GP Update

General Practice Services Committee

A QUARTERLY NEWSLETTER FROM THE GPSC

SUMMER 2017

Patient medical home: improving quality of care through teams in practice, networks and the community

The GPSC is working with family doctors, divisions of family practice, and other partners toward achieving the patient medical home model of family practice, which will form the foundation for integrated primary care in BC. Patient medical homes are family doctor practices supported to provide full-service family practice through working with other doctors and networks, having access to multidisciplinary team members, creating linkages to community and health authority primary and community care services, and using their own data for quality improvement activities.

Rather than replacing the doctor-patient relationship, physicians working with team members can enhance and support it. Patients have the confidence that their doctor is linked to all the services they need. They develop relationships with their doctor's team working with their doctor to help them have better access to services within the practice and linked to the practice. Physicians caring for a defined practice population are better able to provide comprehensive care when supported by team members such as RNs, social workers, and pharmacists working within their scope. This can ease pressures, allow doctors to maximize time and capacity in their role, and achieve a healthier work-life balance in a supportive practice environment.

Some physicians already work in teams within their practices, networks, and communities, including many rural physicians, who do so to maximize limited resources and capacity.

Within networks, doctors work with other physicians and specialty care providers to improve quality and access to care for patients. Networks enable doctors to share workload and resources to effectively meet the needs of patients.

Teams in practice

In practices and small health care settings in rural and remote areas, the added expertise of nurse practitioners, nurses, social workers, and other allied health providers can support enhanced quality of care and enable doctors to focus on patients' high-level medical needs.

Nurses can address immediate basic health concerns, prepare patients for their appointment, provide preventative screening, assist patients in managing chronic diseases, and carry out post-appointment follow-up to arrange lab work, X-rays, and additional care.

Social workers can support patients with social and financial challenges that also impact their health. They connect patients to community services and agencies, reporting progress to the family doctor in person or through a shared EMR. Integrating social workers into a health care team enables a practice to enhance quality and provide patients with access to whole-person care.

Doctors around the province are working to add allied health professionals to their practices. Family doctors in **East Kootenay** and Kootenay Boundary communities have seen strong benefits for patients and practices through inclusion of social workers.

Continued on p.2

what's **inside**

New mobile app for BC Guidelines

The new BC Guidelines mobile app makes it easier for doctors to access the latest medical evidence. The free app offers more than 50 evidence-based guidelines and protocols on a variety of clinical conditions and diseases written specifically for BC's health care practitioners. The mobile app works without Internet connectivity so busy practitioners can instantly access BC Guidelines on any Apple or Android mobile device no matter where they are working. Other BC Guidelines products include patient guides, summaries and flow sheets. To download the app, visit **bcguidelinesapp.ca.**

Patient medical home: improving quality of care through teams in practice, networks and the community *Continued from p.1*

Kootenay Boundary-area physicians who piloted the integration of social workers and RNs in practice came to appreciate and embrace the team model, enthused by the changes they saw in their patients and the improved quality of their working lives.[1]

Networks of family physicians

Networks are foundational to the development of the patient medical home model in all communities, large and small, and to improving patient access to quality care.

In the city of Richmond, which has smaller, unique neighbourhoods with distinct socio-economic, cultural, language, and health care needs, the local division demonstrated the value of **neighbourhood networks**. The networks brought together collegial clusters of family doctors based on geographic area of practice, and enhanced linkages to health authority and community services. Neighbourhood networks and other network models can:

- Enable coverage support through cross-coverage and shared locums.
- Provide team-based care by pooling resources for shared space and scheduling.
- Reposition solo or small group practices to be connected with others, enabling more efficient recruitment of locums and permanent physicians.
- Create more efficient groupings of physicians to which other health services can be added, such as chronic disease nurses, clinical pharmacy services, and psychiatry services.
- Support teams of physicians in generating collaborative solutions to address local challenges.
- Serve as "infrastructure" to pilot or implement further innovation.

Community linkages

At the community level, BC's health authorities are in the process of realigning and streamlining their primary and community services. Over time, doctors will have access to simplified connections to specialized community services (health authority services and multidisciplinary teams), enabling them to more easily arrange comprehensive care for vulnerable patients, such as those with mental illness/substance use issues and the frail elderly. These community linkages will be key to building an integrated system of care that wraps around patients and families.

At the Chilliwack Primary Care Clinic, vulnerable patients with complex medical needs who don't have a family doctor receive comprehensive care from a team of doctors, nurse practitioners, and other health professionals. The approach has helped a number of vulnerable patients in the community transition to family doctors, and has resulted in at least 150 fewer ER visits and 1,634 fewer acute care bed days (measured between August 2014 and June 2016).

Communities in Fort St John and the Interior are home to community-based primary care teams comprising partnerships between doctors, divisions, health authorities, and government. In **Kelowna** and **Kamloops**, two new seniors' wellness centres opened in spring 2017, giving doctors direct access to an interdisciplinary team.

Doctors in these communities are looking forward to having access to specialists and other health care professionals, as well as an opportunity to increase their own knowledge and skills through working with these team members.

"It's an excellent opportunity to develop additional knowledge and skills within the family physician community while working closely with the geriatrician and other team members."

– Dr Sohayl Ghadirian, family physician, Kelowna

Flexible team-based care and network models, tailored to local needs, have clear benefits. There are challenges to overcome, including limitations of the fee-for-service model, and the time commitment required for busy doctors to make changes to clinical processes and build relationships with allied health professionals. Learnings from many practice and division models are informing the plans of the GPSC and its partners to address these challenges. Plans include exploring alternative and sustainable funding models and creating a suite of evidence-based education and in-practice supports for doctors, ranging from technology to quality improvement. All divisions have access to $250,000 to support the local development of patient medical home and change management work. Ultimately, teams in practice, networks, and communities can enhance comprehensive care so that patients can maintain their health, improve their quality of life, stay independent longer, and avoid hospital visits.

As more supports fall into place, models of team-based care and networks are expected to expand across BC to advance the patient medical home work and enhance access to quality care for patients.

For more stories about how doctors and divisions are working in teams, visit **gpscbc.ca/our-impact/team-based-care**.

[1] *A GP for Me Provincial Evaluation: Case Studies of Innovation – August 2016*

Equipping doctors with mental health/ substance use skills and connections

In late 2015, Dr Jill Cunes, a family doctor in Golden, BC, was one of half a dozen GPs in her region who signed up for the Practice Support Program Child and Youth Mental Health (CYMH) module. As one of 12 physicians working in the only health clinic in town, she and her colleagues cover all the health needs of the surrounding population. Since joining the clinic in 2013 she's noticed an increasing number of youth and young adults coming forward with mental health and substance use concerns.

"I am not sure if it's a true increase in incidence, or whether it is simply more youth being aware and seeking help," notes Dr Cunes, a member of the Golden LAT. Nevertheless, since the need for care has increased, she wanted to keep current so signed up for the module.

Enabling family physicians to have up-to-date skills and knowledge was one of the key reasons the Practice Support Program (PSP) developed and released the CYMH Module in 2011.

Established in 2007 under the Joint Collaborative Committees of Doctors of BC and the BC government, the PSP provides a suite of evidence-based educational services and in-practice supports to improve patient care and doctors' experiences. One of 11 training modules created by PSP, the CYMH module is primarily aimed at family doctors to support them to identify, assess, manage and treat children and adolescents with mild to moderate mental health disorders, specifically anxiety, ADHD, and depression.

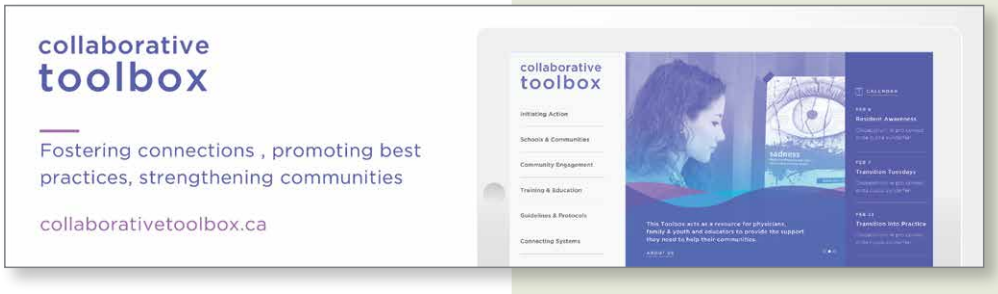
The module's goal is to improve physicians' knowledge and aid their collaboration with other parts of the child and youth mental health system, such as with pediatricians, local mental health service providers from the Ministry of Children and Family Development, psychiatrists, and nongovernment community agencies.

During the module, these allied professionals are invited to attend the sessions and present to doctors about their specific services. Cunes found that the PSP module was a valuable use of her time, connected her to other care providers in the region, and updated her with screening tools and algorithms for care.

"I really believe in keeping up-to-date with regular CME (continuing medical education)," she said. Her colleagues share that view, she notes, as the majority of them have also taken the PSP-CYMH module since its debut.

The module was a pivotal precursor to the establishment of the CYMHSU Collaborative — for doctors and other service providers who attended it in the Interior, it identified the gaps in care, and spurred them to find solutions. This seeded the Collaborative, bringing together multiple partners to take on some of the issues.

Since the Collaborative started, more than 1,600 doctors and Medical Office Assistants in BC have taken the module. As well, at least 10 LATs have made promoting participation in the module one of their objectives. The PSP program administrators note that since 2013, the CYMH module has been held a total of 92 times in the five health regions.



An evaluation by Hollander Analytical Services in June 2015 found that of the GPs who completed end of module surveys, 96.1% agreed or strongly agreed that attending the CYMH module had helped them improve the care they provided to their CYMH patients.

This story was originally published in Shared Care Committee's Legacy Report: Progress of the Child and Youth Mental Health and Substance Use Collaborative.

CYMHSU Collaborative wrap-up

As the Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative starts to wrap up, the 250+ participating physicians have identified the importance of ongoing collaboration between family doctors and specialists who care for children and youth with mental health and substance use concerns. The Collaborative created two "legacy" items focusing on sustainability of the work, relationships, and models of care developed and emerging:

Legacy magazine, distributed at the initiative's final CYMHSU Congress, uses stories and pictures to explore how the Collaborative started, who was involved, and the scope and diversity of its activities and impact.

The Collaborative Toolbox compiles tools and resources created and tested by the Collaborative since 2013, including suicide prevention toolkits, resource prescription pads, common consent forms, ER protocols, and online CYMHSU learning modules. The Toolbox builds on the "all learn, all share" approach to support Local Action Teams, physicians, school personnel, youth and families, and others in supporting the mental well-being of children and youth.

For more information about the magazine and toolbox, visit **collaborativetoolbox.ca**.

Meet the GPSC: Dr Richard Crow

Dr Richard Crow is the Executive Medical Director for Island Health's Population and Community Health Portfolio. In this role, he co-manages several island-wide programs, including Mental Health and Substance Use; Public Health; Child, Youth, and Family Services; Seniors Health Strategy; End-of-Life Services; and Integrated Primary and Community Care. He is a Clinical Assistant Professor in UBC's Faculty of Medicine and Affiliate Assistant Professor, University of Victoria, Division of Medical Sciences, and became a Fellow of the College of Family Physicians of Canada in 2000.

He has previously served on both the Specialist Services Committee and the Shared Care Committee. He has a special interest in population health, prevention, and vulnerable populations. Previous leadership roles include Lead Faculty - Curriculum for the Family Practice Residency Program at UBC, President of the Victoria Medical Society, and VP Medicine for the Vancouver Island Health Authority.

Dr Crow received his BSc, MSc, and MD degrees from UBC and completed his family practice residency at the University of Western Ontario. He then moved to BC and practiced family medicine for over 20 years, mainly in Victoria.

Provincial supports for pain management opioid prescribing

Many BC doctors are using a number of learning and support tools provided by the GPSC and the Ministry of Health to assist patients managing chronic pain, to help with substance use issues in their communities, and to comply with the opioid prescribing standards announced by the BC College of Physician and Surgeons in 2016.

GPSC fees

The GPSC GP Mental Health Planning Fee (G14043) is payable upon the development and documentation of a patient's mental health plan for patients resident in the community. Patients must have a confirmed axis I diagnosis of sufficient severity and acuity to warrant the development of a management plan, and both alcohol dependency (303) and substance abuse (non-nicotine) (304) qualify as axis I diagnoses. If this fee is billed for a patient with either alcohol or substance abuse issues, all other criteria of the fee must be met. For more information, refer to the GPSC's mental health billing guide at **gpscbc.ca**.

Opioid use disorder guideline

The BC Centre on Substance Use and the Ministry of Health's A Guideline for the Clinical Management of Opioid Use Disorder provides evidence-based recommendations to physicians and nurse practitioners for the clinical management of opioid use disorder. As of June 5, 2017, this guideline replaces the College of Physicians and Surgeons of BC's Methadone and Buprenorphine: Clinical Practice Guideline for Opioid Use Disorder as the provincial guideline for the management of opioid addiction. For more information, visit **bccsu.ca**.

Pharmacare

PharmaCare covers Methadose™ for maintenance and buprenorphine/naloxone under its Psychiatric Medications Plan (Plan G). By covering these drugs under Plan G, 100% PharmaCare coverage may be available to more individuals with lower incomes. For more information, please refer to the Coverage of Methadose™ and Buprenorphine/Naloxone under Plan G and PharmaCare Newsletter at **www2.gov.bc.ca**.

Provincial substance use treatment beds

Thirty new provincial substance use treatment beds are open and accepting referrals for adults around the province. Twenty of the new beds will be provided by Phoenix Drug & Alcohol Recovery and Education Society in Surrey, and 10 will be provided by Cedars Discovery Centre in Cobble Hill on Vancouver Island. To learn more, visit **bcmhsus.ca**.

Withdrawal management guidelines

The Ministry of Health's two new guidelines (one for adults and one for youth) for biopsychosocialspiritual withdrawal management seek to capture the full range of underlying causes of substance use. Recovery plans developed from such assessments seek to address the impacts of substance use on an individual's physical and mental health, social support circle, and spiritual or moral values. For more information, visit **health.gov.bc.ca**.

Doctors of BC Communications
Suite 115 – 1665 West Broadway
Vancouver, BC V6J 5A4
T: 604.736.5551 F: 604.638.2920

GP Update is produced by the General Practice Services Committee (GPSC), one of four joint collaborative committees that represent a partnership of the government of BC and Doctors of BC.

The GPSC strengthens full-service family practice and comprehensive patient care in BC with its programs and initiatives. For more information, visit **gpscbc.ca.**