Prince George Division of Family Practice
A GPSC initiative

five years strong EST. 2009

Division Newsletter

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

November 2015
Issue 12

Team-Based Care: Lessons From a Canoe Trip

By Garry Knoll

After several years of not experiencing "wilderness" camping, we decided to get out there before we thought up too many reasons to never go. Some things didn't go well at first.

One person brought cheap, inadequate wheels for portaging their canoe. They decided to use them despite skeptical looks all around. **Let people use what they have/know, if no one's life is at stake.**

I forgot a backpack for a companion on the trip. Nuts! I had wondered why that was on the list. So we shared the load among the team. Bad idea. The first portage was rainy, awkward, unplanned, late-starting, & challenging. The loads for some (me) proved too heavy. We decided to take the first camping opportunity instead of torturing everyone with a second, longer, more-rutted portage & a late evening camp setup. **Re-evaluate the plan in light of new information and work out a compromise.**

I discovered at supper that I brought the wrong connector for the propane tank. A fire ban was in place so the traditional option was not to be. I decided that I needed to return early in the morning over the last portage to get propane. **Take responsibility to remediate one's own mistakes as soon as they happen.**

Also in the morning, my companion with the lousy canoe cart asked me to take the lousy wheels back & rent a proper cart for them. Yes! I rented him a proper pack as well. **Allow people to self-assess their choices, gracefully change their mind, facilitate without blaming. Focus on the larger picture.**

We had hoped for fair weather but planned for rain. When the hailstorms hit, we decided to alter our day's plan (see "re-evaluate the plan..." above) and take cover. As much as we wished to be safe at home & off the route, we had committed to a journey for a rich experience, despite the risks. We all had to figure out a way through the storms—no one is left behind and everyone's contribution is required for the success of this journey. There was no way to turn back, progress only lay ahead. **Each had to decide if they were to be part of the problem or part of the solution.** I knew my companions, including the rookies who had not done this before; they were all part of the solution.

Despite the bumps along the way, the trip through the wilderness was spectacular. We also forged deeper relationships along the way. I expect the same as we as we journey toward **Team-Based Care**.

Physician Leadership Resources

By Bonnie Bailey

Research & discussion papers regarding the value of collaborative care & working in Interprofessional Teams (IPTs) have become more commonplace & accessible in the last 10 – 15 years. Much of the literature suggests that interdisciplinary collaboration is the best way to provide quality health care.

Working collaboratively is not a new concept, as family doctors often seek out & rely on cooperative interaction with a variety of allied health care professionals. As we move forward in partnership with Northern Health (NH) on the Team-Based Care model, what may be different is how collaboration is defined & understood, & how leadership & decision-making appears at various points within the continuum of patient care.

Research & experience has shown that working together does not guarantee a well-functioning team. We recently did a small scope review of current national & international papers to see what they were telling us about readying individuals for working in teams. It was not surprising to see that assessments of the approaches often referenced open & participatory communication, role clarity, & adaptive leadership, along with shared (or group) decision-making, as being crucial to success. Unfortunately they frequently spoke to the "what" & not to the "how."

As Team-Based Care is being implemented, the Division is looking for ways to support physicians with the "how" through various resources & sessions, such as the Nov. 18th & 25th Interpersonal Communication Module (Interprofessional Team Curriculum), & the Dec. 2nd members' meeting with Dr. Rahul Gupta on optimizing provider resilience & Team-Based Care.

There are also well-regarded websites, such as the Institute for Healthcare Improvement (IHI) http://www.ihi.org/Pages/default.aspx, that have information about team-based service delivery & improving patient care.

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Inside this issue:

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

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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.

PG Patient Attachment

Based on data available to us, we have been able to track our progress of matching every citizen who wants one to a family physician. We know confidently that 80,000 Prince George citizens are now attached to a family physician. We also know from census data that approximately 7 to 10% (or upwards of 9,000 people) of the population are not looking for a family doctor.

Dec.12, 2014 Division opinion piece: PG Citizen

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 princegeorge@divisionsbc.ca

Pertussis: The Role of Public Health

By Dr. Sandra Allison, Chief Medical Health Officer

All Public Health (PH) follow-up for Pertussis is performed by PH nurses; cases are contacted by phone. The main purpose of follow-up is to ensure appropriate treatment & to identify contacts.

- "Contact" is defined as 5 minutes face-to-face (think uncomfortably close contact), more than 1 hour in a confined space (ie: a vehicle), or contact with the respiratory secretions of a confirmed case. Of the close contacts, public health identifies:
  - ✓High risk contacts – infants less than one year, pregnant women in third trimester
  - ✓Contacts with symptoms
- High Risk contacts
  - ✓At greatest risk of severe disease
  - ✓Risk of pertussis is shared with the clients
  - ✓Offered chemoprophylaxis, regardless of symptoms
- Symptomatic contacts
  - ✓**tested***
  - ✓**AND treated****

* Nasopharyngeal swab cultured in Amies Charcoal – PCR and culture will be performed.
** Overtreatment of viral infections may be an outcome. Given the current epidemiology, the need to decrease pertussis in the community outweighs this risk.

In the interest of space for the article above, the Division Leadership & Info feature has been co-opted in this issue.
Please refer to the Spring issue or contact our office if you require information.

Improving Practice Through the Use of Care Plans

By Cathy Textor

My colleagues and I have been trying out the "Care Plan" since the member meeting last Fall. We are far from having a Care Plan for every patient; however, we are using it more and more in our office & treat each one like "a work in progress." Most are pretty sparse so far. Working in a multi-doctor practice, it is critical to have clear communication tools for seamless handover & for patient continuity. We require an EMR that allows each practitioner to build on the patients' information in a way that is easy to read – I do not have time to review a year's worth of progress notes before seeing each patient. It has been a great tool for communicating key conversations that previously were buried in the encounter notes.

Early on, that section in MOIS seemed so daunting. I've still not really got it figured out. What goes in the Care Plan? What section do I use for what information? Do I have time for this? We try to incorporate documentation in the Care Plan as part of the everyday workflow of the office. In fact, we are using it in a way that decreases the need for documentation. For example, the population we have started with is our Complex Care patients. Historically, we were writing large notes in a template format – these notes were time-consuming.

Easy things to start with have been (by heading):
- GOALS: quantitative targets (ie INR and A1C targets).
- PREFERENCES: level of intervention discussions, care that patients decline (ie influenza immunization, prostate cancer screening), consent for us to communicate directly with family members.
- PLANNED ACTIONS: smoking cessation action plans, follow up plans for cancer patients after d/c from BCCA (ie q6 monthly physical exams, qyearly CXR, Tamoxifen x 5yrs).
- BARRIERS: mobility issues, transportation issues.
- RESOURCES: specialist names, home & community care, counselling services, supportive family members, enrollment in the palliative care program/palliative care benefits.

I often fall into the thinking that the Care Plan is "my plan" for the patient; I am trying to remember that the Care Plan should largely outline the "patient's plan" for how they receive care. It cannot be a make-work project, nor can we expect these to be complete, ever; they are a work in progress as the patients' needs, health status & priorities change. It has the potential to be a powerful communication tool for transitions in care; most importantly though, it should improve the quality of patient care.

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

Bittersweet Observations from the Trenches

By Tammy Attia

Suite #4 in the J.G. McKenzie Building was one of the first practices in Prince George to have the privilege to work with an innovative multidisciplinary team. They called themselves the Integrated Health Team for Seniors - or IHTS - at the time.

The success of the team was astonishing. We discharged elderly patients with more confidence, knowing their transition home would be seamless. We came to love working in a multidisciplinary team. The communication among us was comfortable & collegial. Moreover, prospective studies showed our seniors' enjoyed all the benefits of the IHTS goals.

We were excited to learn of the team's expansion: similar to when patients experience success with a new therapy, we thought 'more of this must be better!' The team started seeing other populations at risk, the team's skillset expanded to include OT, PT, life-skills, mental health & primary care nurses. We adapted & re-adapted to their ever-changing title; we now know them as the Primary Care Team #2.

However, it was then that I started to notice some changes: patients had to wait increasingly longer times to be seen, some even lost to follow-up. Hospitalizations were increasing. We started receiving notices to hold referrals; the team seemed overwhelmed. These observations seemed at odds with our initial experiences with the team. I perceived the resources of the team were getting spread thin. Physicians felt conflicted whether to refer to the team or not; on the one hand, we were trying to promote the vision of a primary care home, on the other hand, we began to worry whether our system was sustainable. I perceived some barriers to making the system efficient; the referral process was cumbersome, redirected/re-triaged referrals prolonging wait times for much-needed care.

There is no doubt that all of us in the trenches, whether family doctors, nurse practitioners or allied health professionals, strongly believe in working as a team. Indeed, we know of strong evidence for the primary care home. However, trust & good communication among all members is needed for that home to be functional.

Before we build a home, we need to count the cost. We also need an architect, of sorts; otherwise, we are not building anything, only patching up what is broken. Perhaps a public health physician needs to collaborate & oversee what resources are needed for the populations we serve, & how our resources should be distributed? Perhaps expansion of the teams should be slowed to what is manageable? Most of all, all voices need to be heard & valued to build a robust team. It is heartening to see the doors of communication open lately. Let us work together toward giving our patients - & their families - not a home of discord, but a home of distinction.

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

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Fall Member Meeting: Wednesday, December 2nd

1730—2100 Civic Centre Rm 208. All Family Physicians & Family Practice Residents welcome! Dinner, sessional payments, Resident honoraria provided. Join us for a session on:

Quality Improvement & Physician Wellness: Optimizing Provider Resilience & Team-Based Care

with Dr. Rahul Gupta, ICF Certified Coach & MBSR Facilitator

Physician Leadership Resources cont'd from page 1

By Bonnie Bailey

While doing the review, we came across other interesting sites offering a variety of resources that support interdisciplinary collaboration. These are:

Enhancing interdisciplinary collaboration in Primary Health care (EICP)
http://www.eicp.ca/en/toolkit/default.asp
http://www.eicp.ca/en/toolkit/hhr/training-and-education.asp

Nova Scotia Health Authority, Leadership Learning Resource Centre
http://libguides.cdha.nshealth.ca/LeadershipDevelopment/OnlineResources

We recognize that implementing Team-Based Care by introducing IPTs is a work in progress, requiring fundamental changes in current approaches to patient care. Collaboration between the Division (supporting Primary Care Homes) & NH (supporting the IPTs) is crucial. As more information & resources become available to support you in this transformative work, your Division will keep you updated.

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.

If you no longer wish to receive Division newsletters, please e-mail *gbrawn@divisionsbc.ca* for removal from the distribution list.

GPSC Visioning

The GPSC Visioning Steering Committee recently invited input from family doctors on the future of Primary Care practice in BC. By the end of the engagement period Sept. 30th, "about 1100 GPs participated in the online discussion and 500 in the digital dialogues." Results are available to be viewed at www.gpscvisioning.ca

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

Team-Based Care: Experiences On The Front Line

By Jessica Zimbler

Often a challenge in primary care is getting patients the services they need when they need them. A recent patient experience of mine comes to mind: Greg is a 26 year-old man who lives at home with his mom. He started seeing me due to increasing anxiety and panic attacks. We talked about counseling and medications; Greg wasn't interested in either. He saw me a few more times and was aware he was suffering, missing work and losing touch with friends. He agreed to a trial of medications and I put in a referral to the Interprofessional Team (IPT) for counseling services. The next week, Greg was in my office in crisis. He was not coping, not sleeping and in full-out panic. While with him in the room, I messaged my MOA to phone the IPT to ask about getting him seen urgently. Near the end of our appointment, Greg received a phone call – it was the IPT scheduling his intake. He left the office with a clear plan and I was satisfied knowing he was in good hands.

My experience with the IPT has not always been characterized by such quick and timely responses or successes. There have been times when people may not have been contacted, numbers were changed or faxes misplaced. In the last 2 months I have noticed an improvement, specifically in the communication I receive from the team; acknowledgement of referral receipt, intake notes, notification if they cannot contact a patient, discharge from services. It is true that waitlists can be long, and it can be hard for our patients in need of services to wait. But there is a huge change going on, and I am hopeful about the ultimate benefit of working with interdisciplinary teams in Team-Based Care for my patients.

The Coaches' Corner

By the Coaching Team

Hello Everyone from your Coaching Team!!
The coaches have been working with physicians to develop Care Plans. One observation is that there seems to be a clear difference in the way that offices with inter-professional teams (IPT) and those without are using the Care Plan. Unfortunately, in some offices attached to IPTs, the Care Plan seems to have become a make-work project associated with frustration and delays in patient care. Including the Care Plan in the referral to the IPT was intended to provide a concise health summary to supplement a referral letter emphasizing the current concern. However, creating a Care Plan for this purpose has proved to be time-consuming and not helpful. As practice coaches we feel it important to revisit the original intent of a Care Plan – to alleviate documentation, improve communication between health professionals, & improve patient care by respecting patients' wishes, their unique barriers to receiving care, & their goals.

There are offices successfully using the Care Plan in day-to-day practice, slowly building the number of patient charts that have Care Plans & building on them with each encounter. Some of the things that are being put into the Care Plan are:

- Complex Care & Mental Health Planning: Utilize the extra planning time to develop a Care Plan that will avoid documenting in encounter notes & avoid having to search for separate notes in the future.
- Cancer Care Follow Up: The Care Plan can be utilized to act on certain information from the referral letter ie ordering follow-up tests & linking the relevant consultation to the Care Plan.
- Recording INR, A1C, LDL and other targets.
- Engaging patients in goal-setting and self-management.
- Advanced directives.

We understand these frustrations & advise you that the Division is currently working with the teams on a more streamlined referral process. The Coaches participate in working groups with NH to bring your experiences forward & to come to a solution that works for everyone. Your feedback is essential in this time of development. In the meantime, please do not hesitate to call any of the coaches for assistance!

Coaching Team

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Clinical Programs Lead

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Heather Chafe
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Instructions on Uploading Your Patient's Care Plan to PowerChart

The coaches have received several questions about uploading care plans to PowerChart. Below are the steps to share your care plan. Contact a coach if you have any questions.

1. **Go to patient's care plan and click "Copy to Clipboard" on the top right**
2. **Log into Power Chart**
3. **Select the appropriate patient. Select the most recent or most relevant encounter the patient has had. Avoid attaching to a diagnostic test.**
4. **Click on Documents on the left hand side**
5. **Click on Add button (small paper symbol with a star)**
6. **In the Type drop down menu, select Shared Care Plan**
7. **Type care plan in Subject, and then paste the care plan into the blank field.**
8. **Click Sign, and Save & Close**