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

February 2012
Issue 5

From the Desk of the President

By Garry Knoll

RETIREMENT!!!!
"How do I provide a robust primary care home for my patients….. after I retire"

A primary care home is a place where our patients receive comprehensive, longitudinal, coordinated, holistic, patient-centered, accessible primary care. We are focused on improving the type of care we give and increasing patient safety in this increasingly complex work that we do. We know that whenever there are transitions in care the risk for adverse effects happens. Perhaps the most common situation that we see is after discharge from hospital, where plans laid out while our patients were cared for by a different team come to us. We have all expressed frustration with this. Our patients experience similar frustrations.

We rarely see retirement as a transition in care. Certainly, when I am thinking about retirement I'm very excited about all the non-medical things that I'm going to get to do that I have not been able to. However, my patients need to be looked after in the transition. Succession planning is something that many of us have to be intentional about. We are so often just bogged down in getting through our day that we don't have a lot of time to plan how our patients are going to be cared for beyond our retirement. As ethical physicians, we have a responsibility to make this next transition as smooth as possible. Many of our frail elderly and complicated patients will have a difficult time. I know that many of you are thinking about this. When I think about transitions I think about how I can modify my practice now to make it attractive for physicians who are coming after me. I think about the "fit" of the personality of the new recruit. I wonder about the way that I have kept my health records, whether it is on paper or in an EMR. Will a new recruit be willing to work with the records that I have? I know from exposure to residents in training that all of them are adept at using an EMR and do not place practices with paper records on their priority list. Virtually no newly-graduated doctor wants to practice as a solo physician. They are trained by teams of healthcare professionals and this is their usual choice for practice in the future. Do I have call group? Is it functional? Are the relationships healthy, robust and accountable?

The recruitment of a succeeding colleague is highly competitive. There are many places to connect with young doctors in the community: noon-time rounds at the hospital, the CME events (like Jasper Feb. 2nd), the Bob Ewert dinner, Northern Doctor's Day, and any time you see a young doctor in the hospital in their long (resident) or short (medical student) white coats! Remember that all of our interactions with learners at any stage in their education may become a collegial, partner relationship….we never know.

On page 6 I have collected a list of tips to help prepare yourself, and your office, for succession (and success!) If you have other suggestions, can you let us know as we develop some resource materials for our members thinking about this? Thank you.

…see page 6

Members Shape Division Initiatives: Summary of Nov. 9th, 2011 Member Meeting

By Olive Godwin & Gail Brawn

The Prince George Division of Family Practice (PGDoFP) hosted its 5th member meeting on Nov. 9th, 2011. As always when the members gather to share their time, energy, and thoughts, the Division benefits greatly as we continually reference the meeting experience and the evaluations. We received 28 evaluations from the 31 attendees, gleaning input on: what was most/least useful, education/information session requirements, and suggestions for improvement. The meeting was rated 3 out of 4 or better by 92% of the attendees.

Three small group sessions were held on the topics of Multidisciplinary Care, Coaching, and Optimizing EMR Use for Population Health Outcomes. The latter was facilitated by Patty Belda and Bill Clifford, and it became a foundational piece for finalizing our decision to focus our population health efforts in the 3 key areas of HIV, smoking cessation, and obesity. (See *The Power of the Divisional Data Strategy* article on moving this initiative forward).

The next member meeting is scheduled for **March 27th, 2012** and your Division needs your participation and your input. We are encouraging members who have not yet experienced a member meeting to come out and join us, as well as all of the returning members to come and to bring a colleague.

We are soliciting feedback and input on topics for the agenda. This time you can do that via e-mail, phone, or a note in the Division mailbox (UHNBC Doctor's mailroom), and soon you will also be able to give us anonymous feedback through electronic surveys connected to the newsletter. And of course your comments at the meetings are always carefully considered.

Inside this issue:

Upcoming Events

- **IPC Member Meeting**
  Thursday, March 8, 1200—1300, UHNBC Room 410
- **Division Member Meeting**
  Tuesday, March 27, 1730 - 1900, Civic Centre
- **Division AGM**
  Friday, June 15, 1200 - 1300, UHNBC Room 410

Join us for Division of Family Practice Board meetings the 3rd Monday of every month, 1700—1900, at the Division office #201, 1302—7th Ave.

Prince George Division of Family Practice Leadership

Board of Directors

Garry Knoll	Board Chair/Physician Lead
Barend Grobbelaar	Vice Chair
Ian Schokking	Treasurer
Zoe Redenbach	Secretary
Phil Asquith	Member at Large
Patty Belda	Member at Large
Khalid Javed	Member at Large
Denise McLeod	Member at Large
Dick Raymond	Member at Large
Bill Clifford	Ex Officio (IMIT)
Dan Horvat	Ex Officio (NMP)
Bert Kelly	Ex Officio (NMS)
Muhammad Shahnawaz	Ex Officio (FP Dept. Head)

Executive Committee

Garry Knoll	Board Chair/Physician Lead
Barend Grobbelaar	Vice Chair
Ian Schokking	Treasurer
Zoe Redenbach	Secretary
Bill Clifford	Ex Officio (IMIT)
Dan Horvat	Ex Officio (NMP)
Denise McLeod	Member at Large

Division Staff

Olive Godwin	Executive Director
Mary Severson-Augustine	Project Manager/Coach
Joy Schwartzentruber	Practice Improvement Coach
Cheryl Marsolais	Administrative Assistant
Gail Brawn	Executive Assistant

Committees and Physician Leads for Projects & Initiatives

Attachment Initiative Co-Leads	Barend Grobbelaar
	Dan Horvat
Attachment Small Working Group	Bill Clifford
	Olive Godwin
	Barend Grobbelaar
	Dan Horvat
	Garry Knoll
	Zoe Redenbach
	Ian Schokking
	Mary Severson-Augustine
Collaborative Services Committee	Olive Godwin
	Barend Grobbelaar
	Dan Horvat
	Garry Knoll
	Mary Severson-Augustine
	City Representatives
	Northern Health Representatives
Primary Health Care Clinic—Lead	Barend Grobbelaar
Recruitment & Retention—Co-Leads	Ian Schokking
	Ed Marquis
Supports for Primary Care Homes —Lead	Not occupied
Reducing Demand Through Healthier Communities—Lead	Not occupied
Newsletter Physician Editor	Zoe Redenbach

Interested in taking a role? Helping with a committee?
Contact Olive Godwin at 250-561-0125 or
pgdofp.coordinator@gmail.com

The 4 Strategic Directions of Attachment

As outlined by Barend Grobbelaar in the May and August 2011 issues of our newsletter (accessible on Sharepoint), Attachment is a chief aim of the Division. The 4 Strategic Directions, formerly referred to as Pillars, are addressing Prince George's unattached patient profile as compelled by these Northern Health statistics for 2010/2011:
→Total Population: 90,000 →Unattached Patients: 12 - 15,000 →ER Visits: 44,512 →In-Patient Cases: 10,742

Behind the scenes we're always advancing the goals of the 4 Strategic Directions of Attachment, some of which we cover in more detail in this issue

Physician Master Agreement Negotiations

Negotiations towards creating a new Physician Master Agreement continue between the BCMA and the Ministry of Health. The current agreement expires Mar 31, 2012. The negotiations have affected our work at the PGDoFP, but we hope that a resolution will soon be put into place. We are fortunate in that we have PGDoFP board members who are also board members of the Society of General Practitioners (Phil Asquith) and the BCMA (Dan Horvat), who are able to keep us apprised of developments.

This Just In!! Residential Complex Care Program Agreement Finally Signed!

The Residential Complex Care Program, an agreement between the PGDoFP and the Ministry of Health, has finally been signed! It has been agreed that physicians who continue to look after nursing home patients will receive $350.00 per year per patient. The current agreement dates from Jan 1, 2012 to Mar 31, 2012, but extension beyond that date is very likely. We will be sending out more information about this agreement, information on requirements, and how to submit for billing in the near future.

The Power of the Divisional Data Strategy *

By Barend Grobbelaar & Bill Clifford

Following conversation and deliberation with members and partners, the Division board has settled on three priority areas to focus on this year to demonstrate our ability to positively impact planning, decision making and clinical outcomes. This will be achieved by generating *accurate* population-based data in the three specific areas. We intend to demonstrate our Division's unique ability to produce such data. We will then be able to demonstrate *in real time* the impacts on clinical outcomes and population health that flow from availability of this data. The three areas are:

- ☐ Smoking cessation
- ☐ HIV testing
- ☐ Obesity

Each priority area is described in a separate box below, with key ICD9 codes, Measures, and other important features. In our next newsletter, we'll show you what we can do with these measures and we will provide more information and evidence about Metabolic Syndrome, and the Edmonton Obesity Staging System (a way of looking at "Obesity that Matters"). As you start collecting this data, please note that all smoking/overweight/sedentary patients will qualify for the behavioral counseling fee (14066), which is described on page 5 in the *Coaches' Corner*. If you have any difficulty in entering this data, or would like to learn yourself how to run an audit, please contact the Division office to speak to a Coach!

*** This Just In:**
The PGDoFP Board was recently informed that the Divisional Data Strategy will now be known as the Physicians' Data Collaborative. Please contact Olive Godwin at pgdofp.coordinator@gmail.com if you have any questions.

SMOKING CESSATION

Northern Health has an ongoing smoking cessation initiative, the NICC program, and the Ministry of Health is paying for some smoking cessation medications. Family doctors accurately documenting smoking status will generate valuable data through AMCARE, to see if these programs are making a difference.

For documentation, particular attention is necessary to two groups:

<u>The 12-19 year age group</u>

This is needed to ensure that the frequently changing smoking status is documented. To facilitate that, a new MOIS function in HEALTH MAINTENANCE (Control-H) is proposed to prompt for updated smoking status every two years for all in this age group. For members of the over-19 age group who have been previously documented as smokers, the prompt will be every 5 years.

<u>Non-smokers!</u>

This seems counter-intuitive, as being a non-smoker is not a problem. However, if no smoking status is documented in the chart, we cannot know if the person is a non-smoker, an undocumented smoker/ex-smoker, or simply a patient of whom the question has not been asked!

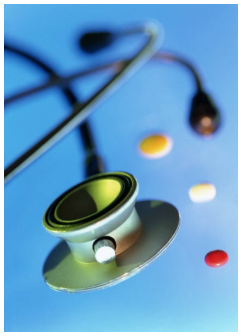
With our data, we will be able to assess the impacts of NH programs which have been ongoing for some years and the impact of our recent NIC counseling fee on smoking cessation rates. This is invaluable information for resource planning.

In Measures (Alt 3):	Packs/day (**34494**)	Pack-Years (**34496**)
Smoker	#	#
Ex-Smoker	0	#
Non-Smoker	0	0
In Health Issues (Alt P):		
For Smoker	From patient chart – Go to Health Issues (Alt P) – New record – fill in start date (approx. date is ok, if known) - tab to ICD9 code and use the pick list (F4) i.e. Tobacco Dependence (3051) or most appropriate dx	
For Ex-Smoker	If Tobacco Dependence (3051or most appropriate dx) is not already noted, follow steps as above "For Smoker". **The key here is to add an "end date."** (Approx. end date is ok)	
For Non-Smoker	Enter **nothing** in Health Issues!	

***Divisional Data Strategy*...continued on page 4**

Philosophy of Divisions of Family Practice (from the Provincial Administrative Handbook)
At its core, Divisions of Family Practice is an initiative to strengthen the voice of family physicians and improve patient care at the community level. It is founded on commitments to working collaboratively to solve problems of local importance, building capacity at the local and regional level, and building relationships and trust with patients, communities, and other partners in provincial health care.

Divisional Data Strategy…continued from page 3



HIV

It is estimated that 25% of people in British Columbia who are infected with HIV are unaware of their status. The Province, in partnership with the Centre for Excellence, has undertaken a "STOP HIV" initiative with two pilot sites. A screening subcommittee of the STOP HIV project has recommended increased screening through expansion of *provider initiated* testing. Routine offer of testing is recommended for:

- Individuals with a greater risk for HIV infection (e.g. IVDU, Men who have sex with Men, etc.)
- Those who are seeking or requiring testing for *any* STI or blood borne infection
- Settings with a higher expected prevalence of HIV (e.g. living on or near the street)

Meanwhile, in keeping with US CDC and other recommendations, the Medical Health Officer in the Vancouver Coastal Health Authority has suggested that everyone between the ages of 13 and 64 who has ever been sexually active be routinely tested annually to increase diagnosis and to decrease stigma associated with testing.

The PG Division of FP hosted an HIV focus group consisting of physicians, NPs, and Public Health to discuss these recommendations. This group felt that locally we should focus on the three Centre for Excellence testing recommendations listed above. In particular, we felt that we should strive to improve the rate of offering HIV testing to all those having any STI or blood borne pathogen test. (A recent audit by a PG Family Practice resident has shown that we may be testing as few as 16% in this group). Routine annual testing in the 13 – 64 year old age group can also be offered but is a more difficult goal to achieve.

MOIS will be updated to prompt for an HIV test whenever an STI test is documented. This prompt will be found in Health Maintenance (Control-H). The prompt is looking for testing within the period 1 month before and 3 months after STI/blood borne pathogen testing. You will also be able to see the date of the last HIV test for any individual age 13-64 and exercise your clinical judgment about offering routine screening. In the future, we hope to have a function allowing "testing declined by patient" to be recorded. The scorecard will be adjusted to show the rate of HIV screening in association with STI/blood borne pathogen testing and the overall rate of HIV screening in 13-64 year olds. At this time, we are not aiming for 100% in the latter but it will be useful to monitor the trend in the total population screening rate.

OBESITY

The "Obesity Epidemic" is topical with global Interest. The Division's intention on producing useful population-based data in this area will facilitate our partnering with the City, School District, gyms and other interested community groups to positively impact health outcomes for our population. Accurate real time data could significantly improve the community response to Healthier Living messaging. We would like to include measures for future use in consideration of METABOLIC SYNDROME (see our next Newsletter for more information and evidence about this subject).

For our purposes, we simply need to collect the correct measures; analysis of the data can be adapted as new knowledge becomes available. With the measures entered, you will be able to run a report on MOIS which will identify all patients who meet the current criteria for Metabolic Syndrome for entry in the problem list. We recommend that you follow the current guidelines for FBS and LIPID screening (e.g. primary lipid screening not indicated in females unless there is a concern about Metabolic Syndrome). We also would like to routinely document ethnicity: Asians and Blacks are known to have significant differences in health risks, measures, and responses to treatments. First Nations populations are suffering with higher incidence of Diabetes and Obesity and in need of more proactive engagement as a whole. If you have any difficulty in entering this data, or would like to learn for yourself how to run an audit, please contact the Division office to speak to a coach!

Measures (Alt 3)			Health Issues (Alt P)	
Measure	**Code**		**ICD-9**	**Definition**
			Choose from pick list (F4) most appropriate dx	
Physical Activity (minutes)	PA/wk (39959)		Overweight (27802)	BMI >25
Waist Circumf. (cm)	WC (1976)		Obesity (2780)	BMI > 30
Height (cm)	Ht (1948)		Morbid Obesity (27801)	BMI > 40
Weight (kg)	Wt (458)		Metabolic Syndrome (2777)	Any 3 of: -WC > 102 men, >88 women -HDL < 1.03 men, <1.29 women -TG > 1.7 -FBS > 5.6, or on DM meds -BP > 130/85 or on BP meds
BMI	BMI (951) (MOIS will calculate this, if Ht and Wt prev. entered)			
Alcohol Intake	Drinks/Wk (39957) or Drinks/Day (3553)			
Ethnicity	Located in "Demographics" under "Patient Detail," with a drop-down menu			

The Coaches' Corner

By Mary Severson-Augustine & Joy Schwartzentruber

Prevention Fee Code (14066): Proactive Care and Physician Compensation

Many physicians already know that effective January 1, 2011, there was a new incentive introduced (billing code 14066). The incentive targets specific patient populations: obese, unhealthy eating, smoker, and/or physically inactive populations. Physicians can proactively seek patients out that would benefit from such interventions, or respond to a patient request for preventative care. The incentive is payable to physicians who complete a "Personal Health Risk Assessment" with their patients and develop a plan that recommends proven interventions. Each physician can bill $50.00 for up to 100 patients that meet the criteria. Please see this website for specific details: http://www.gpscbc.ca/system/files/GPSC_Billing_Workbook_January_2012.pdf.

Because we are just beginning a new billing cycle in relation to the 14066 (prevention fee code), this is a great time to begin thinking about and planning how you will identify, see, and plan proactive care into your work day. Please refer to Drs. Grobbelaar & Clifford's article on page 3 to see specific details of how, and what, to record into your EMR so that you may extract data in a meaningful way. You've heard the saying, "good data in = good data out." This data will be instrumental in shaping the way you practice, as well as informing or addressing issues at a population health level. If you would like some assistance in getting started, feel free to contact one of the PGDoFP coaches.

The Primary Health Care Clinic is scheduled to open in June, 2012!

By Zoe Redenbach

The PGDoFP has been working hard at getting the PHCC, which will offer multidisciplinary care for 5,000 unattached residents of Prince George, off the ground. After extensive investigation of multiple sites and serious financial negotiations, the Commonwealth Health Centre has been chosen as the site of the PHCC. Structural plans have been finalized, and the construction/tenant improvements for the 7th and Quebec St. site were put out to public tender.

As you may have heard, we have been generously promised $375,000 by the Spirit of the North Foundation towards the costs of construction. We are also partnering with Northern Health for the staffing of the clinic, which will likely employ three full-time nurse practitioners, two full-time-equivalent physicians, and a mental health and addictions worker. The PGDoFP also intends that the PHCC be the home base for a "roving" multidisciplinary team which will be a resource to family physicians in their offices, for help with patients who have complex needs. Recruitment for these positions will begin soon.

Website of Interest: www.ihi.org Institute for Healthcare Improvement

Combining Practice Improvement With CME

By Bill Clifford & Mary Severson-Augustine

There are three or four small groups of physicians in Prince George who participate in the McMaster University-based Foundation for Medical Practice Education "Practice Based Small Group Learning" (PBSGL). PBSGL provides doctors with a way to keep current and informed about a number of diseases and conditions and gain valuable Mainpro C CME credit.

One of these small learning groups has been working with Bill Clifford and Mary Augustine, PGDoFP coach, to take it one step farther. What happens after the module review and discussion is really cool. The coach and physicians remotely access the EMR and conduct a number of reports to see, compare and look for ways to improve based on what they have learned from the module. Based on the findings and the future "practice support" that will be needed, the coach can work to fill in the gaps and assist medical office staff to be able to support these changes.

If you are interested in participating in PBSGL, there are two options. If you know of an existing group that might have room (generally 8-10 members are considered the upper limit of capacity; 7 is said to be optimal), you can work through the group facilitator to become registered. Alternatively, you can form your own group which requires that one member obtain formal training as a facilitator. The group must have at least 5 paid-up members to be registered with the program.

Of course small groups can be organized independently of a formal program much like the old "journal clubs." A large New Zealand Division of Family Practice was very successful in banding together in small groups for guideline discussions, mini-audits, etc.

The PG Division of Family Practice very much supports the small group learning concept; however, it is organized and will provide as much coaching support as resources allow should you wish to engage in this kind of activity. For more information, contact Mary or Joy.

Victoria, Nanaimo & the Sunshine Coast are the Newest Divisions (from the *Divisions Dispatch*, Dec. 2011)

The Sunshine Coast Division of Family Practice represents family physicians in Earl's Cove, Gibsons, Langdale, Madeira Park, Pender Harbour, Robert's Creek and Sechelt. Nanaimo represents the communities of Gabriola Island and Nanaimo, while Victoria covers the Victoria area. With these additions, there are now 29 Divisions in BC that encompass 103 communities. Over 3,000 family physicians – or 88% of family doctors in the province – can participate in a local Division. Find information about each Division and the area it serves at www.divisionsbc.ca.

Division Members:

Interested in helping with Recruitment and Retention of Family Physicians to Prince George? Contact Ed Marquis or Ian Schokking, co-leads for the Recruitment and Retention Committee. Or, for more information and recruitment opportunities, contact Sheilagh Wilson, our contact at Northern Health (sheilagh.wilson@northernhealth.ca)

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Do you have any topics that you would like to see discussed in a future newsletter? Any questions? Would you like to submit an article for our next Division newsletter? Please send to Gail at gbrawn@divisionsbc.ca

Retirement!!!!...continued from page 1

Some tips that you may find useful as you begin to prepare for transitioning your practice (and finding someone to transition it to!)

Approaching residents and new doctors (this is much like courting a spouse):

- Use all the communication skills that you know and use every day with your patients!
- Have an interest in them as persons; know something about their personality, interests, family
- Be persistent and kind • Approach regularly

My house is in order:

- My Medical Office Assistant(s) understands the transition that is going to happen. I have consulted them
- My records are in order:
  - * Legibility
  - * Problem lists
  - * Current Medication Lists
  - * Progress Notes
    - ~ SOAP Format?
    - ~ 3W's (why the patient came, what was wrong and what was done)
    - ~ The College of Physicians and Surgeons has lots of online resources to look at. There is a medical records course that is very good that is run every year: https://www.cpsbc.ca/files/u6/Medical-Records-in-Private-Physicians.pdf

My call group is supportive:

- They are reliable • They are easy to work with • They have a similar philosophy and style of medical practice

My lease and ownership arrangements are clear

My practice income summary is up-to-date

I am willing to have a flexible transition:

- I have willingness to work alongside the new recruit for a period of time
- I am willing to hand over control in a graduated fashion • I am willing to "let go"

Your suggestions/tips as we develop resource materials for our members would be greatly appreciated. Thank you.

MOA Locum List Update

Since the Division launched this small but important service in August 2011, 6 MOAs have signed up to be available to locum. Three physician's offices have requested our list, and we've received numerous inquiries. If your MOA needs some support for a well-deserved break, contact Cheryl.

Call for Participation in 2012 Nomination Committee

By Zoe Redenbach

The PGDoFP Annual General Meeting is coming up on June 15th, 2012! At that meeting, elections will be held for the four rotating board positions that will be coming up for election this year. Currently, the four board members all intend to run again (Garry Knoll, Barend Grobbelaar, Ian Schokking, and Phil Asquith). However, a nomination committee has been struck to ensure that anyone else who would like to run is able to!

The terms of reference of the Nomination Committee states that it will include four people: One board member (who will be Dr. Zoe Redenbach again this year), one non-board member, and a third who can be board or non-board. The Executive Director, Olive Godwin, also participates as an Ex-Officio Committee member.

If you are interested in being on the Nomination Committee, or interested in putting your name forward in the election, please contact Zoe Redenbach (250-564-8500 or zoe.redenbach@gmail.com). A general call for nominations will go out in March.

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