GPSC
General Practice Services Committee

April 14, 2016

Over the past several months, the GPSC has been engaged in strategic planning to inform the development of a three year work plan and to set the future directions and priorities of the committee. Through this process the committee has taken into account several inputs. This includes the visioning process with BC family doctors; lessons learned through A GP for Me; Ministry of Health strategic policies; Doctors of BC strategic directions; models of care in other jurisdictions; impacts of programs and initiatives of the GPSC as well as through the collaborative partnerships over the past several years.

The Ministry and Doctors of BC, through the GPSC, are committed to continuing to support full service family physicians, and to enabling family practices to evolve towards a model that optimizes their ability to provide comprehensive primary care services in response to the needs of patients in their community. In addition, supporting family practices to link effectively with each other and to integrate with health authority primary care services (inter professional teams) will provide patients with access to care that is coordinated, comprehensive and based on longitudinal relationships.

At its recent March meeting, the GPSC discussed the Ministry's policy direction to improve patient access to comprehensive primary care services by integrating full service family practices with health authority primary care services (inter professional teams) through Primary Care Homes (PCHs), and this policy's relationship to the Canadian College of Family Physicians Patient's Medical Home family practice model.

The committee concluded that the direction and attributes underlying the PCH and the PMH work synergistically with one another. The PCH places emphasis on the need to integrate Health Authority primary care services with the family practice/networks in order to enable and support access to comprehensive services for a defined patient population and community; and, the PMH places emphasis on the importance of the doctor – patient

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longitudinal relationship , achieving a standard of practice that enables the best possible health outcomes for patients by ensuring that patients have appropriate access to care that is comprehensive and coordinated. Similarly, the 10 attributes described by the Canadian College of Family Physicians PMH are inherent in the Ministry's policy direction and the PCH.

Additionally, the GPSC has drafted revised definitions of these attributes adapted to the BC context, and added two additional concepts (11 and 12). These will be further refined as the work progresses:

1. Patient-centered, person focused care: Care is centered on the needs of the patient, family, and community. Patients are empowered in optimal self-management, and contribute to the development and assessment of the practice and community care models.
2. A personal family physician: Physicians have a defined patient panel, and patients and physicians have a shared understanding of their mutual relationship.
3. Continuity of care: A longitudinal patient-physician relationship supports patient care across the continuum of patient care, spanning all settings. The enduring relationship between the patient and doctor is key, supported by informational continuity (two way communication that informs appropriate and timely care). This enables coordination of care.
4. Comprehensive care and coordination of care: Family physicians provide their patients with a core scope of primary care services that also meet population and public health needs. The family practice acts as the hub for coordination of broader comprehensive services.
5. Timely access: Patients are able to access their own family physician, or failing that, their practice, on the same day if needed. Patients know how to appropriately access advice and care on a 24/7 basis.
6. Team-based care: Practices include more than one GP working with an expanded interdisciplinary team within the practice, and/or available within the community, with a focus on relationship based care.
7. Education, training and research: The practice promotes mentoring, training and research.

8. Internal and external supports: The practice has a business model which supports longitudinal, comprehensive, coordinated, team based care, as described above, and the system provides supports to enable this model of primary care.
9. Evaluation and QI: Physicians, other members of the practice and patients are involved in clinical quality improvement activities at a practice, community and system level.
10. EMR: Physicians and staff in the practice are able to use the EMR effectively, and use data collected through the EMR to inform quality improvements in patient care. The EMR is able to link appropriately with other providers and parts of the system, including other community providers, pharmacies and acute care facilities. One patient, one record, appropriate access.
11. GP networks supporting practice: Physicians practice as part of groups/networks of care to meet the primary care needs of their patients and their communities. (This could include networks of practices partnering to offer extended hours services, cross coverage, comprehensive services, on-call).

12. GP networks supporting Communities: The GP practices and networks are integrated within a primary care home.

GPSC and its partners have a shared goal of making high quality primary care services accessible to all the citizens of BC. To achieve this, GPSC's priority is to support family practices in moving toward the PMH attributes (including full service, comprehensiveness, access, etc.) regardless of specific practice design and remuneration models. As well, supporting GPs to participate in networks as appropriate, will enable them to better meet patient & family, physician and community needs. A critical element is supporting GPs in working collaboratively with Health Authorities to develop effective shared models of care with interprofessional teams and thus achieve the shared goals of the Primary Care Home.

Next Steps:

- GPSC will be developing its work plan to reflect this shared vision for primary care, with priorities that support full service family practice and the transition to new models of integrated, team based care.

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- GP practices will be supported to evolve towards a model of care that ascribes to key attributes from the Canadian College of Family Practice Patient Medical Home, adapted to the BC context and are well placed to have a central role in the primary care home .

- Doctors will be supported to work together to provide the full scope of services and access to care for the population in their communities or networks of care.

- GPSC will be examining and realigning its resources to support this transformative change in primary care.

- GPSC will endorse and support Divisions of Family Practice in their work with Health Authority partners through the Collaborative Services Committees and Interdivisional Strategic Councils in developing enhanced models of integrated care.

- GPSC will be working with its provincial partners to enable and support integrated solutions in the design of programs and incentives at a provincial, regional and local level.

Yours truly,

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