Risk Management Plan

Introduction

A GP for Me is a Provincial initiative that strives to reduce the number of unattached patients in BC, strengthen their primary health care system and improve doctor-patient relationship and the support for vulnerable patients. The Powell River Division of Family Practice developed a community specific plan, which was approved April 1, 2015 and will run till March 31, 2016.

The plan focuses on four (4) initiatives:

1. Recruitment and retention of physicians
2. Increase attachment of vulnerable and complex patients
3. Seniors' connectivity and support
4. Practice management support

This document lays out the risk management approach, process of risk identification and qualification and discusses the top five risks identified for this project and the mitigation strategy.

Risk Management Approach

The Project Manager is responsible for the overall risk management of *A GP for Me* project in Powell River. The top risks will be monitored by the assigned risk owners and any changes or concerns will be brought forward to the weekly team meeting. Quarterly, a formal status update will be provided by the risk owners and risks will be reviewed, including the risk qualification and the mitigation strategy. Changes will be added to the risk register.

Upon the completion of the project, the Project Manager will complete a risk analysis and provide recommendations for future projects.

Risk Identification and Qualification

Project risk were identified in a meetings with the previous Project Coordinator, the Executive Director of the Powell River Division of Family Practice the Project Manager, during a meeting with the project team, and an interview with the physician project lead. Risked were scored on impact and probability by the Project Manager in dialogue with the Executive director and physician project lead. Risks and scores where finally discussed with the project Steering Committee.

Risk Mitigation and Avoidance

Risks responses and risk owners are identified by the project team and responses will be managed within the project scope, time and budget constraints.

Top Five (5) Risks

The top five risks to this project are:

1. *An NP in GP clinic is not financially sustainable for GPs*

Due to the current financial model, where no overhead is paid for the NP in the GP clinic, the model might not be financial sustainable after the financial contribution by the division is no longer provided. To mitigate this risk, the division will develop a business case that paints a more holistic picture on the impact of the NP in the GP clinic, including system cost savings and qualitative impacts for all parties involved. Additionally, potential billing efficiencies for the GP will be included.

Furthermore, the Division will connect with other locations, such as Pemberton and Trail, where an NP is integrated into a GP clinic.
Lastly, additional funding might be made available by the division to extend the pilot to explore the full impact of a NP in a GP clinic.

2. *Lack of physicians' and community partners' capacity due to competing initiatives*

Especially in a small community people are easily spread thin. Although we cannot control other community initiatives, there is a risk within the organization that the division takes on other initiatives that pull physician and community partner resources away from *A GP for Me* project.
Regular communication between the Executive Director and Project Manager is needed to prevent this. Additionally, members engagement will be monitored and a plan development to schedule new initiatives for after GP for Me.

3. *Physician partners cannot find employment*

In the past, the inability for physician partners to find meaningful employment has been one of the reasons to move away from Powell River. A community approach with the support of a variety of community partners needs to be developed to mitigate this risk. Additionally, recruitment material needs to paint a realistic picture to manage expectations from new GPs and attract the appropriate people.

4. *Division Members don't support philosophy of NP and disengage from Division*

The work of a Nurse Practitioner is not supported by all division members. It is important to remain neutral in our communication and provide members a choice if they want to engage in the initiative. Additionally, the division will try to have a wide variety of initiatives to ensure each member is engaged and feels supported

5. Reduction of unattachment impacts Emergency Department (ED) GPs/physicians

Changes in unattached patients impacts the number of ED visits, which will impact the work of the physicians working there. Changes to ED visits need to be monitored and the potential negative impacts should be explored with physicians. If needed, a local solution needs to be found.

Risk Register

Strategies

E	Evaluation
G	General
IA	Increasing Attachment
PMS	Practice Management Support
RR	Recruitment and Retention
SC	Seniors' Connectivity and support

Risk Owners

BB	Brendan Behan
CB	Cara Bratseth
CK	Christien Kaaij
GC	Guy Chartier

	Strategy	Risk	Probability	Impact	Level	Mitigation	Owner
1	IA	NP in GP clinic is not financially sustainable for GPs	8	10	80	Connect with Pemberton and other NP initiatives to discuss strategy; Access additional division funding to extend pilot to buy more time.	CB
2	G	Division takes on other initiatives that pull-physician and partner resources away from A GP for Me project	8	9	72	Regular communication between ED and PM; Phase initiatives for start after A GP for Me/Shared Care; Develop year plan. Monitor members' engagement.	GC
3	RR	No employment for GP's partner	8	8	64	Create community partnerships; manage spouse's expectations; ensure recruitment materials provide realistic picture.	CK
4	IA	Division Members don't support philosophy of NP and disengage from Division	7	9	63	Keep open communication with members; ensure participation in division activities is optional; try to have a wide variety of initiatives to ensure each member is engaged/feels supported.	GC
5	G	Reduction of unattachment impacts Emergency Department GPs/physicians	7	9	63	Monitor ED visits; discuss impact with ED GPs/Physicians; find a local solution	CK
6	G	Division members don't see results or value of the initiatives and disengage from the division	6	10	60	Have regular check-ins with diverse members; adjust plan if need to fit members need; provide regular and clear communication; share successes with members.	GC

	Strategy	Risk	Probability	Impact	Level	Mitigation	Owner
7	RR	Lack of up-take retention planning	7	8	56	Have private face to face meetings with physician; use a flexible approach to meat physicians where they are.	CB
8	G	Community members and stakeholders don't see results by the end of the project	6	9	54	A plan will be developed to monitor and report on some key results after project completion	GC
9	RR	Recruitment and retention strategies are not sustainable by PRDFP after A GP for Me	6	9	54	Design all processes with future limitation in resources in mind.	CK
10	RR	A GP for Me sets expectations that Division cannot maintain	6	9	54	Manage expectations; Provide clear communication; Provide face-to-face information after project; develop realistic sustainability plan.	CK
11	PMS	Cannot attract appropriate staff	6	9	54	Start recruitment early.	GC
12	G	Division members feel overwhelmed and start disengaging due to high number of initiatives	6	9	54	Division member engagement tracking system; Regular communication to and from Division organization planning and project planning.	GC
13	G	Steering committee members start disengaging	6	9	54	Ensure committee members are utilized; select topics/conversation based on membership; Ask appropriate questions to solicit engagement; and provide monthly updates.	GC
14	E	Evaluation activities are too overwhelming for GPs	6	9	54		CK
15	G	Division is unable to take on other work outside of A GP for Me/Shared Care, which upsets members	5	10	50	Follow up in person with GPs and look at other options.	GC
16	SC	Health Link cannot accommodate GP/community needs	8	6	48	Explore options with executive director; develop exist strategy.	CK
17	E	Insufficient data to assess outcomes	6	8	48	Collect own data; and use qualitative and quantitative data.	CK

	Strategy	Risk	Probability	Impact	Level	Mitigation	Owner
18	SC	GPs do not utilize Health Link	8	6	48	Practice support to integrate referral process in GP's workflow; and detailed pre-assessment of GP needs for service development.	CK
19	SC	Community members don't access Fetch	6	8	48	Community engagement event and communication strategy; and review of pop-up survey to evaluate potential changes needed.	BB
20	SC	GPs and MOAs don't use FETCH	6	8	48	Practice Support strategy to promote use of FETCH.	BB
21	RR	Materials don't reach targeted audience	6	8	48	Investigate from current physicians how they heard about Powell River; develop a distribution plan; and use division and other community members to distribute material.	CK
22	RR	Joint recruitment (VCH, City) does not suite GP recruitment	6	8	48	Creation of physician profiles to ensure partners are aware of what GPs are looking for.	BB
23	RR	No support by GPs to plan/investigate the future recruitment needs	6	8	48	Have open up-front discussion with clinics and make support optional.	CK
24	G	Staff/Contractors are pulled into other division activities	6	8	48	Regular communication to and from Division organization planning and project planning; and regular staff meetings. [Staff time tracking?]	CK
25	SC	Community partners don't update/use Fetch	5	9	45	Community engagement event and communication strategy.	BB
26	SC	Community organizations don't want/cannot update own database	5	9	45	Yearly review; have system in place for smaller (temporary) initiatives; and have easy feedback button build in to website.	BB
27	RR	Lack of up-take of new-to-practice coaching	5	9	45	Proactive local engagement strategy; focus on billing optimization.	CB
28	PMS	GPs don't want practice support	5	9	45	Look for quick wins for initial engagement; and upfront effort on relationship building.	CB
29	G	Project staff cannot be retained until end of contract	5	9	45	Quarterly communication with staff/ED; and develop an alternative staffing plan.	GC

	Strategy	Risk	Probability	Impact	Level	Mitigation	Owner
30	RR	Tourism/City PR don't deliver desired products	6	7	42	Regular review and meeting process set-up to ensure materials stay on target.	BB
31	IA	NP patients feel attachment to clinic	7	6	42	Clear patient communication materials and plan.	CB
32	IA	VCH does not see financial value for NP in GP clinic	5	8	40	Developing a clear business case that demonstrates financial, work load savings; and reach out to Pemberton.	
33	RR	Unable to attract new physicians	4	10	40	A GP for Me Recruitment and retention strategy.	
34	RR	No temporary housing options available	4	10	40	Create community partnerships; and maintain up to date contact list for rental properties.	
35	IA	VCH does not see the value	4	10	40	Clear initial service agreement with role charity and scope; regular working group meetings; and PSC support.	
36	IA	Additional attached patient are upset when pilot discontinues (increase in patient dissatisfaction.	8	5	40	Clear patient communication materials and plan.	
37	IA	GPs don't see overall value	4	10	40	Developing a clear business case; and develop indicators for increase in work satisfaction.	
38	IA	VCH discontinues support	4	10	40	Keep VCH highly informed and engaged; and have clear understanding of decision making process of VCH.	
39	IA	GPs don't want to expand to take on complex patients	5	8	40	Ensure the referral process is clear and fair; and provide additional PSP support to lighten physician's workload.	
40	IA	GPs feel their workload is increasing instead of decreasing as there is work NP cannot do (some medication; forms)	5	8	40	Weekly clinic huddles supported by Practice Support; and develop plan for shared-care of GP patients in exchange.	

	Strategy	Risk	Probability	Impact	Level	Mitigation	Owner
41	SC	Data is not up to date	4	9	36	Develop community engagement event and communication strategy; send yearly reminder; have yearly review; and have easy feedback button build in to website.	
42	SC	GP/MOA feel their work is increasing due to paperwork and follow-up resulting from referrals	4	9	36	Review system; integrate into GP workflow process; Provide practice support.	CB
43	RR	New development relationship between Division and City of Powell River is damaged	4	9	36	Regular updates from project team with ED; set clear expectations; and accept lower quality of materials if needed.	
44	RR	Messages are not suitable for physician recruitment	4	9	36	Clear initial agreement on what messaging should be; and regular check-ins to ensure messaging stays in scope.	
45	RR	Clinics feel Division is interfering with business	4	9	36	Have open up-front discussion with clinics and make support optional.	
46	PMS	Division PSP staff unable to find resources/knowledge needed to effectively support GPs	4	9	36	Connect with other divisions; and connect with PSP.	
47	IA	NP is pulled towards other areas by VCH (i.e. residential care)	4	9	36	Keep VCH highly informed and engaged; Have clear understanding of decision making process of VCH.	
48	IA	Financial gain to the system cannot be proven	5	7	35	Reach out to other pilots; explore data collection with evaluation team; build strong relationship with VCH; build strong relationship with MOAs; and capture qualitative improvement.	
49	RR	VCH PSP feels replaced by local clinic support person and disengages from community	4	8	32	Upfront relationship building to ensure PSP skill set maximized as appropriate.	
50	RR	GPs don't want practice support	4	8	32	Make support optional; and ensure available support is flexible and catered to physician's needs.	
51	E	Evaluation activities are too overwhelming for patients	4	8	32		

	Strategy	Risk	Probability	Impact	Level	Mitigation	Owner
52	IA	NP burns out	3	10	30	Monitor workload via MOA and weekly clinic huddles.	
53	RR	Division is caught in the middle of competition for GPs	3	10	30	Ensure position stays neutral; and communicate with all clinics at the same time as much as possible.	
54	G	Contractors damage Divisions reputation	3	10	30	Have regular meetings; set clear parameters, i.e. around confidentiality; and build a culture of respect and openness.	
55	IA	GP-clinic does not see the value	3	10	30	Clear initial service agreement with role charity and scope; regular working group meetings; and PSC support.	
56	G	Insufficient workspace is hindering project execution	4	7	28	Use of Regional District Board Room as needed/available; use of home offices; and reconfiguration of current office space.	
57	SC	Community organizations don't want to participate	3	9	27	Large community event; show success; and continue promotion.	
58	RR	Tourism/City PR don't deliver on time	9	3	27	Have regular contact with Tourism/City PR; and provide support if needed.	
59	G	Project loses focus and creeps out of scope	3	9	27	Regular review of work plan.	
60	SC	FETCH does not capture information that GPs/MOAs need re: services	3	8	24	Identify gaps and relay to FETCH for potential changes to database.	
61	G	Original targets are set too high	8	3	24	Iterative re-evaluation of original targets.	
62	E	Insufficient access to stakeholders	3	8	24	Close communication with Project Lead; develop an implementation Gantt chart in-line with project work plans.	
63	E	Evaluation does not measure local output/outcomes	3	8	24	Develop metrics together with evaluator.	
64	RR	Community partners don't support recruitment/retention	2	9	18	Initial "integration needs assessment" on incoming physicians so community support can be targeted; and clear communication messaging and plan to promote needed community support.	

	Strategy	Risk	Probability	Impact	Level	Mitigation	Owner
65	RR	Health Match BC hinders local recruitment	3	6	18	Be aware of provincial recruitment and retention; pre-discuss Powell River plans.	
66	RR	Roles at different levels are not clear	3	6	18	Be aware of provincial recruitment and retention; pre-discuss Powell River plans.	
67	RR	Interfering with clinics own recruitment	2	9	18	Have open up-front discussion with clinics and make support optional.	
68	RR	GPs don't want PRDFP engagement in recruitment/retention	2	9	18	Have open up-front discussion with clinics and make support optional.	
69	IA	GP-NP don't work together as a team and NP is unsupported	2	9	18	Weekly clinic huddles supported by Practice Support.	
70	IA	NP has insufficient # clients	2	8	16	Communication strategy to promote referrals to NP.	
71	RR	Tourism/City PR go over budget	2	6	12	Request regular budget updates	
72	G	Division members feel unwelcome due to large use of hub space by project team	2	6	12	Use of Regional District Board Room as needed/available; use of home offices.	
73	SC	Database does not work	1	10	10	Closely work with website builder.	
74	IA	NP leaves	1	10	10	Local practice support staff to stay closely connected to NP.	
75	G	Project runs over budget	1	9	9	Regular meetings PM and ED; Clear budget outline.	
76	IA	Community does not support NP work	1	4	4	Provide clear communication to general public about the role of the NP.	