benefit you're your willingness to share your story with us.

