Readers' Choice:

GPSC 2019

General Practice Services Committee

Welcome

We invite you to read our 2019 GPSC Readers' Choice story collection—ten of the stories read and shared most by doctors and divisions over the past year, according to metrics that include web traffic, sharing/repurposing via Divisions Dispatch, and feedback from readers.

2019 was a busy and integral year for our collaborative work to build an integrated system of primary and community care in BC. Many divisions of family practice around the province are now at various stages of building primary care networks (PCNs), with patient medical homes (PMH) at their foundation. Health care teams are at the heart of this work, and over the course of 2019 we saw many examples of how team-based care is improving access to care, and ensuring family physicians feel supported in doing the work that brought them to the medical profession; the work they love to do. These successes are reflected in a number of stories in our Readers' Choice collection this year.

Ensuring doctors are supported in achieving attributes of a PMH in their practices, incorporating allied health providers, and participating in PCNs was an important focus for GPSC in 2019. We've had feedback from many doctors around the province about how GPSC incentives and PSP supports have enabled them to improve practice efficiency and patient care, and we shared many of these stories across our channels as well.

As well this year we have featured many stories about how, in the midst of our broader work to build PCNs and achieve system change, local divisions continue to create grassroots programs and initiatives that support family physicians and improve patient care in new and exciting ways.

You will see all of this work reflected in our 2019 Readers Choice story collection—we hope you enjoy these stories and are inspired by the work of your colleagues and your fellow divisions.

Thank you for your continued support.

Dr Shelley Ross, Co-Chair
Ted Patterson, Co-Chair
General Practice Services Committee

Improving access and meeting patient needs in Prince George

When it comes to providing the best possible care for her diverse patient population, Prince George physician Dr Susie Butow relies on the support of the primary care team in her practice. In fact, she's never worked any other way.

"I have the fortune to have never been in practice without being integrated into an interprofessional primary care team," explains Dr Butow. "With my team, I can spend more time focusing on and addressing the social determinants of health, which not only improves the health of my patients—it creates healthier communities overall."

Dr Butow's practice functions as a fully realized Patient Medical Home (PMH)—meaning that she and her team provide person- and family-centred care by incorporating team-based care, panel management, continuous quality improvement, and support from multiple physician networks. "As a result of this work," she says, "I have been able to improve patient access to our clinic significantly."

The Prince George Division of Family Practice began implementing PMHs across the community in 2015. Working within a PMH, physicians can:

- Increase their ability to provide optimal care for patients, and conveniently access a full range of supports and services for patients.
- Spend more time on difficult diagnoses and strengthening patient relationships.
- Reduce the burden of caring for patients alone, which can help to prevent burnout.
- Increase the efficiency of the practice and streamline processes to maximize time, resources, and capacity.

The General Practice Services Committee—a joint initiative of Doctors of BC and the Government of BC—provides physicians with a variety of supports to incorporate PMH attributes into their practices, including clinical and practice management tools, incentive fees, and coaching and mentoring. Dr Butow has benefited from the Practice Support Program's coaching services in particular.

"I have a practice support coach that helps to keep me on top of my QI goals and keeps me connected and engaged in this work," she explains.

This support has enabled Dr Butow and the practice to build a team of health providers that supports patients' needs in a comprehensive way. "Having a team of nurses and allied health providers to support my work and my patients' health is so reassuring," she says. "The support from our team makes me feel less overwhelmed by the magnitude of complex patient needs."

Dr Butow feels strongly that adopting the PMH model of care in her practice has better enabled her to do the work she loves to do, and to embrace the aspects of care that brought her into the medical profession in the first place. "This way of working allows me to really feel as though I'm addressing patients' medical needs rather than just rushing them through my clinic," she says.

"I can't imagine being able to provide this level of comprehensive care for my patients without knowing I have the support of my team alongside me."

1,700+

Family doctors have received panel management support from PSP

Reducing physician burnout: clinic support for patients' social issues can help

Physician health and wellness has been identified as a quality indicator in the overall functioning of health systems[1], essentially positioning physician health as an additional component of the triple aim[2]. The GPSC and Divisions of Family Practice are supporting system change and specific initiatives to address physician burnout, as part of the commitment to improve the patient and provider experience of care.

Preventing burnout is recognized as a significant component in ensuring physicians feel healthy and able to continue providing access and support for their patients.

The Physician Health Program notes that physician burnout is more prevalent and more intense among BC physicians than it has been in the past, and it details strategies and resources that can help[3]. In addition, a new study shows that physicians may find additional support through working in a patient medical home or as part of a primary care network. The study, published in January 2019 in the *Journal of the American Board of Family Medicine*, found lower rates of burnout reported by primary care physicians who felt that their clinic had a high capacity to assist patients in meeting their social needs[4].

The study also found that physicians working in clinics with "patient-centered medical home" status (US terminology for patient medical home) reported higher capacity to support patients with social determinants of health.

Many initiatives are currently underway in BC through the implementation of patient medical homes and primary care networks that connect GPs to a supportive network of other physicians and allied health providers, enabling them to better support patients with social issues. Below are a few examples of work that has already resulted in physician feedback on reduction of burnout.

Fraser Northwest Division of Family Practice

Clinical counselor initiative

Fraser Northwest's primary care network enables doctors to refer patients with mild-to-moderate mental health and substance use challenges to timely care and support from local clinical counselors[5]. One family physician has commented that before the service was available she felt she didn't have the supports and skills to help patients with mild-to-moderate mental health issues, so she gave what she could—her time. She found herself advocating for her patients, including completing their insurance and disability paperwork on evenings and weekends, and was soon experiencing symptoms of burnout. With the counseling referral system in place, the doctor feels that she isn't left to help patients alone—a significant step in alleviating the feelings of burnout she was experiencing.

Nurse in practice initiative

Fraser Northwest's primary care network has also placed several RNs in physician practices in the region, enabling physicians to better support vulnerable patients and connect them with resources and services in the community. One physician has described feeling burned out and overwhelmed trying to connect patients with local services and help them access the community support they need. His nurse in practice has helped significantly—in one case, a pregnant patient with bipolar disorder needed support and the nurse was able to spend significant time with her, ensuring she had access to resources and community services to support her through her pregnancy. This support put the physician's mind at ease and allowed him to focus on providing pregnancy care for the patient[6].

Rural and remote: Gabriola Island

Gabriola Community Health Centre patient medical home model

The patient medical home team-based care model at the Gabriola Community Health Centre enables clinic GPs to work closely with a mental health nurse, social worker, occupational therapist, long-term care case manager, and visiting psychiatrist. According to one clinic doctor, the team environment has reduced feelings of burnout for the clinic's GPs—she praises the team for alleviating pressure on her role, and for helping her realize she doesn't have to be the whole support system for her patients[7].

As primary care network implementation work continues around the province, the GPSC looks forward to gathering more information about the impact teams can have on reducing physician burnout, and ensuring doctors are freed up to do the work that brought them to the medical profession in the first place—the work they love to do.

To learn more about patient medical homes, primary care networks, and team-based care, visit www.gpscbc.ca.

Refer to *bcmj.org* for references

Group CBT appointments: Enabling GPs to support patients with mild to moderate mental health issues

Statistics show that one in five Canadians experience a mental illness or addiction problem in any given year, and one in two will experience a mental illness by age 40[1]. Mild to moderate depression and anxiety comprise a number of these cases.

According to a 2016 report from the Canadian Chronic Disease Surveillance System, about three-quarters of Canadians who used health services for a mental illness annually consulted for mood and anxiety disorders.

Cognitive behavioral therapy (CBT) is often recommended as therapy for mild to moderate anxiety and depression, and has proven to be as effective as antidepressants in treating depression[2] and most anxiety disorders[3]. CBT therapy is covered by MSP, but waits for psychiatric support are long, meaning patients often look to their GP for care. In fact, 80% of people with mental health issues receive care in the primary care setting[4].

A grassroots solution in Victoria and the South Island

Surveys show that 24.3% of Vancouver Island residents report suffering from anxiety and depression[5]. Recognizing that GPs on South Vancouver Island needed more support to care for these patients, the Victoria Division of Family Practice and the Shared Care Committee funded the development of CBT Skills Groups, with Shared Care and the South Island Division of Family Practice also supporting the project as a mental health initiative for South Vancouver Island.

The skills groups are based on CBT principles and practices. Sessions focus on self-management, providing participants with a variety of coping tools so they can decide what works best for them. The CBT Skills Group program, which is designed to be delivered within primary care, was co-developed by psychiatrists and family physicians. The groups are funded by MSP billing, meaning the only cost to participants is a $35 fee to pay for the program workbook (and this fee can be waived in cases of financial hardship). Each cohort accepts up to 15 people, and sessions run between 90 and 120 minutes. The program supports GPs to do training and develop CBT skills, increasing their confidence in caring for patients with mild to moderate mental health conditions, and enabling them to diversify their practice and care for patients in their own clinics. Participant feedback has been positive, highlighting the quality of the facilitators, affordability and accessibility of the program, and the fact that the group format allows for peer support and reinforcement that participants are not alone.

A sharable model of care

Once physicians were trained and the program was established in Victoria, psychiatrists on the project team trained a group of South Island Division physicians to expand the service to the Western Communities and the Saanich Peninsula. Currently, both the South Island Division and Victoria Division–trained facilitators work together to service the South Vancouver Island region. The program and its referrals are administered by the CBT Skills Groups Society of Victoria.

With support from the Shared Care Committee, the Victoria program has spread to a number of communities across BC, including Vancouver. The Vancouver Division of Family Practice funded the development of the program in its own community, which now runs with seven locally trained physician facilitators and its own dedicated referral centre. The Victoria Division shared all of its materials (workbook, referral form, and processes) and provided ongoing advice to initiate the program in Vancouver.

Divisions and physicians who would like to learn more about CBT Skills Groups, or who are considering adopting the model, can visit the Victoria Division website[6] or the Shared Care Learning Centre website[7]. The Shared Care Learning Centre features a profile for CBT Skills Groups, including a readiness assessment and details for how divisions can get started in implementing the program.

For more information, click here to read the in-depth scientific article about the Victoria/South Island CBT Skills Group initiative published in the October issue of the BCMJ, which contains detailed data about the initiative's success.

Refer to *bcmj.org* for references

New mothers get great care in Burnaby Maternity Clinic

The Burnaby Maternity Clinic, a GP-to-GP network that supports family doctors to provide care to pregnant patients in Burnaby.

"It's the best kept secret in the Lower Mainland," says Dr Shelley Ross, General Practice Services Committee (GPSC) Co-chair and family physician at the clinic.

A key goal of the clinic it to keep maternity patients in a primary care setting throughout their pregnancy, reducing the need for them to be seen in the specialty setting.

In addition to GP referrals, obstetricians are redirecting low-risk patients back to their family doctors and recommending the Burnaby Maternity Clinic as the best place for them to continue receiving care in pregnancy.

The clinic functions as a GP-to-GP network and is comprised of six family doctors who work together to provide 24-hour care to maternity patients. Located on the first floor of

Burnaby Hospital, the network maintains wraparound care for patients throughout pregnancy, labour and delivery, and up to six weeks post-partum.

With support from the GP network, family doctors who do not provide obstetrical care in Burnaby can be confident their patients are well looked after. "If a physician has a patient they only want to see up to 20 weeks of pregnancy, they want to know they have someone who is willing to take that patient on for the rest of the pregnancy, do the delivery, and send them back," says Dr Ross. "We have such a network in Burnaby."

This model has been shown to provide better access to continuous care, which means shorter wait times, fewer complications and interventions, and lower costs to the health care system. There is less burden on obstetricians as well, whose main focus is critical obstetrical care and high-risk pregnancies.

"In Burnaby, we are building a model which improves the care we are able to provide as GPs," says Dr Lemke.

"The future is one of collegiality and working together, enabling the shared delivery of primary maternity care." As well as emphasizing the benefits of keeping maternity patients in a primary care setting throughout their pregnancy, the clinic encourages other GPs to consider offering maternity services at the clinic.

Two promotional videos have been created to showcase the clinic and its services: one highlights the benefits of the clinic to other family physicians and the other for GPs to display in their waiting rooms that demonstrate the clinic's services to prospective patients.

For more information about the clinic and the network of GPs, visit the website.

The best thing about practising on Gabriola Island

Residents of Gabriola Island banded together to build a leading-edge community health facility through volunteer efforts, fundraising, and collaborating with local partners and stakeholders when a lack of available clinic space began to impact the island's ability to recruit new doctors and health care providers. That theme of collaboration continues through the very successful team-based care model now functioning within the clinic, which has exceeded all expectations for success since opening its doors in 2012.

The Gabriola Community Health Centre is owned, maintained, and administered by the Gabriola Health Care Foundation—a non-profit society formed by island residents. While the centre was built prior to the formation of the Gabriola Island Chapter of the Rural and Remote Division of Family Practice, the division and chapter have been instrumental in initiating a part-time social worker, telehealth videoconferencing equipment and support, development of the Health and Wellness Collaborative and the Palliative Care Working Group, and more. Island Health and other local health care stakeholders also support the centre.

Two of the clinic's GPs, Drs Francis Bosman and Tracey Thorne, were part of the community effort to build the clinic. Dr Bosman feels that strongest part of the clinic's foundation lies not within in the clinic building itself, but in the strength of its multidisciplinary team. "The best thing about practising on Gabriola Island is we've created a great team," he says. "We have a social worker, mental health nurse, visiting psychiatrist, home nursing, occupational therapist, long-term care case manager, and community paramedic, along with a team of doctors who work together extremely well. We all 'case conference' around patients with problems and solve the problems as a team."

Relying on the individual expertise of their team members enables Drs Bosman and Thorne to focus on patient care. Dr Thorne says, "Instead of me trying to be an inexperienced and ineffectual mental health nurse, I actually have a very experienced and wonderful mental health nurse I can go to. She can give me her skills, her feedback, and we can really work on improving someone's overall situation."

Maureen Zdancewicz, the clinic's former Community Health Nurse, appreciates the open lines of communication between team members. "I'd say it's one of the best places I've ever worked because of the interdisciplinary team approach," she says. "The doctors here make it easy because their door is always open. Collaboration is something that happens daily, and I think because of this our patients get better care."

This team approach has been particularly helpful in caring for vulnerable and marginalized patients, and patients with mental health and addictions issues. The clinic's social worker plays an important role in referring vulnerable patients to the clinic, explains Dr Thorne. "One of our social workers also works at PHC (the community social service agency on the island) and she will meet people there who've been reluctant to access medical care for whatever reason—historical biases or concerns they've had in the past. She builds relationships with them, and through the trust they have in her she can transmit that trust to me or one of the other physicians who she feels is the best fit."

Vulnerable patients who have mental health and addiction issues can access services at the clinic from both a social worker and a mental health nurse, who collaborate on patient care, community outreach, and crisis intervention. Their work has made a significant impact on the number of people who turn up at the clinic in the midst of a mental health crisis. Realizing that they were seeing far fewer people in crisis, mental health and addictions nurse Cathy Fox reached out to the local RCMP to see if they had seen a similar change. "The amount that they've had to intervene or transport has dropped by 83% since the social worker and I started," said Ms Fox. "So those are pretty fantastic stats!"

Dr Thorne agrees. "This reduction means mental health patients are getting treated and cared for by the appropriate people instead of having to come into conflict with the RCMP. This frees up their time to deal with other folks more appropriately, and it also means we're taking care of people before they get to that crisis point of an RCMP call."

While the clinic focuses on providing primary care services in its team environment, visiting specialists who provide secondary care services are becoming an increasingly important component of the team. Clinic physician Dr Maciej Mierzewski explains, "We have this great primary care home, but we're trying to extend it to secondary care too. Gabriolans on the island have access to some of the secondary care specialists who've decided to visit us. This makes it much easier for all of us – much easier for Gabriolans because they don't have to travel to Nanaimo."

The team environment at the clinic hasn't just improved support and care for local patients—having a team to rely on has also reduced feelings of burnout for the clinic's GPs, says Dr Thorne. "Burnout can be a really big issue in rural communities because physicians are on-call, they're doing emergency, they're doing mental health, they're doing primary care, and they're often doing that without anyone else to support them." The clinic team makes her feel like she's doing her job better, and like she's part of a system of care. "We're so grateful and so lucky to have all these other people working with us," she says. "[The team] helps us realize that we're part of an overall system – we don't have to be the whole system. When you don't feel like all that pressure is resting solely on you, it gives you a lot more freedom to work differently and to think more broadly."

Team members feel the same way. Maureen Zdancewicz says "We're such a special clinic because I'm working as part of a team—I have experts all around me for every need. We're really providing holistic care for people in this community, and it's working – we're getting feedback that this is how health care should be."

To learn more about the Gabriola team-based care model, watch the video "Gabriola Community Health Centre: Much more than a clinic" or visit gabriolahealthcentre.ca.

Click here to read the full article.

The Fraser Northwest Nurse Debbie Initiative: Bringing Primary Care to Patients' Homes

In 2015, family doctors with the Fraser Northwest Division of Family Practice identified a need for more support and services for frail elderly patients, many of whom were presenting in the emergency room with issues that could have been managed at home.

The division hired a nurse—Nurse Debbie—to support family doctors in caring for these homebound frail elderly patients. This innovative role extended primary care services into patients' homes, ensuring they could receive the care they needed quickly before health issues could develop further.

This type of team-based care model has been identified as a top priority in improving care for patients around the province. Health care teams are being built in patient medical homes within family practices, through primary care networks in communities, and within urgent primary care centres. These teams can take several forms and can comprise a wide array of allied health providers, including nurse practitioners, nurses, physiotherapists, dietitians, and social workers. The home nursing team-based care model built into the Nurse Debbie initiative was so successful that the service was expanded by the Fraser Health Authority, becoming the Fraser Health Primary and Community Care Nursing Program.

Grassroots beginnings

The original Nurse Debbie began the process of supporting Fraser Northwest family doctors by meeting with them to review their patient panels and identify suitable patients. Then, under the direction of each doctor (as an extension of the doctor's office itself), Debbie began providing care for frail elderly patients in their homes, eventually seeing an average of seven patients per day.

Between January and December 2016, Nurse Debbie saw 469 patients in their homes. This in-home primary care support prevented more than 500 patient visits to the ER and thousands of patient bed days, saving an estimated $3.1 million in health care costs.

Inspired by the results being achieved by the Nurse Debbie initiative in Fraser Northwest communities, Fraser Health created the Fraser Health Primary and Community Care Nursing Program. They hired Nurse Debbie to run the expanded program, as well as two other nurses to provide the same services in the region. The health authority also established a support team to streamline assessments and paperwork and create more efficient connections to patient supports.

Fraser Health and divisions also worked with GP offices to ensure that nurses are able to access physicians' EMRs in order to share patient information—a key component in ensuring the program's success. Nurses are now able to send messages to physicians within their EMR about the care they've provided, and doctors can stay up-to-date on their patients' conditions while their patients stay safely at home.

In addition to Fraser Northwest, three other divisions of family practice have now implemented the Fraser Health Primary and Community Care Nursing Program.

Chilliwack (including Agassiz-Harrison and Hope)

Twenty RN/LPN teams are now working in pairs across Chilliwack-area communities. These teams collaborate with family physicians or nurse practitioners to support patients with advanced health care needs, and arrange support from occupational therapists, physiotherapists, and social workers as needed. Over a 10-month period, the work of the first team resulted in an estimated 19% reduction in ER visits and a 21% reduction in inpatient days.

Ridge Meadows

Twelve primary and community care nurses are now providing care in alignment with all GP offices in Maple Ridge/Pitt Meadows. An evaluation of the initial 8-month Primary and Community Care Nurse pilot program showed a reduction in ER visits and highlighted a number of positive patient stories and experiences. Providers reported that the model improves interconnectedness and accessibility of services for patients and enables them to be seen in a more timely fashion.

Surrey–North Delta

In 2018, the division partnered with Fraser Health's Home Health Program to deploy a primary and community care nursing model across the community. Through the program, nurses partner with family physicians to better support their most frail and complex senior patients, assess their safety, and assist with acute medical needs. Nurses also guide patients to self-manage their conditions and connect them to a team of allied health professionals including occupational therapists, physiotherapists, dietitians, and social workers, as well as other resources in the community.

Region-wide success

A 3-year analysis of the Fraser Health Primary and Community Care Nursing program followed 1071 patients for between 6 months and 3 years. The analysis showed that 596 ED visits were avoided and 15 464 bed days were saved between 2016 and 2019.

There are now 29 nurses working in the Fraser Health region extending primary care services into the homes of elderly residents. Nurses see five to seven patients per day, and patients can call them directly or be referred by their family physician. Through the Primary and Community Care Nursing Program, Fraser Northwest's grassroots Nurse Debbie initiative lives on—improving quality of care and providing peace of mind for patients and providers alike.

To learn more about patient medical homes, primary care networks, and team-based care, visit www.gpscbc.ca.

Proactive panel management improves practice efficiency in Cowichan Valley

New to practicing in Canada and a recent resident of Cowichan Valley, BC, Dr Vitaliy Kubatskyy was uncertain about how many patients would be under his care. At the advice of the Cowichan Valley Division of Family Practice, Dr Kubatskyy contacted Mai Bennett, Practice Support Program Regional Support Team Coordinator, for support.

"It was my second year of practice, so it was good to know how many patients I could manage efficiently," said Dr Kubatskyy. "I wanted to make sure I was not underserving my patients."

Mai pointed Dr Kubatskyy in the direction of the new step-by-step GPSC Panel Management Workbook, which they used to assess his panel at about 1,100 active patients.

"I was expecting closer to 2,000 as I had taken over a full-size practice. This prompted me to open my practice to new patients."

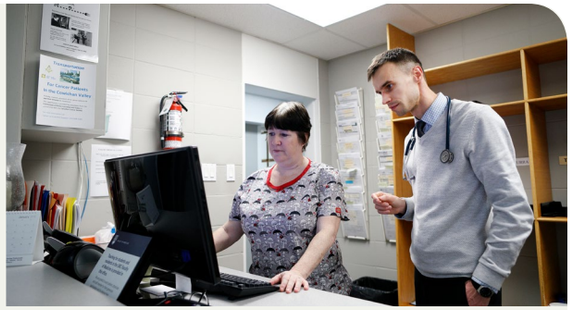
This access to more up-to-date patient records gave Dr Kubatskyy options for improving the patient experience by providing more comprehensive care and shortening wait times.

"I wanted to expand care beyond the immediate problems presented by the patient."

As a family doctor who understands that people often receive vaccinations at clinics or pharmacies without informing their GP's office, Dr Kubatskyy decided to review and improve immunization records of his patient panel. Choosing pneumonia immunization as a standard of care for his patients in the 65+ age group, he found that while most these patients had records of being immunized against flu, only a small number had records of their pneumococcal vaccination status.

With Mai's help, Dr Kubatskyy set up an EMR trigger to inform him of patients whose records lacked pneumococcal-related information and to generate the necessary chart task to document whether the vaccine was given or declined by the patient.

When seeing these patients for regular visits, Dr Kubatskyy verified their immunization records and recommended missing vaccinations where appropriate. Thus, the number of pneumococcal vaccine records more than doubled within two months.



Dr Kubatskyy also works with a registered nurse who follows up with patients about their pneumococcal vaccination status when she sees them for annual flu shots. Supported by Mai, he continues to progress with his patient panel immunization registry and is excited to spread the workflow process to other vaccinations, including tetanus boosters.

"It's important to tailor this process to your practice needs to keep you motivated. I've saved time with my overall enhancement of my EMR skills and usage, improved care of my patients, and this proved to be business efficient."

Click here to learn more about the workbook, in-practice coaching, and other GPSC supports for panel management, or contact your PSP Regional Support Team.

Kootenay Boundary Wellness Project supports good mental health for doctors

Doctors around the province are constantly working to balance patient care, office management, and an increasing volume of paperwork, with their personal lives and family obligations. It's become more important than ever to ensure that physicians feel connected, and that they are armed with skills to deal with difficult situations.

Recognizing this, the Kootenay Boundary Division of Family Practice initiated the KB Wellness Project in 2018—a program that focuses on ensuring division members have access to peer-to-peer connections in their communities. Organizing space for physician connection and arming members with skills to deal with difficult situations means doctors feel supported in maintaining their mental health as they manage their busy workloads.

Dr Todd Kettner, Project Manager, explains how the program, called "Unplugged for Wellness," works towards two fundamental goals. "The first [goal] is to reduce stigma around mental health issues for physicians by opening up conversations," he says. "And the second is to facilitate meaningful connections between doctors."

It can be difficult to try and squeeze these events into doctors' already full calendars. But as the Kootenay Boundary Wellness team has found through their evaluation research, even just knowing that these events are available is a source of encouragement to physicians.

"Though some doctors may not be able or want to attend a certain event, they still feel the positive effects that these events represent," says Dr Kettner. "And the fact that these events are brought to smaller communities across the division makes doctors feel that there is a real effort to accommodate everyone regardless of their location."

Events have included informal coffee meet-ups, outdoor excursions, guest speakers, and guided weekend retreats. The events that have garnered the most positive feedback are the focused learning events. But as Dr Kettner points out, the success of these events lies in the combination of practical advice and open discussion space.

"We've found that the purely 'for fun' events don't have the same interest and impact as the learning events," he says. "It works to draw participants in with a cerebral objective and then give space for the natural cross-talk and bonding to happen."

Other considerations that are key to successful events include scheduling 3-4 months in advance, providing iterative feedback to members, and not overscheduling events (which can cause additional stress to the already overloaded physician).

Transforming Our Work retreats: Creating space for open dialogue

As physicians, Drs Tandi Wilkinson and Lee-Anne Laverty are passionate about physician mental health and wellness. As certified yoga teachers, they have seen the positive effects that yoga, meditation, and open discussion can have on maintaining good mental health. Combining their unique skill sets, Drs Wilkinson and Laverty host Transforming Our Work, a series of wellness retreats for specialist and family physicians across the Kootenay Boundary region.

To date, Drs Wilkinson and Laverty have received positive feedback about the retreats. Using principles of transformation from yoga, participants are empowered to focus on difficult issues in a safe, supportive atmosphere. The philosophy is simple: create a safe space for dialogue to arise naturally.

And doctors who participated in the retreats are echoing the desire for less time spent listening and more time sharing. As one physician writes, "It's so fundamentally different to listen to someone talk compared to actually having to practice these things. Having these hard conversations, sharing things, and crying in front of people; all of those things are so much more powerful than just listening."

As a way to extend this philosophy beyond the two-day sanctuary of the retreat, Drs Wilkinson and Laverty introduce the doctors to the idea of "failure friends." A failure friend is a concept that Dr Wilkinson was inspired to explore after learning about it from Dr Sarah Grey, internist and medical educator from Toronto. During the vulnerable period of time after experiencing a perceived failure, it's pivotal for doctors to have peer support. A failure friend is a fellow physician to whom another physician can reach out to express feelings of failure, frustration, or disappointment. The failure friend's role is to listen without fixing, normalize the experience, and provide empathic support.

"Failure friends help illuminate what you're thinking and how to be self-emphatic and work forward from there," reports a physician. "I think the failure friend concept is an essential part of doing the work."

Continuing the research

Dr Wilkinson's work in rural family practice and emergency medicine is coupled with her research into physician wellness. She was recently awarded a Rural Scholar Research Grant through UBC's Department of Family Practice, and is currently involved in a qualitative study on physician peer support.

"When you take away the stress of having to 'fix' your colleague, and just recognize that it's normal to feel pain in response to difficult situations, it is quite liberating to just listen and provide support," she says. "It is actually one of the reasons most of us go into medicine – to make a difference." Her early research suggests that simply hearing that these difficult experiences are normal, and that we may be doing better than we think, plays a significant role in retention.

Through member feedback and research, the iterative process that the division applies will ensure that the events they host will positively impact their physician members, and the community at large.

When technology meets a team: happy patients, an enjoyable workplace

Dr Steve Hansen and his practice team – MOAs Jenelle and Melissa, RN Kari, and LPN Connie – are committed to practice excellence. As a skilled, well-coordinated, and hard-working collaborative team, they each work to the top of their scope to support a large patient population.

Committed to continuous improvements, the team has significantly enhanced the efficiency of their practice using skills and knowledge acquired through the Practice Support Program (PSP). They have listened to patients' concerns, maximized the functionality of their EMR, made workflow improvements, and are putting new panel management skills to work to use their EMR data for proactive care.

"We have an incredibly busy office – a large maternity practice," explains Dr Hansen. "There's a lot of disruption, and no extra capacity. Each day is full. When it is busy and there is not a lot of margin, the more efficient we can be, the better."

Having a strong team spirit is key to their success. Everyone is willing to take on different pieces of work, and support each other to make change happen, all for the benefit of patients.

"This practice embodies the essence of a productive team culture," says Shefali Raja, who supports the practice as part of Fraser Health's PSP regional team. "They have trusting relationships and share the same values. They enjoy the challenge of growing. And they do it with a great deal of enthusiasm."

Putting patients' experiences first: cutting wait times by two-thirds

In 2018, the team used the electronic patient experience survey tool to ask 140 patients for feedback about the office environment, their relationship with the doctor, interactions with the health care team, and self management confidence. Results were generally positive, with the exception of access and wait times.

Through a variety of strategies – which included educating patients about planning for effective appointments and completing forms - the practice was able to reduce wait times by two-thirds. The average time from patient's arrival to being seen was reduced from 60 minutes to 20 minutes.

MOA Jenelle says that patients are happier and pleased when there is often no wait at all. "It makes a huge difference for us."

Panel management: proactive care instead of catch-up care

As an early adopter of panel management, the practice took the first essential step of reviewing the status of 14,000+ patients, and identified 4,464 as being currently active. With further cleanup of active patient data, they were able to create disease registries and pull reports for proactive care and preventative screening such as immunizations.

"We are now identifying patients who should be coming in regularly if they are not already," says Jenelle. "In the past, we weren't doing proactive care to this degree. We had no system to capture those. Now, we have a cleaner system, we are more efficient. And it feels amazing knowing the patient is getting the care they need."

"It feels like more of a team approach now," says Kari, the practice RN." I didn't know how to call these patients in, or what kind of system to use. Now the flow is better."

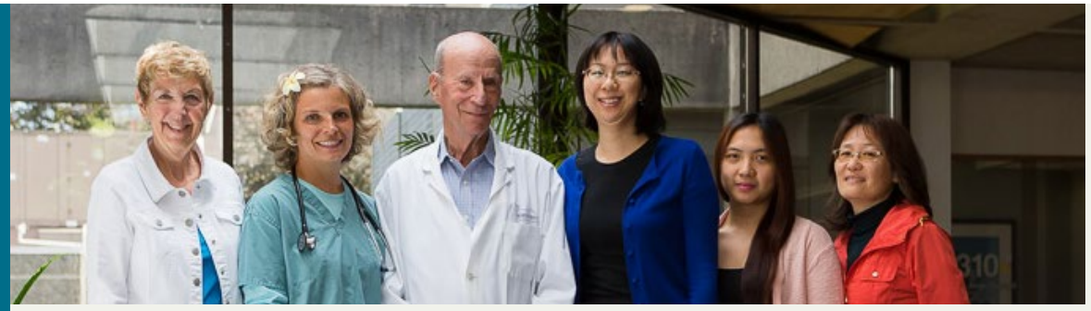
With clean lists, the team can ensure that patients with complex care needs have a documented care plan with follow-ups planned. "We can block time off for diabetes and complex care appointments six months out," says Melissa. "We have a clear plan for maternity patients. So it is a lot better for time management."

EMR functionality: no more sticky notes

Jenelle and Dr Hansen note that communication has improved too.

"Instead of giving the doctor sticky notes that say, "'this patient has a question," we can now set up tasks and reminders in the EMR. The doctor responds back, and it creates an electronic note in the chart for future reference," says Jenelle.

"You don't waste a lot of time finding things. You know where everything is," says Dr Hansen. He compares using an EMR to learning a new language: "It takes a few years to learn and express yourself naturally without thinking about it," he says. "Overall, I think it has made the practice a more enjoyable place to work."



Supporting team-based care in family practices: Incentive fees, education, and resources

The GPSC is working with its partners—including family doctors, local divisions, and health authorities—to transform primary care in BC by creating patient medical homes and primary care networks.

The goal is to enable access to quality primary health care that effectively meets the needs of patients and populations in BC.

Patient medical homes (with family physicians at the centre) form the foundation for primary care networks, which bring together services and organizations to better coordinate care for patients. Team-based care is the overarching principle of this work. When GPs work in teams—whether those teams are located in their family practice or in the community and linked to the practice—this care model can broaden the availability of clinical supports for patients.

Working in teams benefits family physicians in a number of ways. Teams enable doctors to:

- Distribute responsibilities.
- Streamline patient referral and patient care processes.
- Ensure patients have timely access to a primary care provider.
- Decrease the burden of caring for patients alone.
- Attract locums and new GPs to their practice and community.
- Focus on chronic and preventive patient care needs.

When doctors share responsibility for patient care with a team of care providers, patients benefit as well through timely access to a primary care provider and continuous, coordinated care.

The GPSC supports GPs to work in teams in their practices through incentive fees, education and training, and the GPSC Team-Based Care Reference Guide.

Incentive fees

The GPSC offers family doctors eight incentives that enable them to delegate certain tasks to team members in their practice. To qualify, the team members can be employed in the practice or work in the practice with their salary paid directly or indirectly by a third party. For more information on team-based care incentive fees, doctors can visit www.gpscbc.ca or email gpsc.billing@doctorsofbc.ca.

Table 1. The PSP's seven-part team-based care learning series

1. Foundations: Introducing team-based care and interprofessional competencies, role clarification, and medico-legal liability.
2. Patient-Centred Care: Developing a team that enhances quality patient care.
3. Interprofessional Communication: Understanding individual styles and building effective interprofessional communication.
4. Team Functioning: Developing strategies and mechanisms to work together.
5. Interprofessional Conflict Management: Understanding and resolving interprofessional conflict.
6. Collaborative Leadership: Understanding characteristics, mechanisms, and benefits of collaborative leadership.
7. TBC Practice Approach: Integrating content to support the development of a TBC approach for a practice team.

Education and training

To help doctors enhance patient care by working in primary care teams, the Practice Support Program (PSP) offers a seven-part learning series (Table 1), supported by in-practice facilitation.

No matter the type or size of team, these sessions can help develop key competencies for building successful team-based care in practice.

Practice teams are encouraged to participate in sessions together. The Foundations session is open to all interested doctors and team members and is a prerequisite for the next six sessions. Subsequent sessions are available to practices currently working in teams or those in the process of implementing a team into the practice.

This three-credit-per-hour group learning program has been certified by the College of Family Physicians of Canada for up to 48 Mainpro+ credits. The program consists of in-person learning sessions, action planning, and integrated learning packages.

The program is designed to be adaptable, flexible, and streamlined. Sessions are 2.5 hours long and can be tailored to reflect physicians' practice needs. Physicians are encouraged to include all members of their practice team, and sessions are kept focused and interactive by including a maximum of 20 participants.

Once doctors and their team members complete the program, in-practice coaching and support is provided to help them implement what they have learned.

For more information, doctors are encouraged to contact their PSP Regional Support Team, or email psp@doctorsofbc.ca.

GPSC Team-Based Care Reference Guide

The GPSC has curated a list of links to tools and resources that support doctors to develop and lead practice teams, including templates, sample documents, and planning guides. These resources are made available by the GPSC (Practice Support Program and Divisions of Family Practice), the Ministry of Health, and stakeholder organizations.

Resources are categorized as follows:

- Practice management (compensation, job descriptions samples, practice tools, privacy and legal, and patient medical record).
- In-practice coaching and education.
- Frameworks.
- Patient engagement.

For more information about these team-based care supports, email gpsc@doctorsofbc.ca.

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