GP Update

GPSC
General Practice Services Committee

A QUARTERLY NEWSLETTER FROM THE GPSC

FALL 2016

Oceanside Division board chair finds insights learned through GPSC program pay off

Dr Kevin Martin says he isn't a natural leader, yet he found himself in a leadership position after joining the Oceanside Division's board.

"I was frustrated with the system in the local area and I realized that I could either sit and be frustrated and do nothing about it, or I could try to be part of the solution," says Dr Martin. He soon recognized the complexities of chairing a board, which is why he enrolled in SFU's GPSC Leadership and Management Development Program.

"As physician leaders, there are automatic assumptions that we have the skillset to be comprehensive leaders within health care systems. For the most part, however, our skills lie in the realm of clinical diagnostics and science," says Dr Martin, one of 28 in the program's sixth cohort. "I was already working as the division's board chair and rapidly realized that I did not have any skills in terms of understanding governance and fiscal responsibility. That's why I decided to go on this course, and it certainly helped in those areas."

One of his objectives was to learn the practical aspects of governance.

"I'd never overseen a budget, apart from my own personal budget and my clinic's budget. I'd never worked in a non-profit environment."

The program taught Dr Martin something about his own leadership style. That was an exercise the class tackled in the first of its five modules, Building Support: Peer, Governance and Multi-stakeholder Leadership.

Dr Martin realized that he's a "disruptive innovator" who questions the facts on which the status quo is based. He's not afraid to disrupt and reform a system that's not based on solid outcomes data.

"I tend to be more of a proactive leader, when it comes to systems change," says the native of South Africa, who moved to Vancouver Island in 2008. "South Africans by nature are able to engage in tough debate and dialogue without there being interpersonal fall-out. I believe that trait is very effective in leadership as it allows for tough conversations to occur, within a context of enduring respect and collegiality."

The program helped each participant understand his or her leadership style, acknowledge that it was innate, and then use that leadership style for the greater good.

Dr Martin concluded that knowing yourself well allows you to know others well. If your leadership style can't interconnect with styles of other partners in multi-stakeholder initiatives like the division, that's a weakness, he says. "And if you can use that leadership style in a way that enhances its positive side, but also allows for engagement with other leadership styles, then that's a strength."

The program's other modules were Strategic Leadership and the Responsibility of Governance;

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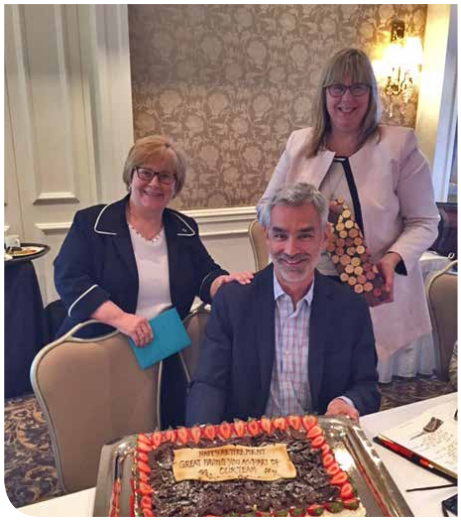

Dedicated GPSC member announces retirement

The GPSC congratulates Dr Bob Burns on his retirement. Dr Burns has served on the GPSC committee for nearly four years as a representative for the Vancouver Island Health Authority. The committee thanks Dr Burns for his contributions at the monthly GPSC meetings and at the Evaluations subcommittee. Dr Burns' passion for high-quality and well-integrated primary care will be missed.

Dr Shelley Ross recognized for her contributions to achieving excellence in BC's health care.

GPSC co-chair awarded Dr Cam Coady Medal of Excellence

Dr Shelley Ross has been recognized as an outstanding physician contributor in BC by Doctors of BC. The Dr Cam Coady Award commemorates Dr Coady's great love of medicine and ensures that his goals and objectives to achieve excellence in health care continue to be fostered.

Awarded the medal of excellence for her accomplishments in improving health care in BC, Dr Ross' hard work and dedication have strengthened primary care across the province.

For 30 years, Dr Ross focused her career on family practice medicine with a significant emphasis in obstetrics – delivering close to 300 babies every year. In 2012, Dr Ross closed her practice to step into the role of President of Doctors of BC. Since then, she has been co-chair of the General Practice Services Committee and the Practice Support Program Steering Committee, and is a member of the Shared Care Committee.

Dr Ross' commitment to health care extends to her personal time and on both national and international stages. Dr Ross represents BC on the board of the Canadian Medical Association (CMA), chairs the CMA Governance Committee, and is the Secretary General to the Medical Women's International Association (MWIA). And, in the past, Shelley has been President of the Federation of Medical Women of Canada and the MWIA.

In addition to her advocacy work through these committees and boards, Dr Ross continues to serve patients throughout BC doing full-service family practice locums and obstetrics in maternity clinics and hospitals.

Working together to meet residential care needs

Like many communities around BC, the South Okanagan region has faced significant challenges in meeting the medical needs of seniors in residential care. A reason for this trend is that while the number of seniors continues to grow, the number of physicians with practices that focus on residential care is declining.

The physicians of the South Okanagan Similkameen (SOS) Division of Family Practice decided to take an innovative approach to ensuring these seniors get the best patient care. With financial support from the Ministry of Health and BC Divisions Innovation Funding (and later by the General Practice Services Committee), the physician team became one of five prototypes to build and put in a place a plan to enhance care for seniors in residential care. Over three years, they have made significant strides. The number of proactive physician visits to patients in the facilities has gone up significantly, while the number of emergency department visits has dropped. And, physician participation in patient care conferences has increased dramatically.

"Collaboration has been the key to our success," says Dr Bob Mack, one of two SOS residential care medical coordinators. "Everyone involved – physicians, facilities and patients – was experiencing frustrations with residential care services. By sharing our perspectives and working together to develop solutions, we've already seen great improvements and have laid the foundation to continue that trend."

Opportunities for Improvement

The first step in their plan of action was to gather critical pieces of information so that the team clearly understood the challenges they faced. Dr Mack and his fellow medical coordinator, Dr Mark Lawrie and QI Coordinator Arlene Herman, connected with SOS physicians, Penticton Hospital emergency department personnel, MOAs, facility staff, and patients and their families to assess needs and hurdles to care.

Here is what they found: seniors in residential care were over-reliant on emergency department visits for matters that could be handled at the facility. However, residential care staff cited difficulty in reaching patients' physicians for non-urgent care and had come to rely on the emergency department for non-acute matters. While MOAs did receive fax requests for physicians to attend their patients in facilities, there often wasn't enough information to assess urgency.

When they looked into why physicians weren't more present they learned some interesting things. It became clear there were two very different situations in the communities that comprise the SOS region. Summerland has two facilities that are located just 100 metres apart. On average, Summerland physicians had 12 residential patients, six in each facility. This proximity and historical culture led to Summerland physicians typically visiting residential care patients on a monthly basis. In contrast, Penticton physicians had challenges with the number of facilities and covering the distance between them. Patients were spread across five facilities in different parts of the city. The area's 40 physicians also averaged 12 residential care patients each but they were spread across Penticton with only one or two in each facility, which made regular proactive care difficult and resulted in visits being mostly in response to acute situations. Possibly due to their infrequent attendance, physicians didn't feel they were part of the team at the facilities and were prevented from optimizing on-site care due to a lack of available tools such as suture kits.

Collaborative Solutions

The Division created three quality improvement working groups, Communication, Care Conferencing and Palliative Care, to explore different aspects of the care mix.

"There was a clear need for better communication between physicians and facilities," says Arlene Herman, SOS project lead. "One of the first things we have done is to pilot a communication tool called the SBAR (Situation-Background-Assessment-Recommendation) which we adapted to our needs." *Continued on p.3*

Working together to meet residential care needs *Continued from p.2*

SBAR is a tool that promotes efficient and accurate communication between physicians and facility staff by effectively and reliably sharing patient information. It communicates the urgency level to physicians and generates timely and appropriate responses

"This tool is used when requesting a visit or further instruction from the physician about a patient. Now, physicians can more accurately assess patient needs and it has dramatically improved their response time. It has proved to be very successful in our pilot; Interior Health adopted our form as a template," says Herman.

Most Responsible Physicians became eligible for $200 per year for every patient they saw twice or more in six months at the facility. This additional funding was designed to support proactive visits to residents including medication reviews and end of life discussions. In addition it compensates physicians for the extra travel time and the additional time it takes to treat patients with complex care needs. As well, facilities now stock supplies such as the requested suture kits to help physicians provide more in-house support.

"Our physicians feel a deep responsibility to their patients and there is a strong desire to remain their patients' physician when they move to a residential facility," says Dr Mack. "Logistically, that can be a challenge but making visits more efficient and effective has led to an increase in proactive visits. While we didn't measure the baseline number of visits before the prototype began, there was a 58% increase in proactive visits since the first reporting period and almost certainly a far higher increase from the baseline."

To reduce emergency department visits for acute after-hours care, SOS negotiated the extension of the hospital's Doctor of the Day jurisdiction to include residential facilities. The Doctor of the Day receives $250 for the added responsibility. With this additional coverage, the number of emergency department visits dropped 25% in the 13 months after the prototype began. Also, the gap between emergency visits and hospital admissions decreased, providing evidence that those patients sent to the emergency room were more suited to hospital care.

Physicians have also become more frequent participants in patient care conferences, which bring together everyone who supports a patient at a facility to discuss health changes, medications and forecasted needs, including palliative care. Before the prototype, physicians rarely attended, at least partly because the conferences often conflicted with their practice schedules. Now, they are held when the physician can attend, completed within 20 minutes, and result in a solid care plan more than 90% of the time. MRP attendance has increased 175%.

Looking Forward

SOS' prototype has shown clear improvements in residential care and in the satisfaction of everyone involved. Dr Mack believes there are still opportunities for further improvement.

"We're now at a place where we can take a deeper look at polypharmacy," he says. "We also believe greater efficiencies and better care can be had if we are able to 'cluster' care. This would entail having a small number of physicians in each facility, each caring for a larger number of residents. That is a long term goal but working together, I'm sure we can achieve it."

The GPSC's residential care initiative is designed to enable physicians to develop local solutions to improve care of patients in residential care services. Since 2011, the initiative was prototyped by five divisions of family practice: Abbotsford, Chilliwack, Prince George, South Okanagan Similkameen, and White Rock-South Surrey. Building on the significant learnings of the prototype communities, in 2015, the GPSC committed up to $12m annually to expand to residential care patients in more than 90 communities across BC. As of July 2016, almost 68% of these communities have implemented a local solution.

A GP for Me: Doctors spearhead team-based care

The A GP for Me initiative has helped move physician leadership, partnerships, and innovation to a new level, establishing a strong basis for the continued evolution of primary care and creation of patient medical homes.

It has served as a testing ground for various models of team-based care. By the end of 2015, more than 100 allied health professionals had joined doctors across BC to support patients; mainly vulnerable and marginalized individuals with complex health conditions. In many cases, a team approach has been life-changing for patients, and deeply satisfying for doctors.

Here are examples of doctors who are shaping team-based care models:

- Dr Kile Stevens of Penticton was one of the founders of the Martin Street Outreach Clinic in Penticton. There, doctors, a social worker and mental health professionals work together to support 500+ patients dealing with mental health and/or addictions issues.
- Dr Tracy Monk of Burnaby helped to spearhead the Sunshiners Network, a service that provides vulnerable, homebound seniors with access to health and community supports through their doctor's office.
- Dr Sheila Findlay of Nanaimo is co-director of the new Wellness Centre in the John Barsby Community School, where teens in grades eight to 12 can get primary care services at school.
- Dr Ursula Luitingh of Maple Ridge brought a registered nurse into her practice. In Ridge Meadows, the addition of RNs and/or physician extenders have saved up to 2.5 hours a day for some doctors.

Read these doctors' stories at:
www.divisionsbc-primarycare.ca/success-stories/doctors-experiences

A GP for Me is a joint Initiative of the Government of BC and Doctors of BC.

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Ensuring Quality: Roles, Responsibilities and Accountability; Leading Innovation and Resource Allocation; and Building Sustainable Partnerships and Collaborations. It was rounded out with peer discussions and group exercises like a simulated board meeting.

Dr Martin – whose division is one of BC's smallest, with 27 members altogether and only six on its board – says he's already used the skills he's gained through the course to help in two vital endeavors and in one important effort that's coming up.

"I used a lot of the governance, fiscal responsibility and collaborative work training to get the 11 small divisions together to have a collective impact study on our infrastructure funding," says Dr Martin, whose group shared its findings to the GPSC. "And I used it as well in forming a recruitment and retention collaborative with the municipalities in Oceanside, and to look at establishing a publicly funded multi-physician community clinic."

Dr Martin is also using skills gained through the course in planning for his successor.

"I'm going to start to train the new chair and hand over all of the different concepts of governance, financial responsibility, all the financial stewardship, and all of the other skills that I've learned through experience but also through the course, to the next chair, so that there will be more seamless continuity."

To learn more about the program, visit **www.pspbc.ca.**

Divisions of Family Practice members win RCCbc Awards in Excellence in Rural Medicine

Drs Jel Coward (Rural and Remote Division), Norm Lea (Kootenay Boundary Division), and David May (Powell River Division) have received the Rural Coordination Centre of BC's Awards in Excellence in Rural Medicine for 2016.

The Awards honour rural physicians whose contributions to the practice of rural medicine have improved the health and well-being of their community.

Dr Jel Coward is the Physician Lead for the Pemberton chapter of the Rural and Remote Division. Dr Coward works with his partner Dr Rebecca Lindley in a group practice that provides full-service family practice and emergency medicine to the community. Dr Coward also makes fly-in visits to three isolated communities each week, and is a member of Pemberton Search and Rescue. He is a founding member of the Canadian Society of Mountain Medicine, and developed the team that provides the Wilderness Medicine Course at the Rural Emergency Continuum of Care conference.

Drs Coward and Lindley are co-architects and directors of The CARE Course, an emergency medicine course for rural health care providers. The program focuses on delivering high-quality medical education that will help to strengthen rural communities.

Dr Norm Lea of Nakusp is the Continuing Professional Development lead for the Kootenay Boundary Division. Dr Lea moved to Nakusp in 1988 intending to stay for one year, and 28 years later is still practising rural medicine in the community. Dr Lea is a recipient of the Queen's Diamond Jubilee medal (2012) for his dedication in ensuring that residents in the community have access to medical coverage and services –specifically, his efforts to ensure the emergency room stays open to provide immediate care when needed.

Dr David May is a board member at the Powell River Division. He is a full-service family physician, and has worked in the community for 25 years. Dr May also works as an anesthetist, and runs a consulting practice in palliative care and chronic pain. He is a member of the PSP chronic pain planning committee and serves as physician lead on the Powell River Division's Shared Care Committee Palliative Care initiative.

In addition to honouring rural physicians, the award was presented to two multidisciplinary health care teams--the first time in the history of the award that health care teams were nominated. The Sustained Community award was given to the physician/nurse practitioner team at Waneta Primary Care Clinic in Trail (clinic team members Dr Blair Stanley and Lori Verigin NP are members of the Kootenay Boundary Division), in recognition of the team's work in sustaining the health of the community over many years.

The Resilient Community award was won by Cascade Medical Centre and Princeton General Hospital for overcoming challenging situations to improve the health and well-being of the community. Support and facilitation for the medical centre is provided by the South Okanagan Similkameen Division and Interior Health. The Division has supported the centre through providing MOA peer mentoring, human resource management support, access to a specialist (through Shared Care), and a Community Worker – a role funded by A GP for Me to support patients who had psycho-social issues that were causing or exacerbating medical issues. Dr Ella Monro, who accepted the award on behalf of the centre, is a member of the South Okanagan Similkameen Division board.

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