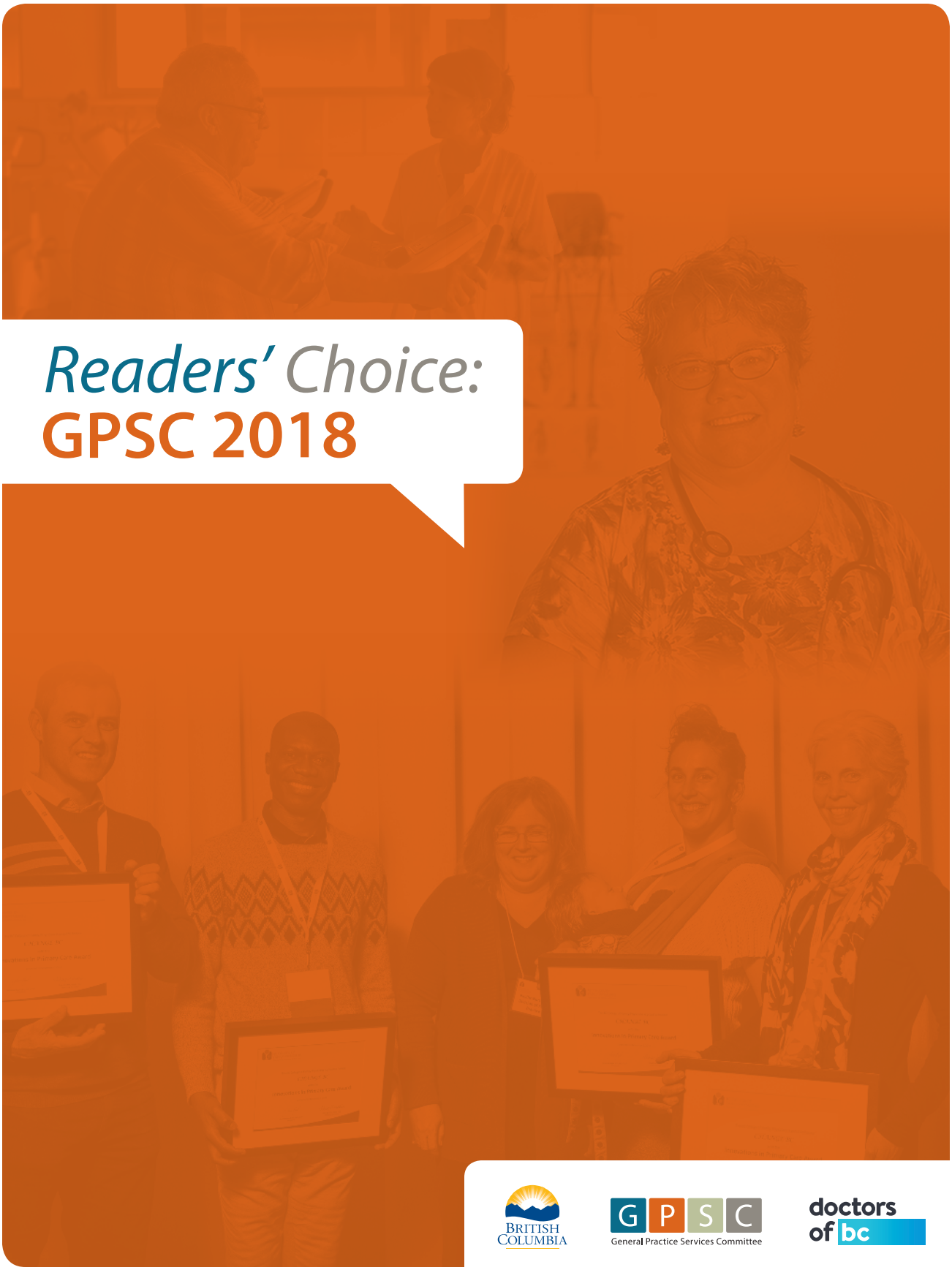


Readers' Choice: GPSC 2018

BRITISH COLUMBIA

GPSC General Practice Services Committee

doctors of bc

Welcome

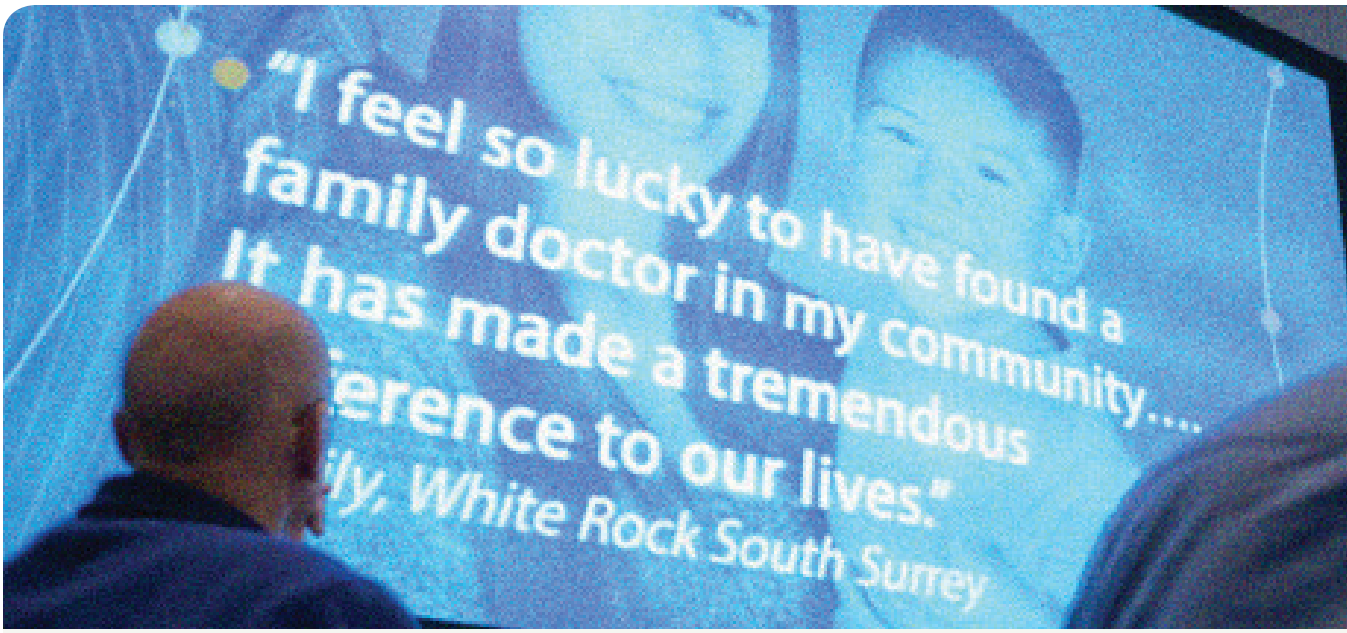
We invite you to take a look through the collection of stories in this booklet, which showcase the breadth and diversity of GPSC-related projects underway around the province. This compilation features 10 of the stories you read and shared the most with your colleagues last year.

These stories were originally featured through many different channels, including GP Update, Divisions Dispatch, the BC Medical Journal, and the GPSC and Divisions websites. While dozens of stories were published last year, the stories in this collection are the most popular. You may see a few stories that you missed over the course of a busy year: for example, stories about division-led initiatives that improve access to primary care through school-based clinics, or recruitment efforts throughout the province.

As evidenced through these stories, physicians' efforts to improve primary care through the GPSC and its initiatives continue to have a significant impact on patient care. We hope you enjoy this opportunity to learn more about how doctors and their community partners are working to enable access to primary health care and meet the needs of patients and populations in BC.

Thank you for your continued support.

Dr Shelley Ross, *Co-Chair*
Ted Patterson, *Co-Chair*
General Practice Services Committee



'Skills, not only pills:' Nova Scotia adopts BC innovation in adult mental health care

An innovation in adult mental health care developed by BC doctors is changing the way GPs practice medicine, and changing patients' lives. Its success has inspired Nova Scotia family physicians to adopt it widely across the province in 2018.

The adult mental health (AMH) training offered by BC's Practice Support Program (PSP) equips family doctors with tools and skills to diagnose and treat mild to moderate mental health conditions—mainly anxiety and depression—in their practice. With the training, GPs are more confident, able and willing to support patients with these conditions in their office setting, without referring them to a specialist or relying on medications as the sole approach to treatment.

In BC, most adults with mental health conditions receive some or all of their care from a family doctor. Yet GPs often have limited training and tools for mental health care, and they may not be able to get to the bottom of an issue during a short appointment. Patients, in turn, don't always speak up. As a result, they can miss opportunities for early diagnosis, be under-treated with medications only, or face long waits for specialists who are in short supply.

These circumstances are changing, thanks to the vision of BC psychiatrist Dr Rivian Weinerman and early adopter GPs like Dr Frank Egan—who, in collaboration with clinical partners and GPSC, designed and launched the PSP AMH module across the province starting in 2010.

Today, more than half (1,640+) of BC's practising family doctors have taken the training and integrated new tools into their practice which they can use at the time of a patient visit.

The doctor starts with a diagnostic interview to identify mental health conditions. In cases of mild to moderate anxiety and depression, the GP then partners with the

patient over a series of visits to manage the condition. Together, they use a combination of cognitive behavioural therapy 'light' skills (as an effective anti-depressant), a self-care workbook, and the Canadian Mental Health Association Bounce Back telephone coaching program.

"We found that these skills and tools increased GPs' confidence in diagnosing, treating, and developing care plans for these patients, and in prescribing and relying less on medication," says Dr Weinerman. "And it increased ability for their patients to return to work. And those results persisted three to six months after the training.[1]"

"Then we thought: if you give GPs these skills and decrease their anxiety, their attitude might also change," she says. "If they had more confidence and were more comfortable asking the questions, and felt they had the skills, they would be more welcoming to these patients, less avoidant, and therefore we'd see less health care provider stigma."

AFTER COMPLETING THE PSP ADULT MENTAL HEALTH MODULE

89.7% OF GPs SAID IT IMPROVED PATIENT CARE

94.7% OF GPs SAID IT HAD POSITIVE IMPACT ON PATIENTS

In 2017, in a double-blind study, Dr Weinerman and her colleagues were able to show those results. "We saw an decrease in social distance," she says, "meaning, the distance the doctor put between them and the patient—an important dimension in stigma. The doctors were more welcoming to their patients.[2]"

Dr Frank Egan uses the tools on a daily basis in his Victoria, BC practice.

"It has changed the way I practice medicine for mental health patients," he says. "Now, instead of shying away a bit from taking on someone with depression, I embrace it. I have more confidence and clearer insight into what my patients need and what type of follow up I can provide. I feel I can support them in their recovery in a much more valuable and authentic way than I did before I went through the training. And I know where my limitations are, and when it's time to refer a patient."

NOVA SCOTIA, NEWFOUNDLAND, AND PRINCE EDWARD ISLAND HAVE ADOPTED PSP's ADULT MENTAL HEALTH TRAINING

"I think the stigma has lessened with patients as well. They are much more willing to discuss their mental health, much more open to treatment, and more knowledgeable about their mental health."

Dr Andre van Wyk from Langley has seen patients whose life trajectory has changed as a result of having tools that he can use in the practice. "I've had lots of cases," he notes. "One had fallen out of society, was unemployed and into drugs. He has turned that around and is gainfully employed, owns his own house with his partner, and is on the right path to success. I credit [the PSP AMH module] with that."

"The patients feel listened to. Their issue is acknowledged and they have more wraparound care. Not just, 'here's a pill, goodbye.' Patients are getting a more comprehensive approach to their mental health issues than before."

Based on the BC experience—where family doctors are more confident and willing to manage their patients' conditions and patients are doing better with fewer medications—a group of GPs in Nova Scotia trialed the module and saw similar successes. They are now rolling it out across that province to family doctors. Newfoundland is lining up to follow.

Sources:

1 Mental Health Practice and Attitudes Can Be Changed

2 Impact of Skill-Based Approaches in Reducing Stigma in Primary Care Physicians: Results from a Double-Blind, Parallel-Cluster, Randomized Controlled Trial

What new doctors want: How to bring more family physicians to BC

New physicians in BC are keen to work in team environments where 'someone has their backs'—where they will benefit from collegial relationships in which experienced physician mentors can help them navigate those early practice years.

That was the key theme at a panel discussion of new doctors and family residents at the recent General Practice Services Committee Spring Summit. The panel members shared their hopes, aspirations, and concerns for their future careers, and what can be done to build the types of practices that will ensure new doctors want to come and practice in our province. Physician recruitment and retention is a key priority of Doctors of BC as we work with our partners at the Ministry of Health and health authorities so that all British Columbians can access the care they need.

A major concern expressed by panel participants related to physician burnout. With rates of burnout rising, it's easy to see why new doctors are focused on ensuring they can leave their patients in good hands when they need a break. One resident commented "We see ourselves in practice where there's good team support—where work-life balance can be achieved." According to the resident, this means a practice environment incorporating nurses, nurse practitioners, and allied health providers, in addition to a team of physician colleagues.

The group of new doctors pointed out that med school training prepares physicians to work in a collegial environment in which trainees rely on and consult colleagues regularly. Few of them can contemplate caring for patients in a solo practice—a concept they perceive as lonely and isolating.

Mentoring plays an important role for new doctors as well. Rather than practising alone in a new community where they're unfamiliar with local processes and resources, new doctors value an environment where

colleagues and allied health practitioners can help them learn the ropes. This applies to operational aspects of family practice as well. Almost all panel participants described the MSP billing system as "intimidating," and—in the case of one international medical grad accustomed to a salaried environment—"incomprehensible."

All participants expressed valuing the support of physician mentors and knowledgeable MOAs to help them navigate the billing process, but at the same time, they would prefer not to manage or be involved in the business side of clinics at all. It would be great, said one participant, to "start working in a clinic that's ready to go—where everything is sitting waiting for doctors to just come in and treat patients."

As they discussed billing and administration challenges, participants shared their thoughts on compensation and payment models as well. While compensation is fundamental to lifestyle and job satisfaction, participants said, they are open to considering new pay models.

"Offering longitudinal patient-centred care and not fee-centered care allows FPs to work in a way that benefits their patients," explained one resident. She also feels strongly that payment per day for GPs should match compensation for competing hospitalist and ER jobs, which, she says "arguably have a much better team-based model, and are therefore intrinsically more attractive to new grads."

Overall, it appears that new doctors and residents welcome a move toward practices that include health care teams to support doctors in providing patients with continuous, comprehensive, and coordinated care.

These changes are already underway. The General Practice Services Committee (a partnership of Doctors of BC and the BC Ministry of Health) is supporting doctors around the province to transform their practices into patient medical homes—family practices in which care is provided by teams that include doctors, nurses, and allied care providers.

Patient medical homes then link to primary care networks, which seamlessly connect patients with specialist care and community services. These changes will ensure patients get the care they need, when they need it, and provide the type of working environment that will ensure new doctors feel confident in setting up practice in BC and providing care for communities in the future.

FOR THE FIRST FIVE YEARS AFTER GRADUATION:

32% OF RESIDENTS SEE THEMSELVES WORKING IN COMMUNITY-BASED FAMILY MEDICINE.

50% OF RESIDENTS WANT TO WORK IN A COMBINATION OF COMMUNITY-BASED PRACTICES, PROVIDING LOCUM COVERAGE, OR IN SPECIALTY SETTINGS SUCH AS HOSPITALS, RESIDENTIAL FACILITIES, OR IN EMERGENCY MEDICINE.

91% OF RESIDENTS FELT THAT CHANGES ARE REQUIRED IN HOW PRIMARY CARE IS DELIVERED IN BC.

SOCIETY OF GENERAL PRACTITIONERS OF BC RESIDENT SURVEY

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."

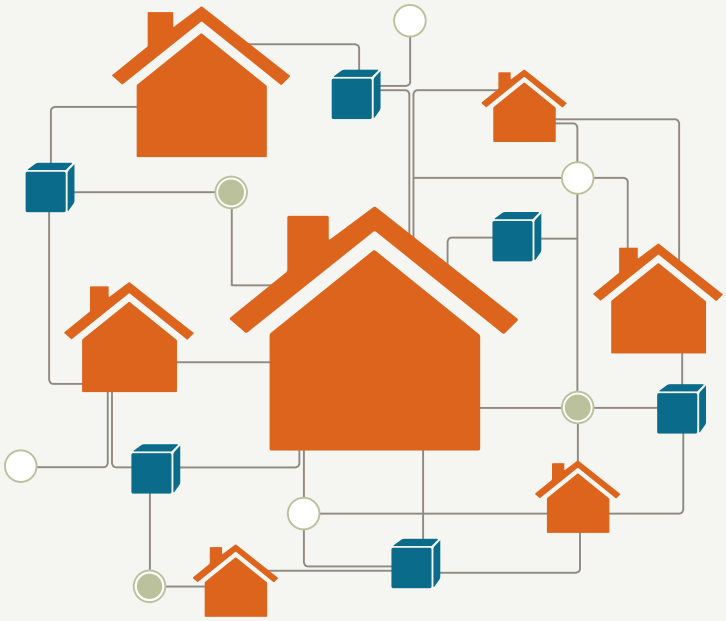
"Because we are aware of the patient's health history and needs, we can see each other's patients as needed," adds Dr Kuljit Sajjan.

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.

"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."

PRIMARY CARE NETWORK (PCN)

Get access to the right care for your patients, quickly and conveniently.



"[Our patients] 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.

Doctors of BC empowers women physician leaders

From her early days practising in a small rural community in Nova Scotia, family doctor **Dr Sheila Findlay** understood how physicians can make a positive difference in the lives of patients and colleagues, and in their communities.

"I was one of just two physicians in town," says Dr Findlay. "In that environment, there were many paths to pursue under a broader scope of general practice at both a patient-to-physician level and within the community."

During this time, she also saw how strong leadership and creative thinking could improve patient care and relationships, and how GPs could be influencers in their communities and within the health care system.

"My colleague had done some really innovative things," says Dr Findlay. "She'd set up diabetes and asthma education and clinics, which were well ahead of their time. We also ran a little hospital, and in a two-doctor town, what you do completely influences the hospital environment."

She eventually moved to Nanaimo, where she was inspired by the early days and excitement around the growing Divisions initiative.

"The idea that we could have better relationships with our health authority and other partners was key to convincing colleagues to get on board," she says. And her own passion for giving voice to GP concerns and influencing system change to benefit her community led to her "accidental leadership" with the brand new Nanaimo Division of Family Practice, where she served in various roles, including 3.5 years as Board Chair.

Challenges for women leaders

"Women bring a unique voice to the table. Supporting a balance in representation will enable the profession and partners to move forward well together."

Like most leaders, Dr Findlay possessed a vision for change, passion for the work, and collegial spirit. But like many women, she found balancing her leadership work with the responsibilities of managing childcare issues and running a household challenging. She highlights one of the many realities Doctors of BC is

working to better understand in its pursuit of diverse representation and inclusivity at all tables.

"Leadership is wonderful, fascinating, endlessly rewarding," she says. "But I needed more time for my family life. This is the only reason I stepped away from my leadership role."

"I'm not sure how we can mitigate these challenges," says Dr Findlay. "Women bring a unique voice to the table. Supporting a balance in representation will enable the profession and partners to move forward well together. I've worked with some extraordinary colleagues and been fortunate to see this in action."

Training supports through Doctors of BC

In addition to balancing personal and professional responsibilities, all physician leaders face a management learning curve, which can be steep, as they assume new and numerous responsibilities.

As part of Doctors of BC's commitment to support future leaders, scholarship funding is available through programs such as the Physician Leadership and Quality Improvement Training scholarship funded by the Specialist Services and Shared Care Committees, and the GPSC's Leadership and Management Development Program.

Dr Findlay took part in the LMDP, which made a big difference for her.

Training through the Doctors of BC and the collaborative committees was transformational.

"It honed skills that were there but needed polishing. It gives you the language to explain the rationale, the skills to facilitate, the nuts and bolts to run Boards more efficiently, and the administrative leadership skills and know-how."

— Dr Findlay

200+ GPs HAVE PARTICIPATED IN GPSC'S LEADERSHIP AND MANAGEMENT PROGRAM

Her experience mirrors that of nearly half of all physicians interviewed for a recent physician leadership review, who cited the LMDP as a critical milestone in their leadership journey.

That review also outlined the various roles physicians play as leaders, including influencer, conduit, collaborator, transformer, negotiator, advocate, manager, and fixer, highlighting the relationship-building at the heart of their work.

"To me, the roles of influencer/transformer have been the most important," says Dr Findlay, who also serves on the SGP Board and was past Chair of the Department of Family Practice in Nanaimo. "Many people have told me it's about relationships, relationships, relationships. But until there's trust in that relationship, it's tough to move the work forward."

Role models for future leaders

Physician leaders like Dr Findlay, who champion the possibilities of working together with colleagues and partners, can be role models who encourage and prompt the collective and individual leap of faith sometimes needed to move things forward. This proved the case with the Divisions initiative, where some initial scepticism about the initiative eventually receded—Today more than 90% of GPs in BC are engaged in a division.

From the perspective of her role as a physician leader, she offers some advice to women considering leadership roles.

"Be courageous; step forward. It's daunting to dip your toe in, but the rewards are huge. You gain a different perspective on how fortunate we are to work as GPs. We have a unique window into patients' lives that enables us to influence at the personal, professional and system level."

Family doctors work with teams at Martin Street Outreach Clinic to help patients at risk get their health and lives on track

People in the Penticton area who have mental health or substance use challenges are getting their lives back on track thanks to a committed, caring team made up of doctors, mental health professionals, and a social worker at the Martin Street Outreach Clinic.

The clinic is a welcoming and comprehensive health care environment established in May 2015 as a partnership between Interior Health and the South Okanagan Similkameen Division of Family Practice. Doctors work closely with mental health professionals and a social worker to ensure that patients have well-rounded medical and community support.

Without assistance, high-risk patients—who frequently have no family doctor—often have nowhere to turn but the emergency room of their local hospital, putting additional strain on the system.

Dr Kyle Stevens is one of five doctors working at the clinic. "In the past, I would see patients who needed help finding housing, for example, but I didn't know how to help them," he says. For vulnerable people, a few days without shelter or health care can mean drastic health complications, resulting in hospitalization.

"Now a social worker is working with patients to find housing, helping them fill out forms for welfare benefits, and connecting patients to community services that are available to help them."

"The Family Practice Incentive Program supports and provides guideline-informed care in such areas as chronic disease management, maternity care, mental health, and care for the frail and elderly."

The Martin Street Outreach Clinic continues to provide primary care for complex MHSU patients in Penticton, and is considered part of the South Okanagan Similkameen division's Primary Care Network.

Robin* was one of those patients. Before she came to the clinic, her life was in a downward spiral because of her addiction to crystal meth and she was couch-surfing. Today, Robin has her own place and describes herself as totally stable and living a normal life. She credits much of her success to the support of the team—a caring mental health support worker, the social worker, and family physicians. "If it weren't for them, I would be in a completely different situation," she says.

**Name changed by patient request*

Physician team relocating to Vancouver Island thanks to multi-division collaboration

The **Vancouver Island Regional Recruitment and Retention Working Group** works together to assist GPs as they explore practice options on Vancouver Island. The "Island Collaborative" (as the divisions call themselves) has a one-for-all and all-for-one philosophy—they approach the challenge of attracting new GPs to their communities by setting competition aside and working for the collective good.

Recently, the Island Collaborative had an opportunity to do just that. Drs Ian and Marie Hellen Cafferky, a husband-wife physician team from Ireland, were considering moving to Vancouver Island, and Dr Ian Cafferky made plans to visit the island to scout out potential communities on the lower island in which they could set up practice. Four divisions swung into action, preparing a meticulously planned multi-division welcome for the potential recruit. Dr Cafferky says:

"I visited Vancouver Island for a week in early October. As part of my site visit I visited practices in Victoria, Sidney, Nanaimo, and Oceanside... I had envisioned a very hectic week with a lot of site visits and it certainly was a packed week! But the four divisions individually and collectively couldn't have made it easier and I was really happy with how the week went."

The divisions worked together to schedule community visits, and due to their communities' proximity, Victoria and South Island embarked on planning their recruitment welcome activities (referred to as "red carpet" experiences) together. The red carpet experiences were tailored to highlight each community's unique attributes—local realtors and businesses provided real estate info, presentations, and catered lunches. Dr Cafferky was provided with opportunities to connect with doctors in local practices as well, to determine whether they would be a good fit.

"I visited Vancouver Island for a week in early October. As part of my site visit I visited practices in Victoria, Sidney, Nanaimo, and Oceanside... I had envisioned a very hectic week with a lot of site visits and it certainly was a packed week! But the four divisions individually and collectively couldn't have made it easier and I was really happy with how the week went."

"Finding the right practice fit is part of the equation. Helping recruits find like-minded physicians with whom they'd wish to practice is as important as finding the right geographic location." —Myla Yeomans-Routledge, Physician Recruitment Coordinator, Nanaimo Division of Family Practice

"I was really impressed with the way all the divisions seemed to genuinely want you to make the right decision for you and your family, and I never felt I was getting the 'hard sell' in an area or that there was any competition or rivalry between the divisions." —Dr Ian Cafferky

The new recruits decided to join a Nanaimo-area clinic. Their arrival will prevent two sets of retirement-related unattachments in a clinic that was considering closing altogether had those positions not been filled. Dr Cafferky felt that his time spent touring prospective communities with Nanaimo, Oceanside, Victoria, and South Island Divisions was a great introduction to Island life:

"Having travelled such a long way and it being my first time on the Island I really wanted to get a taste for the various divisions/areas and I certainly felt that I got this over the week. It was a really great experience and a fantastic week all round... a great introduction to the Island. I'd definitely recommend it to anyone thinking of relocating to Vancouver Island." —Dr Ian Cafferky

The Vancouver Island Recruitment and Retention Working Group continues to work toward their common goal of attracting more physicians to work on Vancouver Island. All division coordinators now meet monthly with their Island Health representatives to review vacancies and opportunities in their communities, and the working group has decided to meet more frequently—on a bi-monthly rather than a quarterly basis. The group is also working to more clearly map out each member's individual role in the recruitment process.

Division-led school clinics improve access to care for students around the province

The concept of students being "sent to the school nurse" when feeling unwell is ubiquitous in popular culture. The reality in BC schools is much different—while health authorities coordinate school- and community-based public health services like immunizations, health education, and health promotion initiatives, most students don't have access to in-school health care services on a regular basis.

Statistics show that as many as 60% of youth who are worried about a health issue do not consult a health care provider and avoid going to a doctor's office. This may be due to barriers like transportation challenges for rural students and the universal challenge of needing to miss class in order to attend a doctor's appointment during regular office hours.

Recognizing the challenges faced by students around the province in accessing primary care, four divisions of family practice have partnered with local health care stakeholders (often through Child and Youth Mental Health and Substance Use local action teams), school administrators, and students to create accessible clinics in local high schools. These clinics give students barrier-free access to birth control, STI testing, mental health support, and lifestyle counseling from teams of providers that can include doctors, public health nurses, social workers, and counselors. Care models at these clinics provide a useful example of how health care teams can address gaps in care and provide full-spectrum care for vulnerable populations.

Nanaimo

In partnership with Island Health, the Nanaimo Ladysmith School District, and other community agencies, the Nanaimo Division of Family Practice opened the first division-organized school clinic at John Barsby Secondary School in 2016. The clinic's care team includes doctors, public health nurses, and child and youth clinical counselors. The clinic enables students to access primary care in a confidential, safe, familiar setting, without leaving school grounds. Students can make an appointment (or walk in) to address any issue—from an injury to sexual health—and clinic staff bring together additional supports for teens at risk and with vulnerabilities, such as those facing complex social situations (e.g., poverty) or an unstable family life.

Following the success of the clinic model at John Barsby, the division and its community partners opened a second school clinic, the Nanaimo District Secondary School Wellness Centre in September 2016.

Northern Interior Rural

Barriers to accessing care have had a negative impact on health outcomes for youth in Vanderhoof; there, students have experienced increased rates of teen pregnancy and sexually transmitted infections and face challenges connecting with local mental health resources. To improve health outcomes for these students, the Northern Interior Rural Division and its partners created the Nechako Valley Secondary School Clinic, at which six family doctors have been providing weekly clinics since January 2018.

Shuswap North Okanagan

According to school district data, 20% of students at Salmon Arm Secondary rely on school buses to get to school, meaning that at least one in five students

would need to skip school in order to attend a doctor's appointment during clinic hours. To eliminate this barrier to care, the Shuswap North Okanagan Division and its partners worked to open a new wellness centre on campus, providing care one day per week from a health care team that includes a family doctor, nurses, and counselors. A student council was created to guide the planning process, ensuring that youth had a say in determining which services were needed most, how best to deliver them, and how to make the clinic accessible and teen-friendly.

South Island

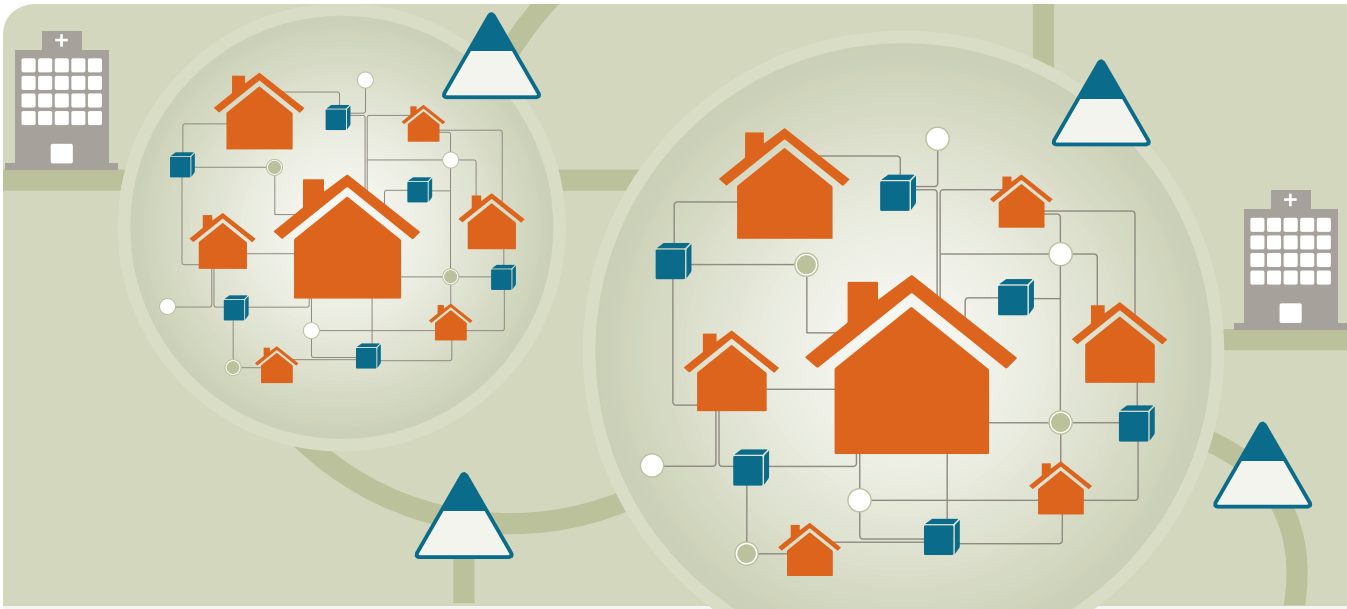
In 2016, the South Island Division participated in the creation of three school-based clinics—Belmont Secondary Wellness Centre, Royal Bay Secondary School Clinic, and Edward Milne Community School Clinic—with help from the Sooke/West Shore local action team. Key partners included Island Health, School District 62, school principals and staff, and public health staff. Student input and engagement were a major focus in the creation of all three clinics, with the formation of youth health committees to determine what the clinics look like and what services they offer. The school clinics are complemented by a community-based youth clinic for youth who feel there are still barriers (i.e., stigma and anonymity) at the school-based clinics.

Belmont Secondary Wellness Centre was initially planned as a nurse-managed wellness centre. Support from the division and the local action team enabled physician services to be added to the centre, meaning students can now receive full-spectrum care.

Royal Bay Secondary School Clinic provides services from a team of health care providers and incorporates a youth sexual health ambassador role. In addition to informing clinic services, the clinic's youth health committee meets twice a month with the local action team engagement coordinator to discuss ways to promote the clinic's use.

Edward Milne Community School Clinic offers family physician services half a day per week with three local physicians sharing the role with support from a medical office assistant provided by Island Health.

For more detailed information on the team-based care models and partnerships involved in these division-organized school-based clinics, visit www.divisionsbc.ca/provincial/schoolbasedclinics.



Patient medical homes in rural BC

The introduction of the BC patient medical home last year prompted many rural GPs to reflect on how they are currently working, including working in teams to deliver integrated services and whole-person care that wraps around patients.

"Many small rural communities are ahead of the curve and doing this work very well, out of necessity," says Dr Rebecca Lindley, Chair of the Rural and Remote Division of Family Practice.

She explains that working together and being creative is what health care providers in small communities do to make the most of scarce resources, optimize capacity, and minimize the impact of provider departures from the community.

Health care providers and patients in rural communities must also contend with challenges such as weather, geography, limited resources, and services available only at a distance. These challenges are particularly acute for rural GPs and others providing outreach services to remote communities. In this context, collaborative, creative approaches have been integral to supporting patients and colleagues. These approaches also provide valuable learnings for physicians and partners across the province who are working toward the patient medical home model in their communities.

In addition to working in teams, many rural GPs and other health care providers work as generalists across the full spectrum of services, including primary, community, acute, residential, palliative, maternity, surgical, and other specialized care. So patients may see the same rural care team for a minor illness, acute emergency care, speciality care, home care, or palliative care.

The result is patients have access to a team, and care is usually well-coordinated within a community.

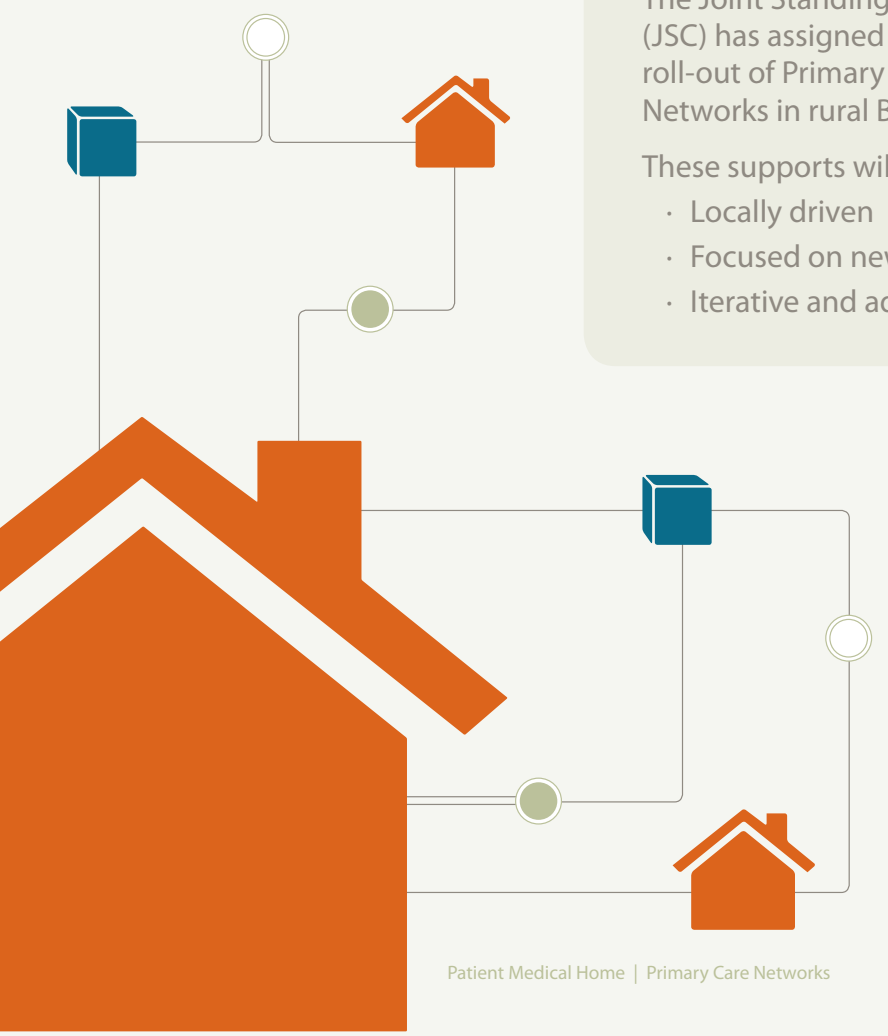
The model—the combination of teams and services provided—may look different from one rural community to the next, depending on geography, socioeconomic factors, and available resources and services.

"While there are improvements to be made, the experiences of rural communities can contribute insights to the enrichment of patient medical homes right across the province," says Dr Lindley. "The enablers and supports that are needed to improve patient medical homes in rural areas may be very different from the resources needed in larger areas and must be individualized to each community."

The Joint Standing Committee on Rural Issues (JSC) has assigned resources to support the roll-out of Primary Care and Community Care Networks in rural BC.

These supports will be:

- Locally driven
- Focused on new projects
- Iterative and adaptive to feedback



Patient Medical Home | Primary Care Networks

Freeing you up for what brought you into the medical profession, and to do the work you love to do.

Enhanced MOA role improves practice efficiency and patient care, supports team-based model of care

"At our Garden Park clinic, we're always looking for ways to optimize how we work and support our patients," says Dr Presley Moodley, one of the Abbotsford practice's four family doctors, who are supported by a team of eight part- and full-time medical office assistants (MOAs). "As part of the Abbotsford Division of Family Practice's A GP for Me steering committee, I learned about the Advanced Medical Office Assistant (AMOA) program at University of the Fraser Valley and thought it offered a great opportunity to benefit everyone at the clinic."

University of the Fraser Valley developed the program to enhance practice capacity and patient experience by providing MOAs with training and tools to expand the scope of their jobs. In recognition of the value it could offer local practices, the program's creation was fast-tracked, going from concept to operation in just nine months. Garden Park MOA Kristin Candy was one of the first to participate, taking classes evenings and weekends during the eight-month program.

"I learned so much," says Kristin. "It was also surprisingly manageable because the courses are developed for people who are working." One of the program's projects resulted in Kristin developing a comprehensive office manual that includes protocols and policies, as well tools like supply lists, billing information, and community resources.

"The manual she created has become invaluable for us," says Dr Moodley. "It helped the office become more organized, ensures things are done consistently, and is a terrific reference for new staff. If I'd asked her to do this at work, it would have taken many months. Just the manual alone improved our efficiency but the AMOA has done more than that. Kristin proactively suggests improvements on a regular basis. The other MOAs now go to her with questions they used to ask me or my colleagues, which saves us a lot of time."

Based on learnings from the AMOA program, Kristin also introduced group patient visits at the clinic. By reviewing the patient panel, she identified some chronic conditions many patients live with and has organized by-invitation hour-long meetings between one of the clinic's doctors and up to a dozen patients.

"The AMOA has been terrific for my career," says Kristin. "It gave me more than enhanced skills and the confidence to seek out opportunities for improvements. I built relationships with MOAs in other offices and we're still in regular contact. Every office works a little differently and it's so valuable to be able to pick up the phone and find out how others do things. We're still learning together, even after the program is over."

For doctors considering the program for their own MOAs, Dr Moodley says, "It's important to choose someone who is the right fit for the program. Kristin was excited about embracing change and taking a leadership role. We've already seen many benefits. Now, we're looking at bringing other health professionals into our practice to offer broader team-based care and I'm sure she'll have thoughts on how to optimize that."

"The Family Practice Incentive Program supports and provides guideline-informed care in such areas as chronic disease management, maternity care, mental health, and care for the frail and elderly."

"So far, we have only done a few but they are a tremendous value-add for patients and by proactively supporting patients in managing conditions like diabetes or congestive heart failure we may be reducing their need for one-on-one appointments later," says Dr Moodley.

Kristin agrees the format works well for the right patient groups. "Patients learn from each other's experiences and questions. They might not have thought of a question themselves but when someone else brings an issue up, everyone in the group gains knowledge."

Thanks to the more active role Kristin was playing running the clinic, she was promoted to office manager when the position became available.

Pacific Northwest doctors use team-based approach to support patients with metabolic syndrome

This story has been edited to add information about awards won by CHANGE.

In fall 2017, the Pacific Northwest division launched a year-long pilot of a diet and exercise program to help patients with metabolic syndrome, a health disorder that leads to chronic diseases such as diabetes and heart disease. Called CHANGE (Canadian Health Advanced by Nutrition and Graded Exercise) BC, the initiative supports patients through a team-based care model that includes GPs, a dietician, and a kinesiologist. After assessing each patient, the team creates a plan to meet their distinct needs, taking lifestyle, income, physical abilities, and exercise preferences into account, and participants' family doctors oversee the program and monitor their patients' progress.

Now underway in Smithers, Houston, and Haida Gwaii, the local initiative is based on Metabolic Syndrome Canada's CHANGE program and marks the first time the program has been offered in BC.

Representatives from the Pacific Northwest division, including Drs Brenda Huff, Wouter Morkel, and Onoura Odoh, presented an update on the initiative at the recent GPSC Spring Summit, during the Team-Based Care Buffet session.

"Metabolic syndrome impacts one-in-five Canadians, so the potential benefit of the CHANGE BC program is huge," said Dr Morkel, who is leading the initiative in

"As family doctors, we are always looking for new and better ways to support our patients' health," said Dr Morkel. "We hope this pilot will become a lasting program that can serve as a model for other BC communities."

Smithers. "We are thrilled to introduce this program to British Columbia as pilots in other provinces showed such strong benefits for patients."

An article by Metabolic Syndrome Canada published in the Canadian Medical Association Journal on the results from Alberta and Ontario CHANGE programs showed 19 per cent of participants saw complete reversal of one or more metabolic syndrome conditions over 12 months. An additional 42 per cent had a decrease in the number of metabolic syndrome criteria within the study period, and the 10-year risk of heart attack was reduced by 17 per cent on average.

"As family doctors, we are always looking for new and better ways to support our patients' health," said Dr Morkel. "We hope this pilot will become a lasting program that can serve as a model for other BC communities."

In May 2018, the CHANGE BC program was awarded the Innovations in Primary Care award by the BC College of Family Physicians, and the BC Rural Healthcare Award for Effective Healthcare Partnerships, which recognizes five family physicians from the Pacific Northwest Division who are leaders in CHANGE BC: Drs Jaclyn Black, Brenda Huff, Greg Linton, Matthew Menard, Wouter Morkel, and Onuora Odoh.

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