Moving Forward:
Creating a system of primary & community care in BC

General Practice Services Committee

Message from the GPSC

The GPSC has been working on a vision and strategic plan to guide our work over the next few years. In the GPSCs strategic planning process, we took learnings from A GP for Me into account, considered the results of the GPSC visioning process, reviewed information from other jurisdictions, and reflected on the strategic directions of the Ministry of Health and Doctors of BC.

The GPSC's vision is a patient medical home for all BC residents that provides the highest quality of care and is seamlessly linked with the broader primary care and health care system.

Our goal
British Columbians will have an easily understood, recognizable, co-ordinated system of care in their communities. Based on the foundation of the patient medical home and supported by integrated primary and community care services (both health authority and community agency services), the system will wrap around patients and their families for the best quality patient care.

Over the past decade we have made a lot of progress in our collective work to support full-service family practice and strengthen primary care, but we are sure that you will agree, there is more to do. There are still too many British Columbians –especially those with complex and chronic care issues– who are unable to access continuous, coordinated primary care services. The primary and community care delivery system as a whole continues to be fragmented. In practice, there are multiple, but often uncoordinated, primary and community care resources in the community. This structural service fragmentation does not serve patients well. We also have a changing work force via retirements and physician practice styles, administrative burden and recognition of the importance of work-life balance. The GPSC is committed to taking the next steps to support an expanded and integrated primary and community care system that wraps around patients and their families. To achieve this, we need to work with and support family doctors to increase capacity and access to high quality care in their practices and communities, and for these practices to be able to link seamlessly with realigned health authority primary and community services with clear patient pathways between primary care and specialized services.

As we move toward implementation of an integrated system of care and the establishment of networks of patient medical homes and primary care homes, this presents an opportunity for family doctors in our province to build on the foundation of the significant work completed over the last few years, and to take us to the next level. The reality is that change is happening – and we've heard from physicians that you are keen to be leaders in this area.

The GPSC is committed to providing tools and resources to support you in your practice, and to working with the divisions to ensure you have capacity for leadership and coordination, are supported, and feel connected to the provincial strategy and directions. The GPSC is also committed to providing you with clear, timely communications. The information here is just the start –watch for continuous updates.

The GPSC looks forward to hearing your input as the provincial strategy and direction continues to unfold. E-mail us at gpsc@doctorsofbc.ca with your thoughts and questions.

Defining the Patient Medical Home & the Primary Care Home

Before we get into the details of the plan, let's clarify what we mean by the terms patient medical home and primary care home, as these concepts are critical components.

Patient Medical Home (PMH) is a family practice defined as the place patients feel most comfortable to discuss their personal and health concerns. The Most Responsible Provider – usually the family doctor but sometimes the

nurse practitioner– works collaboratively with a team of health professionals, either within or linked with the practice, to deliver longitudinal, comprehensive and co-ordinated care of patients.

In BC, the patient medical home is being recognized as the foundation on which to build a streamlined and accessible service to patients.

The service attributes of patient medical home are based on the framework and pillars created by the College of Family Physicians of Canada (CFPC). Based on the CFPC definitions, the 10 attributes of the PMH are:

CFPC's 10 attributes of a Patient Medical Home

1. Patient-centred Care
2. Personal Family Physician
3. Team-based Care
4. Timely Access
5. Comprehensive Care
6. Continuity of Care
7. Information Technology Enabled
8. Education, Training, and Research
9. Evaluation & Quality Improvement
10. Internal & External Supports

To acknowledge the central role that networks of family physicians/patient medical homes will play through divisions and in their partnership with health authorities, the GPSC has added two attributes of a patient medical home. They are:

GPSC's two additional attributes of a Patient Medical Home

11. FP Networks Supporting Practice
    Physicians practice as part of groups/networks of care to help meet the comprehensive primary care needs of their patients and their communities. This could include networks of PMHs partnering to offer extended hours services, cross coverage, or on-call.
12. FP Networks Supporting Communities
    Supported by the Division of Family Practice, The PMHs are networked to enable better coordination, partnership and integration within a broader system of primary care and community services

As the GPSC is working on adjusting the attributes of a PMH in BC, click here for a draft list of 12 attributes. We will share more information as it is available.

Primary Care Home (PCH) describes patient medical homes (full-service family practices) or networks of patient medical homes linked with health authority and community agency primary care services which form the foundation of a coordinated system of primary and community care within the community. This team-based approach includes other health professionals working together with family doctors, forming networks of care.

In the PCH/PMH, care is provided in and/or coordinated across clinical settings including:

- Ambulatory/office practice.
- Hospital and long-term care institutions.
- Emergency care settings.
- Care in the home.

Across these clinical settings, communities will vary in how the comprehensive primary care services are organized and offered. This might look quite different in rural vs urban communities.

Main streams of work

Stream 1: Patient Medical Home & Primary Care Home (Primary Care Services)

The GPSC is leading this stream of work. The GPSC and divisions will support physician practices to enhance patient access, build practice capacity and improve quality of care by working with them to adopt the attributes of the patient medical home. Further, the GPSC and divisions will support practices to work with health authorities to link health authority and community agency primary care services as part of the primary care home, and to develop clear and simple pathways between primary care and specialized services. The establishment of PCHs will be physician-led and supported by the health authorities.

The GPSC's work includes:

- Identifying and refining the PMH design, approach, outcomes measures, and supports needed for physicians and divisions to implement and support patient medical home/primary care home model including integration of interprofessional teams within the practice and connected to the practice.
- Co-leading in developing provincial policy and direction for community systems of care.
- Allocating resources to support physician practices to adopt the full attributes of the patient medical home, including panel identification and assessment and implementing team-based care into their practice.
- Providing provincial leadership, direction and support to divisions of family practice to enable their capacity to provide leadership and support to their physician community and practice.
- Exploring and supporting the development of clinical networks of care.
- Supporting alternate business models for implementing team-based care and the patient medical home.
- Supporting physicians and health authorities to come together and co-plan a system of primary and community care at the local level.

Supporting a Team Based Approach for the Patient Medical Home

The integration of interprofessional team members with family doctors is an attribute of a well-functioning patient medical home. There is an opportunity to expand capacity and access though team-based approaches to family-based practice by adding nurses and other primary care staffing resources into the team staff mix and skills management. This could encompass:

- Including NPs as partners in practice.
- Including Registered Nurses and Licensed Practical Nurses as part of the practice.
- Accessing other primary care provider resources access to community and other government ministry resources.
- Optimizing the scope of practice capacity of the physicians, MOAs, and other providers to meet patient panel health care needs.

The Ministry of Health will work collaboratively with Doctors of BC to modify Health Human Resources policy and payment methods and to establish targets to support these changes, starting with a nurse in practice model in proof of concept communities (see below).

Stream 2: Specialized Care Services

The health authorities will lead in streamlining and integrating health authority public health, community services, and specialized services to better link and integrate with the patient medical home/primary care home.

The goal in this stream of work is to optimize and re-orient health authority, community-based care and specialized community services so they can more effectively link, and in some cases integrate, with the primary care home comprised of networks of patient medical homes and health authority primary care services. This gives the potential to access other resources through health authority partnerships such as additional nursing capacity,

social work, mental health resources. The physicians, through local divisions of family practice, will provide input into the design of these services, and help enable linkages with the primary care home.

The initial focus will be to provide specialized care for complex medical and/or frail elderly patients (including dementia, palliative care, and end-of-life care) and services for patients with moderate to severe mental health; substance use, or comorbidity. This will later include surgical services and cancer care.

This also builds on previous work done through the Integrated Primary and Community Care initiatives, and the Integrated Health Networks. The overall system of care is being represented through a Health Service Target Operating Model (TOM) which shows the patient medical home in relationship to other aspects of the health care system. Based on the foundation of the patient medical home, linkages to accessible, appropriate health authority services for primary care and specialist needs will be developed in each community, reflecting the Triple Aim goals of improving the system for patients and providers, improving health outcomes, and optimizing value in the system.

On a local level, these pieces are brought together through partnerships between divisions of family practice, community specialists, the health authority, and other community services as appropriate to the local community needs and realities.

The provincial goal is to co-create and implement an easily recognizable patient-centred system of primary and community care that will be underway across 61 geographic service areas (GSA) and their component communities within the next three years.

In some cases, the GSA boundaries correspond nicely to the divisions of family practice. In other cases, one division encompasses more than one GSA, a GSA contains multiple divisions, and some GSAs do not contain a specific division. This is a detail which will need to be reconciled as we move forward, but for now, we are using the boundaries as recognized by the Divisions of Family Practice initiative as a platform to get underway.

Proof of concept communities

A number of communities will be identified as accelerated or proof of concept communities. Moving quickly in partnership with their health authorities, these early adopters represent areas where patient access to primary care remains a significant issue. Lessons from these and all divisions and communities will help to inform the work going forward.

As these communities are identified, the Ministry, Doctors of BC, and the GPSC will meet personally with the associated divisions to:

- Explore past and current work done by the division to lay the foundation for this current direction.
- Understand supports needed by the division to enable and support the PMH and the broader partnership work on the local level.
- Confirm the role of the division and partners in this work.

On a local level, support and oversight to the two streams of work will happen through a local collaborative steering committee (CSC) which includes the health authorities. The local CSC will be closely linked to a provincial team representing the GPSC, Doctors of BC, and the Ministry of Health. This joint provincial team will work with the division and local partners in moving through the development and implementation of the proof of concept phase and supporting change in the practice and community. This process will help to define the broader provincial approach.

It is recognized that many other divisions and communities are currently involved in this work as a continuation of your A GP for Me work as well as in keeping with previous strategic goals of your division and health authority partnerships. To help continue and spread the momentum, information, tools and resources will be shared widely

with all divisions as they are available. The GPSC will be focused on the provincial approach for implementation of the PMH/PCH concurrently with the support of the proof of concept communities. All divisions and practices have the opportunity to continue with the foundational work they are doing now, and to participate in this work and to benefit from tools, resources, and lessons learned as the work progresses. More information on supports and resources for divisions will be available following the GPSC meeting in September.

Next steps

To support and enable this system change, our current work includes:

- Working with divisions to clearly understand and implement resourcing needed to support both proof of concept and broader provincial PMH implementation.
- Working with PSP to refine and direct service in keeping with this strategic direction.
- Exploring how to optimize the use of incentive fee resource.
- Working together to better define the role of the Division of Family Practice in supporting this work.

Looking ahead, on September 13, the GPSC will be meeting with the physician leads of each division to discuss and validate the current thinking about the PMH/PCH design and expected outcomes of this work, discuss the role of the divisions and the GPSC and resourcing needs in supporting this work, and the work that is occurring in the proof of concept communities.

The GPSC and its support team will continue to work with physicians to further develop and move the understanding of the patient medical home and the primary care home from aspirational to more specifically what this will look like in a doctor's office and hope to be able to provide this next layer of clarity by late October.

By November, we will have defined specific resources and supports for practices and divisions. And, at our provincial event on November 27 and 28, we will be able to have a deeper discussion about how we are going to move forward together.

Also, we will are developing and adapting new and existing tools and approaches including:

- Access to block incentive fees based on patient panel.
- Communications materials and supports.
- Access to Ministry of Health practice level data to the practices.
- Specific supports for development of a core multidisciplinary practice team.
- Exploring how to support networks of family practices.
- Support limited implementation of nurse in practice model in proof of concept communities.
- Integrating learning from A GP for Me team based approaches.
- Enhancing scope of MOA as part of the practice team.
- Develop QI-focused content targeted to support doctors in achieving the attributes of the PMH including using information from panel identification and assessment and PSP's small group learning session content in a standardized curriculum-based format.

Questions/comments?

Watch for regular updates from the GPSC. We welcome your comments, questions, and suggestions. Please e-mail us at gpsc@doctorsofbc.ca.