The British Columbia College of Family Physicians (BCCFP)
Submission to the Select Standing Committee on Health, July 2016

Submission to the Select Standing Committee on Health

Introduction

The BC College of Family Physicians is the provincial Chapter of the College of Family Physicians of Canada and serves as the home of family medicine in British Columbia, representing more than 4600 family physicians. Our mandate is to support family physicians in providing the highest quality patient care through practice improvement and continuing professional development and to advocate for the Patient's Medical Home model of primary care: patient-centred, team-based family medicine.

The BCCFP's recommendations for the Select Standing Committee on Health focus on the Patient's Medical Home (PMH) as a strategy for establishing and maintaining a sustainable, quality health care system. Specifically the recommendations will address how the PMH model serves to improve health and health care services, optimizes working conditions to support recruitment and retention and enables the creation of a cost effective system of primary and community care built around interdisciplinary teams.

The Patient's Medical Home

Our vision of the Patient's Medical Home (PMH) in BC is one in which every person will have access to a family practice in a primary care setting that serves as their medical home. The PMH model puts the focus on patient and community care needs by enhancing a team-based approach to access to care, illness prevention and health promotion, and engaging all providers and patients in improving health outcomes.

The Ministry of Health's strategic initiatives include establishing Primary Care Homes across British Columbia, building an integrated system of primary care based in part on establishing formal linkages between family practices and health authority primary care services. The overall aim is to create inter-professional teams that can better meet the needs of the patients and the communities in which they live. The BCCFP proposes that the expected efficiencies of the Primary Care Homes will only be achieved by ensuring those family practices within are also adequately resourced to implement the ten pillars of the PMH. Evidence shows that the synergies of collaborative team based care are not reached through a collection of individual, solo or group, family practices.

Working in Teams

From the results of our member survey conducted last year, and the GPSC Visioning exercise it's clear that family physicians within the province want to practice as part of a team of health care professionals. This data has recently been reinforced by the National Family Medicine Longitudinal Survey (2015 – 2016) that indicates over 87.1% of new family physician graduates wish to practice within interprofessional team-based models. If significant changes to community practice models are not implemented across BC, the province risks losing many new graduates to nearby provinces with well-established team-based care models.

However, those community care changes that are implemented must be flexible. Other member survey data demonstrates that family physicians do not require a defined basket of services. There is a clear recognition amongst family physicians and communities that medical home models must be organized specifically based on the care needs of the patients and their community.

Therefore it is important to recognize that transforming the primary care system will require multiple parallel system changes, including alternate funding models and education supports to help family physicians appropriately address the specific care needs of their community and change the way that they practice to best meet those needs.

Impact on Sustainability

The sustainability of BC's health care system depends on ensuring a strong foundation of primary care and family practice. Access issues, changing demographics, and the lack of institutional and community support for patients with chronic health conditions can lead to inefficiencies and be costly. The complexity of the system and the patient care needs now extend well beyond the scope of any one health care provider, even family physician generalists.

International research, such as that of Starfield, provides evidence of the correlation of access to effective family practices with better population health outcomes[i]. A strong and high-performing primary healthcare system with a central role played by family physicians has the potential to deliver better health care for the population as a whole, including those with chronic diseases.[ii], [iii]

Through provincial / regional support, every family practice can become a PMH, offering patients timely access to comprehensive, coordinated, and continuing care provided by family physicians working within health care teams. Teams may be physically or virtually linked, and may include a variety of health care providers depending on the needs of the patient and their community.

Moving Forward Successfully

To move forward successfully, the following areas must be addressed:

- FPs must be supported in providing the full spectrum of care and team members encouraged to work to full scope of practice
- Physical infrastructure redesign to optimize team-based care with consideration of purpose built facilities
- Continuing education for family physicians and teams to support effective collaborative team-based care
- Practice support to engage family physicians and teams in change management and continuous quality improvement
- Alternative models of remuneration
- Flexibility in team composition as determined by patient and community care needs

Working to Full Scope of Practice

The PMH is where patients can present and discuss their personal and family health concerns and receive a full spectrum of care. Relationships between patients and family physicians and other health care providers are developed and strengthened over time, enabling the best possible health outcomes[iv] for each person, the practice population, and the community being served.

Physical Infrastructure

The majority of family practice offices in British Columbia were not purpose-built to support collaborative team-based care of the PMH nor were community services organized in the integrated networks of the PCH model of care. Supports and expertise will be needed to consider the current stock of physical space, practice infrastructure and community services and dedicated resources will be needed to support practice relocation or design modification and service coordination to facilitate heath care provider collaboration.

Training and Continuing Professional Development

As the government moves forward with the process of establishing Primary Care Homes across the province, we offer our expertise in implementation of a core component of the PCH's, the PMH model of team-based care. In addition, as the provincial representatives of the organization that sets the standards for training, certification and continuing professional development in family medicine across the country we also offer the provision and accreditation of education opportunities designed to meet the evolving needs of family physicians in BC. As an example, over the next year we will be addressing the educational needs specific to team-based care and practice improvement in our new strategic continuing education plan.

Support for Change Management

In addition, through Information shared by others such as Group Health Cooperative in Washington State that has implemented PMH-like models, we have learned the importance of change management[v]. Successful implementation of both the PMH and PCH will require support for team members in general and family physicians in particular to have "protected time," so that physicians are paid to participate in team meetings and quality improvement to truly engage in this transformative work.

Alternate Funding Models

It is our understanding that the government is open to exploring alternative models of remuneration for family physicians in BC. The College of Family Physicians of Canada (CFPC) has recently created a new resource: Best Advice Physician Remuneration in a Patient's Medical Home. This resource is based on the CFPC's cross-Canada experience in establishing the Patient's Medical Home model of primary care. Published in May 2016, this new PMH remuneration guide is a timely resource as the Ministry of Health develops a draft policy for funding models to support the implementation of Primary Care Homes in BC. Importantly, the guide describes the impact of different pay structures on patient and community needs, as well as providing an overview of current Canadian remuneration models.

At the BCCFP PMH Symposium held in April 2015 provincial primary health care stakeholders agreed unanimously that remuneration review was one of the top three strategic priorities for moving team-based care. Our National organization continues to evaluate the different provincial models of PMH and additional guides for PMH implementation are expected. With a representative on the CFPC PMH Steering Committee and based on our experience, the Chapter can facilitate the translation of any new recommendations into the provincial and local BC contexts.

Flexibility in Team Composition

Finally, based on provincial experience and evidence from the literature, there is a need for flexibility in the composition of interprofessional teams. Within the past decade several attempts at introducing team based care within BC have been tried: the placement of chronic disease nurses within individual family practices, integrated health networks, the collaborative services committees; all with variable success. The BCCFP proposes that similar 'fixed' approaches will similarly achieve variable success. To be successful, team-based care models must consider community needs and more specifically family practice patient panels[vi]. These needs and panels will then best determine the team members required to provide appropriate care. The family physician is trained as an expert in managing complex medical and social conditions. It is essential that team members' roles are complementary, and optimize the ability for all to work to scope.

Conclusion

The PMH brings the above elements to enhance the delivery of primary care. PMH model with its ten pillars is flexible; it reflects and responds to the changing needs of populations. It is founded on the physician–patient relationship that is supported by an interprofessional team of care providers[vii]. The PMH will foster improved service alignment within the PCH's and will therefore help to improve the health and health care for all in British Columbia.

Through robust government support the PMH model integrated with system wide Primary Care Homes would see the following outcomes:

- Timely Access: reduces waits in family practice by better use of teams and same-day scheduling
- Health Promotion[viii] and illness prevention: focuses on wellness and chronic disease management
- Value for money[ix]: patients with own family physician as a regular care provider have lower rates of hospitalization and better health outcomes[x]
- Sustainability[xi]: better allocation of resources and funding, and recognizes usage patterns such as a need for greater supports for home care
- Efficiency[xii]: invest in British Columbian's health and improve access[xiii] e.g. in the early years of life, reduce strain on other parts of the health care system

To achieve these objectives, Patients' Medical Homes will need the support of the government through leadership, public messaging and resources. All stakeholders including government, the public, family physicians, other medical and health professions and their organizations, must participate in establishing and sustaining this primary care transformation.

Final Recommendation – Patient's Medical Home:
The government should move to strengthen and support primary care in BC through: sufficient physician and health care provider resources, and support for the infrastructure and governance to promote the Patient's Medical Home model provincially.

CLOSING REMARKS
The BCCFP continues to advocate on behalf of our members and their patients to help improve primary care. By improving the health of British Columbians through the Patient's Medical Home model, there will be fewer demands on the health care system, quality of care will be advanced, and we can work together to foster an efficient and effective health care system.

Endnotes:

[i] Starfield and Shi. (2004). The medical home, access to care and insurance: a review of evidence. Pediatrics, 113(5), 1493-1498;

[ii] Alan Katz, Richard H. Glazier, and Janani Vijayaraghavan, The Health and Economic Consequences of Achieving a High-quality Primary Healthcare System in Canada – "Applying What Works in Canada: Closing the Gap," Improving Primary Healthcare in Canada (Ottawa, Ontario: Canadian Health Services Research Foundation, January 2010),http://www.chsrf.ca/Programs/PrimaryHealthcare/ImprovingPrimaryHealthcareInCanada.aspx.

[iii] Hollander, M.J., Kadlec, H., Hamdi, R., & Tessaro, A. (2009). Increasing value for money in the Canadian healthcare system: New findings on the contribution of primary care services. Healthcare Quarterly, 12(4), 30-42

[iv] Beal, A.C., Doty, M.M., Hernandez, S.E., Shea, K.K., & Davis, K. (2007). Closing the divide: How medical homes promote equity in health care: Results from the Commonwealth Fund 2006 health care quality survey. *The Commonwealth Fund.*

[v] Reid, R.J., Fishman, P.A., YU, O., Ross, T.R., Tufano, J. T., Soman, M.P., & Larson, E.B. (2009). A patient-centered medical home demonstration: a prospective, quasi-experimental , before and after evaluation. American Journal of Managed Care, 15(9), e71-e87.

[vi] Schoen, C.O., Squires, D., Doty, M., Perison, R., & Applebaum, S. (2011). New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated. *Health Affairs, 30*(12), 2437-2448.

[vii] Barret, J., Curran, V., Glynn, L., and Godwin, M. (2007). CHSRF synthesis: Interprofessional collaboration and quality primary healthcare. Ottawa, ON: Canadian Health Services Research Foundation

[viii] Starfield and Shi.

[ix] Reid et al.

[x] Starfield and Shi.

[xi] Statistics Canada (July 2008) Primary health care teams and their impact on processes and outcomes of care - Khan, S., McIntosh, C., Sanmartin, C., Leeb, K.

[xii] Beal et al.

[xiii] Schoen et al.