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

November 2016
Issue 14

Patient-Centered Care

By Garry Knoll

I remember "joyfully" registering for Ball Room dancing with my dear wife a few years ago. Disclaimer: She may recall the events somewhat differently. I thought dancing was all about me. I had to lead ....of course. In a while, we had better communication in the many ways dancers do, and we began to move from one place on the dance floor to another, enjoying the movements, music and each other, hardly thinking about foot placement. I began to see that she was a better dancer than I and if I could showcase that, our dancing was much more enjoyable.

Patient-Centered Interviewing is like a dance. The interview begins somewhat tentatively. But then, with an encouraging question, nod or pause, the conversation flows through a series of movements that convey an experience. It is rarely linear. While the conversation develops, I think of the things I need to know to make sure the dance works. But as I let the patient "lead" I learn much more, in a shorter time than through interrogation.

If I can get patient-centered interviewing right, could I get patient-centered care right? I think so. I think the give and take of dancing aptly describes how I react to patients' preferences, hopes (goals), and their stage in enacting their participation (planned actions). I will begin to understand the challenges they face (barriers) but will have a deeper understanding of who they are as a person.

My challenge is to create an environment where we can dance. As a novice dancer (and doctor), I was very rigid and controlling: "WE ARE GOING OVER THERE!" Now, we eventually get there, but maybe not directly. Do I have a way to communicate other than face-to-face? Is it convenient enough that we can even get together to dance? These are MY barriers, and I am challenged every day to hold on to whatever is good and right. But....my idea of what is good and right are somewhat different than what they were before, and this will improve patient care.

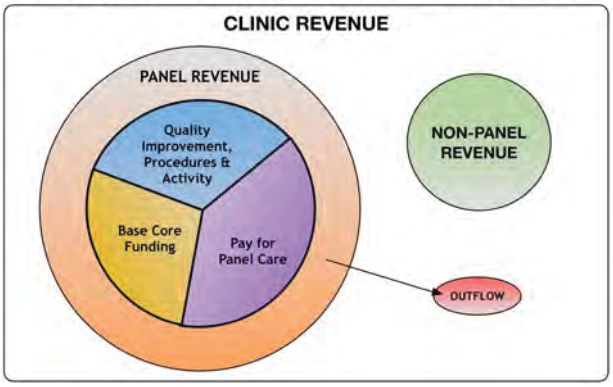
Ft. St. John Physician Compensation Model & Patient-Centered Care

By Bill Clifford & Megan Hunter

Many of you may have heard of the new compensation model in Fort St John. The model arose out of recruitment and retention issues in the community, but it is hoped that it can be disseminated farther throughout the north, and the province, to facilitate more effective patient-centered care while improving the provider and patient health care experience. The "Primary Care Physician Compensation" model (PCPC) uses a blend of population-based funding and fee-for-service (FFS). For patients enrolled in PCPC, physicians are prepaid for most of their work based on practice size and complexity and their participation in quality improvement. Physicians continue to bill FFS for services that are not in a core "basket" (the basket of services includes inpatient care but not obstetrics). They also continue to bill FFS for WorkSafeBC and ICBC-related services as well as for patients that aren't enrolled in the program.

By moving away from FFS as the main source of compensation, physicians will be able to work more closely with interprofessional teams, focus on accessibility and continuity, and work more to encourage health promotion and preventative care. Testing of the model is currently underway in Fort St. John, and the PGDoFP has been in discussion about extending participation to Prince George for testing in a more urban environment. As provincial developments unfold, the Division will communicate with members to discuss the model in more detail with interested practices.

Fort St. John Primary Care Physician Compensation Model Framework



Throughout this issue: Quotes from our members on *What does Patient-Centered Care mean to you?*

INSERT: *Create a Welcoming Environment* by EQUIP Healthcare is a simple example of incorporating patient-centered care into your busy office

Fall Member Meeting: Wednesday, Nov. 23rd, 1730—2100
Join us to discuss: *What does Patient-Centered Care mean to you?*
*** Each Physician who attends may bring 1 MOA (honoraria available) ***

Details:
- **UHNBC LDC Room 0501**
- **All Family & ER Physicians & Family Practice Residents welcome**
- **Dinner, sessional payment, Resident honoraria provided**

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

Join the work of the Division! If you are a Physician interested in participating as a Board or Committee member, please contact the office or a Board member:

Phil Asquith
Susie Butow
Bill Clifford
Keri Closson
Barend Grobbelaar
Garry Knoll
Satish Mann
Rachel McGhee
Ian Schokking
Cathy Textor
Jessica Zimbler

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.

Costs vs Benefit in Patient-Centered Care: A Learner's Perspective

By Christina Boucher, PGY1 Family Practice, UHNBC

A few months into family practice residency, I feel I will never know enough about medicine. Which is why I'm delighted and surprised at my ability to sometimes successfully navigate clinical decision-making, and create a plan. What I was not prepared for was the realization that patients don't always want to unquestioningly take my apt advice. They have their own ideas about what is best for them.

I recently participated in the care of a patient, Mr. A, who came into the clinic with right lower quadrant abdominal pain. I ordered bloodwork and an outpatient CT, and based on these tests made the diagnosis of acute appendicitis. I phoned Mr. A, who was at work and reluctant (but ultimately agreeable) to come in to hospital. After consulting with the general surgeon, he opted for medical management with antibiotics. He had a very important family commitment the next day that he would have to miss if he had emergency surgery.

On learning about his choice, I was dumbfounded and worried. The next week I saw him in clinic for follow-up. Mr. A was feeling better after the antibiotics, had an elective appendectomy booked later that month, and was pleased with the care he received and with my efforts. This is patient-centered care; the patient's values were at the center of the management decision after all the medical expertise had been effectively translated and communicated. If it had been up to me, I would have booked the surgery on the same day, thereby reducing my worry about adverse medical outcomes. Ethically, there is something wrong with my paternalistic way of thinking. Scientifically, there is evidence to support that taking the patient's ideas about his or her health into account leads to improved health outcomes.

Patient-centered care as an operational construct is usually measured within research by patient self-report. Outcomes other than patient satisfaction that appear in the literature include health outcomes as well as cost effectiveness. Increased delivery of patient-centered care is associated with higher patient satisfaction, improved morbidity and mortality, and decreased cost and usage of the health care system [1,2,3]. My case exemplifies this and there is copious high-quality evidence supporting the same.

Patient-centered care is associated with higher self-reported satisfaction with the achievement of six components: (1) physician exploration of the patient illness experience; (2) understanding of 'the whole person;' (3) finding 'common ground' in management decisions; (4) preventative health incorporation; (5) enhancement of the patient-physician relationship; and (6) realistic practice[3,5]. Recognizing and promoting patient expertise has been seen to empower patients and improve quality of life, especially in patients with chronic disease[5].

Evidence supports the idea that higher satisfaction with care actually leads to decreased usage of the health care system, which translates directly into cost savings. A metric comprised of the first three components of patient-centered care (above) was positively associated with a 50% reduction in diagnostic tests and referrals[3]. Another study found that increased frequency of patient-centered care recorded in visits was associated with fewer primary care visits, fewer hospitalizations, and fewer diagnostic tests ordered[4].

In medical school, we were taught to FIFE patients, to explore their feelings and expectation of care regarding their illness experience. Significantly less time, if any, was spent on showing us how to incorporate FIFE data into the treatment plan. For myself, the next step in learning to practice patient-centered care as a learner is to start dealing with the feelings of uncertainty and distress that arise when there is a mismatch between the patient's goals - and my goals - for their care. I am going to reframe my role as doctor-as-teacher, and focus on knowledge mastery and translation in a partnership with the patient.

For references noted above please visit https://www.divisionsbc.ca/prince-george/news

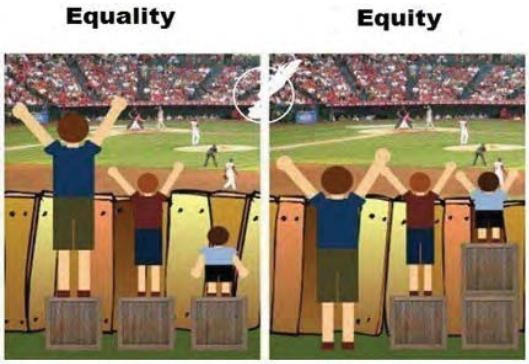
What does *patient-centered care* mean to Division members?

* *Always having the patients' perspective in mind when providing care and respecting and valuing that point of view.*
* *I have never thought there was any other type of care...is there?*
* *Patient-centered care means a tailored approach that takes the knowledge provided by evidence-based medicine and applies it to a specific person in the context of that person's history, family, and community; where evidence meets common sense.*

What Does a Health Equity Lens Add to Patient-Centered Care? By Annette J. Browne, PhD, RN on behalf of the EQUIP Research Team

Patient-centered care is an important means of fostering patient participation in their own care, and respectful relationships between healthcare providers and their clients[1]. A health equity lens builds on the notion of patient-centered care by focusing attention on strategies that can "close the health equity gap" by paying particular attention to those at greatest risk of poor health.

Health equity is not the same as equality in health, as shown in the diagram below. Health equity is defined as the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *Health inequities* are unjust and avoidable, and represent unacceptable differences in health between and within groups of people[2]. Inequities are not only pervasive but increasing throughout Canada and globally[3].



Primary care providers can play an important role in delivering patient-centered care *and* in reducing health inequities[4-7]. While health care providers alone do not have the power to improve all of the multiple determinants of health, they do have the power to address health inequities directly at the point of care, and to impact many of the determinants that create these inequities.

Beyond the moral argument for providing accessible, patient-centered care to those who need it most, there is also a strong economic argument for providing equity-oriented health care at all levels[4]. People experiencing the greatest socio-economic inequities often have the poorest health[4]: improving health care experiences and outcomes for this group will, therefore, result in the greatest gains, reducing costs to the system.

There are many actions that health care providers and organizations can implement to make their practices more equity-oriented. The EQUIP research team is developing a Health Equity Toolkit aimed at primary care providers and organizations. Please check out some of the Health Equity Tools at: www.equiphealthcare.ca/toolkit.

For references noted above please visit https://www.divisionsbc.ca/prince-george/news

What does *patient-centered care* mean to Division members?

- *To me, patient-centered care is listening, making a connection, and trying to meet my patient where they are at.*
- *I feel technically patient-centered care means actively eliciting the patient's needs and values in their medical care. I feel this plays out practically by putting high value on the Doctor-Patient relationship with every encounter.*
- *Tailoring our practice style to what best meets our patients needs.*
- *Patient-centered care means putting the patient, and their family, at the center and building around them the supports and services necessary for optimal health care.*
- *Patient-centered care involves taking care of patients' health issues with them while being mindful of their experience of both their health and your management.*
- *That is meeting them where they are at with a non-judgemental approach, helping them make incremental improvements and hopefully inspiring them to make significant changes over time.*

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. Contact Olive Godwin at 250-561-0125 or ogodwin@divisionsbc.ca

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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M—Th 8:30—4:30 (closed 12—1)
F 8:30—12:00

Peer Mentoring—Docs Helping Docs

Many of our fellow Division members will act as peer mentors.

Who?

- Garry Knoll
- Barend Grobbelaar
- Ian Schokking
- Paul Murray
- Bill Clifford
- Denise McLeod

When?

Whenever works for you, 15—60 mins

Where?

They will come to your office

How?

Contact these mentors directly

What?

- EMR Optimization
- Workflow strategies
- Tips & tools
- Sharing best practices

MOA Peer Mentors also available. Interested in becoming a mentor? Contact the Division office for more detail.

Patient-Centered Care in Family Practice Teaching

By Susan Knoll & Ingrid Cosio

The term "Patient-Centered Care" has been around for a long time; it certainly was when I trained back in the dark ages. The reason it has stuck around, I think, is that there is evidence it changes the outcomes of our interactions with patients. "Problems identified by physicians have greater congruence with those reported by patients; patients are more compliant with recommendations; patients recall information better; monitoring of physiologic variables…is improved; patients are less anxious; and patients and physicians are more satisfied with visits."[1]

The teaching of this 'skill' (as its components do not necessarily come naturally, even in good communicators) is one aspect of what we call "Behavioral Medicine," which I think of as the art of medicine. In theory, this skill underpins all teachings over our two-year residency, as it applies to every patient interaction and should be modeled by every preceptor. Family Practice preceptors are expected to include teaching and feedback in this skill as part of the day-to-day experiences of our residents. Direct observation by preceptors of clinical encounters with appropriate feedback helps refine this skill. Required videotaping of clinical encounters provides a variation on the observation theme, where the resident and preceptor watch an encounter together. This allows the resident to pick up on body language or habits he/she may not be aware of and gives the opportunity for immediate feedback.

Evaluation of a resident's skill in patient-centered care is provided at mid and final rotation assessments as well as in the daily formative feedback in the form of field notes. Evaluation and practice are offered several times each year in the form of practice Simulated Office Oral Exams (SOOs). The CFPC certification exam offers the ultimate evaluation at the end of residency, with half in the form of five SOOs, which must be passed in order to obtain a practice license, and was dreamt up as a way to assess this specific skill. I guess it's important for more than one reason!

1.Stewart MA, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impactof patient-centered care on outcomes. *J Fam Pract* 2000;49(9):796-804.

What does *patient-centered care* mean to Division members?

- *To me, full service family practice at its core is about the continuity of care and having a trusting relationship with my patients.*
- *I actually find it hard to sum this up. In a way it's easy: "Our focus is on the patient." In a way it's hard: "The doctor and the patient don't have to fight an inefficient system." Unfortunately often a lot of our time (and theirs) is spent working through operators, forms and unclear pathways.*
- *Understanding your patient :)*

The Coaches' Corner

By the Coaching Team

Using MOIS to Support Patient-Centered Care

As EMRs continue to evolve to complement best practice and patient care, physicians must also find ways to balance new work flow, current workflow, and what's best for patients.

The care plan in MOIS speaks to patient-centered care, allowing physicians and clinicians to share a side of the patient story that may not necessarily be told by the health conditions or long term medication list. The care plan creates the opportunity to record and share information that could greatly impact a patient's care, such as their advance directive.

Many of you have probably heard a colleague or coach speak about how recording the advance directive in Preferences can be shared through Power chart, but there has been less conversation about other parts of the care plan that can provide equally important information. For instance, in the Barriers to Care folder, you may record information about anything that makes accessing appropriate care difficult for the patient. An example may be a patient that doesn't have transportation or a driver's license. This type of information can prompt your office, or any clinician working with the patient, to take into consideration that appointment times are limited to when friends or family can provide a ride.

The care plan can also be used as a way to empower your patients to take control of their own health. MOIS has built-in features, like goals and confidence levels, to support patient self-management. For those of you practicing Brief Action Planning, this is the perfect place to record the patient's personal goals. This section also provides insight to clinicians on the health priorities of the patient, which may differ from your priorities. Similarly, the care plan will be used by your interprofessional team (IPT)(OT, PT, mental health clinician, social worker, primary care nurse, etc.) to improve communication and support integrated health care delivery. The IPTs currently working with physicians have their own instance of MOIS and are being trained on using the care plan for documentation and communication. For more care plan examples, ask a coach for our one-page information sheet. We are also happy to work with you on how care planning can assist you with your busy work flow.

Coaching Team

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Article References for: Costs vs Benefit in Patient-Centered Care: A Learner's Perspective

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2. Patient-centred primary care in Canada: Bring it on home. (2009). College of Family Physicians of Canada. http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/Bring20it20on20Home20FINAL20ENGLISH.pdf
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Article References for: What Does a Health Equity Lens Add to Patient-Centered Care?

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EQUIP Healthcare
Research to Equip Primary Healthcare for Equity

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2. Farmer P: **Reimagining equity.** In *To Repair the World: Paul Farmer Speaks to the Next Generation.* Edited by Weigel JL. Berkeley and Los Angeles, CA: University of California Press; 2013: 2-6
3. Canadian Institute for Health Information: **Trends in income-related health inequalities in Canada: Technical report.** Ottawa, ON: Canadian Institute for Health Information; 2016.
4. Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J: **Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper.** Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.
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7. Browne AJ, Varcoe C, Wong ST, Smye VL, Lavoie JG, Littlejohn D, Tu D, Godwin O, Krause M, Khan KB, et al: **Closing the health equity gap: Evidence-based strategies for primary health care organizations.** *Int J Equity Health* 2012, **11:**1-15.

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Top 10 things your clinic, practice or department can do to

create a welcoming environment

Display **words and phrases in local languages or dialects**

Begin and end every phone call with **"thank you for calling"**

Provide coffee, water or snacks to patients while they wait

Display **local art**

Ask patients about **basic resources like food, clothing and shelter**

Create a separate waiting area for families, women or elders

Display posters and signs conveying that patients deserve to feel welcome and respected

Have a support person, elder or therapy dog **present in your waiting room**

Seek feedback from patients with a survey, comment box, or patient advisory committee

Tell returning patients **"It's nice to see you again"**

EQUIP Healthcare
Research to Equip Primary Healthcare for Equity

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