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

Reflection on Quality Improvement In Squash (*Medical Practice*): Illustration of a Plan-Do-Study-Act Cycle

By Garry Knoll

I decided I want to be a better squash player [*doctor*]. The word "better" in that statement is rooted in my nature. Some would play for other reasons. But I want to be better [*this is my Goal*].

This is what I did... First, I simply played more often [*Do*]. I became more familiar with the many possibilities on the court, how the play happens and how the ball will bounce [*Study*]. My play improved - but only a bit. Soon I plateaued, and the same guys kept beating me by the same 2 or 3….okay, 4 or 6 points [*Study: data collection*]. I bought a better racquet and shoes [*Plan*]. Better shots. But why do my feet still ache? [*Study*]. Farrance orthotics - fantastic [*Act*: *thought outside the box*]. I ride my bike to work (conditioning, save gas and commute time), so I can get around the court better [*Do*] but it doesn't give better results against a smart player [*Study*]. I do a little boring resistance training [*hard work*]. But way better shots now. Finally…..I took lessons. These actually produced best results for the effort made [*Act*: *ask an expert/coach*]. Duhhh!

What did I learn? If I never thought about playing better and then decided to pursue this goal, I would likely be making the same mistakes or have lost interest completely. Being better gives me more pleasure and better results.

Last October we audited all eligible patients for colorectal cancer screening, dragged them in and talked them through screening. We have at least one ***very grateful patient***. Doing the same old thing gives the same old results. I would rather play than practice (see patients rather than practice smarter). When I play and get exercise I am less sleepy in the day [*unanticipated outcome*]. I have choices; some of them are easy. Some of them need an investment of time and resources. I should take more lessons.

….I think I would like to be a better piano player….

What's Up at the Division

By Olive Godwin

As you are all aware through the many emails, invitations, and event notices you receive from us, there is a lot going on at the Division and in Primary Care in general in PG. I wanted to take this opportunity to give you an update on a few of the new initiatives.

The Working Group on Sustainable Inpatient Care: six of your colleagues, led by Dr. Catherine Textor, are working hard on researching and designing new ways of delivering inpatient primary care at UHNBC. We hope this will be work you can be proud of and will want to share in. You can look forward to hearing about the progress so far at the March 7th Department of FP, UHNBC meeting.

The Division has joined with NH to host two full-time locum positions that hopefully will be the beginning of a **Practice Coverage Program** for PG GPs. This initiative will provide some coverage for all full service FPs who struggle to find someone to cover when they need time off and hopefully will serve as a recruitment tool at the same time. The Division will schedule and support the locum doctors, who have signed a tripartite offer letter with PGDoFP and NH, outlining the terms and requirements that need to be met to be eligible for all full-time sign-up incentives available to all new FPs in PG.

We would also like to announce that the Northern Divisions of Family Practice, in partnership with NH, have been successful in acquiring Shared Care funds for a **Northern Shared Care Psychiatry Collaboration (NSCPC)** project. This initiative, led by Dr. Catherine Textor and Dr. Aarti Jani, is focused on improving the coordination of care for people requiring Mental Health and Substance Use services, especially where Primary Care and Specialist Services are called on to work together in service of the patient. The work of the NSCPC will have a regional systems component lead by Project Managers from Novatone Consulting, as well as locally-focussed work in all 3 Health Service Delivery Areas. The project is overseen by a Regional Steering Committee. The local PG work began mid-Feb. with the hiring of a PG Shared Care Coordinator, Sharon Tower. Watch for meeting invitations from Sharon shortly, asking for your input into what needs to change and how the changes should be implemented. You will meet Sharon as she assists the Coaches to deliver Learning Session 1 of the MH PSP modules starting Mar. 8/17.

Also see the references to **Pathways** and to the **new NH/Division Practice Coach** on this issue's last page.

We look forward to seeing you at the **Spring member meeting** on Mar. 29, and to continuing to support you all in achieving your practice goals.

March 2017
Issue 15

Spring Member Meeting: Wed. Mar. 29th 1730—2100

Theme: ***Reflecting on Your Practice: QI in the Primary Care Home***

Accredited by UBC CPD
UBC CONTINUING PROFESSIONAL DEVELOPMENT FACULTY OF MEDICINE

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

*** 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**

BC Rural Health Conference

May 12-13 (Fri-Sat) Prince George Civic Centre

Up to 13.0 Mainpro+/MOC Section 1

Target audience: Rural physicians, emergency physicians, family physicians, sub-specialists, nurses, nurse practitioners, midwives, paramedics, residents & students

Register by March 6th and catch the early bird prices: www.eply.com/RHC2017

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.

PG Practice Coverage Information: https://www.divisionsbc.ca/prince-george/locums

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.

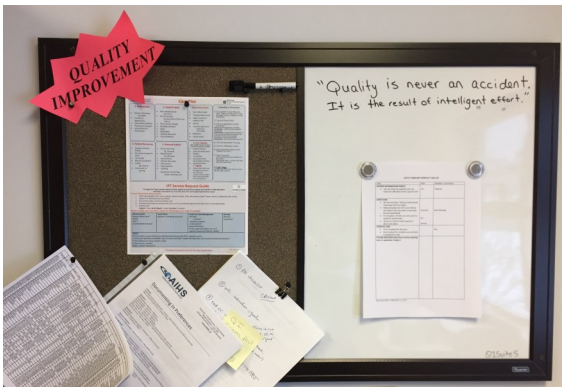
Demystifying Quality Improvement (QI)

By Christine Brenckmann

Quality Improvement was always something that we wanted to do, and knew we should do, but was just one more thing to tack on to the end of an already long day. Much like flossing and Kegels, it inevitably was left by the wayside in favour of rounding, notes, paperwork, phone calls, and teaching. Things changed when we started to see QI as a tool for making our day more satisfying and less frustrating. We did 3 simple things:

1. sent an email to our coach, Tammy – she is "in charge" of our QI, which takes the pressure off a little; she sets up meetings with the doctors, residents, and MOAs in our practice
2. bought a QI whiteboard/corkboard for our office – this is a daily visual reminder of QI; everyone including residents and MOAs has access and can contribute; this encourages a team approach and models QI to residents; residents are keen and can share practices from all over PG
3. made a list of the things we find frustrating – this helps us identify areas for change; Tammy can drop by when she has time and can review our list and develop an agenda for the next meeting.

One of the first things we have tackled is care plans. I was on maternity leave when they were introduced. When I came back and tried to refer someone for counselling, I was told that I had to write up a care plan. Initially developing a care plan was just another hoop to jump through. However, looking at our list, we thought we would try out care plans as a possible solution for some of our problems.



We started doing care plans for all our complex care visits and it has had several benefits:

1) a place to record target INRs and A1Cs (goals)
2) a to-do list for reconciling investigations/referrals (planned actions)
3) an opportunity to prepare for expected decline
4) an opportunity to engage select patients by giving them a copy of their care plan for correction and for their records
5) a diagnostic tool for undiagnosed symptoms
6) an opportunity to identify gaps in care
7) a summary that is useful for us, locums, consultants, community providers, and hospital providers (reduces unnecessary repetitive chart reviews) and to give patients when they travel.

This approach has helped us to get the ball rolling. We look forward to more satisfied doctors and patients!

Mental Health Planning: Right Patient, Right Time, Right Place

By Devan Reddy

Ed. note: coming out of the recent Chronic Pain session there was significant interest in Devan's multi-visit model for using the Mental Health planning incentive fee. As such, we asked him to provide more information on how that works.

When I started practicing in Prince George I received a bit of advice from my senior colleagues: "Know the Blue Book." Although it sounded more like an ominous warning than friendly advice, I never really appreciated what it meant. I now understand that having this knowledge would allow me to make the business case for any new initiative I was to undertake in my practice. As chronic disease management became more complex with more time demands, knowing the "Blue Book" alone was not enough to allow the time resources my patients' care needed. I have attempted to solve this by following the concept of: "Right patient, Right time, Right place."

Using this I scoured the very helpful GPSC website and SGP resources to look at what a year's worth of visits would look like for a patient who had a chronic pain condition. The chart in the newsletter insert is a summary of my take on a chronic pain patient.

The example in the insert is not perfect, and better solutions from the Ministry of Health regarding chronic pain billing codes are in the works to facilitate this work. (I heard this from Minister Terry Lake himself at a provincial pain summit.) I hope you find this helpful and would love to get your impression of it. Finally, if you are interested, assistance with designing other summaries that facilitate the time resource/capacity to deliver care that benefits both patient and provider would be greatly appreciated.

See newsletter insert - *Quality Improvement: Mental Health Planning in the Office*

The QI Journey: From Paper to Perfection (or at least close to it!)

Phil Asquith, as told to the Division Coaches

As coaches, we work with many physicians at different stages of quality improvement (QI) in their offices. Some physicians start with goals as small as deciding when to check the printer paper stock for reordering, and some re-haul their office processes for the sake of improved patient care and office efficiency. Dr. Phil Asquith chose to go big or go home. On April 24, 2015, Phil shared with his coach that his goal was to make his office completely paperless. We recently sat down with Phil to look back at his QI journey and to discuss how he chipped away at his goal.

Q: What got you interested in quality improvement?
A: I started hearing about QI from other doctors and the Committee Supporting Primary Care Homes. The CSPCH allowed me to see improvement can be big-picture, like in HDC [Health Data Coalition], or at the practice scale with scorecards, or at the patient level with control H. However, it was really the drug interaction functionality that sold me.

Q: What has your paperless journey been like?
A: I switched to MOIS in 1994 and was mostly using it for billing. I threw in a couple recalls and long term medications, but didn't pay attention to coding. In 2014 I cleaned up the data to meet the objective data dashboard standards, but didn't submit because I wasn't interested in typing encounters. In 2015, I started using the measurement template for things like smoking and weights. Now, that's the first thing I do with new patients. In 2016, I decided to work on coding when I realized I could use a drug interaction functionality if I coded. On Jan. 7, 2017 I started dictating progress notes [using Dragon Medically Speaking software].

Q: How was your office staff involved?
A: My MOA scans results into MOIS and we had a student nurse in summer 2015. She helped enter smoking statuses, heights, weights, and other measures.

Q: Did you ever want to give up?
A: I caught myself a few times at the end of a long day saying, "I will just do it next time!" Then I thought, "if I let myself get away with this now I won't do it later!"

Q: Was there anything that made it easier?
A: It helped that a large volume of data was coming in automatically with CDX hospital reports. My record was building itself going forward. Now, every piece of paper is scanned and shredded. I haven't put paper into charts in 1.5 years. It also helps that I do my own billing because I know the ICD-9 codes for problem lists. Templates are useful too, especially for consults. I also wouldn't be doing encounter notes if it wasn't for Dragon dictation.

Q: How did patients react to the computer?
A: I'm always struggling. I find it's hard to not interact with patients while I am on the computer.

Q: Have you achieved your goal?
A: I'm still working on letting go of the security blanket. Once in a while, I go into a chart for older results. We then scan it to the chart instead of putting it back in the file. Next, we have some office processes that need to catch up with being electronic. For example, knowing which patient is in which room. Before, the chart would be waiting outside on the printer.

Q: What advice would you have for anyone thinking of going paperless?
A: Go slow and don't worry about the past; 90% of the past you don't need. As long as you have a great problem list and medications you have most of what you need.

Northern Health QI Leadership Training Resources

By Candice Manahan, NH Executive Lead, Physician Quality Improvement

Northern Health Physician Services would like to highlight some of the resources and opportunities available to local physicians through Northern Health and the Joint Collaborative Committees. These resources focus on supporting physicians to make the changes that they want to see in the health care system. Some examples include:

- Tuition reimbursement up to $10,000 per year for Leadership Training (i.e. Physician Leadership Institute Courses) or Quality Improvement training (i.e. Institute for Healthcare Improvement or BC Patient Safety Quality Council)
- Staff can come to your department meetings or other quality committees to help to identify quality issues that you would like to work on, find the data/information that you need to make meaningful improvements, complete chart audits, and/or implement tests of change to help improvements. The staff can also help evaluate new projects or provide project management.
- Funding is available to reimburse you for your time away from practice to work on quality improvements in your hospital.

For a more complete list of opportunities or resources available to you, contact your UHNBC Specialist Services Committee (SSC) QI Coach Shelley Movold or phone 778-349-6274.

Physician Health

The **Physician Health Program** supports and 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 info 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

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

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

Pathways – A 'Made in BC' Specialist Referral Resource

By Bonnie Bailey & Lauren Lamont

Designed by GPs for GPs, Pathways is currently being rolled out across the Divisions of Family Practice in the north. This work is being supported by Lauren Lamont, Northern Region Pathways Administrator.

Pathways is a user-friendly online resource that allows GPs and their MOAs to quickly access current and accurate referral information, including wait times and areas of expertise for specialists and speciality clinics. It also includes hundreds of patient and physician resources that are categorized and searchable.

Users can easily search for a specialist by practice location, languages spoken, or even gender. Once a specialist profile is selected, information about pre-consultation requirements (ie blood-work, imaging), how a patient will be contacted, and directions and parking instructions for patients is given.

Lauren will be in touch with PG family physicians in the near future to arrange user access and provide a brief in-office learning session to support you in getting the most effective use out of Pathways.

FAST FACT #1

Pathways currently has **3,350** active users in **20** Divisions of Family Practice across BC

FAST FACT #2

The number of GP users increased by **84%** and the number of specialists users increased by **112%** in the last year

Introduction: Laura Parmar, Practice Coach

Welcome to Laura, who is a former Research Associate with NPiC. Originally from Calgary, Laura has 2 stepchildren, has studied in the Philippines, & sings in the Nove Voce Choral group. She is looking forward to supporting physician practices in her role as a Northern Health Coach at the Division.

Coaching Team

Megan Hunter
Clinical Programs Lead

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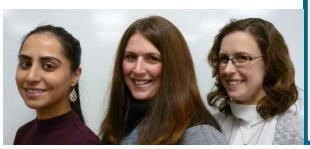
Heather Chafe
On leave at this time



The Coaches' Corner

By Bill Clifford & Tammy Bristowe

AMCARE to HDC: What Does This Mean?

You may be hearing the buzz letters "HDC" as Coaches come around to ask you for information to switch over your AMCARE account to the Health Data Coalition (HDC). So what does this mean? The HDC is a non-profit society that brings together the AMCARE (Aggregated Metrics for Clinical Analysis and Research) and PDC (Physicians Data Collaborative) networks into a single unified resource (basically, now a provincial resource rather than just a Northern one!) Like AMCARE, the HDC contains no personal patient data. It is entirely aggregate data, e.g. the number of diabetics who had their blood pressure taken in the last year. This data is further aggregated into groups larger than the clinic that contributed it – e.g. the City of Prince George. Also like AMCARE, access to the HDC data is very restricted. Contributors can only see data for other contributors or groups of less than 6 contributors by mutual agreement.

So far, 95% of HDC data comes from practices in northern BC! (Representing over 160,000 patients.) But the potential for having 95% of BC's population represented is immense. So what does this really mean for you? Although the data in the HDC pulls from the same data as your scorecard, HDC offers a visual representation with graphs that the scorecard does not provide. You can see the improvements that you have made in your practice over time or assess areas that may need improvement. Most importantly, there are enhanced ways that you can see how you are doing in comparison with others to inform how you prioritize your quality work. Many of you have been practicing "good data in" techniques and now can reap the benefits of your hard work with HDC in order to further analyze trends and query data to answer clinical questions.

The HDC viewer is far more powerful than what is currently available in AMCARE. Physicians can set any number of measures as favorites, pre-define what groups they want to use for comparison, see comparison data for as many as 5 groups at a time, and more. For the competitive spirit, HDC will also show you where you rank in any group you have access to with any indicator. Of course, you can't see who the other clinics or providers are without having a sharing agreement.

Let your Coach know if you want to delve into your data, and we can arrange for a demonstration from HDC or immediately start identifying indicators that you may be interested in analyzing.

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Insert

Quality Improvement: Mental Health Planning in the Office

By Devan Reddy

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Utilising Mental health care plan 14043

Right patient:

Needs

1. Severe interference in ADL's with **AXIS I +** or
   - Addiction
   - Homelessness
   - Cognitive impairment
   - Nutrition
   - Or Pain yellow flags!!

Right time:

14043 Payable in addition to same day: 30 mins

14044-48 Additional counselling items 20 mins

CDM fees payable same day

00120 bill all 4 before 14044

Telephone/email fees also now available

Community conferencing fees can be billed same day

Right place

Service# Type of Visit Fee	Fee code	Value	Max allowed
1 Office Visit	00100	$35	
2 Mental Health Planning Visit	14043	$100	1 yearly if applicable
Office visit	00100	$35	
3 Community Patient Conferencing	14016 x 1	$40	
4 Telephone Follow Up	14049	$15	5 per 8 month period
5 Counseling (#1 MSP)	00120	$52	
6 Counseling (#2 MSP)	00120	$52	
7 Counseling (#3 MSP)	00120	$52	
8 Office Visit 00100 296	00100	$35	
9 Counseling (Acute Crisis - #4 MSP)	00120	$52	
10 Community Patient Conferencing	14016x1	$40	
11 Telephone Follow Up	14049	$15	
12 Counseling (Acute Crisis - # 1 GPSC)	14044	$52	4 per year
13 Community Patient Conferencing	14016 x1	$40	
14 Telephone Follow Up	14049	$15	
15 Office Visit	00100	$35	
Total		**$665**	

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Remember...Contact your coach if you have any Care Plan questions!

Care Plan

Prince George Division of Family Practice
A GPSC Initiative

1. Preferences

- Advance Directives
  Eg. MOST
- Treatment Agreements
- Vaccination Declined
- Pharmanet Consents
- Info Disclosure/ Permissions

2. Goals/Targets

- Non-standard Goals
  Eg. A1C <8
- CA Survivorship
  Eg. Quantitative-Chest xray 1 per yr
- Diet, Exercise, Weight
- Smoking Cessation
- Sleep
- Meditation
- Lifestyle discussion
- Future Referrals

3. Barriers to Care

- Can't afford meds
- Transportation issues
- Safety concerns/ violence risks
- Low IQ
- Treatment Agreement Adherence (running log)
- Behaviour
- Psycho social

4. Patient Resources

- Support of family, friends
- Son drives to appointment
- Spirituality
- Recovery programs
- Habits
  Eg. Exercise
- Home care for bathing

5. Planned Actions

- Chronic Pain Plan
  Eg. Tapering
- Mental Health
  Eg. CBT goals
- Interventions
- Lifestyle discussion
- Assessments
- Tapering Meds
- Teaching

Eg. glucose monitoring, inhaler technique, etc.

6. Auto Populate

(Data "pulled" into the Care Plan if you have entered them in MOIS)

- Health Conditions
- Long Term Medications
- Allergies
- Connections
- Associated Parties
  Eg. Emergency Contact
- Extended benefits

7. Tagging

- Patient chart items can be tagged to show on the care plan.
  Eg. Measures like PHQ9 or GAD7,Extended Benefits from Demographics.

Uploading to Powerchart

1. Go to patient's Care Plan and click "Copy to Clipboard" on the top right. Create a snapshot in the second tab.
2. Log into Power Chart.
3. Select an appropriate patient encounter.
   When choosing please consider...
   1st priority – current active inpatient encounter
   2nd priority – most recent encounter in local community (Nice to have but not essential -most recent inpatient encounter in local community)
   3rd priority –avoid historical encounter.
4. Click on Documents Viewing.
5. Click on Add button (Add+).
6. In the drop down menu, select "Shared Care Plan".
7. Type "care plan" (or "care plan/advance directive) in Subject.
   Then paste (ctrl + v) the Care Plan into the blank field.
8. **Click "Sign".**

(or the Care Plan will not be viewable by other Users.)

IPT Service Request Guide

northern health
the northern way of caring

If urgent or if you need to discuss further please send service request and call IPT at 250-565-2612

Patients who have access to ICBC, WCB, EFAP and Extended Health Benefits should explore those options first prior to accessing IPT Services.

In your referral letter please include:

1. Client demographic info: name, address, phone number, PHN, alternative contact[6] (name, phone, relationship with client)
2. Reason for referral/resources needed
3. Any known safety concerns/violence risk[3]
4. If known, best times to connect with client, or if a coordinated appointment with clinic is most appropriate

Mental Health	**Social Work**	**Long Term Case Management**	**Nursing**
Mental Status Exam[7] PHQ9[7] GAD 7[7] Suicidal ideation & plan[7]	Barriers to accessing resources[3]	ADL/IADL - Finances[3] - Mobility/Transfers - Frailty (CSHA)[7] Recent fall history Family support/caregiver burn out[4] Cognitive assessment (MoCA, MMSE)[7]	Relevant assessment

PT/OT

If home safety: recent fall history, palliative performance scale (PPS), cognitive screen
If acute post-operative orthopedic: type of surgery and date[7], weight bearing status, post-op precautions/contradictions[1]
If wound/pressure injury: location, stage[7]
If chronic pain: consults[7]
Other: relevant assessment

* Numbers correspond to the Care Plan sheet sections above.

Ver. 2016-10-11