GPSC
General Practice Services Committee

General Practice Solutions

A Quarterly Newsletter from the GPSC

Partners in Nanaimo come together to discuss opiate use

After a recent policy change meant that opiate prescriptions for non-cancer pain would no longer be prescribed for use outside of the emergency department at the Nanaimo Regional General Hospital, many physicians were left wondering how they could improve their prescribing practices.

When the Nanaimo Division of Family Practice was planning its second continuing medical education (CME) event, members felt it would be beneficial to focus on opiate use in their community and best prescribing practices. "Our goal is to address relevant and topical concerns for Nanaimo and Gabriola Island physicians, focusing on local resources and inviting other members from the community to either educate or help doctors in tackling local health care issues," said Dr Stefanie Steel, Treasurer of the Nanaimo Division and co-chair of the Division's CME group.

Opiates are prescribed to help patients manage severe pain and when prescribed appropriately, opioid pain medications can result in improved function. However, abuse of these medications has serious health effects and often leads to addiction. Addiction can create a ripple effect through the community that involves mental health, acute care, law enforcement, and others.

To demonstrate the scope of the problem and the far-reaching effects opiates can have, RCMP officers, a pharmacist, the regional coroner, opioid experts Dr Paddy Mark and Dr Keith Phillips, as well as addiction workers from Vancouver Island Health Authority were invited to share their experiences and expertise. "Physicians' rationale for prescribing opiate medications may appear noble but can lead to the patient's demise," said Dr Keith Phillips. "Poor practice can result in increased ER visits, drug overdoses, deaths, drug diversion, and increased crime and prostitution," he added.

Members were provided with a history of opiates, local resources for patients and physicians in need of information and support, and best prescribing practices, including regular urinary drug testing. Members were reminded to look for 'red flags' in patients who may be misusing their prescription by selling it on the street, or who appear to have an addiction. Some of the flags to look for are: lost/stolen prescriptions, early refills, multiple doctors and pharmacies, multiple ER visits, and appearing at clinics in distress and without an appointment.

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New GPSC programs support doctor-patient relationships

The joint GPSC has created two new programs that recognize the importance of continuous doctor-patient relationships.

A GP for Me, sometimes known as Attachment, strives to confirm and strengthen the relationship between family physicians and patients, better support the needs of vulnerable patients, increase capacity within the system, and enable patients who want a family doctor to find one. The In-patient Care program will better support existing care by family physicians for patients in hospitals, and it will replace any prior service agreements between local divisions of family practice and the Ministry of Health.

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—Dr Keith Phillips, opioid expert

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New GPSC programs support doctor-patient relationships – *Continued from cover*

Effective April 1, 2013, the following new fees for A GP for Me and the In-patient Care program are available to family physicians and local divisions of family practice:

A GP for Me

- Zero Sum Attachment Participation Code.
- Telephone Management (Visit) Fee.
- Expanded Complex Care Management Fee.
- Patient Conference Fee.
- Unattached Complex/High Needs Patient Attachment Referral Fee.

In-patient Care Incentives

- Assigned In-patient Care Network Incentive.
- Unassigned In-patient Care Network Incentive.
- Unassigned In-patient Care Fee.
- Enhanced clinical fees for select In-patient MRP services.

Visit **www.gpscbc.ca** for further information.

End of Life module helps family doctors discuss planning for death with patients

Talking about death is difficult, especially for physicians who need to discuss planning for the end with patients. Dr Marnie Jacobsen of Trail had been delicately raising the subject with her patients for many years, but now she is equipped with new skills and tools to confidently discuss the matter thanks to an innovative program for BC doctors.

"People don't want to think about dying, but most have a fairly good idea of what they do or don't want done to them at the end," says Jacobsen. "Physicians need to understand which patients are reaching the end of their life and open the conversation while these patients aren't in crisis, but in a more planned and less emotional situation. This gives patients the opportunity to think about what they really want."

Jacobsen was one of the first BC family physicians to put into practice the lessons, tools, and resources of the End of Life module, a recent offering from the Practice Support Program (PSP). The PSP is a training and support program for physicians and their MOAs designed to improve clinical and practice management and to support enhanced delivery of patient care.

Physicians who participate in the End of Life module learn how to identify patients who could benefit from a palliative approach to care; increase confidence and communication skills to enable advance care planning conversations; and improve collaboration with palliative care and non-palliative specialist services, patients, families, and caregivers.

> *"This module enables family doctors to add end-of-life planning to their regular practice of medicine," says Jacobsen. "At the beginning of life, we do regular check-ups, and throughout a patient's life we complete various checks. At puberty, we discuss sexual activity and do pap smears. At 50 we do a mammogram. The End of Life module creates a standard of care for people reaching that stage of their life, asking them how they want their care to unfold as they head toward the end of their lives."*

She believes this standard of care will become the family physician's guideline for approaching the issue of death, instead of skirting around the issue. "This helps demystify and regularize the fact that we all die, that we should do it the way we each want."

The module introduces physicians to forms and resources for patients that support them in making decisions and ensuring that these decisions are legally accepted. "It also helps improve my communication with other health care providers before a crisis develops," notes Jacobsen. "I'm now more proactive in terms of getting the plan in place, the communications in place, the allied health care workers in place, and providing patients with peace of mind that they will be able to die on their own terms without losing their autonomy as they get closer to death."

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First Musculoskeletal (MSK) module train-the-trainer session a success

On April 4 and 5, the Practice Support Program (PSP) held the first of two Musculoskeletal (MSK) module train-the-trainer sessions at the Westin Wall Centre in Richmond.

Family and specialist physicians led the sessions during which family physician practices were trained in the use of tools and resources designed for treatment of patients with MSK conditions.

Approximately 30% of all visits to family physicians are related to MSK complaints, some of which can prove challenging to identify and manage due to a lack of appropriate diagnostic, psycho-social, pain, and ongoing management assessment and treatment tools.

The MSK module aims to addresses this challenge by providing training, tools, and resources for family physicians in the treatment of four key MSK conditions: osteoarthritis, low back pain, rheumatoid arthritis, and juvenile idiopathic arthritis.

Module training enables family physicians to: identify red flags and make a correct diagnosis, outline treatment options (including appropriate medications), and improve communication with their patients and collaboration with their specialist colleagues as well as the broader multidisciplinary team that provides care for patients with MSK conditions.

This focus on effective shared care of MSK is reflected in both the development of the module and the train-the-trainer process—the more than 180 participants also included specialist physicians, MOAs, physiotherapists, PSP coordinators, Ministry of Health staff, occupational therapists, and patients.

"Input from the various health professionals who provide care for these patients has been integral to the module development," says Liza Kallstrom, PSP Content and Implementation Lead, "and case studies used throughout this two-day session reflected the role of each member of the care team."

The MSK module also highlights the importance of patient education and self-management in achieving better health outcomes and provides effective patient self-management tools.

> *"When patients are engaged in their own health care, they tend to have better health outcomes and a better care experience," says Kallstrom. "The MSK module patient tools and resources support patients to become partners in their care."*

The MSK module is one of a number of PSP modules that are the focus of the Clinical Usability and Standards Project (CUSP) on which the PSP and PITO are working together. CUSP aims to integrate EMR systems and PSP module tools and resources, particularly developing EMR-enabled versions of a number of tools and resources. Integration of some of the MSK tools (templates) into some EMR systems was well-received by session participants.

Over the coming months, family physician and MOA participants will test out what they learned in the first train-the-trainer session. They will re-convene during the second session to report back on their successes and difficulties, recommend changes, if necessary, and receive special training on how to facilitate training sessions themselves.

The second MSK train-the-trainer session is scheduled for October 23, 2013.

Visit **www.pspbc.ca** for more information.

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Her patients have been relieved to have their doctor broach the subject of death and advance care planning. Myrtle Haas, 79, had the end-of-life discussion with Jacobsen after dealing with the death of her sister. "After seeing what my sister went through, I was happy to talk about my plans," says Haas. "It's not fun to have that conversation. We're not looking forward to the end of life, but we're all going to get there. She was very caring and has a great sense of humour, which was helpful."

Jacobsen says that once a physician has approached the topic with a patient, their families also find it a huge relief. "If the family doctor opens the subject, you remove the taboo of talking to family about it," she says. "If you do it in a setting of an office visit, where critical illness isn't right in front of you like in emergency or a hospital room, you're much more likely to get a logical, thoughtful plan for the patient's end of life."

Partners in Nanaimo come together to discuss opiate use – *Continued from cover*

Attendees and participants quickly realized that the varying knowledge and perspectives of the community partners and physicians demonstrated the need to address the problem collectively. "Health care is a team approach," said Nanaimo area pharmacist, Russell Beales. "Patient care has so many layers that there has to be a way of bringing people together to solve the issues. We're all here tonight to avoid addiction."

"The event helped demonstrate that as doctors we are aware of the importance of the problem and are taking action, with the help of our community partners," said Dr Steele.

GPSC welcomes new co-chair

At the end of February, Nichola Manning stepped down from her co-chair responsibilities on the GPSC to focus exclusively on her role as Assistant Deputy Minister, BC Ministry of Health. After serving on the committee for six years, Kelly McQuillen assumed the ministry Co-chair role in March.

Kelly is the Executive Director of Primary Health Care and Specialist Services, Ministry of Health, a branch aimed at improving effective integrated primary, acute, and community care. This includes, as one key enabler, a focus on fostering government relationships with physicians and other partners in the health care system.

She also co-chairs the Specialist Services Committee and the Shared Care Committee and has 24 years' experience working at the Director and Executive Director level within the federal as well as provincial and territorial governments. She is committed to patient and provider partnerships in care, quality improvement, and system redesign.

Making telephone consults easier

From time to time, family physicians will need to consult with a specialist by phone about a patient. Specialists get paid for providing this telephone advice and need patient information from family physicians in order to invoice. Family physicians phoning specialists for advice to manage a patient's care can help by sending the following information to the specialist's office around the time of the consult:

- Name of patient.
- Date of birth.
- Personal Health Number (PHN).

This simple step streamlines the consult and helps specialists to avoid spending time on non-medical concerns and family physicians to more quickly obtain the advice they seek.

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For more information, visit **www.gpscbc.ca** or **www.bcma.org**.