Monitor

South Island
Division of Family Practice
A GPSC initiative

Child and Youth Mental Health and Substance Use Collaborative

In the Community

There are three medical clinics operating in schools in West Shore and Sooke. Here, Clinical Admin Assistant Ashley Birtwistle chats with a student patient at the Belmont Secondary School Clinic.

Photo credit: Rick Robinson

Two Local Action Teams (LATs) within the South Island Division of Family Practice's Child and Youth Mental Health and Substance Use Collaborative have an impressive list of accomplishments over the past two years: three medical clinics in three high schools in Sooke and the West Shore, active parent information and support groups, First Nations cultural competency and mental health awareness events, and improving access to medical service. The Division's LATs are part of 64 operating across B.C., providing timely, coordinated and integrated services directly to a critical group of patients – children and teenagers in need of education, prevention, assessment, diagnosis and treatment of mental health or substance use problems.

Sooke and Westshore Local Action Team

Dr. Ellen Anderson is SIDFP's Physician Lead for the Sooke and Westshore LAT. She says young people have a keen interest in health, and better access to care has been on their wish list for a long time.

"After extensive community consultation, the Sooke Westshore Local Action Team focused on three priorities: prevention and reducing stigma, improving waitlists, and integrating services," she explained. "We've put extra energy into youth and family engagement. All our activities, particularly the school-based primary care services, supported by Island Health sessions, have benefited from a very involved group of youth in each school. They get the word out, offer feedback, and engage with their peers around creating a healthy school community."

The LAT's biggest project was setting up weekly drop-in primary care clinics in three high schools. "The Youth Clinic was no longer operating in Sooke, and one third of Langford residents didn't have a family physician," Dr. Anderson said. "Many students in Langford and Colwood weren't getting their health care needs met – except through urgent care clinics.

"We know through the literature that school-based care is optimal. It increases access and students' ability to handle health care needs, and it reduces stigma. Many young people just don't want to go to their Mom's doctor for medical treatment. From the schools' perspective, they are trying to deal with lots of student mental health and substance use issues. So there was no question that there was need."

The LAT worked closely with a large group of partners, including Island Health, School District 62, and the Ministry of Children and Family Development. "We found great, committed, skilled people interested. Every school clinic has a very different process."

Parent education and support

"A committed group of LAT parents piloted a parent education and support group in Sooke, and then expanded to the Westshore," Dr. Anderson said. "The parents choose the topics, we find space, speakers and infrastructure support and publicize it. We've provided information about getting anxious kids back to school, sleep problems, suicide prevention, ADHD … and all the ideas are generated by parents.

"The groups are up and running now, they will each be embedded in a community non-profit organization, and have recently won a Leadership Victoria award. FamilySmart (www.familysmart.ca) and the Institute of Families provide additional 'Parent in Residence' support to our parents as well. So this work will continue."

In the Community *(continued)*

Saanich Peninsula Local Action Team

There is also a LAT on the Saanich Peninsula, bringing together a wide range of community partners. Dr. Kate Evans is co-chair and the SIDFP Physician Lead.

"It took us a year and a half to build this team, and now, about 30 people attend our monthly meetings bringing all kinds of perspectives. There are many stakeholders from the community, including GPs, a child and adolescent psychiatrist, the Ministry of Children and Family Development, public health, police, and the schools. There is very strong First Nations representation as well, and we hold our meetings at the Tsartlip Health Unit. We also have three or four parent representatives, all of whom have lived experience with youth mental health or substance use."

The Saanich Peninsula LAT focused on three key areas:

- First Nations cultural competency – After discussion and consultation, the group held a series of Blanket Exercises, a re-teaching of Canadian history from the perspective of First Nations. When the event starts, each participant places a blanket on the floor, creating a large mosaic. Facilitators follow a script through 500 years of history from a First Nations' perspective. As disease, residential schools, and the loss of family lands and cultural practices take hold, participants fold up blankets and leave the mosiac. At the end, only two or three people are left.

- Mental health awareness – The school's working group hosted workshops to increase awareness around mental health, reduce stigma, help participants develop coping strategies and build resiliency. More than 200 people showed up to watch *Screenagers*, a documentary film about mental health issues related to growing up in the digital age.

- Improved access to services – The group is exploring the possibilities of a school-based medical clinic on the Peninsula.

On a personal note...

Although family physicians are under enormous time constraints, Dr. Kate Evans says getting involved in the LAT didn't take away from her personal or professional life.

"In fact, I think it's really energized me. It's made me feel very excited about family doctors and our broader role. It's not just one-on-one work with a patient (which I love), but about working together to try and make broad health changes for our community.

"I said the other day – it feels almost like being in residency again, when we were all so inspired by the profession, by the breadth of what we can do as family docs, and seeing that we can really make a difference in the community. I feel like being a real partner at the table with other stakeholders."

Family doctors and registered nurses are changing the way some practices operate

In the Practice

Dr. Tom Bailey, Registered Nurse Lori Grover and Dr. Cheryl Cuddeford on the pro and cons of bringing a nurse into a GP's practice.

The first thing Dr. Tom Bailey is quick to point out: "Not one size fits all. It won't work if you approach it that way."

"It" is bringing a registered nurse into a family practice to work closely with the physician and the patients. The partnership works well for Dr. Bailey and Registered Nurse Lori Grover – and for their patients at the Westwind Medical Clinic in Langford.

"Having nurses work in practices is well established elsewhere in Canada – Ontario and Nova Scotia are particularly strong," Dr. Bailey says. "And the business case is very good in B.C. We have chronic disease management fees, complex care fees and telephone management fees, all of which can support the role of a registered nurse in a family practice."

The bottom line: a 30-40 per cent increase in patients

Bailey and Grover have worked together for seven years – and that history is key to their successful professional partnership.

"I'd worked with Tom as an MOA, then went to school to become a licenced practical nurse, then a registered nurse," Grover said. "He did the research, what we could share in terms of tasks and responsibilities. He knew we could get along, that we worked together well, and we haven't looked back."

"I looked at how many patients I had at the beginning vs. how many I have now – and we have increased the size of my practice to between 30 and 40 per cent. And without working more hours to do that," Dr. Bailey explains. "That's a significant capacity increase, and considering the shortage of physicians, that's a big deal."

A strong business case

"We started this knowing that nurses can work in a practice, but the only way to determine exactly what the nurse is going to do is to start off on the journey," Bailey said. Over time, he and Grover have fine-tuned their practice. "If we are going to do complex care, counselling is probably better done by the nurse rather than the physician, who has more pressures on his or her time. That's where the business case can be made. Working in a fee-for-service model, we have to increase the

In the Practice *(continued)*

capacity of the physician to manage more patients. Otherwise, we would simply be taking our earnings and passing them directly to the RN. But if the nurse spends the time on the visit, and the physician can see one to two extra people each hour, we can pay for the nurse.

"Chronic disease management, mental health counselling, Pap smears, pre-natal intake, well-baby care, memory testing in elderly, most of drivers' medicals, pre-ops, ear syringing, taking patient history and physical information – a lot of that stuff doesn't need the physician to spend 25 minutes with the patient. Having the nurse do that saves the doctor's time. So on the business side, what used to take 20-30 minutes, now takes 10 minutes, and the compensation is the same.

"New complex patients can have a significant resource impact on a practice and they truly benefit from a health care team."

Patients benefit

Dr. Bailey spends three days per week in his clinical practice, and the rest as a Medical Director with Island Health. Grover is available when he isn't, which is a big bonus for patients. "Lori develops a professional relationship with the patient. They will call to speak with the nurse, and she can manage them without me."

"The big talk in medicine is doing collaborative care with other professionals," says Grover. "That's how I would describe it – we enhance each other's practice, we are able to utilize each other's skills to the full extent. I see myself as an extension. If Dr. Bailey is not available to patients, I try to be. We're good at communicating, and we're regularly in touch – in the office, by text or on the phone.

"Our patients didn't know what to expect at first, but now, they expect me to be there," Grover says. "I have patients who want to book appointments specifically with me. Often, they want to ask questions, but don't want to bug the doctor. A lot of my work is returning calls and answering questions, things that Tom has little time to do. It really frees up time for him, so he can see more patients.

"From the patient's point of view, they now have two people checking them out. A lot of docs fear losing touch with their patient, that they won't have a relationship with them if the nurse spends a lot of time with them. But that's not the case in our experience. Patients know they will see Dr. Bailey when they need it. They trust his medical opinion, and they trust mine as well."

Not always a fit

When the model works, it works well. But it's not a fit for every physician. Dr. Cheryl Cuddeford has worked with Registered Nurses in her practice, and enjoyed it. "I was able to accept more patients, and by completing my outstanding documentation and return phone calls, we made more efficient use of my time – and my job satisfaction increased."

But there were "speedbumps" such as understanding the fundamental differences in approach between doctors and nurses.

"The nursing philosophy and approach to medicine is quite different from that of family physicians. We focus on diagnosis, treatment and following the guidelines – and they have a different focus. If there's a time crunch, there is a certain amount of work that we have to accomplish in a certain amount of time. There's usually more 'problem' than 'time', and nurses may not be as familiar with disengaging from a patient's problem. That can create a serious time crunch in the office."

On the other hand, a nursing skillset is "superb for teaching and coaching patients."

There are other concerns as well, including the challenge of working with EMRs, and the difficulty recruiting nurses. Physicians may not offer the same remuneration, benefits and hours nurses would receive if they worked in a hospital. However, Grover says she knows nurses who would love to have "office hours," with evenings and weekends off.

Space can also be an issue. Both Bailey and Cuddeford noted that a nurse needs space to examine and talk with patients. If the physician likes to work with patients in two examining rooms, the practice may require a third for the nurse.

Dr. Bailey cautions that personalities do matter. "I work well with my nurse, we've known each other for a long time. But there's no guarantee that any two people are going to work cohesively together – even if they like each other. If I was advising someone, I'd suggest that they do not have someone else hire a nurse for them. The doc needs to do the hiring. Then, the nurse and the physician need to work out the rules, processes together, rather than using a rigid template. You also have to be willing to work on the fly, and to change what you're doing if it's not working anymore."

"I've worked with four RNs, and integrating a nurse into a practice is not straightforward," Cuddeford said. She has now returned to the traditional family practice model.

A model for the future

Even with these cautions, Dr. Bailey and Lori Grover are enthusiastic proponents of bringing a nurse into a family practice.

"It's a model for the future," said Bailey. "It is something that I believe is likely to be an attractive piece of a practice. If you're trying to get younger physicians to come in and take over your practice – they're more likely to feel welcome and supported if they will be working in a team. More professionals are now being trained in the team-based care model. This will be the way forward in the future."

Curious? Contact Erica

Wondering if a Registered Nurse could work in your practice? Erica Kjekstad with the South Island Division of Family Practice, is developing a generic business case to help physicians look at the option more closely.

"As Dr. Bailey says, the relationship and practice style really dictate what the partnership could look like, not only from the patient care side but also from a profit or loss side," Kjekstad says. "Using the generic business case, I can work with individual practices to determine what the family physician / registered nurse relationship could look like for patients, and calculate if it would be a fiscally smart thing to do."

For more information, contact Erica at erica.kjekstad@sidfp.com or call the South Island Division of Family Practice office: 250 658-3303.

Dr. Ellen Anderson: Getting around

In Real Life

Dr. Ellen Anderson isn't ready to retire. Instead, she's enjoying the range and richness of being a family physician. "There is lots of opportunity to reinvent yourself as a family physician as you go forward. There are few careers that give you so much flexibility and choice. It is wonderful that as we get older, we can say 'What do I want to do now?' and then we can go do it."

Dr. Ellen Anderson is in the process of reinventing herself. She sold her practice a few years ago, but is still a family physician, and she still lives in Sooke. Instead of retiring, she packs a bag every couple of weeks and heads out to relieve other family docs along the B.C. coast.

"One of the most exciting parts of being a family physician is taking on different roles at different times in our lives – and still be a full service doc. We can do different things over the course of our career."

A change of lifestyle

After selling her Sooke practice to a younger physician couple in 2015, she did a few locums in the area, but was drawn to rural communities. She attended the rural locum forum in Nanaimo in 2016. "Most attendees had either just graduated from medical school and were checking out their options before they settled down, or were 'mature' docs - no longer constrained by the demands of raising a young family - and looking for more career flexibility. It was really neat to see that at various points in the trajectory of a physician's career, we can do different things.

Rural medicine challenges

"I've done office-based practice for 35 years. This was an interesting opportunity to step back and say 'well, I still need to make a living, I still have financial responsibilities, will anybody hire me? And can I do it?' There's a certain amount of 'do I have what it takes?' Every doc I've talked to who's gone from an urban to a rural setting wonders: Really, do I know enough?

"Rural medicine is an entirely different gig. You have to retrain, reskill, dig up things you haven't had to do in a lot of years, and really hone your skills. I've always done pre-hospital care, but going to work in a place like Bella Coola – where you are doing primary care, acute care and on-call, is very different from doing a family practice. It requires a whole skill set and it's actually a bit anxiety provoking. I had to re-acquire and update knowledge that I hadn't used in a long time – looking at x-rays, hospital care, resuscitations. If you don't do it, you lose it."

When she's not working, she's taking courses: ACLS, the CARE course, outpatient orthopedics, prescribing suboxone, performing medical abortions, cultural competency, and health care of the elderly. Next on her list is an ultrasound course.

The hardest part? Being away from home and her husband. "Doing two weeks in Bella Coola in the summer when I can hike, is wonderful. Being there in winter – it's a totally different experience." Being on call is also a challenge. "I don't do sleep deprivation as well as when I was younger!" For older docs, mastering different technologies can be a challenge. "I have used five different EMRs now, and I can pretty much figure them out with a cheat sheet."

The benefits

The best part? "The people are amazing. When you work in a community and have the chance to see below the surface, it's way more rewarding. And you have time to spend with them. Working in rural and First Nations communities where patients have a wide range of complex health issues, there are challenges around the social determinants of health. It takes more time – and you need more time. It can take four or five days to get an urgent medevac when the weather's bad."

Money is also part of it. "You can make twice as much locuming, but the logistics, the expectations, the on-call – it all demands more of you, so that makes sense." There's also more flexibility. "If I want to take time off, I just say No. If you want to fill your time, you can easily do that, especially over March break and summer holidays."

Settling in

After a year, Dr. Anderson is getting comfortable in her new groove. She has a quarter-time contract on Cortes Island which gives her patients a chance to get to know her better. She goes to Bella Coola three or four times a year, and has worked in Bella Bella once. She's even gone full circle, returning to Pender Island where she practiced from 1981-1992.

Her expectations are realistic. "I'm not here to advance the cause, I'm just holding the line and giving another doc a break. I practice the best medicine I can, and make sure that when the doc comes back, they aren't coming back to clean up a mess. Having things taken care of is important. Going in thinking that I'm going to rescue anyone or anything is a dangerous assumption."

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