

General Practice Solutions

A Quarterly Newsletter from the GPSC

Maternity Care for BC program delivers for Vancouver GP

Dr Eamonn Rogers considers obstetrics to be a highlight of medical care. That's why he wanted intense obstetrics training before he set up a private practice.

"I like that it's usually a pretty joyful area of medicine. You're dealing with a certain amount of vibrancy, happiness," says Dr Rogers, who has almost finished the Maternity Care for BC (MC4BC) program and works as a Vancouver locum GP.

In response to a community need for more patient access to maternity care, the GPSC launched MC4BC in 2008 to support physicians who want to begin or maintain obstetrical care in their practices, or reintroduce it. In 2014, after an evaluation, the program was re-launched with its scope expanded to include post-program mentorship, antenatal/postpartum care support, a moderated maximum number of births per participant, and a self-directed learning experience.

Since starting the program, Dr Rogers has moved from participating in few births to delivering more than 35 babies and assisting in 15 additional births. He's one of a number of doctors who've chosen to add obstetrics to their practice or enhance their existing maternity care.

Dr Rogers, 31, heard about the program from colleagues. One of his preceptors when he was a resident at St. Paul's Hospital was a recent graduate of the program and she recommended it highly. He was intrigued by the prospect of preceptors, hands-on experience, financial support, and a schedule that could adapt to his own.

So about seven months after his residency had ended, he enrolled in the program, which funds doctors working under a preceptor offering obstetric care, for up to 20 deliveries with the preceptor. MC4BC's flexible set-up means doctors can choose when they want to do their clinical and delivery work within a one-year deadline.

Dr Rogers set aside a block of about six weeks at Burnaby Hospital, where he worked on a heavy call rotation of 24 hours on and 24 hours off, with breaks, in the in-house clinic and the delivery room.

"I saw anything and everything that came in," he says.

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A GP for Me moves forward

While the formal implementation timeframe of the provincial A GP for Me initiative is winding down, local divisions of family practice are continuing many of their activities and innovations to improve patient access to primary care, which remains a priority goal for the GPSC.

Work continues to recruit more doctors, assist retiring doctors with planning and transition of patient panels, bring in locums and supports for current doctors, make practices and office systems as efficient as possible, and bring together more health care teams to support patients. Physicians are also continuing to use practice-level incentive fees to attach and deepen support for vulnerable patients.

As doctors and divisions build on the work started through A GP for Me, patient benefits are also growing. So what do those results look like so far?

To the end of 2015, 103,000 vulnerable patients who did not have a doctor were matched with one through practice-level incentive fees. At least 60,000 people were attached to doctors when their GP retired or left their communities, and 167 family doctors came to practice in BC communities.

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—Dr Eamonn Rogers

A GP for Me moves forward
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These numbers and patient benefits have grown more in the months since, as much of the work on the ground has started to take hold; we will see a more precise data reflecting impacts in the months ahead.

The impacts of A GP for Me are not just about the numbers. They are also about the real life experiences of patients, doctors, and communities. You can read A GP for Me success stories on the provincial Divisions of Family Practice website at www.divisionsbc-primarycare.ca/success-stories/local-successes.

A GP for Me has been successful in many other critical ways. It has elevated collaboration to a whole new level as divisions and doctors have come together with hundreds of partners to improve the primary care system. It has tested many innovations and approaches to creating capacity and improving access and care, including new models of team-based care.

These are significant accomplishments that have established an essential foundation for the continued transformation of primary care and emerging GPSC strategic directions. Stay tuned for next steps and many more positive changes for providers and patients ahead.

A GP for Me is a provincial initiative of the Government of BC and Doctors of BC.

JCC Showcase

Physicians and health care providers gathered for the first-ever Joint Collaborative Committees (JCCs) Showcase in February 2016. The event was part of the annual BC Patient Safety & Quality Council Forum. To see some great stories and information that capture the day and the JCC's work, please view the digital narrative at: www.rxinnovate.ca.

Coordinating a community-wide approach to enhance residential care

One of the main challenges for patients at residential care facilities across the province is getting timely, onsite care. Elderly residents often end up being transferred to the emergency department if their physician cannot be reached. Not only are these trips costly to the system, they put vulnerable patients at risk with increased stress and exposure to infection and other illnesses.

Access to onsite care was just one of the issues facing the nine publicly-funded residential care facilities in the White Rock-South Surrey (WRSS) area. The launch of the residential care prototype in 2011 created the opportunity for the WRSS Division of Family Practice to develop a coordinated, community-wide approach to facility-based medical support. The results have been impressive, with the number of emergency room visits and polypharmacy rates down substantially.

"Several years before the prototype, I'd agreed to become medical director at the facility across the street from my office because I wanted to help a vulnerable population," explains White Rock-South Surrey residential care physician lead Dr Steve Larigakis. Apart from some sessional and regular fee-for-service payments, the role was voluntary and had to be balanced with a busy practice. Fortunately, Dr Larigakis' business partner agreed to share the responsibility with him.

Across the region, a patchwork approach to care arose, with varying systems at each facility. What was needed was a coordinated system that enabled physicians to meet both residential patients' needs and the many other demands on their time.

"When the residential care initiative launched, I was asked whether White Rock-South Surrey physicians would be interested in developing a prototype that focused on creating best practices," explains Dr Larigakis. "So we held a meeting of all the facility medical directors and unanimously decided that if we worked together, we could improve the situation for everyone."

Identifying Needs and Creating Solutions

To address the need for onsite care, the medical directors agreed to provide all nine facilities with 24/7 access to a physician by forming a call group. If a facility could not reach its own medical director, staff would call a centralized number to be connected to the on-call physician, who would provide onsite care as needed. The medical directors also agreed to take on the role of Most Responsible Physician for patients awaiting attachment so they could be more quickly transferred from acute to long term care.

To enhance physicians' expertise in providing care to the frail elderly population, the prototype included a provision for medical education sessions in which experts would share their knowledge on particular aspects of care and afterward physicians could share successes and troubleshoot solutions for things happening in their own facilities.

The prototype plan created greater physician presence at residential facilities and increased participation in patient care conferences with facility staff, families and patients. Reducing polypharmacy was a key focus of these conferences, which touch on all aspects of patient care.

Building on Success

When the prototype had been underway for four years, the Division undertook an in-depth evaluation process to assess its effectiveness.

Emergency room transfers dropped 45% the first year and had fallen 60% from pre-prototype levels by year two. On average, polypharmacy rates dropped between 20 to 50%. Physicians, facility staff, patients and families all reported strong satisfaction with the new system and resulting enhancement in care.

Dr Larigakis credits the prototype's success to two factors: having the resources to support change and the power of collaboration.

"As physicians, we often work in isolation and the collaboration that's resulted from the prototype has been so beneficial," says Dr Larigakis.

"Working together to share knowledge and in-facility patient support has led to better continuity of care and we've been able to provide it in a way that's manageable with our schedules. We're working as a team with facilities and patients, which provides a higher level of satisfaction to all of us."

Looking forward, White Rock-South Surrey physicians plan to focus on further reducing polypharmacy, expanding the prototype's reach by inviting the medical directors of the area's two private residential facilities to join the education sessions and call group, and building the initiative's sustainability by mentoring new physicians with an interest in frail elderly care.

The GPSC's residential care initiative is designed to enable physicians to develop local solutions to improve the care of patients in residential care. 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 the initiative to residential care patients in more than 90 communities across BC. As of May 2016, almost 60% of these communities have implemented a local solution.

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Previously, he had performed about six deliveries during his two months of obstetrics during his first year of residency. During his second year, however, his training was focused elsewhere and he had fewer obstetrics opportunities.

"The MC4BC program was an opportunity to gain experience and increase exposure to ante- and post-partum care," he says. In addition to enhancing his expertise and confidence, "I got to see what the lifestyle was like –being a low-risk obstetrics provider– and how I could incorporate it into my practice."

He describes the MC4BC program as "very easy to enroll in and work through."

Dr Rogers grew up in Norval, Ontario, a small town outside Toronto. He hopes to establish a family practice in a rural setting where he can watch the community grow over many years.

Obstetrics fits into that long view. "It's a part of being able to give comprehensive care to patients in my future practice."

For Dr Rogers, the combination of hands-on clinical care, the potential challenge of acuity and the chance to build relationships with his patients over the course of pre-natal visits, the birth process and post-natal care is immensely appealing.

"Patient continuity and continuity of practice is a big reason that I got into family practice in the first place, so this is a natural extension of that," he says.

For more information on the GPSC's MC4BC program, please visit: www.gpsc.bc.ca.

Visioning Engagement Report

Last summer and early fall, the GPSC invited family doctors in BC to speak up about how they want to practice and care for their patients in the future. More than 30% of family doctors participated in our province-wide engagement process to help create a GP vision for the future of primary care. Feedback was compiled into a *Visioning Engagement Report* which is available as "Reporting out: family doctors provide vision for the future" on the members section of Doctors of BC's website: www.doctorsofbc.ca.

Key feedback:

- The family doctor-patient relationship is strongly valued as the foundation for effective longitudinal care.
- The GP's role as a generalist is important and the scope of primary care services available in communities through GPs should be maintained or expanded. This full scope of services may be achieved in the future by a group of doctors rather than by a single provider.
- Family doctors are open to considering practicing in interdisciplinary family care teams in the future, including both as teams of GPs, as well as with allied health care professionals. Many GPs felt there was a strong linkage between clinical and business autonomy.
- Physicians highlighted the importance of paying attention to physician wellness as ever-increasing pressures from a progressively demanding practice culture impacts physician mental health and well-being. The three main causes: practice coverage challenges, administrative burden, and remuneration.

The visioning consultation, along with the work of divisions on the ground in their communities, and the strategic priorities of the GPSC's partners and other Joint Clinical Committees, are critical inputs in the GPSC's development of a GP vision for primary care. The vision will drive the work of the GPSC for the foreseeable future. 3

Divisions of Family Practice – Strengthening our Common Agenda

On June 16-17, physician leaders and managers from 35 divisions and representatives from GPSC that include Doctors of BC, the Ministry of Health, and health authorities will gather for learning and exchange, focusing on the ways in which divisions' collective efforts are having an impact on BC's primary health care system. There will be an emphasis on dialogue among divisions about strengthening our common agenda, and how local learnings can be shared.

The first day will feature division-hosted sessions that include shaping a vision and strategies for improved rural health systems and practices, the Northern BC experience in implementing the primary care home, widening the effort to understand the social determinants of health, achieving change through collective impact, and reducing information technology silos affecting MDs in BC.

The second day will focus on the new outcomes framework and on governance options in light of the new BC Societies Act. There will be time dedicated to the GPSC's strategic direction, including discussions about support and resourcing to physicians and divisions.

For more information on the event, please visit www.divisionsbc.ca/provincial/roundtable.

Creating a learning resource: Collaborative information sharing between divisions

An important part of the success of the Divisions of Family Practice initiative can be attributed to divisions sharing learnings and building on successes achieved. Identifying opportunities to create and share learning resources is a key part of the process. A recent project involving the Kootenay Boundary and Vancouver divisions is a great example.

On March 10, 2016, the Vancouver Division of Family Practice hosted a session in its ongoing speaker series on team-based primary care in Alberta. The session featured Dr Phillip van der Merwe from Alberta Primary Care Networks, who spoke about the evolution of primary care reform from 2003 until the present.

Hearing about the session, Kootenay Boundary Division of Family Practice Executive Director Andrew Earnshaw recognized an opportunity to share the information provided at the event with his own division, and with other divisions throughout the province. Kootenay Boundary communications manager Paul Edney then contacted the Vancouver Division and offered to coordinate the creation of a video resource from the event. This included arranging for a film crew to attend the event with equipment and lighting, and offering up his own film editing skills to craft the video into a polished learning resource.

Mr Edney then reached out to the provincial Divisions office to see if there was an opportunity to split the cost for funding the project, since the result would be a learning tool for all divisions. It was agreed that the cost of the videographer would be covered, while Kootenay Boundary funding would be used to edit and post the video online. As a result of this collaborative coordinating and planning process, the Vancouver/Kootenay Boundary video resource, entitled *Team-based Primary Care – the Alberta Way*, is now available online at www.divisionsbc.ca/vancouver/speakerseries.

Division staff and physicians can watch the 40-minute video to learn:

- What are primary care networks (PCNs)?
- How do they work and how are they funded?
- How is being a GP in a primary care network different from being a GP before networks were created?
- What is working well for PCN members?
- What are some challenges of PCN participation?
- Has any evaluation research been undertaken on the effectiveness of networks?

The video is a great example of the benefits to be gained from divisions collaborating to share resources and learnings.

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General Practice Solutions is produced by the General Practice Services Committee (GPSC), a committee of the Ministry of Health and Doctors of BC.

The GPSC strengthens full-service family practice and comprehensive patient care in BC with its unprecedented programs and initiatives.

For more information, visit www.gpsc.bc.ca.