The Pulse

Guest Editor: Dr. Ash Ahmed November 2020

Prince George Division of Family Practice
A GPSC initiative

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

FROM THE DESK OF THE PRESIDENT

By Dr. Susie Butow

2 Sustaining a strong community of family physicians

For years now, physicians have been experiencing burnout, leading to significant personal distress, moral injury, substance use/abuse, a change in career, and suicide, among other effects. Three years ago, at a Members Meeting, our Division began a conversation about this. We talked about recognizing and measuring our compassion fatigue, but we didn't really advance the conversation about managing it.

The system is broken, we say, and must change in support of its providers who are paying such a terrible price to provide care to our patients. We then wait for change and it doesn't come. What does come is the twin pandemics of coronavirus and opioid abuse, along with lots of gratitude from our leaders and partners about the hard work we do and our quick adaptation to new ways of working. While the acknowledgement is appreciated, there is no accommodation for this extra work, nothing to offset it. No lightening of our already heavy load of work.

So, this means that *we* must change, if the system won't. The Serenity Prayer asks for "the serenity to accept the things we cannot change, the courage to change the things we can, and the wisdom to know the difference." The pandemics are beyond our control, as is the healthcare system as a whole. What courageous change can we do individually, or together as your Division, to help you work in a way that won't lead to burnout?

CHANGE BALANCED WITH A COLLECTIVE VOICE

By Olive Godwin

2 Sustaining a strong community of family physicians

It is with some regret that I write my last submission for the newsletter. But I also feel joy and anticipation, for you, for this organization, and the road ahead. I believe we are in a time of significant change and something different is called for on the next leg of the journey. My stepping away will make space for that something different to emerge.

We accomplished a lot together since incorporation in 2009! The PG Division is solidly established. Thank you to all the hands that played a role in that, the many members who contributed on the Board and committees, and the many staff who toiled tirelessly to build the foundation we have today.

In 2009 it seemed simple, we worked to help everyone understand the opportunity and power of a collective physician voice through the structure of Divisions. But today it is much more complex. I wonder what the future holds? From the information that we have seen over the last few months, I expect we will see family physicians working in a very different way going forward, probably delivering more care virtually using more technology. Hopefully we will see physicians working closer to the top of their scope. I expect there will be many other primary care providers and physician extenders in the system, and patients will have an enhanced role on the health care team. As you know, there are new contractual opportunities being offered, I do wonder about the potential loss of autonomy, especially if there is a significant uptake of contracts! Hopefully planning for any of these changes includes input from the collective voice of late-, mid-and new-to-practice physicians.

OUR Hx

By Dr. Barend Grobbelaar

4 Influencing and informing the system for positive change

The Prince George Division of Family Practice was incorporated in the summer of 2009. The newly incorporated Division was in the fortunate position of having thought through many of the community's primary care needs in the preceding years, as the Primary Care steering committee had been struck in Dec 2006 by NH. The areas of focus of that committee were data-driven QI in physicians' offices, frail elder care and the unattached and marginalized population. It was this advance planning that allowed the Division to rapidly take advantage of the opportunities afforded us through this new Divisions structure.

In the early years, we were directed by the Ministry to shelve our work on our comprehensive plan and focus on developing a sustainable inpatient Doctor of the Day program. This was achieved by the end of 2009 with the signing of our first inpatient service agreement with NH and MoH. A service agreement for residential care followed in 2013.

We then turned our focus back to a more comprehensive approach to our community's primary care needs. Throughout that time and until the Physicians Information and Technology office (PITO) was disbanded in 2013/14, we shed significant blood, sweat, and tears as we fought to have MOIS survive as PITO worked to exclude us from provincial platforms. Fortunately, we prevailed and are now proud to have contributed in a foundational way to Aggregated Metrics for Clinical Assessment Research and Evaluation (AMCARE), and its evolution into the Health Data Coalition (HDC), which holds the future of aggregated anonymized primary care data for the province.

The work from 2013 to date has primarily focused on the integration of primary care services and the incorporation of interprofessional teams to support patients and doctors' offices. This work is ongoing. Integral to this work is promoting and supporting the survival of longitudinal, comprehensive, relationship-based primary care. The Prince George Division believes that sustainable, integrated primary care homes are a necessary foundation for the sustainability and survival of the Canadian healthcare system as we know it.

Fall Members Meeting: Wednesday Nov. 18th, 6-8pm

COVID: Physician Challenges

Location: Zoom / Dinner: Farmhouse Catering / Division Members & NPs welcome. / Session payment for members and resident honoraria provided.

PHYSICIAN MENTAL HEALTH HAS INDEED BEEN TAXED BY COVID-19 IN INSIDIOUS WAYS says Louise Leger

In her article *The Psychological Toll.* Canadian Healthcare Network (Jun 5, 2020) The Psychological Toll. *See excerpt below, to read the entire article please see https://www.canadianhealthcarenetwork.ca/the-psychological-toll*

...Physicians have a high rate of burnout at the best of times, and studies show rates of burnout, anxiety and depression are higher yet during pandemics. Indications so far during the COVID-19 outbreak are that physician mental health has indeed been taxed, and across a larger physician population than expected—in more insidious but less dramatic ways than anticipated.

With reports from Italy's ERs and New York's ICUs, Canadian doctors were prepared for the worst. Doctors expected to be overwhelmed with patients, while possibly deciding who gets a ventilator while watching others die. Some doctors prepared to be redeployed to an unfamiliar front line. The predominant thinking was that the crisis would arrive, create havoc, and then ease off, at which point some sense of normalcy would return.

Instead, the mental health toll for physicians is stretching far beyond the ERs and ICUs. It relates to the uncertainty of the future, our changed way of living and "chronic untreated stress," as one physician put it. From under-employment and long, complicated doffing and donning rituals, to the replacement of in-person appointments with virtual care, the stresses are many.

2 Sustaining a strong community of family physicians

"That surge of patients didn't happen," said Dr. Andrew Clarke, executive director of the Physician Health Program at Doctors of BC. "But people started to realize this is the new normal and it's going to persist for a long time. This suddenly means that I have to reorganize my whole life, and not only my working life, but how I take care of my young kids and how I deal with my aging parents . . . this is way bigger than we thought and we're in this for the long haul."

CARE PLANS AS A WAY TO ACTIVATE PATIENTS

By Dr. Omesh Syal

Patient Activation. COVID-19. Telehealth. Care plans.

We are practicing medicine in a new way. COVID has thrown us for a loop, but we physicians have always landed back on our feet. We have gone from face to face contact to virtual or telephone. So, in this new time, how do we physicians get patients to take charge of their own health? Care plans have always been a great way to engage patients.

Prior to COVID, we sat patients down, spent time with them, went over their conditions, ensured we were both on the same page, and most importantly, updated their MOST and uploaded it to Powerchart. After their visit, patients felt empowered. They were confident in the plan moving forward.

Just because we are not seeing patients face to face, doesn't mean we can't still work on patient activation. Many of us are still doing complex care visits over the phone, but it's difficult after the call to gauge where patients are at, especially our older, more complex ones.

3 Partnering with patients and communities for improved health

One way to ensure patients are activated and engaged in their health after your complex care visit: after speaking with them and uploading their care plan etc., try emailing or mailing their care plan to them. This way, they have a digital or physical copy of their plans for their conditions, an updated MOST/DNR at home, as well as something to refer to if they have any more questions.

In uncertain times, we adapt, we improvise, we overcome, to continue to deliver high quality care and ensure our patients remain "activated" in their own care.

NEW PHYSICIAN CONTRACTS & THE NORTHERN MODEL

By Dr. Bill Clifford

Primary care physicians have been seeking alternatives to fee for service remuneration methods for some time. With increased focus on team-based care and care coordination, Patient Centred Medical Homes initiatives have particularly surfaced this need. In recognition of this, the BC MoH and DoBC have supported various contract and population-based approaches, some of which originate decades back. As you know, we in the north designed and implemented a population-based model over 3 years ago which has been successfully implemented in Fort St. John. Based on that success, the plan is to spread the model in a systematic way across the region and hopefully the province.

During the delay in getting this model established in Prince George, alternatives have emerged, particularly a recently announced blended salary/capitation model available to group practices in BC. There are many things to consider in choosing between those options - too many to present completely in the short space available in a newsletter. The kinds of considerations include model sustainability, alignment with DoFP and PCN goals, effort to fulfill contractual obligations, comparison of absolute remuneration, coherence with the pillars of PCMHs, etc. The northern model was intentionally designed with all of these considerations and more in mind. The design was driven by physicians and approved by the MoH, NH, Divisions of BC leadership, and even local and provincial government officials. It has been proven to be fiscally responsible and therefore sustainable. A large number of changes have been applied to Teleplan so that EMRs (MOIS supports these changes now) can more seamlessly manage patient registration to the practice, while also relieving much of the burden of FFS billing.

4 Influencing and informing the system for positive change

On the issue of remuneration amount, the northern model continues to be tuned to ensure that "physicians are maintained whole" in the transition. While it looks like the Northern Model is a better financial deal than the new alternatives for semi-rural physicians, more analysis is in progress to verify differences, as well inform the model-tuning underway--tuning which already has increased the remuneration in existing contracts. This was actually initiated by government, not by the physicians who were already satisfied with their contracts! Stay tuned for more information as this evolves. It is clear that the FFS hamster wheel days are numbered for those who want to get off of it.

By Bill Gordon

Striving for excellence in all aspects of the primary care home

Hi everyone! A quick Bright Health update…
Firstly, we have some new customers: Our MOIS Cloud product is now being used by several RCCBC pathways, at FNHA and at HealthLink BC. We are truly excited about having signed on these high profile organizations.
MOIS 2.26 is "fully baked" and ready to go! What's in MOIS 2.26? Everything previously announced for MOIS 2.25 and more, including:

Integration with myhealthkey – our patient portal/personal health record solution
We are starting to see patients booking appointments online in myhealthkey. Note that myhealthkey includes Telehealth integration with MOIS and we expect to pass CIX conformance shortly. Once that's done, patients registered in myhealthkey will be able to see their Northern Health labs and imaging reports.

Determinants of Health
Here you can newly document in a dedicated way employment status, education, housing and socioeconomic information.

Web forms
We have and will be using our new support for web forms more and more to customize workflows for clinics. If you have a workflow you wish to optimize, please reach out to us! And, if you haven't guessed, this is a stepping stone on the way to a new web interface…

Panels and Value Sets
Panels simplify data entry, allow the grouping of related measures and let you review trends on a collection of measures. Panels are available wherever Measurement Templates are available. Value Sets represent the possible values of a coded field allowing for more controlled data entry.

A more mature version of the Population-Based Funding model that was introduced in MOIS 2.24
This model is now actively being used at three clinics in Fort St. John and is expected to be rolled-out in Prince George in the spring of 2021.

Support for the DSM-5™ reference set from the American Psychiatric Association

Electronic signatures for prescriptions, letters and forms

Integration with SRFax – an electronic fax service...particularly important when you are working from home or simply away from your fax machine.

We now offer preloaded contact information for many organizations in BC, including pharmacies, crisis lines, OAT clinics, mental health and substance centres, urgent and primary care centres, medical labs, hospitals and First Nations reserves.

Please contact us as support@mymois.ca or at 1-833-255-2447 to schedule an upgrade to MOIS 2.26!

Welcome to new Members:
- Dr. Moad Ajaj
- Dr. Paul Boutcher
- Dr. Dallas Desrosiers
- Dr. David Montoya
- Dr. JD Van Aardt

Welcome new FP resident members:
- Dr. Bre Berg
- Dr. Ronak Brahmbhatt
- Dr. Rachel Chen
- Dr. Chase Crisfield
- Dr. Nicki Gabers
- Dr. Ellen Hosford
- Dr. George Kerezov
- Dr. Kate Knuff
- Dr. Claire Lenouvel
- Dr. Gurparampreet Sidhu
- Dr. Paul Sutcliffe
- Dr. Cassanda Tayler
- Dr. Samya Vellani

Division Staff Updates
- Olive Godwin
  Executive Director until December 11
- Laura Sapergia
  Practice Coach
- Charlene Miller
  Practice Coach
- Christine Speidel
  Pathways Administrator

Tammy Bristowe, Bonnie Mercedes, Laura Sapergia, Charlene Miller

COACHES CORNER

By the Coaching Team

Striving for excellence in all aspects of the primary care home

Panel Management in COVID Coaches have been asked a lot about what is the most important thing physicians can be doing right now for panel management. This is a very busy and exhausting time, we understand that. There aren't any expectations of big QI projects at this time. You are, however, some of the best QI docs in the province, so we are not surprised that you are asking what it is that you can do to help your patients and workflow! We have put together a list of things that some of your colleagues are doing and would love to hear if you have more ideas. These are all things for which you can be compensated under PSP's Facilitation Cycles (up to 15 hours at sessional rate and earn CME). Don't hesitate to call us to run these reports for you:

- *Check in with high risk patients (mental health, frail, elderly, immune compromised, respiratory illness)
- *Flu shot clinic planning (you can still be compensated for clinic planning if clinics complete)
- *65+ without a pneumonia shot
- *Finish complex care and Incentive visits for the year
- *Virtual clinic planning
- *Complete your required 4 annual visits for LTC patients

Other Office Strategies
- Multi-physician clinics using a buddy system for mental health patients, to help share the burden
- Solo physicians thinking of joining together
- Utilizing your IPT as a resource for patients
- Updating website or Facebook page with clinic information and virtual room links
- Having MOA collect emails to send out information for those not using Facebook
- Establish Joy in the Workplace techniques (ask your Coach)
- Checking in with your staff and colleagues regarding mental health and workload

CME Opportunities
As CME opportunities are not as plentiful these days, we have put together a list of ideas to help get your credits this year:
- Using UptoDate
- Facilitation cycles (3 per hour). Each facilitation cycle is up to 15 hours, unlimited cycles
- GPSC Workbooks (up to 75 Mainpro credits)
- HDC Webinars (1 credit for each one-hour session). Also great ideas for facilitation cycles.
- Practice Improvement Groups (Self directed learning)
- Rounds, Northern Drs Day, Calendar of Events: https://physicians.northernhealth.ca/cme

URGENT AND PRIMARY CARE CENTRE UPDATE

By Julie Dhaliwal, Director, Community Services

Prince George Urgent and Primary Care Center (UPCC) is a partnership between NH, Nechako Medical Clinic Ltd. and the PG Division of Family Practice. As of October 14, 2020, there have been 39,256 individual patient encounters provided by the clinic.

Goals

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

- ◊ Provide urgent and primary care services for unattached patients in the community and access to the health team when needed and prepare patients for attachment
- ◊ Provide urgent and primary care services for those who already have a primary care provider, offering extended hours of service with continuity in the primary care network
- ◊ Relieve pressure on the local emergency department and reduce wait times through the provision of rapid care, available evenings and weekends, with the support of an Interprofessional team

Services

- ◊ Nechako After Hours Clinic - GP services for patients with non-life-threatening needs that require same day care, including procedure room.
- ◊ Nurse Practitioner - Daytime follow up, Primary Care for unattached patients, Co located and IPT 7 to provide Team Based Care
- ◊ UPCC RN - RN role works closely with GPs to provide assistance with wound care, nursing assessments, vitals assessment, IV treatment, injections, POCT, assisting with minor procedures, sensitive or complex exams
- ◊ MHSU Clinician (1 on per shift) - Urgent access for patients needing support for mental health and substance use concerns. Patients first seen by GP then referred to the clinician for counselling.
- ◊ Lab & Diagnostics (UHNBC) - Services same as currently offered – hours extended with funding provided by PCN/ UPCC investments. Closed Christmas Day, Labour Day, Good Friday.

For the specific hours of each service, call (250) 645-6900.

NECHAKO MEDICAL CLINIC LTD.

By Dr. Ed Marquis, Medical Lead PG UPCC

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

As you are likely aware, The Nechako Medical Clinic Ltd is contracted by our health authority to provide the "Urgent Care" services to the UPCC. Our current workforce is 38 strong, but we always encourage community GP's to take part of the clinic shift roster. All the physicians that work at the clinic have office clinics of their own, just like you. This is a collegial multidisciplinary environment in which to see patients, endorsed by our PG Division of Family Practice and supported by our NH with nursing, mental health and substance use clinicians, and PPE appropriate to the services provided. UPCC services are available to everyone, regardless of residence – yes, you can see your own patient should they present during your shift. It is professionally rewarding and fun to have some time out of our own space, interacting with colleagues (there are generally two Docs on site during a shift) and seeing a different practice demographic and new faces (or at least the upper nose and eyes given the constraints of today). We are part of the evolving NHA Virtual Health Strategy, so there is the possibility of a "virtual only" shift being offered in the future which would be advantageous to those of us that may not be able to do in-person consults.

Yes, I am selling the opportunity to take up some shifts at the UPCC – the commitment is small (5 shifts/mo for full members or just pick up a shift or two from the swap meet to try it out), the shifts are short (from 1.75hr up to 2.5hr long) and the rewards are high. Please consider "chipping in" and contributing to this community service. No pressure, but for information on application to the clinic please contact Jennifer Talkington at nechakomedical@northernhealth.ca or call 250.645.6901.

We are actively recruiting to the two Practice Coverage positions. Stay tuned for more information in the near future!

PATHWAYS

To list your clinic on the public directory, please contact Christine Speidel at *northernregion@pathwaysbc.ca*

IDOW OR ATTACHMENT ROTA

To join, contact Karen Flores at *kflores@divisionsbc.ca*

Prince George Division of Family Practice Board

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Dr. Shannon King

Your voice matters!

We always welcome comments, concerns, success stories, & challenges. Contact Dr. Susie Butow, Board Chair, *susie@butow.com.*