General Practice Solutions

A Quarterly Newsletter from the GPSC

New PSP mental health module to launch in September

A new Practice Support Program module launching this fall across BC will meet a huge demand for support and training related to the screening, diagnosis and treatment of mental health issues, says Liza Kallstrom, BCMA Lead, Change Management and Practice Support.

"Family physicians need this support because they are seeing increasing numbers of patients with mental health issues," says Ms. Kallstrom. "In 2008, of 733,982 British Columbians receiving mental health care services, 638,208 of them – over 85 percent – were seen by a GP."

Essential to the anticipated success of this module are patient involvement and an evidence-based approach to development – with evaluations taking place every step of the way.

A train-the-trainer phase involved recruiting GP and medical office assistant champions – who will ultimately support their peers in the module sessions – as well as psychiatrists and mental health clinicians, who will act as mentors providing expertise, support and knowledge of local resources to GPs in their region.

"We collected data after the first train the trainer session, during an "action period" where participants implemented what they learned, and after a second session," says Ms. Kallstrom.

"We're also evaluating the June pilot of the module roll-out, taking place in all health authorities, with three learning sessions and two action periods."

The strong focus on evaluation, says Ms. Kallstrom, is to ensure the result is fully informed by participants' needs and experiences: "Mental health care is so complex; we need to get it right."

Challenges to providing good mental health care include stigma (preventing some people from seeking care at all); complexity of symptoms, which make them difficult to recognize or attribute to mental health issues; and cultural or language differences.

These challenges and more have been raised on a listserv developed for GP champions to share their experiences. As well as the challenges, however, Ms. Kallstrom says the listserv discussions reveal physicians' interest and enthusiasm.

"There is no doubt that GPs want to be in a position to offer the best mental health care to their patients," she says. "They are eager to learn more about how to do that."

For more information on the mental health module or other Practice Support Program modules, visit: www.practicesupport.bc.ca

The PSP mental health module aims to:

- increase physicians' confidence in managing depression and other mental health conditions
- increase patient satisfaction
- increase referrals to community programs
- increase number of patients with a care plan
- enable new and enhanced relationships between physicians and mental health clinicians
- increase medical office assistants' confidence in assisting mental health patients.

"Family physicians need this support because they are seeing increasing numbers of patients with mental health issues."

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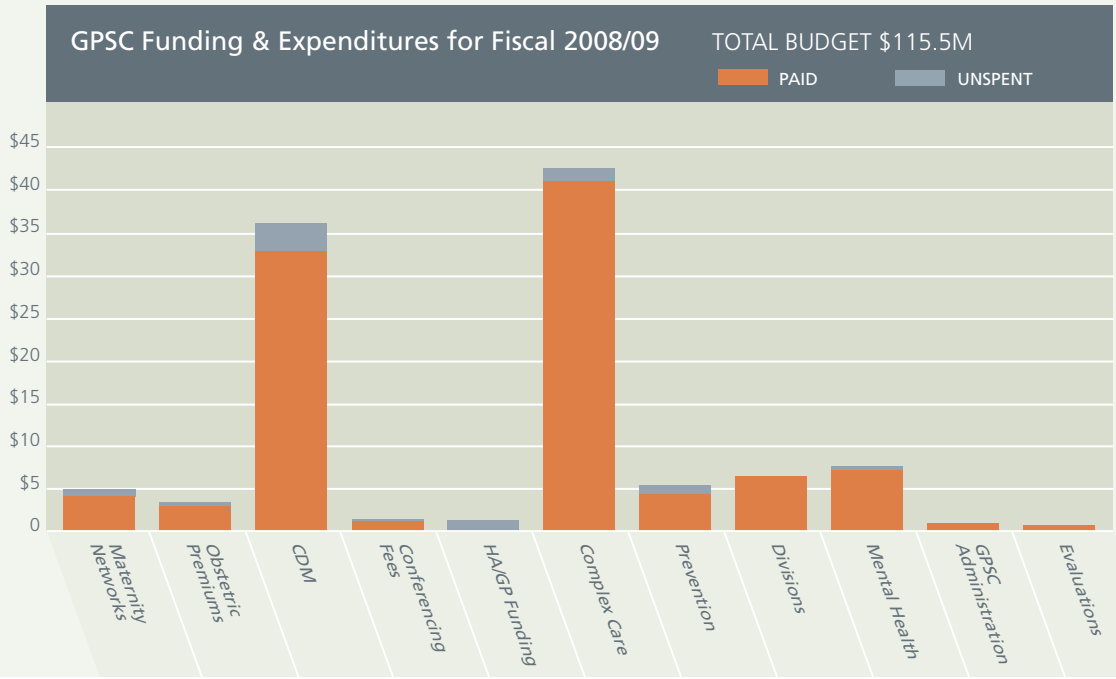

Unspent funds are available to the committee to be used in the following year for one time allocations.

Advanced access strategies adopted by specialists

When endocrinologist Dr. Marshall Dahl returned from holiday last year, his patient waitlist was at three months – much too long, in his opinion. Fortunately, the former BCMA president had heard about a primary care initiative aimed at reducing waitlists, so that's where he turned for ideas.

"It was obvious our office had to improve its capacity and efficiency," says Dr. Dahl, who co-chaired the Ministry of Health-BCMA Diabetes Collaborative in 2004. "There are similarities between primary care and endocrinology practices in that they're both mainly outpatient focussed, so I knew we could learn from their experiences."

Dr. Dahl adapted strategies from a Practice Support Program module called Advanced Access, which has benefited hundreds of GPs and MOAs in health authorities across BC since its initiation two years ago. At its simplest, Advanced Access is a structured method for ensuring patients can get in to see their doctor when they need to. It also significantly reduces the pressure on GPs and MOAs.

Using Advanced Access tactics, Dr. Dahl and his office staff reduced their waitlist to two weeks in a matter of months.

"We thought we might even shorten the wait further but found that most referred patients who were not acutely ill didn't want an appointment right away." he says. "So now we see acute patients as soon as possible and everyone else somewhere between two and three weeks."

Their strategies included using all available office time for patient visits, limiting "no shows" by reminding patients of their appointments and faxing the details to their GP right away, and ensuring appropriate time intervals between visits for any one patient.

"When you're busy, it's hard to keep track of scheduling," says Dr. Dahl. "For instance you might quickly book a patient for a repeat visit in a month, but if you investigate a guideline, it might say that two months is actually best practice."

Later this summer, Dr. Dahl and his colleagues at Vancouver General Hospital (VGH) are opening an advanced access endocrinology clinic.

"The idea is that patients will be seen by the first available endocrinologist – within a week or so," he says. "We'll be promoting the service to GPs and we think it will be particularly helpful for urgent problems and post-acute care patients."

Dr. Dahl, consultant endocrinologist at Burnaby Hospital as well as VGH, sees great potential for the PSP Advanced Access module in other specialist practices. "The strategies make good sense – I think most physicians using them would find they have more capacity than they think."

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Divisions of Family Practice host a day-long workshop

Stephen Brown, Assistant Deputy Minister, Ministry of Health Services (MoHS) is clear and enthusiastic about describing primary care changes that are possible when Divisions of Family Practice are in place across the province. "We have tremendous potential to lead major changes in primary care, by working together," he says. "This has to be done by working together as a group and by trusting each other."

Brown provided the opening remarks at a day-long workshop to kick-off the Divisions of Family Practice initiative. More than 80 family physicians, health authority and Ministry staff, BCMA staff and members of the GPSC came together to learn from the Divisions who have been testing – or prototyping – the process and to contribute to plans to move the initiative forward.

Divisions are affiliations of family physicians with common health care goals and/or in the same geographic area of BC. Together, these groups of physicians have a stronger collective voice and more impact in their communities through their efforts to improve their clinical practices, offer comprehensive patient services and influence health service decision-making.

The June 3rd workshop was designed to share information and experience, with presentations by the three established Divisions (Abbotsford, White Rock/South Surrey and Prince George) as well as group discussions on focused topics. It also encouraged participants to share in developing Divisions to meet a variety of family practice needs – rural and urban, hospital affiliated and non-hospital affiliated, solo and group practices, etc. While there are many ways to view family practice, discussions through the day helped FPs to see areas of commonality as well.

Brian Evoy, Executive Lead for the Divisions of Family Practice, outlined the role of the provincial team in supporting physicians on the 'journey' to become a Division. "We're here to do a lot of the heavy lifting, to bring the right people to the table for discussion and to support you as you talk to your community about its most pressing needs in family practice," he said. "The key to success is that we are flexible – it's one model that supports unique, community-driven solutions."

Three Divisions have been established in the past year, and discussions are underway in several communities where physicians are interested in starting the journey to become a Division. In addition, a Chilliwack group of FPs has just signed its Document of Intent – the first formal step on that journey.

Chilliwack physician lead Dr. Scott Markey was pleased to listen and learn from his colleagues, and to reflect on the discussions that are taking place in his community. "When we talk together, we see that we have so much in common and we learn so much from each other," he said. "I'm leaving here today ready to continue the work with our group, feeling supported and energized by the program."

Palliative care and acute care discharge planning the focus of two new incentives

As of June 2009, BC's family physicians are entitled to bill for the two newest GPSC incentive fees: acute care discharge planning and palliative care planning.

The acute care discharge planning conference fee applies to patients who need support with the transition from an acute care facility to the community or to another facility. GPs are now financially compensated for their participation on the multi-disciplinary care team that assists such patients, including the frail elderly, patients in palliative care or end-of-life care, patients with mental illness, or those of any age who have multiple medical needs or complex co-morbidity.

The fee is $40 per 15 minutes of conference (up to 60 minutes in one day, maximum 90 minutes per calendar year).

The $100 palliative care planning fee compensates physicians for coordinating end of life care, including supporting patients and their families to make end-of-life decisions and helping them deal with grief and loss.

Physicians are required to state in a care plan that the patient is medically palliative and will not seek treatment aimed at cure. Other components of the plan include a pain management strategy, a list of referrals and/or coordination activities to enable access to palliative care services, a list of other health care professionals whose care may be needed, a copy of the patient's most current advance directive (if available), and completion/retention of forms to support a planned home death (if applicable).

The incentive, applicable for community or assisted living care (not hospital or hospice care), also includes phone or email follow-up management fees ($15 per communication up to five per calendar year) after the initial plan is complete.

For more information about the fees, visit https://www.bcma.org/gpsc-gp-services-committee-incentive-update

BC to implement triple aim:

The best care, for the whole population, at the lowest cost

A group of BC organizations is partnering on an initiative spearheaded by the Institute for Healthcare Improvementn (IHI) to:

- improve the health of the population
- enhance the experience of care for patients, families and providers
- reduce/control care costs.

These three objectives underpin the Triple Aim initiative, which kicked off in fall 2007 with 15 organizations in the U.S., England, and Sweden. Last summer, the group expanded to over 40 organizations in additional countries, which is when BC came on board, says Judy Huska, IMPACT BC's Director, Health Improvement Action.

"BCMA, the Ministry of Health Services and all health authorities are involved, as well as IMPACT BC," says Ms. Huska, who is coordinating Triple Aim on behalf of the BC partners. "Participation is voluntary, and even though people are really busy, we're finding they want to be involved because the ideas resonate with them."

The Institute for Healthcare Improvement, a Massachusetts-based not-for-profit organization, has outlined five components of a system that would fulfill Triple Aim objectives: a focus on individuals, families and providers; redesign of primary care services and structures; population health management; a cost control platform, and system integration and execution.

They also suggest roles for "macro-integrators" (entities that can pull together the resources to support a defined population) and "micro-integrators" (a person or team that ensures the best and most appropriate care is provided to individuals). IHI provides coaching to groups involved in Triple Aim.

BC will implement the initiative in three specific settings to start, says Ms. Huska: a youth mental health organization; several BC emergency departments focusing on chronic obstructive pulmonary disease; and integrated health networks.

"Beyond the specific projects, Triple Aim also becomes a lens through which you view health system improvement," she says.

For more information on Triple Aim, contact BCMA Senior Program Advisor Greg Dines: gdines@bcma.bc.ca

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Advanced Access is one of five modules offered through the GPSC's Practice Support Program, whose purpose is to help improve physicians' working lives and quality of patient care through change management strategies. The module involves three half-day workshops over several months, between which are "action periods" where participants implement what they've learned, with support from local PSP teams. For more information: www.practicesupport.bc.ca

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General Practice Solutions is produced by the General Practice Services Committee, a joint committee of the British Columbia Ministry of Health Services and the British Columbia Medical Association.

Formed under the 2004 Agreement between BC's doctors and the provincial government, the GPSC is responsible for developing and implementing strategies that support improvements in primary care.

For more information, visit **www.bcma.org** or contact **Adrianne Darling** at **604.638.2903** or **adarling@bcma.bc.ca.**

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