GPSC
General Practice Services Committee

General Practice Solutions

A Quarterly Newsletter from the GPSC

Maternity Care for BC: A program that offers practical experience and increased confidence

After practising family medicine for more than 20 years, Dr Megan O'Keefe chose to expand the scope of her services to include primary maternity care. She enrolled in the R3 Enhanced skills program, an obstetrics residency offered through the UBC Department of Family Medicine.

It was during the R3 program Dr O'Keefe learned about the GPSC's self-directed Maternity Care for BC (MC4BC) program. MC4BC promotes, supports, and trains BC family physicians to reconnect with low-risk maternity services.

"I was attracted to the MC4BC program because it was more experience," says Dr O'Keefe. "I felt like I wasn't quite ready at the end of the [R3] training, so it was really great to have [the MC4BC program]. It was wonderful."

MC4BC is designed for family physicians to begin, maintain, or reintroduce obstetrical care in their practices, and offers mentorship, hands-on experience, and financial support. The program is funded through the GPSC partners, the Doctors of BC and the BC Ministry of Health.

The program creates practical and learning experiences for doctors. With the support of preceptors, program participants gain confidence and develop skills in hospitals and health care settings across BC.

Dr O'Keefe trained at Surrey Memorial Hospital, which hosted the largest share of MC4BC participants and number of deliveries in the program's first five years. Surrey Memorial Hospital contributed to 47% of graduate deliveries and 89% of graduates achieving the program's intended delivery volume.

"That's what I was looking for. I wanted the volume and experience," says Dr O'Keefe, who has been practising at Lions Gate Maternity Clinic since January 2013.

In one 24-hour MC4BC training shift at the hospital, Dr O'Keefe did 10 deliveries. In addition to labour and delivery, her training included conducting assessments and inductions as well as addressing pregnancy complications.

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Reconnecting Physicians with Primary Maternity Care

On October 1, the GPSC relaunched its Maternity Care for BC (MC4BC) program, which promotes, supports, and trains BC family physicians to reconnect with low-risk maternity services through mentorship, hands-on experience, and financial support. MC4BC is designed for family physicians to begin, maintain, or reintroduce obstetrical care in their practices.

As a part of its mandate to support full-service family practice, the GPSC is committed to increasing the number of family physicians who practice general obstetrics.

Family physicians are eligible to participate if they: have obtained full registration and licensure from the College of Physicians and Surgeons of BC, have obtained hospital obstetrical privileges for the hospital(s) in which the physician receives training, commit to do general practice obstetrics in BC upon completion of the program for a minimum of two years, and complete all required application documentation.

Applications are reviewed and accepted in order of receipt until March 1, 2015. To apply to the program, or for further details, visit **www.gpscbc.ca**.

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—Dr O'Keefe

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NEWS

Creating Opportunities. Bettering Services.

As part of its commitment to improving primary care in BC with innovative programs and initiatives, the GPSC aims to embed evaluation and measurements into its initiatives and to use the Triple Aim as a lens for evaluating activities to support quality, accountability, and organizational learning.

Evaluation frameworks are being developed for many of the GPSC's major programs and initiatives, and a number of key evaluative activities have been initiated, including the Evaluation Technical Advisory Reference Group. The Evaluation Technical Advisory Reference Group will substantively support the GPSC and will offer an external and independent perspective. The inter-professional team of field, clinical, and administrative experts will convene regularly to review proposals and plans for evaluation and to provide advice and recommendations on wide-scale evaluations.

In relation to A GP for Me, the GPSC is working closely with local divisions of family practice in evaluating the implementation and outcomes of their initiatives. The GPSC and the divisions have expressed a commitment to continuous quality improvement and to use PDSA cycles to guide the testing of new ways of practicing, such as team-based care models, to better support patient health. This work is not without challenges, with access to data remaining a significant issue. With the Ministry of Health and health authorities, the GPSC is working to identify opportunities that address the gaps identified by local divisions in data supports for QI and evaluation activities.

The GPSC continues to leverage learning opportunities that provide a platform for doctors to network, influence, and lead BC's primary care system and to improve patient care.

Ensuring primary care for homebound frail elderly and vulnerable patients

A program to provide better care for homebound frail elderly and other vulnerable patients in the Tri-Cities and New Westminster area of the Lower Mainland appears to be reducing the number of hospital admissions and emergency visits for these patient groups.

Initiated in March 2013 by the Fraser Northwest Division of Family Practice in partnership with Fraser Health, the Frail Elderly Nurse Practitioner Program involves nurse practitioners (NPs) – working collaboratively with physicians – providing routine and urgent care for frail elderly, homebound patients in their own homes. These patients either do not have a family doctor, or, if they do, don't visit their family doctor as often as needed for optimal care.

The initiative aligns with the work of the A GP for Me program that many divisions of family practice around the province are pursuing to build capacity so that patients get the care they need. Through divisions, physicians are playing a leadership role, bringing partners together to help find local solutions to challenges faced in local communities.

In the Fraser Northwest Division's program, that partnership extends to nurse practitioners who are working as part of a team with doctors to ensure patients get the care they need. The program provides care for patients with chronic conditions who are able to live at home, but who have difficulty getting out for medical appointments.

> *"There are clearly some underserved areas in our health care system, and nurse practitioners have the training and flexibility to help address some of those areas, working collaboratively with physicians," says Dr Nick Petropolis, physician lead for the program.*

The program's NPs, Charline Hooper and Brenda Eraut, are funded by the Ministry of Health's NP4BC initiative. They make home visits to patients who need that support, and also connect with patients by phone to help manage their care. Hooper currently has responsibility for about 100 patients and has a two-month waitlist for new referrals. Eraut recently joined the team on a part-time basis to help address that demand.

"It's been a big relief for my practice to now have these patients taken care of properly," says Petropolis. "Having Charline provide care in a person's home in a timely way helps us deal with issues quickly before they become serious. If there's something that she feels is out of her scope of practice, she'll discuss it with me, but otherwise, she provides the care without my help."

The program has so far received patient referrals from about 56 of the Division's family doctors, although most of the referrals have come from a core group of five to ten physicians. Petropolis is confident that core group will grow as more GPs become familiar and comfortable with the program.

"We're still finding there are lots of GPs in the community who don't know what the program is about," says Hooper. Earlier this year, posters were sent out to family physician offices in the Tri-Cities and New Westminster area advertising the program to both physicians and their patients. Hooper also expects the physicians she has worked with will help promote the program among their colleagues in the community. She says so far the program has received a lot of positive feedback from physicians, patients, and families.

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"The physicians are happy with the timely assessments and the interventions I can provide, and many of the patients and their families are also happy knowing their health needs are being dealt with in a timely way," says Hooper.

In addition to supporting homebound patients who have a family doctor, Hooper is also working with the hospitalist group at Eagle Ridge Hospital to provide primary care for vulnerable patients who do not have a GP, after their discharge from hospital.

"From the literature, the first 48 hours after discharge is the highest-risk period," says Joan Prociuk, director of Fraser Health's Patient Assessment and Transition to Home (PATH) program. Without dedicated primary care support, Prociuk says these patients very often end up coming right back to hospital after a short time in the community.

"We were really excited to become involved with this program," says Dr Jean Warneboldt, hospitalist lead for the program at Eagle Ridge. Warneboldt says that, in the past, the hospitalists in her group felt at a loss when they discharged vulnerable patients who do not have a GP.

"Charline is a very competent primary care provider and a great fit for these patients," says Warneboldt. "A lot of times these patients don't need to go to hospital, but they do need to be seen, so it's helpful for them and good for the medical system to have someone who can see them in their own environment."

A key part of every patient visit Hooper makes is a medication review, to confirm what's required for the patient's condition and what may no longer be needed, or what could be tried at a lower dosage.

Although the program is still in the early stages of outcomes evaluation, anecdotally these medication reviews appear to be having a positive impact. When they leave hospital, says Prociuk, "many of these patients have a long list of medications from their acute care episode, and the NPs have played a big role in bringing those meds down to a bare minimum."

From the patient perspective, Hooper believes the people she provides care for have seen a definite improvement in their health and quality of life, which she calls "a huge measure of our success."

And evaluation outcomes for the program's first year of operation confirm the positive impact it is having on patients and the health care system. Comparative data from Fraser Health for 34 patients enrolled in the program for at least one year indicate a reduction in ER visits (by 7%), hospitalizations (by 16%), and length of hospital stay (by 17% or 4.26 fewer days); and, the estimated net reduced cost per patient is $3,673.

The 53 patients referred to the program by Eagle Ridge hospitalists, Home Health, and other sources are now attached to Hooper as a primary care provider, and she has access to a physician consult if required. Additionally, at least 10 of Hooper's patients have been attached to a GP, and she has helped facilitate attachment to Home Health primary care for approximately 80 patients.

Although NPs have been involved in home care for some time, Prociuk says the innovative aspect of the Division's program "is having a true partnership between Fraser Health and the Fraser Northwest Division, and having nurse practitioners linking home health, the hospitals, and the family physicians together – that's unique."

For more information, visit **www.divisionsbc.ca/frasernw/FrailElderlyNP**.

NEWS

RX for Health

The Prescription for Health program, developed in partnership between the GPSC and Government of BC in 2011, has discontinued the subsidy component of the program due to low uptake and removed the Patient Voices Network Peer Coaching Program from the prescriptions as the program is no longer operational.

All other components of the Prescription for Health program will continue, including the Personal Health Risk Assessment (fee code G14066) and a referral to lifestyle support programs that will support an individual's lifestyle change goal(s).

The program continues to be available to patients with one or more of the following risk factors: smoking; unhealthy eating; physical inactivity; and medical obesity. General Practitioners are encouraged to continue utilizing the Prescription for Health program for the target patient population as part of a patient's health promotion and illness prevention plan. Through a Personal Health Risk Assessment, physicians recommend age- and sex- specific targeted clinically effective preventive actions, and patients are able to identify a lifestyle change goal which is documented on an Rx for Health prescription; the patient is then referred to a lifestyle support program to support their goal.

Reflecting the recent changes, new RX for Health prescription pads have been mailed to all General Practitioners. Please dispose of the original Rx for Health prescriptions, which will be eligible for reimbursement until December 31, 2014.

More information on the RX for Health program is available on the Healthy Families BC website, **www.healthyfamiliesbc.ca**.

Maternity Care for BC: A program that offers practical experience and increased confidence.
– *Continued from cover*

Of the program participants so far, nearly 100% of those polled agreed that MC4BC is an important support to family physicians by enhancing the care they provide to patients, and that MC4BC increased their confidence to perform obstetrical deliveries.

With a minority of family physicians in BC offering maternity care, the GPSC is committed to increasing the number of family physicians who do general practice obstetrics. MC4BC aims to help stem the tide of family physicians renouncing their obstetrical privileges or choosing to not incorporate obstetrics into their practices.

Maintaining hospital privileges for the purpose of practising obstetrics empowers physicians to be primary care providers who offer comprehensive care to their patients. This continuum of care fosters attachment and nurtures longitudinal relationships.

"I feel much more experienced and confident than would have without the MC4BC program."

For further program details, visit **www.gpscbc.ca**.

MEANINGFUL USE

"We ran the Objective Data Dashboard and the physician was very excited about metrics he can work on right away."

BC Practice Coaches, Fall 2014

Your EMR: The future of your practice

Technology adoption by physicians, and the purposeful use of quality information, is critical to the future of health care. In practice, this is achieved through what is referred to as the "meaningful use" of an electronic medical record (EMR).

Physicians who meaningfully use their EMR not only benefit from improved efficiency, safety and quality of patient care, they are better positioned to manage the increasing numbers of aging patients with chronic health conditions.

Initial EMR adoption with automated billings, scheduling and text notes, helps a practice manage office processes and information efficiently. And, there are even greater benefits in store for physicians who aspire to achieve higher levels of EMR functionality, starting with meaningful use level 3 (MU3).

MU3 is defined as a foundational level of use for clinical effectiveness. At this stage, physicians are consistently entering fully structured data (e.g., problem list, allergies, prescriptions, etc.) using generally accepted coding standards, and using EMR as the principle method of record keeping.

With high-quality, consistent data available at their fingertips, physicians can then use the EMR's more advanced functionality and features to inform decision-making in:

- proactive preventive care and disease management, and patient self-management,
- quality improvement and process efficiency, and
- practice reflection and greater understanding of factors that influence the health of the patient population.

Opportunities built on a foundational level of EMR use, MU3, include the ability to:

- ***Create registries*** of patients with chronic conditions, to better understand, track, manage and improve care (and trigger incentive billing).
- ***Graph medications, lab results and other values*** for informed decision-making.
- ***Share multidisciplinary shared care plans*** and chart notes among a patient's health care team for more timely, data-driven, collaborative care.
- ***Use Practice Support Program (PSP)*** tools along with data, to monitor the progress of patients living with complex conditions such as chronic pain.
- ***Involve patients more actively in managing their health*** by tracking their condition over time and graphing their progress, to help them set and meet goals.

Physicians can go on to share information across the health care system with specialists and other providers, Divisions of Family Practice, and provincial initiatives like a GP for Me.

Physicians who apply MU3 in daily practice will see the value of their time investment pay off. Not only will clinical care be more efficient, effective, and satisfying, patients will ultimately benefit from greater engagement in their health and improved outcomes.

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

Formed under the 2002 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.gpscbc.ca** or **www.doctorsofbc.ca**.