GP Update

GPSC
General Practice Services Committee

A QUARTERLY NEWSLETTER FROM THE GPSC

SPRING 2018

A sense of community benefits patients and providers

As clinical care becomes more complex, providing patient-centred care relies increasingly on coordinated interdisciplinary teamwork. Aiming to maintain a stable culture focused on longitudinal, relationship-based care, the Fairmont Family Practice in Vancouver is an interdisciplinary clinic operating under a population-based funding model. This model enables the practice to work with eight physicians, two nurse practitioners, two visiting psychiatrists, and a nutritionist.

The providers work as a team to plan each patient's care and to share responsibility for all of their primary care needs. To ensure seamless care within the practice, doctors treating colleagues' patients share detailed notes using their EMR system.

"Team communications is key to providing our patients with the best care," says Dr Brenda Hardie. "Our patients know that their care is coordinated because their providers are connected."

"Because we are aware of the patient's health history and needs, we can see each other's patients as needed," adds Dr Kuljit Sajjan.

This collaborative approach has created an effective team that shares responsibilities including urgent care, extended hours, and longitudinal care. To enable responsive care in the clinic, many doctors reserve some same day appointments, and each takes a turn being the "doctor of the day" who has no scheduled appointments and is available to patients with immediate care needs.

> *"Team communications is key to providing our patients with the best care."*

"This gives our patients the support they need in our clinic," says Dr Sajjan. "They don't need to seek care in other settings like a walk-in or ER, where providers unfamiliar with their history may order duplicate labs or cause other unnecessary delays in the system."

The practice is also dedicated to maintaining patient attachment outside regular hours through:

- Extended hours: Doctors take turns opening the clinic on Saturdays.
- Rotating on-call duties: During off hours, the practice's answering service directs patients to call services at BC Women's and Children's Hospitals, connecting them with the practice's on-call doctor to determine the best way to manage care. This may involve providing patient advice over the phone, opening the clinic outside of scheduled hours, or making a home visit.

The team is not only committed to their patients, they take care of each other by covering time off for parental responsibilities and professional training.

"It really matters that our practice has a strong sense of community – extending to our patients and each other," says Dr Hardie.

what's **inside**

Implementing primary care networks

The first phase of implementing primary care networks is to increase the number of British Columbians who have access to quality primary care and are attached to a primary care provider.

Across the province, CSCs are starting to plan how to establish and support – through team-based care– formal linkages between doctors and primary and specialized health authority services.

Communities will be provided funding for change management in order to develop their service plans to implement primary care networks. CSCs are encouraged to indicate their level of readiness and interest to the GPSC as soon as they are ready. The PCN expression of interest process is ongoing over the next 12 to 18 months. The next intakes are on May 1, August 1, and November 1.

For more information including the full list of readiness criteria, visit **gpscbc.ca**.

Meet the GPSC:

Ted Patterson (Co-Chair)

Ted Patterson is the Assistant Deputy Minister of the Primary and Community Care Policy Division at the Ministry of Health. Prior to this appointment, Ted was the Assistant Deputy Minister of the Ministry's Health Sector Workforce Division.

Previously, Ted was Executive Director at the Public Sector Employers' Council (PSEC) Secretariat in the Ministry of Finance, where he was responsible for collective bargaining and compensation strategies for the Health, K-12 and University sectors. In this role, Ted also served as a member of the Board of Directors for the BC Public School Employers' Association and represented government at a number of major negotiation tables.

Ted has also worked in a number of other senior level positions within the Ministry of Health, including Director of Labour Relations and Special Initiatives in the Office of the Chief Administrative Officer.

Ted holds a Bachelor of Arts and a Master of Arts in Political Studies, both from the University of Saskatchewan.

Dr Mitchell Fagan

Dr Mitchell Fagan is a family physician at Murrayville Family Practice in Langley, BC and is also the medical director at the Langley Lodge. Dr Fagan is the former head of family practice at Langley Memorial Hospital, previously served as a CSC chair, and was the vice-chair of the Langley Division of Family Practice for five years.

After working in a two-doctor practice for six years, Mitchell partnered with the Fraser Health Authority to develop and lead an inter-professional multidisciplinary team in a private primary care clinic in 2002. Since inception, the clinic's team-based care approach has strengthened the delivery of full-scope primary care. The clinic works closely with home health, and cares for over 200 frail seniors through the Residential Care Initiative. In addition to his Division involvement, Dr Fagan has provided strategic insight to local government, non-profit organizations, health authorities, and universities through his involvement in regional and provincial committees and initiatives.

Dr Fagan has two children and two massive Newfoundlander dogs. He is also a farmer to more than 20 llamas.

Residential Care Initiative: Early data from seven divisions show positive impact

Early data show Residential Care Initiative (RCI) projects are making a difference in the quality of care provided to seniors living in care facilities. All divisions of family practice are now working on projects covered by RCI funding, meaning that 97% of the eligible 30,000 residential care beds in the province are now covered by projects funded by the initiative. Regional and community level evaluation data from seven divisions (Fraser Northwest, Kootenay Boundary, Mission, Richmond, Shuswap North Okanagan, Victoria, and Vancouver) have yielded data showing that RCI projects underway in those communities are already meeting some or all of the five best-practice expectations, and some are moving toward fulfilling the RCI's three system-level outcomes.

Fraser Northwest

Fraser Northwest division's RCI work has ensured that all residential care patients in New Westminster, Coquitlam, Port Moody, and Port Coquitlam are now attached to a most responsible physician (MRP) (1,722 beds in total). The number of GPs providing care to residential care patients has doubled, reducing the median number of patients per GP from 80 to 35. The division has also implemented a standardized 24/7 call system. In the first 20 months of the program, emergency transfer rates from residential care facilities were reduced by 5%, acute care admissions were reduced by 9%, and acute care length of stay was reduced by 19%. Data show that these results have led to cost savings of more than $1.5 million to the health care system in less than two years.

Kootenay Boundary

RCI projects have greatly improved care for patients in residential care facilities in Kootenay Boundary. The hospital transfer rate for residential care across the region decreased by 34% from 2015/16 to 2016/17, and seniors are receiving consistent care and regular medication reviews. Across Kootenay Boundary, antipsychotic use without a diagnosis of psychosis and the number of patients on nine or more medications are below the IH and provincial averages for all but two facilities, and have declined in the Kootenay Boundary region by more than 12% and 18% respectively over the past two years. As well, family doctors in most communities have now organized regular visits to residential care facilities, reducing the need for unnecessary hospital transfers and reducing critical pressure on the local ER.

Victoria

In Victoria, a new after-hours call system is in place covering all residents (not only those covered by RCI physicians) at each of the included 29 sites. Coverage is provided between 5 p.m. and 7 a.m. on weekends and at all hours on Saturdays, Sundays, and holidays, to ensure that facilities can reach a physician in less than five minutes by calling one convenient number. Call group coverage is optional – MRPs may opt to provide after-hours coverage for their own residents by leaving a note in the resident chart and alerting facility staff. If care is provided by an on-call physician, a follow-up communication is sent to the MRP after each after-hours call to ensure consistency of care.

As well, regular medication reviews are taking place in Victoria care facilities to reduce unnecessary prescriptions and avoid negative interactions between medications. These reviews are scheduled to ensure that both a physician and a pharmacist can attend.

Mission

Regular medication reviews are also taking place in Mission care facilities, helping to reduce the number of patients on nine or more medications by 18% and resulting in a 33% decrease in patient transfers from care facilities to the ER.

Shuswap North Okanagan

In the past year, Shuswap North Okanagan division's RCI work has included proactive physician visits to facilities, meaningful medication reviews, and physician attendance at case conferences. The division has also implemented a system to ensure all residential care patients have an MRP, through which orphaned patients from the community or in alternate level of care beds are assigned an MRP to facilitate their transition to residential care beds.

This work has resulted in hospital admissions from care facilities in Salmon Arm to decrease by 25% in the past year, and a 19% drop in emergency transfer rates from care facilities in that community. Emergency transfer rates from facilities in Armstrong, Enderby, Lumby, and Vernon over the same period have decreased by 25%, and hospital admissions from care facilities in those communities have decreased by 20%.

Richmond

In Richmond, 80% of eligible residential care beds are now attached to an RCI MRP. The division has organized an after-hours call group consisting of 13 physicians, who responded to an average 8 calls per week between May and December 2017. RCI GPs are required to participate in the call group, which ensures continuity and coordination of care for residents.

RCI physicians in Richmond are now actively supporting their colleagues by taking on more patients in local facilities, enabling GPs to reduce their panels and transition care of patients in residential care facilities to an RCI GP. Since the initial launch of RCI in May 2017, four GPs new to residential care have been recruited to join the physician group and, through RCI supports, the incoming GPs were mentored and supported in the provision of residential care.

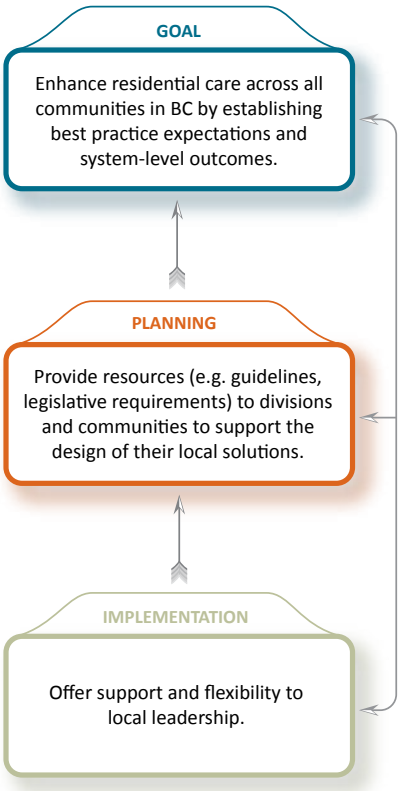
Vancouver

As a result of Vancouver division's RCI work, the number of physicians attached to residential care facilities in Vancouver has increased by almost 50 percent. A total of 2,327 beds are now covered by RCI facility attached physicians.

With the launch of the new after-hours care program, participating facilities are able to access a family doctor within an average of two minutes through a central dispatch.

The division is also supporting newly graduated doctors in taking on residential care patients from retiring doctors, and providing them with access to a mentorship program to support their transition into provision of care in the residential care setting.

Finally, the division has worked to ensure that residents at two Vancouver care facilities who would have been left without a family doctor are now connected with a new family physician, and a mechanism is now in place to ensure that all patients in Vancouver long-term care facilities are connected with a family doctor.



Meeting the system-level outcomes

As evidenced in the data above, these division-led RCI projects have successfully reduced hospital transfer rates through strategies like proactive visits, meaningful medication reviews, and after-hours on-call coverage.

Patient attachment efforts and regular physician visits to residential care facilities have ensured that work is shared between a greater number of physicians, reduced the median number of patients per GP, and enabled doctors to take vacation and sick leave when they need to. This work has dramatically improved the overall patient-provider experience.

These early results from divisions and health authorities around the province show that the Residential Care Initiative is already saving the system money through cost avoidance; e.g., reducing ER transfers and acute care stays, and eliminating unnecessary prescriptions. Once all local and regional data is collected, a clearer picture will emerge of the provincial impact of the Residential Care Initiative, including an estimate of overall provincial cost savings.

Reminder to submit GPSC portal fees

Family doctors are reminded to submit the GPSC Portal (G14070) or GPSC Locum Portal fee (G14071). Effective January 1, 2018, GPs must bill G14070/71 in the following way to avoid billing refusal:

PHN#: 9753035697

Patient Surname: Portal

First Name: GPSC

Date of Birth: January 1, 2013

ICD9 Code: 780

Submitting G14070/71 enables GPs to bill the following fee codes:

- G14075 GP Frailty Complex Care Planning and Management Fee.
- G14076 GP Patient Telephone Management Fee.
- G14077 GP Allied Care Provider Conferencing Fee.
- G14078 GP Email/Text/Telephone Medical Advice Relay Fee.
- G14029 GP Allied Care Provider Practice Code.

For more details about G14070/71 in the related GPSC billing guide, visit **gpscbc.ca**.

Division-led PMH practice assessment event provides valuable physician engagement opportunity

The Central Interior Rural Division (CIRD) hosted three successful events that encouraged members to complete the GPSC Patient Medical Home (PMH) Assessment and provided a great opportunity for individual engagement and conversations with physicians.

"The process allowed us to get more information, including information not in the assessment, which was of great value to the division. Conversations with these physicians are like gold," says Jane Barnett, the PSP coordinator in the region.

Three small groups of four to six doctors (plus staff) gathered in a restaurant's private dining space to share a meal, complete the assessment and brainstorm some community implementation tactics. The group setting enabled a PSP coordinator and division staff to outline the broader context for the assessment within the GPSC strategic direction toward an integrated system of primary and community care. "We could explain why we were asking them to do this and what we were going to do with the data," says Jill Zimonick, CIRD Project Manager. Once the physicians had completed the assessment, staff encouraged them to look toward aspects of the PMH that fit with their own values and circumstances.

The results collected have helped in shaping the division's project work around the PMH. CIRD will also be working with the PSP to address division-wide and individual practice needs identified through the results.

More than 15 divisions have opted to host a group event to encourage doctors to complete the GPSC PMH Assessment. To date, more than 350 GPs have completed the GPSC PMH Assessment.

Advice to divisions interested in hosting a group event:

- Keep the group between 6-30 physicians
- Leave time for group discussion after the survey has been completed (Physician time is compensated through the provincial office).
- Ensure each doctor brings a laptop or tablet to complete the survey and has already received his/her own unique survey link.
- If doctors are from the same clinic, encourage them to sit together, as it will make action planning seamless.

Divisions that have not yet promoted the assessment to members are encouraged to either host a group event in partnership with PSP and the GPSC Evaluation team or ask division members to reflect on their practices and complete the assessment independently in partnership with PSP. The assessment takes about 30 minutes and, upon completion, doctors receive a one-page dashboard report that summarizes strengths and opportunities in their practices, as well as recommendations for tools and resources to support them. Participants can also receive up to one hour of sessional payment through the GPSC Evaluation team and have the opportunity to receive Mainpro+ credits should they decide to pursue practice improvement opportunities with the PSP based on their results. Completion of the assessment is voluntary and all responses are confidential unless participants have consented to share their information with others in their practice, their local PSP team, and/or their division.

For more information about the GPSC PMH Assessment please contact **psp@doctorsofbc.ca**.

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GP Update is produced by the General Practice Services Committee (GPSC), one of four joint collaborative committees that represent a partnership of the government of BC and Doctors of BC.

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