Prince George Division of Family Practice
A GPSC initiative

Division Newsletter

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

April 2016
Issue 13

Inside this issue:

Building Primary Care Homes

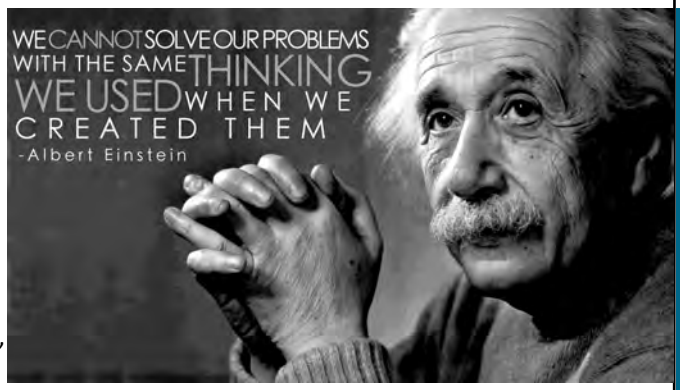
By Garry Knoll

Back in 1995 after I came to PG I spent a week of spare time digging 17 holes (2ft x 2ft x 4ft deep) in my backyard. It was awkward and difficult. My kids wondered what the heck I was doing, especially when the woodpecker fell in one of my holes. I had plans and a vision about the deck I was building. In retrospect, I learned a lot; mostly about how to do it better "next time." But now, I have a very intimate knowledge about my deck, which stands as solid as a rock. I learned many new skills so I could do the whole job. I learned that a foundation is crucial to success. I have never built a house, but I think the same would be true.

I have been thinking about my practice as a Patient Medical Home or Primary Care Home. As we build Patient Medical Homes (http://patientsmedicalhome.ca/) what plan and vision do we have? The CFPC has promoted this concept nationally. Primary Care is at the center of a sustainable health care system, a place where patients and providers have improved satisfaction and where we can attain better health outcomes. Our Division came to this belief independently, but it resonates as the foundation for our future. We are most fortunate to work in a health authority that supports this too. Full service family practice, patient-centered care, a personal family physician, and Team-Based Care are some attributes of a Patient Medical Home.

Are we up to the calling? Can we plan to make solid foundations for our practices and the care of our patients that is constantly improving, rather than doing the same thing over and over hoping for a different result? And if we were able to have such a foundation, then the possibility for a better health care system would be within our grasp. Many things are competing: siloed care; convenient care rather than comprehensive, longitudinal care; ever-narrowing scope of practice; a public misconception that ever-more specialized care is better; remuneration that does not value quality improvement and complexity.

I could go on. There is enough information to guide better choices as we build Primary Care Homes; let's build them to last.



http://www.funchap.com/einstein-quotes/

Primary Health Care: Past, Present, Future

By Barend Grobbelaar

Where have we been?

Provincially, Primary Health Care delivery was significantly degraded over four to five decades as increasing numbers of family doctors walked away from acute care and thus, longitudinal Primary Care delivery. Walk-in Clinics increased. Work provided by Physicians who continued to provide full service family practice was not appreciated nor adequately remunerated. This work became increasingly compromised by a medical association who did not distinguish between longitudinal care and low impact, episodic care. Increasing numbers of family doctors were feeling overwhelmed. We had increasing difficulties connecting our patients to needed services. Physicians working in walk-in and urgent care clinics were earning more for shorter hours without after-hours, night, holiday or weekend responsibilities. Burnout was prevalent. The stage was set for further erosion of our Primary Care system.

Through the 90's there was a growing recognition by the Ministries of Health, both nationally and provincially, that the future of Canada's medical system depended on creating a strong, sustainable Primary Health Care system.

Continued on page 2

BLUE PINE CLINIC PHYSICIAN COVERAGE NEEDED

Have you considered working with patients with complex needs?

The Blue Pine provides an environment that includes longer appointment times & the support of a multi-disciplinary team.

Please contact us if you are interested!

Megan Hunter
Phone: 250-596-8103
mhunter@divisionsbc.ca

Spring Member Meeting: Wednesday, April 27th

Join us to discuss: *What does full-service family practice mean to you and your Division?*

- **1730–2100 UHNBC LDC Room 0501**
- **All Family Physicians & Family Practice Residents welcome!**
- **Dinner, sessional payments, Resident honoraria provided**

Feedback on IPTs

Working in an Interprofessional Team (IPT)? Please let us help you communicate with Northern Health. Let's continue to ensure that Primary Care Providers have a voice in shaping how the IPTs work with the Primary Care Home. Send direct questions, comments, suggestions, complaints, & success stories to Dr. Cathy Textor or Dr. Phil Asquith.

Did You Know?
Society of General Practitioners of BC (SGP)
This site is a resource for current & accessible billing information: www.sgp.bc.ca
Access the site by adding the SGP to your account when renewing your Doctors of BC dues, or click the Join Now button if you are currently a member.

Acknowledgements
We are grateful for contributions from:
- Doctors of BC
- GPSC
- Ministry of Health
- Northern Health
- PSP-Technology Group
- City of Prince George
- Spirit of the North Healthcare Foundation

Your voice matters!
We would love to hear from you; we always welcome comments, concerns, success stories, & challenges. Or join in as a Committee or Board member. Contact Olive Godwin at 250-561-0125/ princegeorge@divisionsbc.ca

The Full Service Family Practice Perspective

By Satish Mann

Over the last 3 decades going through medical school, residency, and now practicing as a full service family physician, I have wondered: am I really making any difference in my patients' lives, and what are we trying to achieve? I think I feel that our patients want to have a doctor who cares about them, listens to them, and is going to be there for them when the need arises. To me, full service family practice is continuity of care and having a trusting relationship with my patients. Being there for my patients in the labor room, hospital, during hospice care, or doing home visits is very rewarding; patients are very appreciative and it builds strong bonds. Once we have a strong bond and a trusting relationship, practicing medicine is just like being on auto-pilot; you don't need to spend a long time convincing patients about different treatment options.

But how do you strike a balance between your personal and professional life? I had to make changes: a 4-day work week, doing regular exercise, dropping out of Emerg, and reducing shifts at the walk-in clinic. The Sept 11th incident in NY City pushed us across the border; I was debating practicing in the USA after residency, but that event changed our lives. Moving to PG in 2002 has been the best thing for our family. Once here, I picked up hobbies like cooking, swimming, snowboarding/skiing, cycling, gardening, etc. I am also involved in the community with volunteer projects like giving talks at events in Punjabi, the annual fundraising bike ride, etc.

Sustainability is an issue. Many of our colleagues are dropping Obstetrics practice. In my opinion, solutions include having OB call groups and encouraging new grads to consider Obs as part of their practice. So far I have found that having coverage for Obs patients has not been a problem, and even finding locums has worked well since our colleagues are always willing to help out. Dr. Rachel McGhee has been doing Well Women clinics out of my office for the last few years, which has given me some free time and has improved patient care. I have also been involved in teaching medical students and residents, and have enjoyed contributing to sustainability in this way as well.

I feel well-supported by an excellent community of physicians and the Division of FP. The Division coaching staff is extremely helpful in problem-solving and keeping us up to speed with changes in the EMR, etc. I feel that time is most precious for physicians and you have to decide how you are best going to use it.

Primary Health Care: Past, Present, Future cont'd from page 1

By Barend Grobbelaar

Primary Health Care transition funds became available to health authorities from 2000 -2006. Despite the hundreds of millions of dollars made available by these funds, there was a lack of progress in evolving Primary Care delivery. In response, the Ministry collaborated with the BCMA (now Doctors of BC) creating the General Practice Services Committee (GPSC). Out of this collaboration came BC's first Primary Health Care Charter, setting the direction, targets and outcomes for a strong, sustainable Primary Health Care system. GPSC initiatives included creating Divisions of Family Practice (2009) and "A GP for Me" (2011-2015), and PG was 1 of 3 prototype Divisions. With the advent of Divisions, family doctors were afforded a vehicle by which to contribute to the restructuring that will achieve a robust, comprehensive, integrated, Primary Care system.

Where are we now?
Over 99% of all family doctors in PG are members of the Division. Most of us provide full-service family medicine that includes inpatient care, after-hours care in emergency, or the afterhours clinic, and for some, obstetrical care, long-term care, etc.

The Division's work centers around designing the Primary Care Home in Northern BC. We are working in partnership with Northern Health to co-design all initiatives affecting Primary Care (ie. Interprofessional Teams, Restructuring Speciality Services), delivering Division-lead, comprehensive, integrated coaching support, and generating real-time, robust clinical data at a practice, community and population level, allowing us to demonstrate the impact of our efforts. We are also leading in engaging family doctors in change management.

Where are we going?
Goals for the next 3-5 years include: a Primary Care Home for all PG citizens; providers will easily connect their patients with the care they need; patients will seamlessly transition between community and acute care systems; communication systems will be developed that support co-management of patients by all providers; produce data which confirms that care meets the Triple Aim and improves the quality of experience for patient and provider.

Specialist/GP Collaboration

By Cathy Textor

Full service medicine has been the norm here for so long; PG has been a place where generalism thrives. We still have that in some of the specialities. For example, it is nice that our patients can see the same general surgeon for their colonoscopy, breast surgery and thyroidectomy.

It was obvious that there was (and perhaps there still is) a need to recruit physicians to the North. We have been very successful - I think that we are at 23 internists and 16 psychiatrists! As our resources expand…Is it becoming increasingly difficult to get a consult? Or is it just harder to figure out who should see our patients? Nevertheless, to me, it feels harder to get patients seen. Or maybe it's because my complex CAD/CHF/COPD/CRF patient who used to be seen and co-managed by myself and one general internist, now has a cardiologist, respirologist, nephrologist and if admitted, a whole new team! Do these patients do better now? I'm not so sure. Perhaps this is all just an expected consequence of growth but, if we do not feel patient care has been improved then "What's the point?"

Sometimes I miss the simplicity of PGRH: doctors lounge/hallway consultations or talking with surgeons over an OR assist. It was efficient, educational and good patient care. Why did that work so well? I think it comes down to relationships; I still breathe a sigh of relief when I know the consultant with whom I want to discuss a patient. Recent work with the Division has focused on just this issue: trying to regain some of the collaborative working relationships between GPs and specialists. Currently we are working with internal medicine and psychiatry. Goals of this work would ensure patients can access the appropriate service when they need it, improve communication, increase capacity by ensuring that stable patients are managed in the Primary Care Home and unstable patients can access care quickly. We are talking about bringing generalism back.

The expectation that the Primary Care Home will provide access to appointments, allied health, and speciality services makes sense; this model should unburden emergency rooms and hospital beds, facilitate seamless transitions between hospital and community, and help patients navigate the ever-increasing complexity of the system. But if we, in the Primary Care Home, cannot access appropriate speciality care for our patients with ease, then I fear we will lose the spirit of full service medicine that has made PG a great place to receive health care and to provide it.

In-Patient Care

By Brian Hillhouse

I find In-Patient Care to be the most demanding but also the most rewarding part of my practice. As a Family Physician I believe it is important to be involved in my patient's acute hospital events, as it allows me to provide more comprehensive longitudinal care. I also find that having prior knowledge of a patient before their acute illness greatly simplifies caring for them during their crisis.

After completing both medical school and residency in Prince George, I have now been practicing family medicine here for the past 5 years. A large part of my practice is hospital-based. In addition to my own practice population I also work in the Emergency Department and with the Doctor of the Day program. In the past I have spent 3 years as the Clinical Associate for the CTU.

Prince George is unique in that we have a Tertiary Teaching Hospital but we also have a significant proportion of patients admitted under Family Physicians. I think this gives Family Physicians here a great opportunity to provide holistic longitudinal care. I do, however, worry about the stability of our current system; there are increasing complexities to In-Patient Care, and there seems to be a growing demand on the Doctor of the Day service. It is my hope that we can continue to adapt - and improve - the quality of care that we provide both in and out of hospital.

Physician Health

The **Physician Health Program** supports & advocates for BC's physicians & physicians-in-training. The program offers confidential support and referral assistance for physicians struggling with issues around: physical & mental health, addictions, relationship difficulties, work place conflict, burnout and stress management.
The service can be accessed 24 hours per day, 7 days per week by phone at 1-800-663-6729. For more information see www.physicianhealth.com

Opportunity: Find a Locum; Get a Locum

The Society of General Practitioners (SGP) has added a *Family Practice Locums in BC* list to their website (http://sgp.bc.ca/locums/). SGP members can post ads at no cost. Locums can customize job searches by filtering for EMR type and job features (OB, ER, etc.) They can also subscribe to receive a newsletter every two weeks.

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Fax: (250) 596-8101
M—Th 8:30—4:30 (closed 12—1)
F 8:30—12:00

PHYSICIANS ACCEPTING NEW PATIENTS

If you are accepting patients, you can be listed via these options:

- Northern Health's number for physicians accepting patients is 250-565-2237; the recording will either provide physician info or will direct patients to the Blue Pine Clinic. Call Switchboard at 250-565-2000 to be listed
- You can also list directly with the Blue Pine Clinic, whose MOAs will screen for patients with no prior PG doctor

Coaching Team

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Clinical Programs Lead

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Heather Chafe
On leave at this time

Karen Gill
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Tammy Bristowe
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Sean Jang
sean.jang@northernhealth.com

Introduction:
Sean Jang, Practice Coach
Sean drove his truck & trailer through the winter storms (simply known in PG as "winter") to join our Coaching Team. A BC native, avid bike rider, skier, hockey player, & Dad to 2 teenage Rep & Jr. hockey players, Sean comes to us from the Kootenays, where he coached for their Division.

Pathways for the North

By Bonnie Bailey & Cathy Textor

Discussions are currently underway between the 4 northern Divisions (Prince George, Northern Interior Rural, Pacific Northwest, and North Peace), Northern Health, NPiC and UPIC about how we will work together to bring a valuable resource called "Pathways" to GPs and specialists in Northern B.C.

Pathways is a user-friendly website, designed by Family Physicians for use by GPs and their MOAs. It is an up-to-date database of specialists, community resources, and allied health services. Users can easily search for a specialist by practice location, areas of expertise/interest, languages spoken, wait times or even gender. Once a referral is made, information about pre-consultation requirements (i.e. bloodwork, imaging), how a patient will be contacted, and even directions and parking instructions for patients is given. This resource is currently being used successfully in various locations across B.C. and is rapidly expanding across the province. Once implemented, physicians will have access to the existing Pathways database as well as a complete database of northern specialists. It is a tool that is designed to improve patient access to specialist care and to improve physician work flow! Stay tuned.

Medication Assessments Now Available Through Interprofessional Teams (IPTs)

By Rob Pammet

A new clinical pharmacist service is available to clinicians as part of the Interprofessional Teams. The medication assessment service can help optimize medications to support chronic disease management of complex patients, facilitate medication reconciliation upon hospital discharge, minimize or resolve drug interactions for patients on multiple medications, and provide patients with medication education. Detailed consultation notes will be sent to your office after the medication assessment is complete. All recommendations will be discussed with the referring practitioner and the patient prior to implementation.

This service has been tested at different sites in Prince George, and has been very well received by both patients and practitioners.

"Working with a community Pharmacist in our practice has been great. Very valuable for patients and for me - I have learned a lot. Our patients love it!"

- Sasha Riome-York

Who should you refer?

- Patients on 5 or more medications (including non-prescription medications)
- New patients with complex medication histories
- Patients experiencing potential medication-related adverse events
- Patients with multiple medication-related questions
- Patients recently discharged from acute care with medication changes
- Patients with difficult-to-manage chronic diseases (DM, HTN, chronic pain, etc.)

IPT-connected patients may also be referred for medication assessment by IPT clinicians; you will be notified if this occurs.

How should you refer?

- Send a service request to your Interprofessional Team for a medication assessment.
- Please include a current long term meds list, as well as any relevant labs, specialist consults, recent discharge summaries as well as any other information you deem relevant.

The Coaches' Corner

By the Coaching Team

Coaching to Support Your Fee-For-Service Office

Many offices have been working hard on quality improvement with the coaching team. This work varies from EMR optimization, to PSP modules, to setting goals around patient care and office efficiency. Our coaching team utilizes many tools and approaches to support the full service family physicians in Prince George. One of the tools we have found useful in identifying areas for improvement is the practice assessment. This reflective exercise not only looks at your day to day office work flows, but also includes audits that identify the prevalence of chronic disease in your panel and gaps in incentive billing.

We have found the assessment has highlighted the importance of keeping health conditions up to date in MOIS. Not only does it inform locums and other care providers, but an updated health conditions also enables your office to perform regular audits. A related process may be to create accurate recall lists to improve patient care and ensure the appropriate incentive claims have been billed. In working with physicians using the practice assessment, we have been able to identify complex care patients and chronic disease management patients that were not billed the previous year.

So far this year 25 physicians have completed the assessment, with another 11 physicians in progress. One to one coaching supports physicians and MOAs break down seemingly daunting improvement goals, into smaller attainable successes. Give us a call if you're interested in the assessment or other quality improvement work!

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Supplement

The Prince George Division of Family Practice's Connection to the Big Picture

By Bill Clifford

In the North, we have achieved much with respect to health care quality and information technology over the last 15 years. Many years ago, our region achieved more than 90% EMR adoption. We have demonstrable, very high, meaningful use of EMRs and have the greatest ability across the country to measure processes and outcomes in Primary Care. We also have a region-wide Electronic Health Record (Powerchart) to view patient and acute care encounter level information, including EMR-generated care plans. With our heads down going flat out to achieve all of this and more, it is helpful to intermittently look around and see what is happening across our province, the country, and even the world.

From a strategic point of view, there are a number of significant broader initiatives:

- In the aftermath of the Cochrane Report, there is a heightened interest in quality assurance and quality improvement at multiple levels leading to provincial level credentialing (i.e. the Cactus System, privileging dictionaries and annual interviews), formal peer review of medical imaging reports, etc.
- The Ministry of Health (MOH) is also supporting a "BC Medical Quality Initiative" (BCMQI) under the leadership of Dr. Martin Wale.
- The MOH has recently released a health care strategy with an associated information technology enabling strategy. Our Division had the opportunity to provide some feedback for this.
- The GPSC recently completed an 8-month general practice visioning exercise to develop a 3-year strategic plan. As initiatives like the "AGP4Me" are winding down, this is expected to provide new kinds of support for Primary Care and quality improvement, while likely aligning with broader provincial implementations of Patient-Centered Medical Homes with integrated teams. The Prince George Division of Family Practice (PGDoFP) provided a lot of feedback in the Visioning process.
- Canada Health Infoway has adopted a new, more open approach to building health information standards and supporting new technologies.

These strategies align with and support a number of local initiatives:

- Patient-centered care
  - The MOH, Northern Health (NH) and other Health Authorities (HA) are investigating ways to provide patients with their health care information through portals or personal health records (PHRs).
  - Virtual encounter support is also under investigation a multiple levels. NH is working with Cisco to find an affordable way to use technology currently available in the HA to support seamless, multipoint virtual encounters between GPs, specialists, integrated team members, patients and their families in any permutation/combination.
  - The PGDoFP is the first in Canada to use electronic care plans in an organized way and is informing a pan-Canadian approach to care coordination through care plans.
- Seniors care - the Deputy Minister of Health is focusing on this. NH physicians from Prince George and Vanderhoof have provided significant input.
- End of Life Care - work is underway across the province to effectively deploy the PSP End of Life module.
- Medication management - what do digital ECGs have to do with it? Much of avoidable medical injury is due to problems with medications, especially in acute care. We are in great need of prescribing decision support, closed loop medication delivery, and medication reconciliation into and out of acute care. For that, we need "Computer Provided Order Entry" (CPOE) but to get there, we need a solid base in the acute care EMR. To that end, NH is working towards providing more "payload" in Powerchart, including interfaced output

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F 8:30—12:00

from things like endoscopy and digital ECGs. NH is also working on support getting Powerchart to accept secure messaging from EMRs - especially care plans and advance directives.

- Chronic disease management continues to be supported by various provincial projects including PGDoFP participation in CHF and Diabetes initiatives.
- In the face of rural recruitment/retention issues and the increasing attention to integrated teams and the patient-centered medical home, there is growing realization that the Fee For Service (FFS) model needs some renovation. Since the inception of the PGDoFP, there has been interest in developing a funding model that blends concepts from FFS, capitation and salary and is heavily informed by EMR data. The North Peace Division of FP, NH and the MOH have together designed just such a model and are close to implementation. The Northern Interior Rural Division (NIRD) and PGDoFP are likely candidates for further deployment once the kinks are worked out.
- Prevention and health promotion is one of the MOH strategic directions - and the blended funding model above has a quality track that will support this. AMCARE (see below) measures things like weight, physical activity and various screening tests such as FIT, HIV (especially in association with BBP and STI tests) and Pap smears.
- Secure texting - asynchronous communication through SMS texting in the line of patient care is becoming increasingly frequent but is at odds with patient privacy/confidentiality and professional regulation. Divisions and Health Authorities across the province are looking for secure alternatives. The PGDoFP, NIRD and UPiC are poised to trial an extension to a product already in use in the North, and one which has some likelihood of being compatible with what other HAs will use or with an eventual provincial solution.
- Interoperability of health records, including the patient's personal health record, is a key provincial enabling strategy. Interior Health and Northern Health have developed the "Clinical Data Exchange" (CDX) to deliver diagnostic test results, transcribed documents, and EMR to EMR communications in a pan-Canadian, standards-based way. CDX currently can deliver all NH transcribed documents, inter-EMR electronic referrals and consultations, and soon will support acute care admit and discharge (including death) notifications. The province is currently examining how this standards-based approach can be deployed more widely.
- Now, we aren't the only ones pressuring for standards around health information - e.g. document naming, measures, problem list reference sets, etc. I co-chair the provincial "Health Information Standards Standing Committee," (HISSC) which is currently implementing a 6-part strategy to improve health information standards and interoperability across the health sector.
- Effective and widespread quality assurance and quality improvement is impossible without availability of data. AMCARE was developed in the North to safely provide useful Primary Care information and is a cornerstone in our Primary Care work. About 100 measures/indicators and attachment information are available for about one-half to two-thirds of the Northern population. To extend this to the remaining 1/3 in the North and to the rest of the province, all Primary Care EMRs must be able to participate. While AMCARE has an open, published standard for data upload, a more robust approach to generating the data is needed. To that end, the "Health Data Coalition" (HDC) has been formed and now enjoys financial support from the GPSC to develop a provincial solution.

There is a lot going on. We are heavily involved in much of it. We are also leading the way in a significant portion. So much so, there is increasing demand for our participation especially because we have the data or an actionable strategy. Our palpable success is the result of the collective work of the membership. Nothing happens at the system level without hard work at the coal face...