BC College of Family Physicians

December 8, 2014

Linda Larson, Chair
Select Standing Committee on Health
Room 224, Parliament Buildings
Victoria, B.C., V8V 1X4

Dear Ms. Larson

Re: Health Care Sustainability: Call for Written Submissions

On behalf of the British Columbia College of Family Physicians (BCCFP) we welcome the opportunity to provide input into strategies to maintain a sustainable health care system for British Columbians. BC family physicians founded the BCCFP sixty years ago, to provide a cohesive, provincial voice for their profession in British Columbia and to ensure — through continuous learning — that members offer the best possible care to their patients.

Family physicians are the foundation of BC's primary care system and we have committed to the triple aim:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

We have consistently advocated for continuity of care in urban, rural and remote communities throughout the province. Focusing on the needs of patients and their families, family doctors provide comprehensive care across the province in a variety of settings including their offices and clinics, hospitals, patients' homes, and residential care.

British Columbia's family physicians are committed to excellence in care and are an integral part of the interdisciplinary teams that support the health and well being of the people of BC.

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This submission will address the priorities set for the BC health system, including strategies that enable a cost-effective system of primary and community care built around interdisciplinary teams and the patient medical home model.[1]

The Patient's Medical Home (PMH) is a model of family practice advocated by the College of Family Physicians of Canada and the BCCFP. It emphasizes team-based interprofessional care that focuses on the needs of the patient and the community. The family practice serves as a central hub of the patient's care, coordinating all medical interactions across the life cycle. The PMH uses the latest methodologies such as electronic medical records and continuous quality improvement to offer timely, accessible and appropriate care.

Ten pillars define a Patient's Medical Home:

1. The care provided in PMH is centred on the needs of the patient.
2. Each patient within PMH has a personal family physician.
3. Care is provided by an interprofessional team of health professionals.
4. PMH ensures timely access to appointments and services outside the practice.
5. PMH offers a comprehensive set of services to meet the patients' needs.
6. PMH builds a relationship with a patient throughout their life.
7. PMH meaningfully and effectively uses electronic medical records.
8. PMH is an ideal site for training a variety of health professionals and supports research.
9. PMH undergoes continuous quality improvement to ensure ongoing excellence.
10. PMH receives necessary supports both internally (administrative) and externally (funding).

There is a growing body of evidence that the type of care provided through PMH-like models result in better health outcomes[2], lower cost[3] and speedier access[4]. As the

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[1] BC Ministry of Health. (2014). Setting Priorities for the B.C. Heath System.

[2] Sung, N., Markuns, J., Park, K., Kim, K., Lee, H., Lee, J. (2013). Higher quality primary care is associated with good self-rated health status. The Journal of Family Practice , 30, 568-575.

[3] Reid RJ, Fishman PA, Yu O, et al. Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. Am J Managed Care. 2009;15(9):e71-e87.

[4] Murray M, Tantau C. Same-day appointments: exploding the access paradigm. Fam Pract Manage. 2000;7(8):45.

burden of chronic disease on the health of Canadians increases, it is important to note that PMH-like models are especially effective at ongoing care of patients with chronic conditions.[5,6] PMH models result in system-level cost savings by reducing the reliance on emergency care.[7,8]

Team-based interprofessional care is one of the key aspects of the PMH model. It serves communities through assembling a team of health professionals whose skills match the needs of the community. Reliable existing connections between health professionals lead to excellent continuity of care experienced by the patients.[9] Practicing to full scope of their training allows all health professionals in PMH teams to provide maximum contribution to the clinic's efficiency and health care value.

Teams with several providers also increase the likelihood of timely appointments – if a patient's personal physician is not available, one of the other health providers can step in, later transferring necessary information for accessible, continuous care. One of the goals of the PMH is to be able to provide same-day access through up to date scheduling techniques. Flexible scheduling, described in detail in the Timely Access guide for PMH, provide concrete steps on achieving this goal.

In order to be most effective, PMH models need to be recognized and supported by all levels of the government as the best way to provide patient-centred primary care. Investing in these models and ensuring patients know of their advantages will ensure a long-term positive development of the health care system.

The BC College of Family Physicians is committed to advocating for the Patient Medical Home model in BC. We know that it is the right model to enable a sustainable health care system. We are looking to collaborate with others across the province to share information and help support implementation of a PMH model that works for British Columbia.

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[5] Green, B. B. (2013). Caring for Patients with Multiple Chronic Conditions: Balancing Evidenced-based and Patient-Centered Care. The Journal of the American Board of Family Medicine , 26, 484-485.

[6] Hudon, C., Tribble, D. S., Bravo, G., Hogg, W., Lambert, M., & Poitras, M., et al. (2013). Family physician enabling attitudes: a qualitative study of patient perceptions. BMC Family Practice, 14.

[7] Specialized community-based care: an evidence-based analysis. (2012). Ontario health technology assessment series, 12, 1.

[8] Khan S, McIntosh C, Sanmartin C, Watson D, Leeb K. Primary Health Care Teams and Their Impact on Processes
and Outcomes of Care. Ottawa, ON: Statistics Canada; 2008.

[9] Mittelstaedt, T., Mori, M., Lambert, W., Saultz, J. (2013). Provider practice characteristics that promote interpersonal continuity. Journal of the American Board of Family Medicine, 26, 356.

The BCCFP wants to be a key contributor in this discussion and we would be happy to present more detailed information to the Committee. We appreciate this opportunity to provide a submission to the Select Standing Committee and to contribute toward improving primary care in BC.

Sincerely,

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President

Toby Kirshin, MHA
Executive Director