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

From the Desk of the President: Networks

By Dr. Garry Knoll

The Ministry of Health has courageously provided funding to Divisions of Family Practice who wish to proceed in developing their own community Primary Care Network. Our recent work to build teams of professionals connected to your practice provides an enhanced Primary Care Home for your patients. Together we are all in a network providing care for patients with complex problems. Each person in a network is unique in their skill, knowledge and attitudes. Variance keeps us fresh and interested but standards give us confidence in the service provided to vulnerable people.

A network is "sensitive" to new developments because it has many "ears" that are connected in many ways. Just think about the mega-network Facebook. Facebook can be exquisitely sensitive to the micro…my visiting daughter dropped her wallet getting my mail at the super mailbox, the mail carrier picked it up, checked her ID, "facebooked" her and returned the wallet all within an hour!

Facebook can be powerful….like the harvesting of vast amounts of personal information by Cambridge Analytica (one stop shopping at its best). Facebook information can be high quality; for example, on the "Wire" Facebook page (where physicists hang out) there is grave concern about where antimatter went (I hadn't noticed) and a discussion of theories to consider. Or Facebook can blow smoke that looks real but isn't, like GOOP's " You Can Drink That" Facebook page which touts a Los Angeles cider called "Blackdog" with activated charcoal that is the healthiest alcoholic beverage sold "in the world" that "pulls out all the toxins" in your body.

What we all contribute to our Primary Care Network that cares for our most vulnerable patients matters. If we commit that all our contributions are patient–centered, safe, efficient, equitable and effective, then we have confidence, reliability and better patient outcomes. Garbage IN, Garbage OUT.

So What Is a PCN, Anyway? Introduction to the Primary Care Network

By Dr. Susie Butow

The term "Primary Care Network" (PCN) may sound new, but it really is just a continuation of the work we have been doing at the PG Division of Family Practice over the past decade. This is a Ministry of Health (MoH) initiative to build on ongoing work to integrate the care provided to a patient in the hopes it will be more seamless for the patient and providers. Simply put, a PCN is meant to enable patients to access the care that fully meets their needs. Not all care providers can meet all the health care needs of every patient; the PCN enables all care providers to work together to provide comprehensive Primary Care services to meet the needs of our patients and the local population.

The MoH has identified 8 core attributes of a PCN including: attachment; after hours access; access to urgent care; virtual/digital access to care; access to comprehensive primary care services through networks of primary care homes; coordination of care with diagnostic services, specialty care and specialized community services; communication within the network and the public about appropriate use of services; and care that is culturally safe. PCNs are expected to attach and provide Primary Care services to a population somewhere between 50,000 and 100,000 people. Earlier this year, the Division, in partnership with Northern Health, submitted a service plan proposal to the MoH for a Prince George Primary Care Network.

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

There are three priorities of the PG PCN: Attachment of the unattached or poorly-attached patients by developing Primary Care outreach teams; bolstering access to existing team-based care by creating more teams to support the existing Primary Care homes; and a focus on provider health and renewal. These priorities are to be supported by several enablers such as exploring a new physician compensation mechanism, improving patient activation to participate in their own wellness, and supporting physician engagement in this work. Other ongoing work that ties in closely with this is the planning for urgent Primary Care services, the Mental Health and Substance Use Model, and the Geriatric Services Model.

These components will be explored in much more detail at the upcoming Nov. 28th member meeting.

November 2018
Issue 18

Fall Member Meeting: Wed. Nov. 28th 1730—2100

Theme: the Primary Care Network

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

Details:

UPDATED Location: LDC room 0501

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

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UBC CONTINUING PROFESSIONAL DEVELOPMENT FACULTY OF MEDICINE

Who's NOT a Racist?

Dr. Terri Aldred, Site Director, Indigenous Family Medicine Program

Indigenous people are among the most marginalized groups in Canada, and in an attempt to address the health disparities cultural competency has become a core skill for health care providers to learn. Although these skills are crucial to improving the health of Indigenous peoples they are not sufficient without addressing systemic racism. Racism in the system reflects the people within it; therefore, to start we need to address our own racism.

Racism or bias is not a moral issue. It is universal. We inherited it from our forefathers who inherited it from theirs. With intent and purpose, bias was embedded in all organizations and systems of colonial empires to promote the dominance of certain groups over others.

These biases still exist in Canada's health care system today as evidenced by "The Truth and Reconciliation Commissions' report" and the paper "First Peoples Second Class Treatment."

We can start to address the bias in our health care system by addressing our own biases.

2 Sustaining a strong community of family physicians

In order to talk about our biases, though, we need to unshame them. We are all racist. All of us. And we are good people. It's not our fault, but it is our responsibility to start to address our biases.

Reflective practice gives us tools to explore our biases in a safe space so we can learn to recognize and mitigate them. Reflective practice is the core skill in cultural competency and fostering physician health and well-being. I believe there are different ways to teach and foster these skills depending on a person's level of bias. A "one size fits all" model of cultural safety is inadequate to call in all health care providers. And this work needs all of us. No one is excluded.

From one racist to another: are you ready to start this conversation?

Attend the member meeting on Nov. 28th to continue this conversation with Dr. Aldred.

Provider Renewal and Resilience

David Kuhl, MD, PhD, Linda MacNutt, MSW, Hilary Pearson, PhD

Health care is about curing and healing, art and science, mind and heart, skills and knowledge, technology and compassion, living and dying. Too often, funding in health care has been based on a business model of efficiency, while experiences of illness and care happen in relationship.

Relationship centred care (RCC) is an approach that recognizes the importance and uniqueness of each health care participant's relationship with themselves and every other person involved in receiving or delivering health care, considering these relationships to be central to high-quality care, a high-quality work environment, provider well being, and superior organizational performance. In balancing evidence-based care with the reality that patients are embedded in a web of relationships, RCC fosters clear expectations, mutual trust, and shared goals.

Current literature underscores the importance of inter-collegial collaboration and embedding teamwork as a core value to respond holistically to patient/family needs and simultaneously enhance provider engagement and sustainability in a health care environment poised for transformational change. The relational quality of the healthcare workplace affects virtually every dimension of organizational performance: decreased errors, decreased mortality, improved patient/provider satisfaction, heightened quality of service, staff retention and budget.

In this context it is imperative that each health care provider practices advanced communication skills, respects colleagues, appreciates the differences between disciplines, promotes authentic teamwork and is unequivocally supported by leaders who actively demonstrate their commitment to core values and behaviours that support collaborative, compassionate practice.

2 Sustaining a strong community of family physicians

RCC provides an overarching theoretical framework for delivering compassionate collaborative care recognizing that compassion without collaboration may devolve into uncoordinated care and collaboration without compassion may result in depersonalized, disengaged care. Together, "compassion and collaboration serve as the foundation for effective partnerships among health care workers, patients, families, and communities. They are also a source of patient and provider satisfaction, human connection, support and resilience". (Lown et al., 2016 p.314).

Attend the member meeting on Nov. 28th to continue this conversation with Dr. Kuhl.

Selected references:

Beach, MC, Inui, T, (2006) Relationship-Centered Care Research Network, Relationship-centered care, A constructive reframing, *Journal of General Internal Medicine,* 21:S3-8

Lee, T.H. *An Epidemic of Empathy in Healthcare: How to Deliver Compassionate, Connected Patient Care That Creates a Competitive Advantage*. McGraw-Hill Education, New York, NY (2016)

Lown, B.A., McIntosh, S., Gaines, M.E., McGuinn, K., and Hatem, D.S. (2016) Integrating compassionate, collaborative care (the "Triple C") into health professional education to advance the triple aims of health care. *Academic Medicine,* 91(3), 310-316

Soklaridis, S, Ravitz, P, Adler Nevo, G, Lieff, S, (2016) Relationship-centred care in health: A 20-year scoping review, Patient Experience Journal, 3(1), 130-145

Sign Up For Direct Deposit! For physicians, particularly for those involved with IDOD &/ or Residential Care. Please contact Heather to sign up, via 250-561-0125 or by emailing hstillwell@divisionsbc.ca.

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.**

Do You Want to Build a SNOMED?

Dr. Bill Clifford, on behalf of AIHS

We are excited to share that the MOIS 2.22 release includes enhanced support for multiple clinical terminologies including LOINC, SNOMED-CT (Standard Nomenclature for Medicine), ICD-9, and ICD-10.

Structured, coded entry of key parts of the health record ensures that information can be reported on and exchanged without loss of meaning. Coded concepts or terms can be represented by either classifications or nomenclatures. Classifications attempt to group concepts into a hierarchy. ICD-9, the standard coding system for physician billing across Canada, retired by the WHO 28 years ago, has only 13,000 groups. Providers struggle to describe the full breadth of findings and diagnoses in such a small number of terms. ICD-10, first endorsed internationally in 1990, improved groupings and increased the number of terms to ~70,000 but still presents similar classification related challenges.

To the rescue is a nomenclature system called SNOMED-CT created by the American College of Pathologists and managed by an international consortium. SNOMED-CT has ~250,000 concepts, including over 100,000 clinical findings. All concepts can have relationships to other concepts – e.g. Henoch-Schonlein purpura is an autoimmune vasculitis and a purpuric disorder. SNOMED-CT has a hierarchical component but it is built from clinically meaningful relationships that are not mutually exclusive.

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

AIHS has built tools to support the implementation of SNOMED-CT in MOIS so that any portion or ordering of a clinical term can be used to quickly find what you want and the diagnosis or finding will be accepted by MSP most of the time. This means that the 1/3rd of encounter diagnoses currently described as "general symptoms" can be easily and accurately coded!

Over time, search functionality and clinical relationships in SNOMED will be improved and embedded more fully in MOIS keeping in mind that structured entry needs to complement the clinical narrative, not replace it.

Northern Health Update: What's New With Interprofessional Teams (IPT)

By Julie Dhaliwal, Director of Community Services, Integrated Primary Care

I am pleased to share with you an update regarding the Interprofessional Teams. We have had several additions as well as some changes to our teams over the past few months. As you may know, Suzanne Campbell moved from the role of Director Community Services PG to take on an exciting opportunity as the Health Services Administrator in Hazelton. As a result of this change, in early June I moved into the role of Director of Community Services, and then we welcomed Andrea Mainer into the Community Services Manager role in early Sept. Andrea is new to NH and Prince George and she brings many rich experiences with her from the Yukon. We are excited to have Andrea join us on this journey of transformational change!

The IPT Leads, along with their teams, continue to strive to develop close relationships with the Primary Care providers. Some of the ways we have been able to develop these close relationships is via regular connection through collaborative care planning rounds, as well as through huddles, texting, and phone calls.

This past spring we received additional funding to support Interprofessional Teams in the enhancement of team-based care, and as a result we have added the following roles to our teams:

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

- 3 Life Skill positions to work across all 5 existing teams
- 2 additional Social Workers to ensure one is dedicated to each IPT
- 1 Mental Health Substance Use clinician added to Team 5
- Increased capacity in Physiotherapy (a part-time position became full-time)
- 3 Primary Care Assistant positions
- 3 Primary Care Nurse advanced hires, to support orientation and ongoing education, in order for the Primary Care nurse role to be full scope

We have grown increasingly aware that we need to keep on reviewing the processes that have been developed to support continuous quality improvement. We will re-communicate this to everyone soon, and we appreciate the opportunity to share this with Division members now.

Welcome to new Members:

Dr. Gordon Chin
Dr. Shannon Kelly
Dr. David Shepherd
Dr. Heather Siemens
Dr. Trevor Tsang

and welcome to new member Residents:

Dr. Bahar Atanur
Dr. Zame Engelbrecht
Dr. Megan Enos
Dr. Patrick Hemmons
Dr. Kyle Ng
Dr. Manpreet Sidhu

Division Staff Updates

- Blue Pine Clinic
  - Team Lead Laurie Zoppi
  - MOA Morgan Shiels
- Division
  - Executive Assistant Heather Stillwell
  - Finance Assistant Gail Brawn

PG Practice Coverage

Dr. Gordon Chin began in this new position on Aug. 1st, 2018. The Practice Coverage position:

- **Provides up to two weeks max. short term coverage.**
- **Physician/Practice standard 70/30 split.**
- **Scheduling is managed by the Division in 3-month increments.**

The first call for May, June and July 2019 was released Nov. 1st/18 & the second on Nov. 15th/18.

Contact: Sharon Tower, Operations Lead stower@divisionsbc.ca

Your voice matters!

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

Coaching Team

Megan Hunter
Clinical Programs Lead

Practice Coaches:
Office: 250-561-0125
pgpracticecoach@gmail.com

Karen Gill
karen.gill@northernhealth.ca

Tammy Bristowe
tammy.bristowe@gmail.com

Laura Parmar
laura.parmar@northernhealth.ca

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- **City of Prince George**
- **Spirit of the North Healthcare Foundation**
- **Shared Care Committee**
- **PHSA/Trans Care BC**

Division Office
#201, 1302 - 7th Ave.
Prince George, BC
V2L 3P1
Phone: (250) 561-0125
Fax: (250) 561-0124
princegeorge@divisionsbc.ca 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)

The Blended Funding Model/Primary Care Physician Compensation Model (PCPC)

Dr. Willie Watt, as told to the Coaches

Dr. Willie Watt is 1 of 7 doctors at the Ft.St. John Medical Clinic using the Primary Care physician compensation (PCPC) funding model for over a year now. With the physician shortage in the North there was a desire to do something different, and Ft.St. John began their pilot of the new funding model in 2015.

Q: In your own words, describe this funding model.
A: This is the intermediate between pure fee-for-service (FFS) and pure salary compensation models.

Q: Was prep needed with regard to MOIS in order to use this model?
A: Significant panel clean-up was required to determine which of our 14,000 patients were suitable to enrol and which received the majority of their care elsewhere. Accurate documentation of health conditions and medications is also an ongoing and essential quality improvement (QI) process.

Q: What conversations did you have to have with your patients about this change?
A: Our clinic manager describes the remuneration model to patients who receive care in different places and they are given a choice of where to be a patient. Otherwise, we haven't been vocal about this change with our patients.

Q: How did you decide which patients would be billed FFS, and which would be part of this model?
A: We began by enrolling as many of our active patients seen in our clinic within the last 3 years. Non- enrolled patients we continued to bill FFS. However, the goal remains to have the large majority of our panel of patients enrolled.

Q: How did this affect your income? How do you split the payment in the clinic?
A: Basically, we are revenue neutral. We are paid base core funding, which is a pre-payment for overhead. Burden of care is determined by complexity index and panel size. [There is also] QI funding [and] a non-basket procedural. If you work the same number of days (not patients seen), your income will stay roughly the same provided outflow costs are well managed.
We pay ourselves $180/hr, regardless of panel size. We include an hour each day for inpatient care. Paperwork and after-hours work is not compensated. Driver's medicals, QI funding and other revenue goes into a common pot to be distributed.
Every quarter, there is a reconciliation and remaining funds or deficiencies are distributed/collected and prorated for each physician by the number of hours worked during that quarter. We win or lose as a group.

3 Partnering with patients and communities for improved health

Q: Have patients or staff noticed a difference? Did you hire any new staff?
A: For the most part, it's business as usual for the staff. However, they are capturing more data in order to have more comprehensive patient charts. Patients also get asked more about screening initiatives.
Patients have noted availability of more same-day access appointments for more timely care.

Q: How did it change the way you practice?
A: As Primary Care clinicians we are now able to provide care for our patients without being as volume-driven. Aside from that, I wouldn't say it has changed the way I practice as much as I had hoped. Perhaps when team-based care becomes a reality this will change.
We also agreed to the quality improvement component of the model. We have an ongoing steering committee with representation from each clinic where we decide on the indicators we will work on. We're trying to be more process-driven, rather than outcome-driven.

Q: Would you recommend this model to other physicians? Why or why not?
A: The model helped us recruit and retain new physicians because we were able to offer them guaranteed income without risk. If you are a "treadmill physician" billing $800,000 a year, then no. Your income will go down and I wouldn't recommend this model. If you work a normal amount in your practice, enjoy the patient care aspect of your work, and don't mind having other clinicians provide care for your patients, this model would work for you. Our group would never go back to fee-for-service.

Attend the member meeting on Nov. 28th to continue this conversation with Dr. Watt.

Contest: R.O.A - Read On Arrival **We're trying something new! Each newsletter will have a question based on the topics covered in the articles; enter for a chance to win a prize! Send your answer - with the word 'quiz' in the Subject line - to princegeorge@divisionsbc.ca.** **This issue's question: *What does RCC stand for?***

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November 2018, Issue 18
Supplement page 1

NEW BOARD COMPOSITION as of AGM 2018

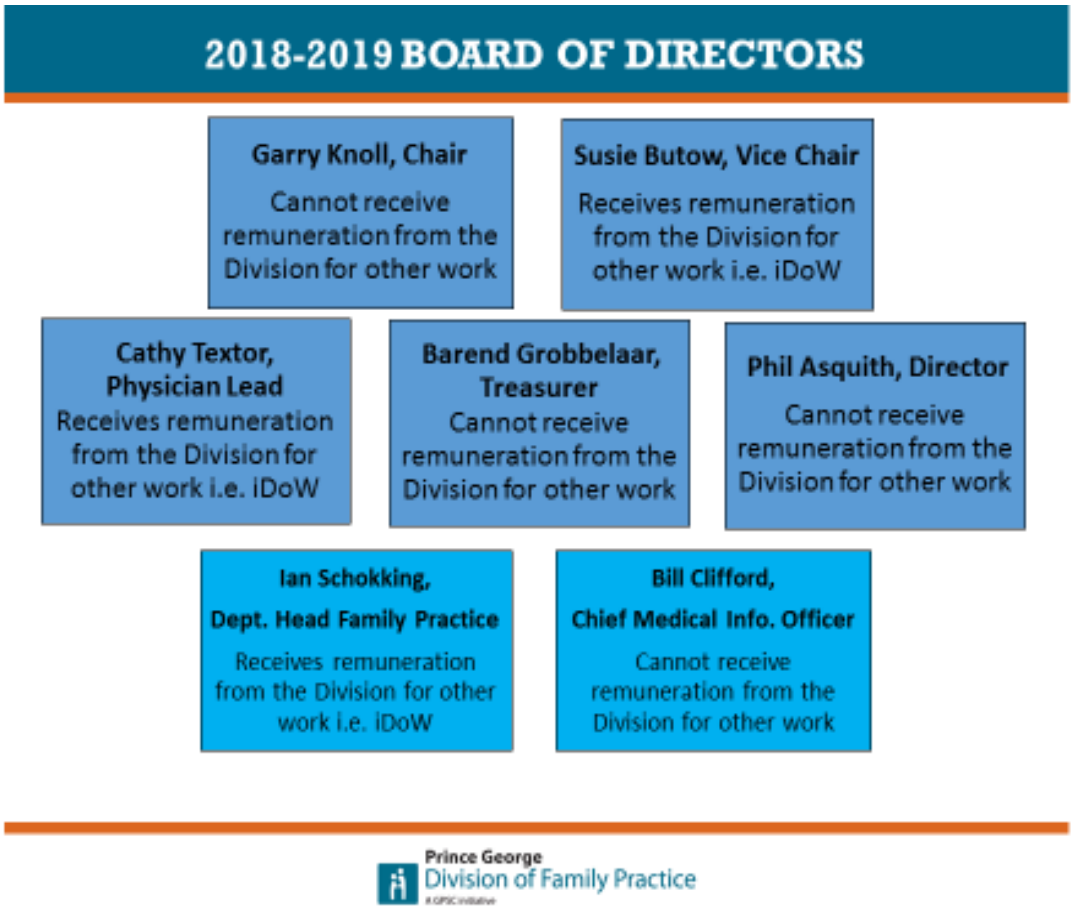
Due to the new BC Society's Act, at the AGM on September 26, 2018, the Prince George Division of Family Practice Members approved a Special Resolution, including: *Effective on or before November 28, 2018, the Society's Board will be composed of a minimum of five (5) and a maximum of seven (7) Directors, in accordance with the following requirements:*

a) *at least three (3) and not more than seven (7) Members may be **elected** as Directors; and*
b) *the Board may, by Board Resolution, **appoint** as a Director up to four (4) qualified Persons who have expertise, skills or knowledge that is beneficial to the Board or Society.*

At all times, no less than a majority of the total number of the Directors must:

a) *be physicians in good standing with the College who are either general practitioners or family doctors;*
b) *not be Persons that receive or are entitled* to receive remuneration from the Society under contracts of employment or contracts for services, other than remuneration for being a Director.*

With the intent to successfully implement the new model, the Board chose to elect an all physician board of five (5) and appoint two (2) Ex officio by virtue of their office. Elected and appointed as follows:



The Board of Directors will be supported by the Finance Committee and by a new Governance Committee and a new Programs Committee. *Members are needed to participate on the Committees* (see over).

Please let us know if you are interested in participating!

* Entitled = signed contract in effect to deliver services

PHYSICIAN LEAD - BOARD MEMBER
Identified through the nominations process; appointed when not elected

Certifying Board of five (5) to seven (7)
Majority must be physicians
Minimum 3 members elected from membership
Up to 4 appointed (doesn't preclude these being members)
Quorum = majority; two must be physicians

MEET QUARTERLY
Board of Directors

The Board of Directors are the leaders of the Division and play an essential role in establishing and safeguarding the vision, mission and values along with cultivating the culture of the organization. The Board is informed by and responsible to the members of the society.

GOVERNANCE	PROGRAMS	FINANCE
Purpose: To ensure the Board fulfils its legal and functional responsibilities through assuring appropriate board recruitment and succession, policy development, and evaluation of the Executive Director, Board and Division performance.	***Purpose: To provide clinical insights and operational oversight to projects and initiatives.***	***Purpose: To support the Board in matters related to the finances of the Society, and address financial matters not addressed by current financial control systems.***
• Executive Director support • Board development, succession/renewal, nominations • Inform Strategic Directions • Review periodically the adequacy and effectiveness of governance documents including the by-laws, policies, procedures, and committee terms of reference, making recommendations for change and/or development as appropriate, to assist the Board of Directors in fulfilling its oversight responsibilities. • Ensure development of risk management policies for Board approval as required, and review those policies on an annual basis.	• Provide clinical advice on current projects and initiatives' activities • Ensure appropriate level of partner, member, and patient engagement • Monitor/support Working Groups (e.g., CSPCH, R&R, and RCI) • Inform members of impact of current activities • Inform strategic plan / strategic directions	• Financial performance / External Audit • Budget development and reporting • Financial Policies • HR – contract management • Insurance / Indemnification • Resources – lifecycle planning / capital purchases

MEET QUARTERLY AT A MINIMUM
Prior to Board Meeting & the nominations process

MEET QUARTERLY AT A MINIMUM

MEET QUARTERLY AT A MINIMUM
In conjunction with financial quarter reviews, audit and budget planning