

Data Submission Guide: Time Spent Delivering Primary Care

An exploratory indicator for D2D 3.0

WHY THESE DATA ARE NEEDED? This information is needed to make sure that decisions about how much capacity exists in teams is based on what we actually do and to correct the flawed assumptions that MOHLTC and others have about the capacity of teams to take on more patients and even cope with existing demands. Without this information, decisions will continue to be informed primarily by beliefs, data about physician head counts and POSITION counts, among other things (regardless of whether positions are filled full-time, part-time or even at all). This is not good enough, and AFHTO needs better data to demonstrate and advocate for the value that teams bring to primary care.

WHAT DATA ARE NEEDED? Three numbers from as many clinicians (physicians and IHPs, including NPs, nurses etc.) as possible to indicate how much time (hours) is spent IN A TYPICAL WEEK on the following:

- 1) **Office appointments** with patients
- 2) **Other activities** defined as: Patient-specific work done outside of office appointments, including but not limited to, LTC or home visits (including travel), EMR documentation, reviewing lab results, phone calls to coordinate care for patients, QI efforts etc.
- 3) **Specialized clinical services** defined as: Shifts in emergency department, obstetrics, anaesthesiology, hospitalist, coroner, locums in other settings etc. (i.e. not your team)

*Please note: *Time tracking is NOT Required**

SUGGESTED APPROACH TO GETTING THE DATA:

NOTE: Teams are encouraged to do what works for them, however the following are recommendations based on the experiences and input we have received to-date and therefore, may help you collect data for this indicator

- **Work through your Medical Lead**
- **Explain the REASON for doing this FIRST** (see above)
- **Refer clinicians to this guide before they decide to participate or not**
- **Voluntary:** Invite people to provide data only if they want to
- **Anonymous:** Do NOT ask people to give their name
- **Team-level data:** Roll the data up and use at the TEAM-level only (i.e. not at the individual clinician level)
- **Exploratory nature:** Team-level data will be available only to the team -- aggregate summary (i.e. at AFHTO-membership level) may be shared externally to advocate for AFHTO members

HOW CAN THESE DATA BE CAPTURED?

- 1) Invite ALL clinicians to provide these 3 numbers via e-mail
OR
- 2) Ask clinicians to complete the following table (paper or electronically, yours and their choice)

Data Element	Response
1. Clinician type	physician or IHP
2. Hours spent on office appointments in a typical week	###
3. Hours spent OUT OF OFFICE delivering primary care in a typical week	###
4. Hours in specialized care in a typical week	###

Suggestion: Ask clinicians to complete an online survey (e.g. survey monkey) based on the above 4 data elements to help you gather the data in one place

- 3) Compile the data using the [D2D 3.0 Data Input Toolkit](#): Tab 3 of this toolkit will help you calculate your team-level data to be added into the D2D 3.0 submission form.

NOTE: your team-level data will be presented on the D2D 3.0 report as a single number (hours) reflecting ALL time spent by physicians AND IHPs per patient served.

HOW GOOD ARE THESE DATA?

- They're an important, valuable and shaky first step ONLY. Therefore, they will be presented as an "exploratory" indicator in D2D 3.0 so there can be no mistake that they represent a starting point ONLY.
- They are better than what is currently being used, simply because they are informed by what actually happens on the front lines.
- The data are estimates by volunteers so they are undoubtedly biased. We encourage teams to not do any individual-level intervention or interpretation of the data as this is not the intended purpose.
- Time tracking would generate more accurate data, however AFHTO has chosen not to do this. By taking time away from patient care, time tracking could paradoxically make things worse in our attempt to make them better. So as always, we all do our best.
- With these rudimentary data in hand, we can recalibrate existing data that are in use NOW to make better decisions about primary care capacity.

WHEN: before January 15th, 2015

NEED MORE INFORMATION? Please contact

- Carol Mulder (Carol.mulder@afhto.ca), Quality Improvement and Decision Support for AFHTO
- Dr Sean Blaine (blaines@sympatico.ca), president of AFHTO and family doctor with STAR FHT.

FAQs – Time Spent Delivering Primary Care

1. Which clinicians should be included in the estimate for time spent delivering primary care?

All clinicians should be included in the estimate either in the “physician” category or the “IHP” category. The IHP category is intended to include all “non-physician” clinicians (i.e. nurses, nurse practitioners, dietitians, pharmacists, social workers, chiropractors, OT/PT, speech language pathologists etc.)

2. Some of our physicians visit both FHT and non-FHT patients in hospital. Where do we count these hours in the estimate?

If the physician considers this as care for their patients that is done “after hours” this would be counted in category 2 (physician/IHP capacity – other activities). If the physicians considers this time as “hospitalist” role, then it would belong in category 3 (physician/IHP capacity – specialized services).

3. Most of our IHPs do their administrative work (e.g. updating EMR etc.) directly after each patient visit, during office hours. How should this time be counted in the estimate?

Whatever time is spent during “office hours” goes into the first category (physician/IHP capacity - office appointments). If they do documentation after hours, it goes in the second category (physician/HP capacity – other activities). In the end, category 1 and 2 will be combined together to provide a single total (at least for this iteration) so do not worry if you count it slightly differently. We invite you to add your comments describing your approach to collecting and entering the data on the D2D 3.0 submission form.

4. Is the name of the care provider necessary for the final submission?

NO – all teams are encouraged to be completely ANONYMOUS in the data collection and submission.

5. Who will this information be shared with?

Team-level data will be available ONLY to the team who contributed them. Data at the membership level will likely be shared with external partners to advocate for AFHTO members – i.e. the data that are part of D2D and will be distributed as they usually are, via anonymous member-level access to team data and external access to a summary of the data at the membership-level only.

6. How should we distinguish between full-time employees and part-time employees, as their hours in a TYPICAL week will be very different?

This indicator is NOT a measure of actual capacity yet and we are intentionally not using FTE as a measure, but rather asking for time spent delivering primary care only and adding it up for the ENTIRE team (i.e. one number for the TEAM, not individual data) and dividing it by patients served to facilitate comparison between teams.

7. How should time spent doing academic activities (i.e. teaching, research etc.) be accounted for?

We are asking clinicians to provide three numbers that are related to the care of a specific patient (i.e. time spent on office appointments, other activities, and specialized services, see the [Data Dictionary Version 4 for a more comprehensive definition](#)). Therefore, time spent doing research, lecturing or other academic activities is NOT counted towards their care delivery time.

8. For academic FHTs do medical residents count in the “total number of physicians in your team”?

If the resident is just watching, and the physician is delivering care, the hours should be recorded for the physician. If the resident is delivering care and the physician is present and actively supervising, that physician can be considered to be sharing in the delivery of care, so it will be counted as time for both of them. We realize that this means supervised care delivery by a resident will often count doubly, and that this could make academic teams appear inefficient in relation to non-academic teams. This can be taken into account as long as teams indicate academic status in their D2D submission.

9. Is there a “minimum” number of physicians and IHPs that are needed to contribute from a team in order to participate in this indicator?

At this point the indicator is intentionally positioned as **exploratory** so there is NO minimum number of clinicians needed to contribute data for. As always, the team-level data in D2D will remain completely anonymous.

10. How will this indicator be presented on the D2D report?

Regardless of the numbers of clinicians in your team who are able to contribute data for this indicator, it will be extrapolated to the entire team (see [D2D 3.0 data input toolkit](#)) and presented in D2D 3.0 as total hours/patient served.

11. Will my team be able to compare to other teams for this indicator?

This indicator will NOT show up on the interactive D2D 3.0 display platform, but rather will reside on a separate tab to indicate that it is exploratory. You will be able to compare results across all teams who contributed to the indicator, however NO teams will be identified as this is a completely ANONYMOUS comparison.