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 2018
Issue 17

From the Desk of the President: A Poem

By Dr. Garry Knoll

Common threads weave through books I read: The Orenda, The Nightingale, The Amazing Adventures of Kavalier & Clay, Anna Karenina, War and Peace.

Those threads emerge in headlines I read....Residential schools, the "60's scoop," Syrian refugees settled in Prince George, 65 million refugees worldwide, stateless Rohingya, Syria, Black America, Stoneman Douglas High School, #MeToo.

And in journals.....Childhood trauma, Trauma manipulates DNA.....

Connections.

Have we as a profession misunderstood trauma all these years?

Can we change what we do?

The Social Determinants of Health Project & Its Ties to Primary Care Networks

By Olive Godwin

The Division's work, since the beginning, has been to help members understand the value proposition of Primary Care, to encourage all members to be part of the solution, and to optimize the collective voice and influence of Doctors.

As we prepare for a new phase of health care transformation we find ourselves aligning our strategic directions with the mandate of a new government and a new Physician Master Agreement. The PG Division is nicely positioned to design a local Primary Care Network which includes new partnerships with patients, Indigenous communities and organizations, and community social service agencies. The hope is that these partnerships will result in more integrated and trauma-informed care to our collective patients.

Family Physicians can contribute to this new landscape by better understanding the evidence and studies on the effects of trauma and deprivation on patients' lives, how toxic stress from Adverse Childhood Experiences (ACEs) can change the makeup of the brain, and the important role resiliency plays in healthy brain development. Situations that might have been considered hopeless are now filled with hope. When we combine a new understanding of the prevalence of trauma in the lives of patients with the power of acknowledgement and access to the tools that promote growth and resilience, Doctors will realize new and inspiring ways to positively influence their patients' lives!

As the Division embarks on our spring theme of Social Determinants of Health (SDH) in Primary Care, it is probably a good time to 'out' myself as a Social Worker and articulate my intentions for this work. I spent my first 20 years working on the psychosocial side of care and didn't fully cross over into health care until 2003, when I joined CINHS (the Native Health Centre) as their Primary Health Care Coordinator. I have always believed that we can measure how well we are doing as a society by how well we care for the vulnerable among us. I made the decision to join the Division movement in 2009 because it was clear to me that the most effective way to work for improved health outcomes for patients was through the group that had the widest and deepest influence on the population: Family Doctors.

Of course, when I got to know Family Doctors I realized that they did indeed have a great impact on their patients' lives, most significantly through their longitudinal relationships with individual patients. Many Doctors didn't yet know the potential of their influence or impact on the health care system and the population as a whole. I have witnessed great strides forward in this medical community and I am proud to be embarking on this new journey with all of you.

Spring Member Meeting: Wed. May 2nd 1730—2100

Theme:
ACEs - Simple Techniques to Promote Resiliency

*** Up to 3.0 Mainpro+ credits available ***

Details:

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

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Your voice matters!

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

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M-F 8:30-4:30

Blue Pine Primary Health Care Clinic
#102, 1302 - 7th Ave.
Prince George, BC V2L 3P1
Phone: (250) 596-8100
Fax: (250) 596-8101
M-Th 8:30-4:30 (closed 12-12:45)
F 8:30-12:00 (open 1-4 alternate wks)

ACEs: the Population Health Perspective

Dr. Sandra Allison, Chief Medical Health Officer

Adverse childhood experiences (ACEs) (or childhood adversity) shape the brain in childhood and subsequently contribute to wellness and adult health outcomes. In the milieu of a nurturing or stressful home and community setting, optimal development of physical health, prosocial competence and coping strategies depends on consistent parental interactions while meeting basic needs and fostering healthy and safe attachment in an enriching environment. Children can either flourish or flounder in their early childhood setting. We now know much more about how childhood adversity impacts health since Felitti and Anda determined the strong relationship between toxic childhood experiences, negative health risks and behavours and poor health outcomes in adulthood. *Alarmingly, those individuals in the 1998 study reporting multiple adverse childhood experiences were found to die several years younger than their counterparts. (1,2)*

Toxic childhood experiences include emotional or physical abuse or neglect, sexual abuse; the presence of mental illness, substance use or violence within the home; separation or divorce of parents or incarceration of a family member. Other traumatic experiences might include online bullying, bullying in school, living with discrimination, being homeless, experiencing natural disasters (like the BC forest fires!), fleeing wars, or gross violations of human rights. With global mobility on the rise compounded by displacement from international crises, Canada can expect more immigrant and refugee families who may struggle with the impacts of adversity. Closer to home, systemic racism and ongoing cultural trauma negatively impacts the health of Indigenous people every day… and across generations. *In the 1998 study, those reporting 7 or 8 adverse experiences were three times more likely to have cardiovascular disease, as well as associations with other health conditions. Indigenous populations reported 2-3 times the number of ACEs of non Indigenous populations. (2,3)*

Fortunately, investing in resiliency building through nurturing and supportive home settings can improve health and relationships beginning in early childhood, and lasting throughout the lifespan. Resilient families have resilient kids. Healthy communities support families to be healthy and resilient. Learning about adversity, and learning to parent positively are important first steps. Meeting children's basic needs, including healthy attachment to parents and other family members is crucial. We can become trauma informed as individuals, and communities, and prompt social changes in how we treat each other, maybe a little better.

3 Partnering with patients and communities for improved health

Research demonstrates that connection to a supportive adult can make a significant difference to a youth's academic achievement, resilience and self-esteem. (4)

A final consideration: Health system sustainability is dependent upon mitigating future burden of chronic diseases such as heart disease, lung disease, liver disease (the very diseases explored by Felitti and Anda) and minimizing risk factors such as alcohol use, drug use, and smoking. Physicians can play a role in educating individuals and families about adversity in childhood and impacts to our health as adults, how resilience can offset adversity through healthy relationships and safe connections to community. Consider social prescriptions? Physicians can also advocate for improved supports for vulnerable families and communities as a whole.

1. https://www.albertafamilywellness.org/what-we-know/aces
2. https://www.ncbi.nlm.nih.gov/pubmed/9635069
3. https://www.hindawi.com/journals/scientifica/2016/7424239/
4. https://reachmilitaryfamilies.umn.edu/sites/default/files/learning_modules/files/1/Module-2-Fact-Sheet-Supp-Relationships.pdf

ACEs increase health risks as follows:

PG Division's Practice Coverage Position

By Sharon Tower

The PG Division of Family Practice has been working with NH Recruitment to develop two Practice Coverage Positions (Locums) for Prince George. We have successfully recruited Dr. Gordon Chin to begin one of those positions in August 2018. Dr. Chin is currently finishing his second year Residency in the Prince George program.

- The Practice Coverage position will provide short term practice coverage, up to two weeks maximum per Physician.
- The Physician/Practice will be responsible for remuneration and pay the locum directly at a standard 70/30 split.
- Scheduling will be managed by the Division in three-month increments on a first-come, first- served basis, with a focus on equitable access for everyone.

2 Sustaining a strong community of family physicians

- The first call for booking requests was sent out on Feb. 27th. August and September are already booked. **There is availability October 4 – 19 and 26 – 31.**
- Requests for coverage November 2018 – January 2019 will be accepted beginning 8:30am on May 1, 2018.
- Please contact Sharon Tower, Operations Lead, at stower@divisionsbc.ca with your requests.

This new program is still being refined by the Practice Coverage Oversight Committee. Further communication will be sent out in late April 2018. We welcome your input/feedback.

Treating the Whole Person: Social Work's Primary Role

By Brigitte Loiselle, Team Lead IPT 5

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Social Workers are uniquely educated and skilled in addressing social wellbeing, and bring expertise in the impacts of the social determinants of health. Working in primary care, we pay specific attention to how people's health status is being detrimentally affected by the social determinants of health and then design health care interventions to address this.

Social Workers use a holistic, trauma-informed lens in our professional practice. Using a client-centered approach based on empowerment, self-determination, human rights, advocacy and the intrinsic worth of all persons, we collaborate with clients, helping them to see their strengths and assets. Keeping abreast of the multitude of resources that are available to assist clients, as well as the processes for accessing them, can be very challenging. As Social Workers, we have a great awareness of the resources available in our community to meet the specific needs of our clients. We are experienced at navigating the various systems involved in accessing these resources, and also have the ability to advocate for those clients who are unable to do so for themselves.

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

Examples of situations that Social Workers are frequently called on to assist with and provide education about include: identifying and raising concerns about systemic discrimination issues, reducing poverty levels, improving income and food security, addressing housing issues and instances of social exclusion, supporting around adverse childhood events and developmental circumstances, and advocating for persons with disabilities.

Guided by our professional code of ethics, Social Workers offer a specialized focus on the interplay and impact of the social determinants on one's physical and mental health. As such, we are well-positioned to provide expert knowledge both to clients and our Interprofessional Team members on the social determinants of health and ways to reduce associated social inequities that occur as a result.

These are the IPT Social Workers:

Brigitte Loiselle – Team Lead IPT 5 & Social Worker
Mary Macdonald – Social Worker IPT
Sandra Harker – Social Worker IPT
Jody Shul – Social Worker IPT
Brenda MacDougald – Casual Social Worker IPT
Melody Black – Social Work Student IPT

Social Determinants of Health Experiences

By Dr. Rob Tower

One of my first classrooms as a high school teacher taught me a lesson I will never forget. I was given a remedial grade eight math class, an assignment few of my colleagues would wish for. There were a lot of characters in that class but one that really frustrated me initially was a young woman who would be asleep at the beginning of each class. I would go back and quietly wake her up and she would be apologetic, but soon, fast asleep again. I found out she lived with her drug-abusing mother and step-father in a chaotic home environment. I just decided to let her sleep as it seemed my classroom was the only safe place she could. Through the ongoing investigation it was found the step-father was prostituting her older sister. I was stunned, and I never saw my students the same way again. The events in our lives have an impact on how we present ourselves; sometimes we recover from those events, but as the Kaiser Permanente Adverse Childhood Event Study (ACEs) has shown, the impacts can be life-long and life-altering.

More than a decade later, I find myself in a different career having the tremendous privilege to practice family medicine. Part of my patient roster includes incarcerated individuals, who by all standards experience elevated ACE scores in greater proportion than the general population. Treating these individuals as their physician requires more than just the empathy I was able to show my sleepy student: I must be able to treat their pathology, which requires understanding the etiology.

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

How does understanding ACEs change the way I practice medicine? Medicine is an art and a science requiring sharp inductive skills to get to a diagnosis. The pathway to diagnosis and treatment can be straightforward, but often it is convoluted and complex. In my experience, dealing with traumatized people can make treatment of disease much more complicated. They can be angry and guarded. They often have secondary gain motivating their presentation of symptoms and can be very manipulative. When I don't do what they want they may lash out with disrespectful language and actions. Understanding something about the trauma they have faced helps me to tolerate the difficult interactions with compassion.

Understanding the risks a patient has when they score high on the ACE quiz offers more than empathy and compassion for patients. Screening with ACE can give physicians the ability to do something more - we can intervene before disease presents. Although the ACE score is one risk factor amongst many, it is worth the time it takes to employ such a non-invasive investigation to secure significant and useful information.

Welcome to New Member Doctors:

Dr. Eugene Anekwe
Dr. Andrew Hamilton
Dr. Wumi Iyaoromi
Dr. Mal Kaminska
Dr. Zoryna Miroshnychenko
Dr. George Youssef

Division Staff Updates

Late winter has seen a number of changes in Division office roles:

- The Operations Lead is now Sharon Tower
- Sharon's former role of NSCPC Project Coordinator & coach support is being filled by Simon Zukowski
- Bonnie Bailey continues with the Division by administering Pathways as a contractor

Sign Up For Direct Deposit!

For physicians, particularly for those involved with IDOD &/or Residential Care. Please contact Gail to sign up, via 250-561-0125 or gbrawn@divisionsbc.ca.

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
Rachel McGhee
Ian Schokking
Theresa Shea
Cathy Textor
Jessica Zimbler

Acknowledgements

We are grateful for contributions from:

- Doctors of BC - GPSC
- Ministry of Health
- Northern Health
- City of Prince George
- Spirit of the North Healthcare Foundation
- Shared Care Committee
- PHSA/Trans Care BC

Poverty Intervention: A Local Example of Advocacy After Identifying the Issue

By Dr. Christina Boucher, Family Practice Resident, & Dr. Eric Butler

Staff at several organizations in downtown Prince George have identified that a substantial number of patients at their clinics, shelters, and drop-in centres have experienced negative health impacts due to a lack of stable housing. Despite the available housing resources in the city, a subset of these patients are continually "falling through the cracks" in the system and as a result are chronically homeless, with worsening health overall. This group of patients are people with complex histories, including physical chronic health conditions, mobility issues, mental health concerns, brain injury, substance use, and a long history of trauma. Often these patients are elder and aging, and a disproportionate number of these vulnerable patients are Indigenous. Due to insecure access to the basic necessities of life (shelter, food and clothing), these people are living in "survival mode." The issue here is one of health equity. In other words, this group of marginalized patients has a very high need for health care, but due to barriers in the system, their access to that care is inadequate.

As part of an advocacy project at the Central Interior Native Health Society, led by Dr. Eric Butler, I began to approach this huge issue using the Figure 8 Strategy for physician community engagement as a guide (Hewitt et al., Can Fam Physician, 2017, Vol 63, p. 586 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5555318/) Main steps here include listening to patients and to other service providers, educating oneself on the issues, and disseminating information. Practically, what this looked like was emailing, phoning and physically walking into every local organization that served this population in order to hear what people working on the frontlines of poverty issues thought. I discovered the organizations working on the ground are operating in isolation, siloed in their efforts, although unified in their assessment of resources that were needed. Overwhelmingly**,** the thinking among Prince George service providers who work with this population is that specialized, supportive housing with wrap-around services is needed as a solution.

3 Partnering with patients and communities for improved health

In a practical approach to identified poverty and housing insecurity, the next steps in our advocacy efforts are to expand the conversation, and involve not just the Health Authority, but also the City government, as well as the housing and social services branches of the provincial government.

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.

Coaching Team

Megan Hunter
Clinical Programs Lead

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Tools From the EQUIP Team

By Colleen Varcoe (EQUIP Health Care)

The EQUIP: Research to Equip Primary Healthcare for Equity *Primary Health Care Study* looks at social determinants of health and how primary care clinics successfully provide care to people marginalized by poverty, racism and other forms of discrimination and stigma.

The EQUIP team, which includes Dr. Heather Smith (and previously Dr. Scott Lennox and Dr. Patty Belda), have produced a series of on-line "Equipping for Equity" modules and a companion toolkit. These evidence-based, practical tools can help individuals and organizations shift their practices and care settings towards equity. They offer practical tips, talking points and pathways to make care settings more welcoming and supportive to people experiencing violence or struggling with substance use. The toolkit offers "walk-throughs" and measurement tools to assess what is happening in your workplace. Trauma and violence-informed care, cultural safety and harm reduction are distilled into videos, templates and action-oriented strategies; the scholarly papers are available, or busy practitioners can simply focus on tools to help deliver care that is effective and acceptable for "complex" patients. Try it: https://equiphealthcare.ca/.

4 Sharing our learning to inform and positively influence the system

The Coaches' Corner

By The Coaching Team

As you read about the ACE questionnaire you're probably wondering: 'how do I fit this into my busy day?'

The practices that had success with recording PHQ9s during the Mental Health module, and recording frailty scores and MOST forms during the end of life module, all pre-flagged patients prior to appointments. This allowed MOAs to print any necessary form or questionnaire, and potentially schedule more time if necessary.

This thinking could be applied to ACEs. One way to identify patients with a high ACE score is to identify those that have been in your offices frequently in the past year. You can do this by going to **Reports > Clinical – Audits > Number of Visits**. In this window, you can adjust age range to 18-120 and change number of visits from 3 to 10 (or whatever makes sense to you!). You could narrow this down further by entering appointment date ranges. This will let you know if one of these patients is already scheduled to see you.

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

At our May 2nd member meeting you will hear about how to approach these tools with patients and what this may mean clinically. In terms of documentation, the ACEs score can be entered under Measures using the code **83191 – ADVERSE CHILDHOOD EXPERIENCES SURVEY (CDC)**. You can also type the quick code "ACES" to find this. Other ways to share or record relevant information is in the care plan. For example, you may want to record the answer to "Do you ever have difficulty making ends meet at the end of the month?" under Barriers to Care.

For more information, contact your coach!

STRESS & EARLY BRAIN GROWTH

Understanding Adverse Childhood Experiences (ACEs)

What are ACEs?

ACEs are serious childhood traumas -- a list is shown below -- that result in toxic stress that can harm a child's brain. This toxic stress may prevent a child from learning, from playing in a healthy way with other children, and can result in long-term health problems.

Adverse Childhood Experiences can include:

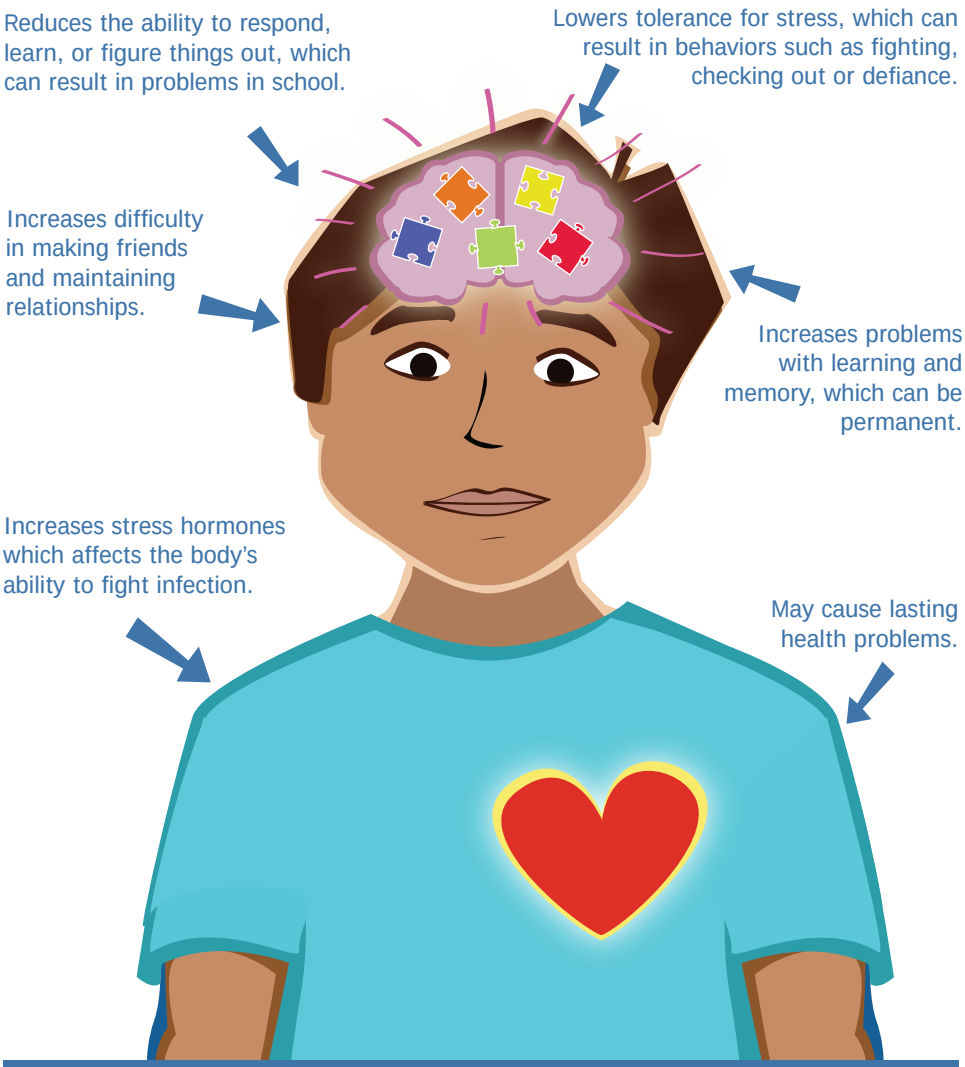
1. Emotional abuse
2. Physical abuse
3. Sexual abuse
4. Emotional neglect
5. Physical neglect
6. Mother treated violently
7. Household substance abuse
8. Household mental illness
9. Parental separation or divorce
10. Incarcerated household member
11. Bullying (by another child or adult)
12. Witnessing violence outside the home
13. Witness a brother or sister being abused
14. Racism, sexism, or any other form of discrimination
15. Being homeless
16. Natural disasters and war

Exposure to childhood ACEs can increase the risk of:

- Adolescent pregnancy
- Alcoholism and alcohol abuse
- Depression
- Illicit drug use
- Heart disease
- Liver disease
- Multiple sexual partners
- Intimate partner violence
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies

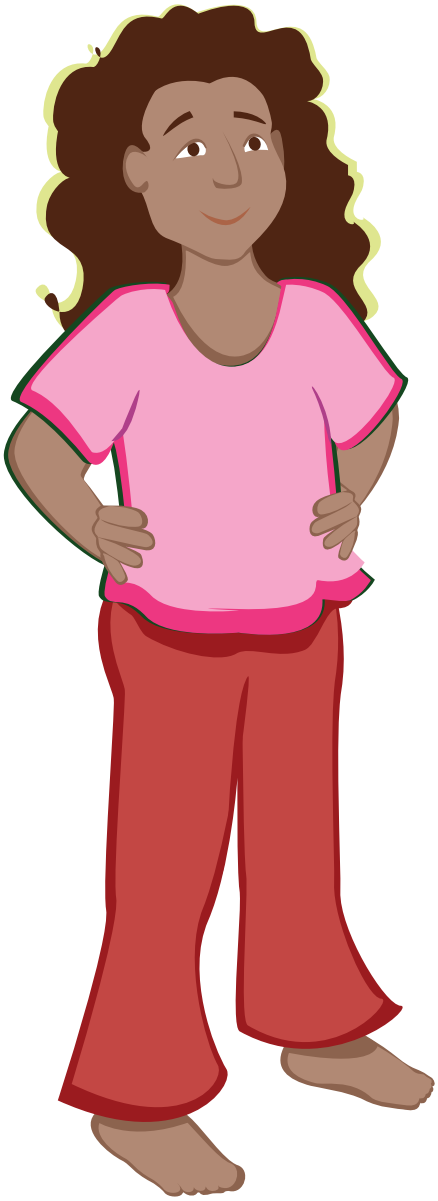
How do ACEs affect health?

Through stress. Frequent or prolonged exposure to ACEs can create toxic stress which can damage the developing brain of a child and affect overall health.



A Survival Mode Response to toxic stress increases a child's heart rate, blood pressure, breathing and muscle tension. Their thinking brain is knocked off-line. Self-protection is their priority. In other words:
"I can't hear you! I can't respond to you! I am just trying to be safe!"

The good news is resilience can bring back health and hope!



What is Resilience?

Resilience is the ability to return to being healthy and hopeful after bad things happen. Research shows that if parents provide a safe environment for their children and teach them how to be resilient, that helps reduce the effects of ACEs.

Resilience trumps ACEs!

Parents, teachers and caregivers can help children by:

· Gaining an understanding of ACEs
· Helping children identify feelings and manage emotions
· Creating safe physical and emotional environments at home, in school, and in neighborhoods

What does resilience look like?

1. **Having resilient parents**
Parents who know how to solve problems, who have healthy relationships with other adults, and who build healthy relationships with their children.

2. **Building attachment and nurturing relationships**
Adults who listen and respond patiently to a child in a supportive way, and pay attention to a child's physical and emotional needs.

3. **Building social connections**
Having family, friends and/or neighbors who support, help and listen to children.

4. **Meeting basic needs**
Providing children with safe housing, nutritious food, appropriate clothing, and access to health care and good education.

5. **Learning about parenting and how children grow**
Understanding how parents can help their children grow in a healthy way, and what to expect from children as they grow.

6. **Building social and emotional skills**
Helping children interact in a healthy way with others, manage their emotions and communicate their feelings and needs.

Resources:

ACES 101
http://acestoohigh.com/aces-101/

Triple-P Parenting
www.triplep-parenting.net/glo-en/home/

Resilience Trumps ACEs
www.resiliencetrumpsACEs.org

CDC-Kaiser Adverse Childhood Experiences Study
www.cdc.gov/violenceprevention/acestudy/

Zero to Three Guides for Parents
http://www.zerotothree.org/about-us/areas-of-expertise/free-parent-brochures-and-guides/

Thanks to the people in the Community & Family Services Division at the Spokane (WA) Regional Health District for developing this handout for parents in Washington State, and sharing it with others around the world.

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Supplement

Kootenay Boundary Division's Path to Integrating Social Determinants of Health Into Primary Care Practice

By Dr. Lee MacKay

Every physician is at least peripherally aware of the impacts that poverty and trauma have on the health of patients, but too often leave medical school under-equipped to integrate this knowledge into the care of patients. This, despite a tremendous body of new evidence that tells us that even the most modest physician effort in this regard can make a huge difference in the lives of our most vulnerable and high needs patients.

During my family medicine residency I looked extensively at how to apply this knowledge to Primary Care. I was most struck by the finding that of the potential life years lost in Canada, 24% is due to poverty compared to 31% for cancer and 18% for cardiovascular disease. I decided to use the leadership opportunities presented to me in my work with the Kootenay Boundary Division of Family Practice to champion rebalancing the time spent on these three issues in Primary Care.

Effective action began with the Kootenay Boundary Division dedicating funds to adapt an Ontario Poverty Intervention Tool, both specifically for Kootenay Boundary, and a version for all of BC. Delivering local CME about the tool helped bring the Social Determinants of Health (SDH) to the forefront of physicians' minds, but during these engagements many colleagues stressed they didn't feel they had the time or skills to act on 'prescribing income.' This led my clinic to apply for funds through A GP for Me for a tapering subsidy from the Division to hire a Medical Social Worker. My clinic colleagues went initially from mild indifference about the Social Worker pilot to saying at the end that she was a 'Gift from God.'

Recognizing the importance of SDH for Patient Medical Home planning, our Division also entered into a partnership with PHSA/BCCDC to use Kootenay Boundary as a pilot region to overlay CDC's Social and Material Deprivation indexes with MoH Chronic Disease registries to determine the relationship between poverty and chronic disease incidence. This groundwork has prepared us for our latest Shared Care project, specifically aimed at implementing in-practice screening in targeted clinics, systematizing the integration of SDH data into EMRs, and promoting the sharing of screening data in General Practice to Specialist Practice referrals, along with CME to increase poverty and trauma-informed care practices amongst our GPs and SPs. Working with these early adopters will help us build momentum towards our end goal of an overarching SDH lens to care in Kootenay Boundary.

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F 8:30—12:00