DOCUMENT OF INTENT

BETWEEN

The Family Physicians of the _____

AND

General Practice Services Committee

AND

_____ Health Authority

AND

BC Ministry of Health

AND

British Columbia Medical Association, operating as Doctors of BC

PREAMBLE

"Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care."(Starfield et al, 2005). [1]

General Practitioners are the cornerstone of Primary Care. General Practitioners, in concert with allied health professionals recognize the importance of long-term person-focused care, or continuity of care as expressed through an ongoing relationship between the patient and his/her primary care provider, has been reinforced through the recent evaluation of the BC-based Full Service Family Practice Incentive Program. This research on the impact of the program, which offers various incentives designed to promote full service family practice, identified an inverse relationship between cost of care and attachment to practice (i.e. an ongoing relationship with a family physician). The more that higher care needs patients were attached to a primary care practice, the lower the costs were for the overall care system (Hollander et al, 2009). [2]

The Primary Health Care Charter and its key initiatives, including Patients as Partners, together with the various initiatives supported by the General Practice Services Committee (GPSC), provide the opportunity to support a shift to a more comprehensive primary care practice, organized around patient needs and with full patient participation, and supported by partnerships between physicians, the Ministry of Health (MoH), health authorities (HAs) and other non-government organizations.

The partners to this document are dedicated to improvement and access in primary care. Primary care is where most people, most of the time, encounter the health care system. As such, it is the greatest point of leverage for improving population health, the patient experience and reducing pressure on the overall system (Hollander et al, 2009). [3] The partners to this document believe a sustainable primary care system is one where there is the least possible distance between the clinicians who deliver care and policy makers.

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[1] Starfield, Barbara; Shi, Leiyu; MacInko, James. Contribution of Primary Care to Health Systems and Health, *The Milbank Quarterly*, 83(3), September 2005.

[2] Hollander, Marcus et al. Increasing Value for Money in the Canadian Health Care System: New Findings on the Contributions of Primary Care, *Healthcare Quarterly* , 12 (4), 2009

[3] Hollander, Marcus et al. Increasing Value for Money in the Canadian Health Care System: New Findings on the Contributions of Primary Care, *Healthcare Quarterly* , 12 (4), 2009

PURPOSE

This Document of Intent demonstrates that the above-named partners support the development of Family Physicians of the _____ (the Division). The purpose of the Division is to provide a collaborative and innovative approach to patient care through this partnership. It is expected that this collaboration will result in:

- Family physicians in the _____ area receiving professional support and the ability to influence patient care in the region
- Patients in the _____ area receiving increased access and enhanced quality of care
- A contribution to sustainability of the health care system.

Divisions of Family Practice (Divisions) will not duplicate the roles and responsibilities of the Health Authority, but will provide family practice clinical influence and leadership at the community, regional and provincial level. It will act as a hub for the integration of care for patients at a community level. The Division of Family Practice will be open to all _____ family physicians offering primary care in their community, including those who provide full service, specialized (obstetrical, ER), hospitalists and walk-in clinic services. A Division also provides the formal platform for the building of partnerships with the MoH, the HA and other partners for better primary care.

This Document of Intent demonstrates the parties' commitment to work collaboratively and does not create any legal obligation between the parties. Collaborative working involves a commitment to the co-design of potential clinical programs in a way that acknowledges the unique perspective of each partner and supports the common goal of improved access and health outcomes for patients.

ROLES AND RESPONSIBILITIES OF THE PARTNERS

PART 1 - Role and Function of the Division of Family Practice

1.1 General Duties

(a) The Division will:

1. Work with partners and allied health professionals to facilitate comprehensive primary health care for the people serviced by _____
2. Work with the partners to reach the aim that everyone who wants to be a part of a Primary Care Home can be attached to one.
3. Work through the Collaborative Services Committee (CSC) to co-develop, co-design, co-evaluate and properly administer clinical Service Agreements and other arrangements, using continuous quality improvement methodology.
4. Work within its sphere of influence to remove family practice barriers to improving care and increasing system sustainability.

5. Work with current HA services, community agencies and/or other health professionals to increase integration and collaboration to improve patient and community outcomes.
6. Facilitate integrated care with Specialists or with other FPs with specialized or focused practices.
7. Work to provide opportunities for increased community family practice organisation such as coordination of call schedules and after hours services, advanced access, and the attachment of patients.
8. Develop leadership, actual and potential, in the physician community and will pursue joint learning with other partners.

(b) The Division will undertake the following administrative functions:

1. Develop infrastructure to receive and disburse Division infrastructure dollars according to local needs and by agreement of the membership and the Partners.
2. Co-chair the Collaborative Services Committee.
3. Provide family physician(s) as member(s) of the CSC as determined by local need.
4. Support the ongoing evaluation of its initiatives, programs and operation.
5. Provide anonymous practice level data to facilitate evidence-informed decision making - such data must be expressly requested by the physician or CSC and disclosed in accordance with all privacy legislation; and the policies/standards set by the College of Physicians and Surgeons of BC. No such data shall be collected from individual physician practices as a result of his/her Division membership, except with the express consent of the physician.

(c) The Division will work with partners to provide its members with infrastructure and clinical supports.

Infrastructure Supports:

1. Professional, clinical and practice supports focused on continuous improvement for patient care and professional satisfaction, such as facilitating or informing members of Practice Support Program (PSP) or Continuing Medical Education (CME) opportunities.
2. Formal and informal networking opportunities.
3. Regular opportunities to be informed and involved.

Clinical Supports:

1. Physician or locum retention and recruitment planning and supports.
2. Support for physician wellness.
3. Roles in medical education through accepting family practice residents, nurse practitioners and medical students, and taking a leadership role in organizing and sustaining activities such as regular medical staff rounds, journal clubs, and subspecialty interests within family medicine.
4. Increased potential opportunities for developing and participating in multidisciplinary models of care.
5. Family practice voice and influence in the community and health authority in the delivery of integrated care.

(d) The Division will work with its partners to provide its community with:

1. Branded awareness of its services, collective hours of operation of the Division members, membership and affiliations in order to enhance patient access and attachment.
2. Comprehensive primary health care, provided in collaboration with other health care providers as appropriate.
3. Continuity of care for patients throughout the ambulatory, ER, hospital, residential care experiences to improve patient experiences and outcomes.
4. A voice in the planning and improvement of the primary health care system for their community.

1.2 Partnering in Health Authority Facilities

The Division will follow all laws, guidelines and rules around operating in HA facilities and work with Department(s) of Family Practice.

PART 2 - Responsibilities of the Partners to the Division

2.1 _____ Authority will:

1. Provide a co-chair and membership to the CSC as is determined by local need, ensuring that membership is at the senior administrative level with executive connection and capable of making decisions on behalf of the HA.
2. Provide membership to working groups, ensuring that local operational directors are supported by the executive.
3. Ensure that the value of its relationship with the Division is widely understood inside the HA.
4. Work through the CSC and its working groups to co-develop, co-design, co-evaluate and new ways of working together, using continuous quality improvement methodology.
5. Work within its sphere of influence to remove systemic barriers to improve care and system sustainability.
6. Explore how the Division can benefit from existing HA systems, such as economies of scale for supplies or purchasing discounts.
7. Partner with the Division to re-orient current health services and/or support multidisciplinary practice and the development of innovative wrap-around services for complex patients.
8. Partner with the Division to ensure functional electronic delivery of lab, imaging, pathology and other regional patient reports to all physicians using Electronic Medical Records (EMRs).
9. Provide regional and community specific data expressly requested by the physicians or CSC and disclosed in accordance with all privacy legislation; and the policies/standards set by the College of Physicians and Surgeons of BC. No such data shall be collected from individual physician practices as a result of his/her Division membership, except with the express consent of the physician. Data may also include demographics and community health status, including disease burden.

2.2 The GPSC will provide:

1. Annual infrastructure funding.
2. A provincial Team to support Divisions of Family Practice and assist all partners in the full use of the initiative, including the facilitation of inter-Divisional communication and collaboration.
3. Ongoing oversight and contract adjudication as appropriate.
4. Support through family practice initiatives including the PSP
5. Aggregate planning data captured from GPSC-funded initiatives.
6. Mechanisms for the voice of the Divisions to be heard at GPSC.
7. Appropriate membership for participation in CSC (moved from MoH section)
8. Support for each CSC to assist in determining the scalability of co-designed initiatives (moved from MoH section)

2.3 The MoH will provide:

1. Opportunities for funding to prototype new models of care or local initiatives as co-designed by the CSC.
2. Details of service funding parameters to ensure equity amongst Divisions.
3. Ongoing oversight and contract adjudication as appropriate.
4. Data including individual practice profiles and overall Division of Family Practice profile - such data must be expressly requested by the physician or CSC and disclosed in accordance with all privacy legislation; and the policies/standards set by the College of Physicians and Surgeons of BC. No such data shall be collected from individual physician practices as a result of his/her Division membership, except with the express consent of the physician.

2.4 The Doctors of BC will:

1. Provide temporary organizational support to the newly developed Division until such time that the Division can discuss and sign contracts.
2. Provide administrative and professional support services where appropriate.
3. Ensure its membership is aware of the Divisions initiative and its important role in improving the primary health care system.

2.5 Building Public Confidence

All partners, including the Division, will seek to make this innovative model extremely visible at the local, regional and provincial levels. To ensure this occurs, all partners will facilitate the publishing or distribution of information and education on primary health care services to the public, highlighting innovative and continuous quality improvement activities.

PART 3 - The Collaborative Services Committee

The CSC provides the formal interface between the Division, the HA and the GPSC [representative of the MoH and Doctors of BC]. The intent of this committee is to ensure strategic alignment, information sharing, and cooperation between the partners in the development and implementation of innovative models of primary care patient services. Membership will be defined in a Terms of Reference to be collaboratively agreed upon by the Partners. The expectation is that HA involvement is at the senior administrative level for the region with executive connection, allowing appropriate influence to effect fundamental changes in service delivery required to facilitate innovative, co-designed clinical services.

As needed, permanent and ad hoc members representing specialists, allied health professionals, the community, patients and other appropriate voices will be added to ensure comprehensive understanding of the community issues and possible solutions. The CSC will ensure that patient, family and community perspectives are engaged throughout the planning processes.

The CSC and its working groups will provide a collaborative venue and new ways of working together. The CSC will co-design clinical programs when all partners agree an issue raised is a priority for all. This assessment is informed by data and when the proposed program area fulfills the objectives of the Triple Aim system of review (improves patient and provider experience, is financially sustainable and improves population health). The CSC will operate by consensus, which is achieved when everyone accepts and supports a decision and understands how it was reached.

The Division and its partners agree to use continuous quality improvement methodology to develop and evaluate all proposed programs and activities. Programs developed using continuous quality improvement are designed to be continuously evaluated. As these programs are implemented, what works is expanded and what does not work is modified and evaluated again.

The CSC, its members, its working groups and ad hoc participants will be supported by the provincial Divisions Team in understanding and using the methods and tools of Triple Aim[4], collaboration and Continuous Quality Improvement[5].

[4] Triple Aim initiatives have positive impact in three areas – patient/provider experience, population health and the financial sustainability of the health system.

[5] See the Institute for Healthcare Improvement website (ihi.org) for the article "Road map for quality improvement" and other resources on continuous quality improvement (CQI). Essentially, programs designed with CQI will have evaluations built in, will be regularly reviewed and, if needed, will be adapted to ensure that the intended results are happening. This contrasts with using evaluation only at the end of a project, when adaption is no longer possible.

PART 4 - Division of Family Practice Programs and Services

The Division may use infrastructure funding and associated supports to work independently when designing and creating solutions to issues of practice efficiency or organization, professional satisfaction, professional development and any other area that does not require the funding, facilities or involvement of its partners.

The infrastructure and funding of the Division are also intended to facilitate the development, implementation and administration of new and innovative patient care programs. In areas of clinical patient care the Division will work with its partners to establish shared areas of priority and work to co-design clinical solutions. These programs are expected to be consistent with the goals of access to care, attachment of unattached patients to community practitioners, sustainability of health care, support for complex patients and continuity of care.

When the Partners agree on programs to pursue, investments in these programs may be made by the Division, the HA, GPSC and the MoH. The GPSC, the MoH and the HA will be involved in the co-design and co-development of any program or initiative of the Division that will require funding outside the Division's resources. The value and outcomes of the programs will be collaboratively evaluated by the partners using the Triple Aim lens and be subject to change and modification. MoH funding support will be based on the principle that any program must be affordable if offered to any appropriate community that desires it and consistency with the Patients as Partners principles and approach.

Priority Areas of the Funding Partners

Below is a list of program areas that have been previously developed by Divisions or which represent the priority areas of the funding partners. They fall under two broad categories of Comprehensive Care & Attachment and Coordinated Care. Divisions are encouraged to use this list to understand the priorities of their partners and to add to it the priorities of their communities.

Example A: Comprehensive Care & Attachment

4.1 Access to Primary Care Physicians

Divisions are encouraged to develop activities to make it possible for people in the community to have access to a family physician. The Division will make a targeted effort to address requirements of high needs patients (See section 4.6 High Needs Patients).

4.2 Enhanced Access Primary Health Care

Divisions are encouraged to consider prototyping enhanced access models, ranging from practice efficiency to new or expanded clinics. These programs reduce the use of emergency departments for primary care and increase patient attachment in the community.

4.3 Palliative Care
Divisions are encouraged to develop programs that provide coordinated palliative care supports and services. Family physicians have always played important roles in providing comfort to their dying patients. These programs provide comprehensive end-of-life care and recruit and support physicians to deliver that care.

4.4 Maternity Networks
Divisions are encouraged to develop programs that support physicians in delivering maternity care and encourage new physicians to join them. One possible program direction could be Maternity Networks that support family physicians in group maternity practice to help prevent burnout. These programs provide access to comprehensive maternity care for patients and recruit and support physicians to deliver that care.

4.5 Enhanced Community Care Capacity
Divisions are encouraged to develop programs and supports that assist the local physician community in recruitment of physicians, the placement of locums and the development of multiple physician practices. These programs could have the additional focus of attaching patients, improving practice efficiency or developing multi-disciplinary practices. These programs reduce the numbers of unattached patients and increase primary care capacity in the community.

4.6 High Needs patients/Integrated Health Networks
Divisions are encouraged to develop programs that link family physicians with existing health authority and community resources. These programs can improve coordinated community care through an integrated team of providers wrapped around high-need priority patient populations. These programs may include services like patient self-management, group clinical visits or increased links to home or community care, all of which can improve patient outcomes for the chronically ill and more effectively use resources. Divisions are encouraged to provide leadership to collaborate and participate in Integrated Health Networks in their communities.

4.7 Integration of Home and Community Care and Mental Health and Substance Use Services with Divisions for High Need Patients.
Building on the many successful innovative projects undertaken in B.C., the Ministry's Integration Strategy is supporting health authorities to realign Home and Community Care, Mental Health and Addictions around Divisions of Family Practice to more effectively link primary care physicians with community-based services, and supporting shared care models of family physician and specialist medical services. As a starting point, current collaborative initiatives will be leveraged to better identify persons at risk, and ensure that they are linked with the necessary services and supports.

Example B: Coordinated Care

4.8 Family Practice Hospital Care Program
In programs such as these Divisions are encouraged to support existing full service family practitioners engaged in hospital care and to encourage others to join them. This will be accomplished by approaches that promote the benefit to patients and professional satisfaction of increased involvement in the hospital and acknowledge the financial realities of being called away from an active practice. These programs reduce length of stay, re-hospitalization and improve patient care.

4.9 Family Practice Residential Care Program
Divisions are encouraged to consider developing programs that deliver proactive as well as urgent primary health care needs of patients in residential care that might otherwise be referred to an emergency department. These programs reduce transfers to the hospital, increase primary care for a vulnerable population and allow more people to die in their residential care homes rather than spend their last hours in the hospital.

PART 5 - Goals

Within one year of signing the Document of Intent, all of the Partners will reflect on progress in any of the following areas:

1. **Improved Patient Care**
   Some examples may include:
   a. decreased unattached patient population
   b. improved access and patient care
   c. an active CSC exploring multiple possible clinical program areas
   d. the community will express greater confidence in the health system
   e. clinical and practice improvement activities.

2. **Increased Physician Satisfaction**
   Some examples may include:
   a. family physicians will feel more connected to each other and experience increased professional satisfaction
   b. recruitment and retention of family physicians will be explored
   c. Division members will feel confidence in their organization and its ability to effectively relate to the partners, providing them with a collective voice used for positive results
   d. Division membership will engage with and include the majority of the community's family physicians.

3. **Improved Health Care Integration and Coordination and Communication**
   Some examples may include:

a. family physicians will be able to identify improved relations with specialists and improved access for their patients to specialty services
b. the Division will have helped to accelerate integration of Health Authority services with primary health care
c. increased awareness among family physicians of HA and community-based services and resources.

4. **Increased Communication and Collaboration Across the Partners**
   Some examples may include:
   a. The partners will have positive reports about the benefits of using continuous quality improvement methods when co-designing programs
   b. CSC actively exploring multiple possible clinical program areas.

5. **Increased Role in Education**
   Some examples may include:
   a. the Division will be known by the universities and be aware of potential opportunities for teaching, training, preceptor and research
   b. increased involvement in medical education of students and residents with an enhanced relationship between professional schools and the GP community.

6. **Improved Public Confidence**
   Some examples may include:
   a. the community will express greater confidence in the health system
   b. visibility of the Division through media, brochures, advertised services and public statements will aid patient awareness of and access to services.

PART 6 - Dissolution

The Partners acknowledge that the collaboration contemplated by the Document of Intent may be dissolved at any time or that any Partner may withdraw from the collaboration at their discretion.

Before dissolution becomes permanent all partners are encouraged to request a hearing of concerns at a meeting of the GPSC.

The Partners to this Document of Intent executed this agreement on the ____ day of _____, _____.

Signed on Behalf of the Family Physicians of the _____,

_____
Dr.
Family Physician

_____
Dr.
Family Physician

_____
Dr.
Family Physician

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Dr.
Family Physician

_____
Dr.
Family Physician

_____
Dr.
Family Physician

Signed on Behalf of _____ Health Authority

_____
_____
Chief Executive Officer,
_____Health Authority

Signed on Behalf of Ministry of Health

_____
_____
Assistant Deputy Minister,
Health Services Policy and Quality Assurance Division

Signed on Behalf of General Practice Services Committee

_____
Ted Patterson
Co-chair

_____
Dr. Shelley Ross
Co-chair

Signed on Behalf of Doctors of BC

_____
Allan Seckel, QC
Chief Executive Officer
BC Medical Association