Prince George
Division of Family Practice
A GPSC initiative

Celebrating 10 Years: 2009–2019

Division Newsletter

A newsletter for Division members: Family Physicians & Family Practice Residents. Please feel free to share with your Health Care partners

April 2019
Issue 19

From the Desk of the President: A REAL STORY

By Dr. Garry Knoll

Why do we try to change Primary Care? A couple moved from their home prairie province to the Kelowna area upon retirement. They were closer to family in this province. Their health deteriorated over the next 20 years. DM, CHF 2° to AS, gastric volvulus, minor CVA's, poor results from bilat TKA's for her and CAD, angioplasty, followed by dementia for him. Truly co-dependant and when she died he was unable to cope. She had been the brains and he the brawn. They never knew who to call about their health needs. They thought Jean was coming to visit Tuesday but Sally would come at an unexpected time and make them bathe when they did not think it was needed.

They said a new person came every time. Family could not connect with anyone who knew about a care plan. Their doc, whom they loved, had no organized review or communication. She could not be reached after hours, had no appointments for urgencies, had no hospital privileges, did not make house calls for housebound patients, and never initiated communication with family. Many specialists gave advice but the couple had difficulty understanding it in context of all their illnesses. After hours advice was to go to a Walk In Clinic. They had a list of phone numbers of allied health professionals and several cards from care providers with titles that did not make sense to them or their family. They found the burden of trying to understand and navigate the system overwhelming and began missing appointments and investigations because it was too much trouble. No one asked them about their preferences in care. The joyful part of their lives came from family and church friends. One of their children took them to his own community in the last 3 years of their lives and cared for them in their palliative years.

4 Influencing and informing the system for positive change

In health care, many new services and programs emerge, and as they come out of the idea hopper, they lay in a heap on the ground disconnected from each other. At the Members Meeting April 24th, we are talking about Patient Care in an Integrated System. Can we make a difference together?

Integrating Care: Across Primary Care, Acute Care, Specialist Care and Specialized Services

By Olive Godwin

If we look at integrated care from the perspective of the patient it is not hard to see what needs to happen across the silos. Patients have expectations that information is shared, their family doctor is coordinating their care, specialist and specialized services are brought in when a higher level of care becomes necessary, and agreements are made about who will do what when implementing the plan of care. But we know that this type of care is not readily available. It is not currently accessible, seamless or coordinated, especially where Primary Care and Specialist Care are called upon to work together in service of the patient.

As we work to define a Primary Care Network (PCN) and a Specialized Community Services Program (SCSP) with those expectations from patients in mind, it becomes clear that integrated care cannot be accomplished without 'working on the system' together to co-design the service model of the future.

In Prince George we have some excellent examples of our emerging system work. The Prince George Joint Leadership for Health Committee (JLC), continues to evolve to ensure all of the parties are represented at a PG planning and governance table. The JLC now has membership from the PG Division of FP, UPIC, many Department Heads at UHNBC, the PG NH Medical Director and Health Service Administrator, First Nations Health Authority, local Indigenous groups - and soon patients - all participating in the collaborative structure required to truly make a difference within the system.

As a clinical example, we have the recent work of the Northern Shared Care Psychiatry Collaboration (NSCPC), where Psychiatrists, Family Physicians, Northern Health Specialized Services and Interprofessional Teams worked together to co-design a service model for mental health and substance use for the north. Other specialties, both in the north and outside of the region, are very interested in looking at how that model can be applied in other areas.

Moving forward, there is partner work under way to develop the new Primary Care Medical Unit (PCMU) on the 2nd floor of UHNBC, as well as the ongoing multi-stakeholder group "Renewed Focus on Over Capacity and Flow at UHNBC." Both are excellent examples of what is possible with true collaboration!

1 Striving for excellence in all aspects of the primary care home

4 Influencing and informing the system for positive change

Spring Members Meeting: Wednesday Apr. 24th 1700—2100
(note new start time)

Patient Care Through an Integrated System

Up to 3.25 Mainpro+ credits available

Details:
Location: LDC Room 0501

- **All Family Physicians, FP Residents, along with Nurse Practitioner and Internal Medicine colleagues welcome**
- **Dinner, session payment for members, Resident honoraria provided**

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UBC CONTINUING PROFESSIONAL DEVELOPMENT FACULTY OF MEDICINE

Patient Activation

By Dr. Susie Butow

In this era of integrating multi-disciplinary teams into Primary Care to support the patient, let's not forget the patient is also a member of the team. In order to be effective team members, patients need to be armed with tools and information about their health.

I'm referring to "Patient Activation," a behavioural concept that really represents the successful outcome of patient engagement. Patient Activation speaks to an individual's knowledge, skill and confidence in managing her own healthcare. It is a better predictor of health outcomes than even socioeconomic status. An 'activated' patient understands her role in the care process and feels capable in managing that role. These patients are more likely to be engaged in positive health behaviours, giving better outcomes. People with low levels of activation are less likely to play an active role in their own healthcare and are more susceptible to poor outcomes.

There is some exciting work underway in our region to support patient activation. As part of the PCN (Primary Care Network) service plan, the Division will be developing a communication and education strategy with patients and care providers to support and increase patient activation. AIHS and NH IT are working together right now to develop a system to enable patient access to their lab and imaging results (see Bill Gordon's article below).

How can we expect patients to make decisions in their own health care if they aren't armed with the same objective information we are? It's our role as care providers to help interpret the information in the context of the patient's social, emotional, and physical health to support and manage the health condition. Activated patients will better understand, contribute to and implement the plans we come up with together.

3 Partnering with patients and communities for improved health

Primary Care Medical Unit

By Dr. Theresa Shea

The Primary Care Medical Unit (PCMU): 24 new beds on the 2nd floor at UHNBC, slated to open on May 22, 2019!!!

The PCMU is a component of a bigger Sustainable Inpatient Care Program. It has two facets - one is a new way of providing inpatient care via the Inpatient Doctor of the Week (IDoW) program, where we take turns doing 1 week of (very well-incentivized - come talk to me for details!) 24/7 care, managing unattached patients that need a GP as MRP. The processes on the unit are designed to deliver inpatient care in a patient-centred, team-based way, with lots of focus on patient activation and efficiency of care. Lots of work by many people has gone into designing new patient and staff processes. Nurses will be empowered to mobilize patients early, encouraging them to eat in the dining room and use the gym on the floor. Most exciting of all, rounding (in general - some exceptions!) will be done in a manner similar to rounding in the ICU: a structured, interdisciplinary bedside round, to improve team communication and understanding of the medical stay. The second facet is attaching unattached patients via a new attachment rota. To avoid unnecessary readmissions and to ensure continuity of care for the patients, they will be attached to a community practice, wherever possible. The attachment rota will also ensure that when you finish an IDoW shift you don't end up carrying a patient burden with you - care is transferred either to Blue Pine Clinic, Central Interior Native Health (CINHS), the next physician on the attachment rota, or the next IDoW. Uptake has been good - so far, we have more than 30 docs on both the attachment and IDoW schedules. To be successful, we need as many docs as possible to participate, so if you would like more information on either of these programs, or want to sign up, let me know (theresa.shea@gmail.com). See you in May on our beautiful new unit!

2 Sustaining a strong community of family physicians

MyHealthKey: Working Toward Patient Access to NH Lab Results and Online Scheduling

Bill Gordon, President & CEO, AIHS

Patients that are more involved in their healthcare – have a higher activation level – generally see better outcomes and reduce costs to the healthcare system. To this end, AIHS has been working closely with Northern Health on a project to enable online patient access to medical records and services.

The first phase of this project has two goals: providing patients online access to Northern Health lab results and imaging reports, and enabling online appointment scheduling for participating MOIS clinics.

How is AIHS helping to achieve these goals? We are building on our recently acquired personal health record solution, rebranding it and integrating it with MOIS. We are also working on enabling the flow of lab results and imaging reports from provincial sources of health information.

The new website for patients will be called MyHealthKey. Once registered in MyHealthKey, patients will be able to logon and see a copy of many of their Northern Health lab results and imaging reports almost immediately after they are distributed. They will also be able to see open slots at participating clinics and book appointments in them. And, they will get reminders for these appointments via email and text.

We think MyHealthKey will be live for some patients and clinics late this year. But, as you can imagine, sorting the registration, consent and privacy concerns represents a significant challenge for both AIHS and NH. We are also working on the list of what lab results and imaging reports will and will not be made available online, and how preliminary results will be handled.

3 Partnering with patients and communities for improved health

Finally, keeping the impact on clinics and providers as low as possible is of paramount concern to us. In fact, we intend for MyHealthKey to have the opposite effect: patients should come in more knowledgeable and clinic staff should have to spend less time making appointments and handling cancellations and changes.

After we complete this first phase, AIHS is planning on adding more features to MyHealthKey and extending its integration with MOIS. Our plans include support for: secure messaging between patients and healthcare providers, virtual/video appointments between patients and healthcare providers, online patient assessments and surveys, patient access and (controlled) updates to demographics, conditions, allergies, medications and goals, and patient access to and uploading of clinical documents.

We will keep you abreast of our progress. Please reach out to us at anytime at support@aihs.ca if you have any questions!

Access

By Dr. Barend Grobbelaar

How do you feel as physicians when your efforts to get your patients the care they need takes repetitive effort, uncompensated time, and ongoing persistence to achieve? How do patients feel as they interface with their doctors' offices with similar frustrations? As we design the future of health care around Primary Care Homes, we need to be mindful that success will demand a service oriented attitude if we want the public to embrace this model.

Historically the ACCESS conversation has predominated around 3rd next available appointment. It is time we look at additional domains. We need to consider the consequences of the time and effort it takes to get an appointment, availability of timely appointments, attitudes displayed while negotiating appointments, long wait times at appointments, and feeling rushed and not heard in the appointment. Doctors who resist running all day on the Ferris wheel of rushed appointments pay the price both in income and often in running late on appointment times.

How do we approach this? We could look at systems and processes where patient satisfaction in particular domains is higher in particular practices. Examples being: investing in appropriate telephone infrastructure for the size of your clinic; exploring the soon-to-be available online booking feature of the Personal/ patient medical record; developing a drop-in component to your practice, particularly making some time for after school and work access; working closely with the new Urgent and Primary Care Centre to facilitate patients receiving timely care; optimizing use of the Interprofessional teams to support the more complex patients in your panel.

This brings us to the intersection between ACCESS and ATTACHMENT. How do we facilitate the promotion of healthy therapeutic relationships, and what approach do we take in dealing with the many hundreds of patients who feel they have lost the therapeutic relationship with their provider and feel trapped and unable to change providers? Maybe the current FFS system contributes to that disenchantment, as it is widely understood to work against service being a central tenet of our system.

There is currently an opportunity for Primary Care Homes in Prince George to opt for a blended payment system, which will allow for many innovations in improving the experience of Primary Care without penalizing the physicians providing that care. Can we as a community envision a time in the future where the population of Prince George embraces its Primary Care Homes, having come to the understanding of the benefits of longitudinal relationship-based care and feeling that they have access to a timely and responsive service?

1 Striving for excellence in all aspects of the primary care home

Northern Health Update: What's New With Interprofessional Teams (IPT)

By Andrea Mainer, PG Community Services Manager, NH

Prince George Interprofessional Teams continue to provide a variety of services through a team-based approach. Our capacity is stretched, as service requests continue to rise. In March 2019, 650 service requests were waitlisted, and as a result, clients are experiencing longer than typical wait times. Primary Care Providers can assist wait time management by identifying the priority level in the service request. You can do that by including a detailed reason for the request with supporting information (e.g. a detailed care plan with copies of the relevant assessments in the chart).

In recognition of the ongoing demands for team-based care, in addition to the resources added to the Teams in summer/fall of 2018, an additional Mental Health and Addictions Clinician position was added last month. The Prince George Division of Family practice, in partnership with Northern Health Community Services, requested significant additional team resources in the recent Primary Care Network service plan. We are eagerly awaiting the final outcome of that proposal.

The Interprofessional Teams work closely with community programs including Home Support, Rapid Mobilization, and Home Care Nursing to support clients to remain independent and at home as long as possible, and actively collaborate with UHNBC when clients connected to the Teams experience admission for acute care.

We continue to work together with Physicians, Coaches and Division staff, in the Committee Supporting Primary Care Homes (CSPCH), to identify and address barriers that currently prevent us from working closely with Primary Care Providers and their patients to deliver timely, comprehensive, longitudinal team based Primary Care. It was decided at the CSPCH that IPT staff would benefit by hearing from Dr. Susie Butow (PCN Physician Lead) and Dr. Cathy Textor (Division Physician Lead) about the details of the PG PCN proposal. In that discussion in January 2019, they heard first hand that their capacity struggles were front and center in the proposal with a request to significantly bolster the current teams.

1 Striving for excellence in all aspects of the primary care home

Welcome to new Members:

Dr. Shannon King
Dr. Dana Thomsen

and welcome to new member Residents:

Dr. Hassan Nijm
Dr. Sadik Alpachachy
Dr. Rae Kamstra
Dr. Ross Williams
Dr. Stacy Cabage
Dr. F. Mona Nasiri

Division Staff Updates

- Blue Pine Clinic
  - MOA Lindi Correia
- Division
  - Programs Administrator Karen Flores
  - NSCPC Administrative Support, Meaghan Alspaugh

PG Practice Coverage

We are actively recruiting a second PG Practice Coverage physician.

-Provides up to two weeks max. short term coverage.
-Physician/ Practice standard 70/30 split.
-Scheduling is managed by the Division in 3-month increments.

First Call for November, December 2019 and January 2020 will be released *May 1st 2019 at 12:00pm and second on May 15.*

Contact: Karen Flores, Programs Admin. kflores@divisionsbc.ca

Your voice matters!

We always welcome comments, concerns, success stories, & challenges. Contact Olive Godwin at 561-0125 or email ogodwin@divisionsbc.ca.

IPT: suggestions, complaints, success stories to Drs. Cathy Textor or Phil Asquith.

If you no longer wish to receive Division newsletters, or need a direct deposit application form, please email Heather at hstillwell@divisionsbc.ca.

Coaching Team

Megan Hunter
Clinical Programs Lead

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Are you on Pathways?

Improve your patient referral to **specialists** and **clinics** with up-to-date information from all of the Northern Region.

Physician resources and **shareable content for your patients** and many more options!

For more info contact **Karen Flores**
northernregion@pathwaysbc.ca

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Blue Pine Primary Health Care Clinic
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Phone: (250) 596-8100
Fax: (250) 596-8101
M-Th 8:30-4:30
(closed 12-12:45)
F 8:30-12:00
(open 1-4 alternate wks)

Coaches Corner: Care Plan Competition

By Karen Gill, Tammy Bristowe, Laura Parmar

We are excited to announce that the Distribution button in MOIS is active! This button allows you to quickly push your patient's care plan to Powerchart, without the 10 steps involved with signing into Powerchart.

First, ensure your patient's name, gender, date of birth, PHN, and Insurance Type match what is in CERNER. If EMR to EMR is not enabled for your clinic connect with AIHS to get it set up. See newsletter insert for steps to upload.

We recommend that you double check the first few uploads but keep in mind that it may take up to six minutes to appear in Powerchart. You may also contact your coach to help you get started.

Please note that Care Plans should be uploaded by the physician not the MOA. Although the distribute button means MOAs no longer have to use the doctor's log in for Powerchart (yes, we are aware it happens!), uploading an incorrect or inaccurate Care Plan is a major security breach. If you'd like to discuss this further, please speak to your coach.

Now that you know how, let's make it interesting! The coaching team invites you to compete in our **Care Plan Competition**! Prizes will be awarded at the Fall Members Meeting to the doctor with the most total Care Plans uploaded and the most Care Plans uploaded during the competition.

Here are a few rules:

1. Health Conditions, Allergies, and Long Term Medications must be reviewed using the Review button to time stamp.
2. Patient must be aware their Care Plan is being uploaded.
3. Patient must have an Associated Party listed (eg: emergency contact, next of kin, substitute decision maker).

Check out the "Prince George Division of Family Practice – Doctors Forum" Facebook page for updates and standings. Contact your coach if you'd like support with Care Plans or identifying patients to start with.

1 Striving for excellence in all aspects of the primary care home

COPD Action Plans

By Rob Pammett, Research & Development Pharmacist, Primary Care, NH

Interdisciplinary care can support even the most challenging patients. COPD is amongst the most common reason for hospital admission in northern BC, with an average cost per stay of over $6000. Pharmacists can help manage people living with COPD by providing a number of helpful services to the care team.

Appropriate and careful review of inhaler technique is the easiest way to ensure people with COPD are getting the most out of their medications. There are now eight different inhaler devices on the market, each with their own unique process for effective medication delivery. Pharmacists can review inhaler technique to assess for proper adherence, as well as recommend alternative devices. For example, I recently recommended a Respimat device for a person who was having difficulty with their Metered Dose Inhaler (MDI). The Respimat technique was much easier to manage and we were able to combine their medications into one device.

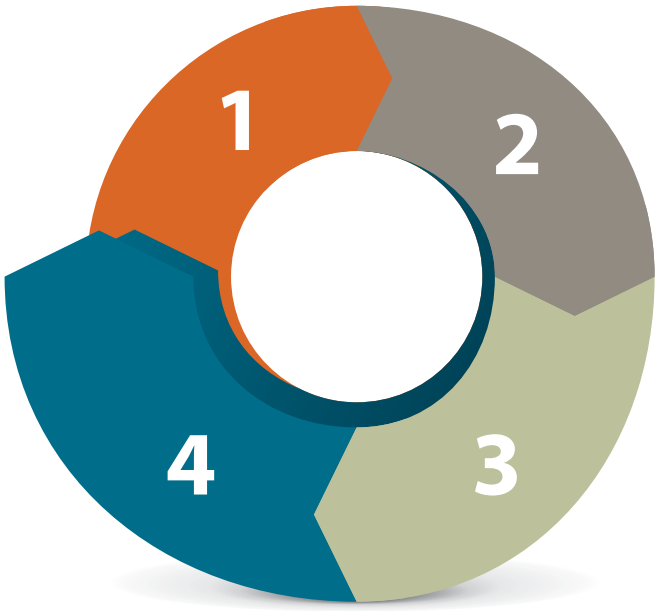
Pharmacists can also help ensure that people with COPD have and understand their COPD action plans. These COPD action plans guide people on when to use inhalers, when to use action plan medications (typically higher doses of their inhaled medications and often oral antibiotics and steroids), and when to seek emergency medical attention. Pharmacists collaborate with prescribers to individually tailor antibiotic selection and steroid dose and provide education on their use. Confident utilization of a COPD action plan can prevent COPD related hospital admission and hasten return to baseline breathing.

Finally, pharmacists can support appropriate stepwise treatment for COPD and rational prescribing of medications. Unfortunately, I still occasionally see Inhaled Corticosteroids as monotherapy for people with COPD, which we know causes harm. Adherence to the algorithm contributes to safe, effective, and rational medication use for managing this chronic condition.

If you would like support with any of the above, or any other medication related issue, do not hesitate to contact me directly or send a service request to the Interprofessional Team Pharmacist.

3 Partnering with patients and communities for improved health

Contest: R.O.A - Read On Arrival **We're trying something new! As with the last issue, each newsletter will have a question based on the topics covered in the articles; enter for a chance to win a prize! Send your answer - with the word 'quiz' in the Subject line - to princegeorge@divisionsbc.ca. This issue's question: *What does PCMU stand for?***



STRATEGIC DIRECTIONS
2019-2021

Prince George
Division of Family Practice
A GPSC initiative

1 Striving for excellence in all aspects of the primary care home

- Align multi-disciplinary care services to primary care practices
- Maximize effective attachment and access to primary care homes
- Provide comprehensive practice support to primary care homes
- Improve primary care in residential care
- Provide effective, sustainable inpatient care
- Improve transitions in care
- Improve the care of marginalized populations

2 Sustaining a strong community of family physicians

- Maximize physician health and resilience
- Recruit and retain an optimal number of family physicians
- Ensure the full spectrum of primary care services are provided by the community of providers

3 Partnering with patients and communities for improved health

- Increase physician leadership in population health
- Build and maintain relationships with community partners
- Engage patients and their families as partners in their health
- Promote the value proposition of primary care and primary carehomes

4 Influencing and informing the system for positive change

- Engage physicians in primary care transformation
- Co-lead the strategic implementation and maintenance of the vision for primary care in the North
- Influence healthcare policy in British Columbia

VISION

"Where we're going"

Healthy citizens served by healthy providers delivering integrated, longitudinal, full-service primary health care in a networked and sustainable system.

MISSION

"How we do it"

Through innovation and by engaging all primary care providers and partners, we will lead and enable a culture of quality that addresses the unique health needs of individual patients and our community as a whole.

GUIDING PRINCIPLES

"How we show up"

- Leading from within and fostering shared leadership
- Working with patients, community and providers in a way that is effective for them
- Fostering cultural humility
- Recognizing the value of interdependent partnerships
- Using data and self-reflection as the foundation for a culture of quality
- Providing stewardship for a sustainable healthcare system

January 2019

Remember...Contact your coach if you have any Care Plan questions!

Care Plan

Prince George Division of Family Practice
A GPSC initiative

1. Preferences

- Advance Directives
  Eg. MOST
- Treatment Agreements
- Vaccination Declined
- Pharmanet Consents
- Info Disclosure/ Permissions

2. Goals/Targets

- Non-standard Goals
  Eg. A1C <8
- CA Survivorship
  Eg. Quantitative-Chest xray 1 per yr
- Diet, Exercise, Weight
- Smoking Cessation
- Sleep
- Meditation
- Lifestyle discussion
- Future Referrals

3. Barriers to Care

- Can't afford meds
- Transportation issues
- Safety concerns/ violence risks
- Low IQ
- Treatment Agreement Adherence (running log)
- Behaviour
- Psycho social

Prepare your CarePlan for upload

1. Click Review in Health Conditions, Long Term Medications, & Allergies.
2. Update Associated Parties if information is available.
2. Confirm patient's name, gender, DOB, PHN, and insurance type match CERNER.

Upload your CarePlan

1. Under the Care Plan section, click Distribute.
2. A new window will open. Check that the correct physician is entered as the author. Select NH POWERCHART as the Primary Recipient.
3. Ensure that Type is set to SHARED CARE PLAN and Diagnosis is entered as COORDINATION OF CARE PLAN".
4. Click Distribute. A second screen will appear, click Distribute again.

4. Patient Resources

- Support of family, friends
- Son drives to appointment
- Spirituality
- Recovery programs
- Habits
  Eg. Exercise
- Home care for bathing

5. Planned Actions

- Chronic Pain Plan
  Eg. Tapering
- Mental Health
  Eg. CBT goals
- Interventions
- Lifestyle discussion
- Assessments
- Tapering Meds
- Teaching

Eg. glucose monitoring, inhaler technique, etc.

6. Auto Populate

(Data "pulled" into the Care Plan if you have entered them in MOIS)

- Health Conditions
- Long Term Medications
- Allergies
- Connections
- Associated Parties
  Eg. Emergency Contact
- Extended benefits

7. Tagging

- Patient chart items can be tagged to show on the care plan.
  Eg. Measures like PHQ9 or GAD7,Extended Benefits from Demographics.

IPT Service Request Guide

If urgent or if you need to discuss further please send service request and call IPT at 250-565-2612

northern health
the northern way of caring

Patients who have access to ICBC, WCB, EFAP and Extended Health Benefits should explore those options first prior to accessing IPT Services.

In your referral letter please include:

1. Client demographic info: name, address, phone number, PHN, alternative contact[6] (name, phone, relationship with client)
2. Reason for referral/resources needed and Urgency (Urgent = 1 day, Semi-urgent = 1 week, Routine = 2-4 weeks)
3. Any known safety concerns/violence risk[3]
4. If known, best times to connect with client, or if a coordinated appointment with clinic is most appropriate

Mental Health	**Social Work**	**Long Term Case Management**	**Nursing**
Mental Status Exam[7] PHQ9[7] GAD 7[7] Suicidal ideation & plan[7]	Barriers to accessing resources[3]	ADL/IADL - Finances[3] - Mobility/Transfers - Frailty (CSHA)[7] Recent fall history Family support/caregiver burn out[4] Cognitive assessment (MoCA, MMSE)[7]	Relevant assessment

PT/OT

If home safety: recent fall history, palliative performance scale (PPS), cognitive screen
If acute post-operative orthopedic: type of surgery and date[7], weight bearing status, post-op precautions/contradictions[1]
If wound/pressure injury: location, stage[7]
If chronic pain: consults[7]
Other: relevant assessment

* Numbers correspond to the Care Plan sheet sections above.

Ver. 2019-04-03