General Practice Services Committee

What We Value: Stories of Most Significant Change (MSC) from physicians, allied healthcare providers, and patients

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Executive Summary

From 2017-2019, 33 stories were collected from seven divisions, across four BC health regions. Patients, family physicians, nurses, other allied health professionals, and community members told stories about the changes occurring in the clinics where they give and receive care – in their Patient Medical Homes.

MSC is more than collecting and reporting stories – it's about having processes to learn from these stories. In particular, MSC allows us to learn about the similarities and differences in what different groups and individuals value based on their role in the health care system. **The method provides some information about impact and unintended impact but is primarily about clarifying the values held by different stakeholders.**

In February 2020, the GPSC Evaluation team held a workshop at the Joint Collaborative Committees Pre-Forum where attendees were invited to conduct a participatory analysis of the Most Significant Change stories. Over one hundred FPs, specialists, patients, division staff and representatives from the GPSC, health authorities and the Ministry of Health reviewed the stories and reflected on the significance of the reported changes. These reflections help to uncover both shared and different values held by stakeholders in our health care system.

Stories covered a range of key topics: team-based care with a nurse, pharmacist and social worker; transitioning from solo to group practice; improving access to mental health care for children and youth, and using EMR to improve practice and care. These stories were analyzed by FPs, specialists, allied health professionals, patients, as well as representatives from divisions, health authorities, the Ministry of Health, and GPSC. This report summarizes the findings from the GPSC Most Significant Change project.

These findings emerged from the GPSC Most Significant Change Evaluation Project. For more information, audio recordings of the stories, and the full evaluation report, please visit the GPSC Evaluation website.

What were the most significant changes experienced so far in the provincial transition to the Patient Medical Home Model?

Team-based Care and effective use of **Electronic Medical Records (EMRs).**

What made those changes worthwhile?

- Improved collaboration between professional from different disciplines
- Reduced FP workload
- Health care providers are able to work at the top of their professional scope
- Improved work-life balance
- Improved patient access to care
- Proactive, whole-person care

What do system actors have to do to enable more TBC and effective use of EMRs?

1. Physicians require support to take part in **planning and administration** of newer models like PMH, including funding, staff support and increased access to data;

2. A **culture shift** is required to embrace consistent and effective EMR use and collaborative approaches including team-based care;

3. Current **compensation models** are not suited to the kinds of collaborative care being undertaken in a PMH model. **Costs** may be higher during the initial planning and administrative phases, while they may be expected to decline over time. The costs and work structures associated with various phases of change will need to be explored to find a sustainable and appropriate funding model;

4. **Team-based care** took many forms, but several issues arose consistently: the need for a sustainable funding model, the need to address different human resource practices across professions and health care settings, and the need to build strong interprofessional practices including role clarification and communication across disciplines;

5. Support is required to address technical and policy barriers in **information management practices and electronic medical records**. Not only do practitioners need to have a more consistent approach to data entry and management, but support is required from policy makers and vendors to implement changes and work toward a more integrated use, access to and management of data that works across health care professionals and settings.

What are the recommended priority next steps for system actors to address?

Prioritize Support for EMR-ready Practices

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- Provide provincial support for EMR optimization and data integration
- Provide guidance and training regarding consistent data entry into EMR to support team-based care and enable an understanding of population health and better allocation of resources throughout the health care system.

Divisions

- Work toward shared access or integration of data to enable providers to access complete and up to date patient information regardless of their location in a private practice, hospital or other point of care;
- Support physicians in paper-based practices to transition to EMR;

FPs

- Ensure that EMRs are set up to support appropriate team access to patient records;
- Implement consistent data entry processes so that EMR data can be used at a bigger scale to support proactive care, use of algorithms, understanding of population health and better allocation of resources throughout the health care system.

- Implement consistent data entry processes so that EMR data can be used at a bigger scale to support proactive care, use of algorithms, understanding of population health and better allocation of resources throughout the health care system.

- Continue to provide coaching and practice support for setting up an EMR, optimizing EMR use, using EMR for proactive care, and team-based care.

Support Planning and Administration

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- Provide sufficient funding and resources to support physicians to participate in planning and administration, including funds for contracted administration, project management and data analysis support through divisions, sessional payments for FP time spent doing planning and administration, and FP training in planning, administration and leadership skills.

- Facilitate access to administrative data to support evidence-informed decision-making.

Divisions

- Ensure that FPs have access to training in planning and administration if desired.

- Support FPs to develop leadership skills.

- Support data gathering and analysis, and provide access to division-level data to support evidence-informed decision-making.

FPs

- Provide access to EMR data to support evidence-informed decision-making.

Continue Building a Culture of Interprofessional Collaboration

GPSC

- Provide training in interprofessional collaboration, ensuring that team members have a solid understanding of role clarification and interprofessional communication.
- Ensure that fees and compensation models support PMH models including co-location, referrals, and primary care in community settings as a normal part of care.
- Provide funding and logistical support to involve community partners and providers in planning.
- Provide evidence about PMH models of care including benefits and costs.

Divisions

- Support FP access to training in interprofessional collaboration, ensuring that team members have a solid understanding of role clarification and interprofessional communication.
- Provide funding and logistical support to involve community partners and providers in team planning.
- Support practices to set up data sharing agreements or appropriate sharing permissions for team-based care.

FPs

- Ensure that teams go through role clarification process.
- Set up process for interprofessional communication appropriate to the practice.
- Participate in PSP TBC coaching and training in role clarification, interprofessional communication and TBC competencies as appropriate.

Address Funding and HR within PMH Model

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- Match fees and compensation models to PMH goals and functions.
- Identify how PMH models will fund:
  - Overhead including space for team members
  - Administration including MOA time
  - Allied health professional time

Divisions

- Support human resource planning and management in private practices.
- Facilitate partnerships with public health agencies to support team-based care, including providing guidance to FPs for negotiating human resource policies appropriate to support team-based care.

FPs

- Determine team-based care needs and most appropriate team structure for the practice.

GPSC PMH Most Significant Change Project

This report presents the findings from the GPSC Most Significant Change project. From 2017-2019, 33 stories were collected from seven divisions, across four BC health regions. Patients, family physicians, nurses, other allied health professionals, and community members told stories about the changes occurring in the clinics where they give and receive care – in their Patient Medical Homes. Stories covered a range of key topics: team-based care with a nurse, pharmacist and social worker; transitioning from solo to group practice; improving access to mental health care for children and youth, and using EMR to improve practice and care. These stories were analyzed by FPs, specialists, allied health professionals, patients, and representatives from divisions, health authorities, the Ministry of Health and GPSC at a participatory analysis workshop at the Joint Collaborative Committees Forum in February 2020. The PMH MSC evaluation was conducted by Broadleaf Consulting.

GPSC provides strategic leadership and supports for the provincial implementation of the Patient Medical Home (PMH) model. The Most Significant Change (MSC) method is intended to capture physician, provider, administrative and support staff and patient stories of change from PMH implementation, and to collect data from other parts of the system that can reflect on the significance of these changes from a variety of perspectives.

Story Collection

The MSC approach involves generating and analyzing personal accounts of change and deciding which of these accounts is the most significant – and why. The GPSC MSC Project asked respondents to share a story of a change resulting from their community's work on implementing a PMH model that has been most significant to them – they were not asked to respond to a particular area within the PMH outcomes or attributes. Stories were collected in two rounds, and a final event was used to conduct a participatory analysis, with over one hundred FPs, specialists, patients, division staff and representatives from the GPSC, health authorities and the Ministry of Health reflected together on the stories and provided their own experiences and perspectives in relation to the changes discussed.

Thirty-three stories were collected, 12 in round one and 21 stories in round two. Stories were collected from the following sources:

Role

- 15 FPs (including 1 locum)
- 4 RNs
- 1 Social Worker
- 7 Patients
- 1 Community Pharmacist
- 1 Division Executive Director
- 1 School Principal
- 2 Office Managers
- 1 PSP Coordinator

Division

- 5 Central Okanagan
- 8 Kootenay Boundary
- 2 North Peace
- 1 North Shore
- 1 South Island
- 8 South Okanagan Similkameen
- 8 Sunshine Coast

What do these stories tell us about the values held in BC's health care system?

MSC is more than collecting and reporting stories – it's about having processes to learn from these stories. In particular, MSC allows us to learn about the similarities and differences in what different groups and individuals value based on their role in the health care system. **The method provides some information about impact and unintended impact but is primarily about clarifying the values held by different stakeholders.** In February 2020, the GPSC Evaluation team held a workshop at the Joint Collaborative Committees Pre-Forum where attendees were invited to conduct a participatory analysis of the Most Significant Change stories. Over one hundred FPs, specialists, patients, division staff and representatives from the GPSC, health authorities and the Ministry of Health reviewed the stories and reflected on the significance of the reported changes – both individually and if the changes were rolled out across the entire province. These reflections help to uncover common and different values held by stakeholders in our health care system, which are summarized below. In the following section, each PMH change strategy is explored in further detail.

Values by stakeholder group based on multi-stakeholder, participatory analysis of the Most Significant Change stories collected for this project:

Family Physicians	Healthcare Administrators (Ministry of Health, Divisions of Family Practice, Health Authorities, Joint Collaborative Committees)	Nurses and Allied Health Providers	Patients
• Patients are active and empowered to be part of the care team • Patients have improved access to care in terms of timeliness and location • Support system for individual physicians: having help to care for patients by tapping into expertise of other types of health care providers and resources • Their work is valued and paid appropriately • Patients get appropriate care • Autonomy • Connection to colleagues • See signs of improvement to their patient's health • Personal wellness, stress reduction, work-life balance • Patients have relationships with all team members that are part of their care • Continuity of care over the patient's lifetime, regardless of changes to the physician or the clinic infrastructure	• Patients are active and empowered to be part of the care team • Patients have timely access to care • Support system for individual physicians • All team members feel valued for their contributions • Patients get safe and appropriate care • Health promotion and disease prevention • Financial sustainability of the system • System change • Collaboration across the system to leverage knowledge and resources	• Patients have timely access to care • Feel like a valuable part of the team and helpful to the physician and patient • Holistic care • Autonomy • Connection to their colleagues	• Holistic care • See signs of improvement to their health, which gives them hope • Access to own health data and help understanding what the data means • Health care providers take the necessary time to understand them and their needs

PMH Strategies leading to Most Significant Change

In this section, stories were grouped together to look at learnings within particular strategies. The first four sections described strategies that were all variations of team-based care, including care with a pharmacist, a social worker and a nurse in practice. Other strategies included moving from a solo to group practice, improving collaboration to increase access to child and youth mental health care, and using EMRs to improve practice and care.

These story groupings were reviewed by multiple diverse stakeholders as part of a participatory analysis that took place at the JCC pre-forum for the BC Quality Forum, as described above. Data from the participatory analysis is included here, as well as quotes from participants. Participants are referred to in the text as readers, and their comments are included to provide a provincial perspective. Where a reader's role is known, they are referred to as such: e.g. "FP reader." When their role is not known, they are referred to as "reader."

Strategy: Implementing Team-based Care with a Pharmacist

Rationale

Awareness of how various drugs interact with each other can be crucial for proper care of patients with complex needs. Since pharmacists are knowledgeable about medication, FPs tried a team-based care approach that included a pharmacist to take care of complex care patients, especially those using multiple medications. The expertise of a pharmacist presented a unique perspective to the FPs and led to more proactive care and an improved experience for patients.

Description of strategy

This strategy added the expertise of a pharmacist to primary care teams, working along side nurses and FPs to change or reduce medications, especially for complex care patients. The role of a pharmacist on a team in Primary Medical Home was to review medications and provide knowledge regarding safe and effective medication use. Pharmacists provided information to healthcare professionals and monitored patients drug therapies to avoid interactions with other medications. Pharmacists also worked directly with physicians in their team to bring up issues and suggestions regarding medications a patient was taking, such as changing doses, stopping medications or giving immunizations. This strategy allowed different health care professionals to work at the top of their professional scope. Patients were at ease as they received consistent messages from their FP and pharmacist. One nurse reported that her team worked for 3.5 months with 4 complex care patients to do a comprehensive review of polypharmacy along side a pharmacist and FP. Another FP reported that over six months, a community pharmacist came in twice a month, and took turns working a half-day with each provider in their practice. Complex care patients benefited most from this strategy.

Change description	Outcomes
Partnerships • Division of Family Practice, MLA and Deputy Minister of Ministry of health	Provider experience • FP indicated that it was reassuring for patients to witness the doctor and pharmacist talking about the pros and

Change description	Outcomes
made changes eventually leading to blended funding model. Awareness • Pharmacist got more insight into the physician-patient relationship and the physician decision-making process. Coordination of care • Pharmacist reviewed the polypharmacy patient files before coming, and FP would arrive, unbiased, to talk to patients. • Pharmacist was involved in care for patients taking 10 + medications then patients taking 5-9 meds. • FPs and pharmacist saw patients together for a few minutes to come up with a common plan.	cons of the medications. Patients were very glad to know that their health care professionals were reconsidering their medications and it led to a good relationship in the community. • Pharmacist indicated that having access to labs, consult notes and FPs was the best scenario for patients. Pharmacist looked at whatever questions the patient asked about; patient might want to look at stopping medications, and pharmacist could help with de-prescribing and reducing medications loads. • Office Manager indicated that pharmacist working with the patient and their provider was the best approach for a patient's health, financial, and medication needs. • FP indicated that patients became more involved in their care/treatment. Cost • Practice was able to retain several graduating residents who were offered the opportunity to access the blended funding model as a preferential way of joining the community.

Main themes

Top of Scope

Having a pharmacist in practice allowed FPs to work at the top of their professional scope. FPs were able to utilize the expertise of a pharmacist and work with complex care patients to do a medication review. Pharmacists were able to work directly with the physician to bring up issues and suggestions, making recommendations like changing doses, stopping medications or giving immunizations. This provided pharmacists, FPs and patients with a full picture of the patient's health. This allowed the FP to make more informed decisions about medications that the patient could take. A pharmacist working in a clinic in the Interior echoed this by stating, *"Working in the clinic gives me more insight into the physician-patient relationship and the physician decision-making process. For example, I now will know the specific reason a patient's blood pressure medication was changed. I also now have knowledge and access to all the factors affecting people's health and can reinforce a consistent message coming from the physician and the pharmacist. It's also an opportunity to learn from each other as healthcare professionals- I'm part of a team reviewing medications focused on current disease states and making more informed decisions."* Since the pharmacist also had the full history of the patient's health, it also

allowed them to provide better advice to the FPs, also allowing pharmacist to work on top of their scope.

Improved Relationships

Having allied health professionals working in clinics can lead to good relationships in the community. FPs improved their relationships with community pharmacists, making it easy for FP to use a pharmacist as a resource. Patients indicated that it was reassuring to witness the doctor and pharmacist talking about the pros and cons of the medications. Patients also felt at ease knowing that multiple care providers were involved in their care. One Office Manager working in the clinic stated that "*[t]he most significant change since having a pharmacist in practice is the improved relationship and communication between patients, providers and pharmacists. Most patients are very satisfied with their visit, happy to have had the extra time with both the doctor and the provider. It's good to see our patients satisfied and happy with their care. Our patient evaluations have all come back with positive feedback.*"

Strategy: Implementing Team-based Care with a Social Worker

Rationale

Counselling patients and filling out paperwork related to patient health can be very time consuming tasks and may be hard for the FP to cover during a 10-15 minute appointment with a patient. FPs felt they could have a better work life balance and reduce their administrative work by having a social worker on their team. Tasks like mental health counselling, paperwork and information about resources related to other socio-economic factors impacting patient's health were tackled by a social worker so the FP could then spend time concentrating on tasks that require their expertise.

Description of strategy

Social workers are professionals dedicated to addressing the psychosocial needs of patients and families. Patient Medical Home teams utilized the expertise of social workers to provide counselling, fill out health related forms and find other resources that could strengthen patient care. In one example, a social worker in team-based care completed forms for access to disability, mental health and social services with patients. One social worker reported spending about 30-40% of time doing counselling for anxiety, depression, stress, coping skills, and grief and loss, 30-50% on forms, and 25-30% on referrals, including assessing clients for relevant programming and making referrals. Mental health, unattached and frail patients benefited from having a social worker in practice.

Change description	Outcomes
Partnerships • A primary health services working group hosted by the municipality included the Health Authority, local	Provider experience • FP reported that AHPs enabled FPs to urgently see patients and hence

Change description	Outcomes
Division of Family Practice, local FPs, local community health groups, and the mayor worked towards the next iteration of what the model should look like and how to fund it. Coordination of care • The social worker was more available than an FP and could provide mental health support. • Social worker did assessments and forms. • Patients that needed help with filling out forms could see the social worker for longer and the FPs only for 10 mins.	reduce the time in the emergency room. • FP reported that increased access to counselling through a social worker reduced the load for the mental health office. • FP reported that patients could be seen by a social worker, which was almost impossible to do prior to having a team-based model. • The social worker completed paperwork, freeing up the FP. • Social worker reported being able to support patients that may not fit the criteria for support through interior health MHSU but need help with finding resources that FPs might not know about. • Social worker could make an impact on a patient with mental health issues. • In one PMH, an agreement between the practice and health authority guaranteed that each referral would get action on the other side. Physicians could determine the urgency of the referrals. Patient Experience • FP stated an improvement in quality of care for the patient. Providers had the resources to ensure that an additional dimension of information about the social situation of the patient was seen, which was invaluable to improving patient care. • High-risk patients could be assessed much faster and FPs received feedback with the information they needed. • FP reported that patient care had improved and it alleviated anxiety of FPs. • FP reported that having a team in the clinic allowed prevention of issues in patients that could have become acute. Other

Change description	Outcomes
	• Working in a PMH created a more dynamic role for AHPs as it was not related to just one aspect of health.

Main Themes

Top of scope

Social workers have a unique subset of knowledge and expertise such as mental health counselling, health related forms that would otherwise fall under the FP's responsibility in a clinic. By having a social worker in a clinic those responsibilities could be transferred to the social worker on the team. FPs might not have the time and knowledge to fill out paperwork that could be covered by a social worker. Social workers could also support patients that may not fit the criteria for support through interior health MHSU but need help with finding resources that FPs may not know about. This would allow the FP to work at top of scope and handle the areas requiring their expertise. This would also give more autonomy to the social worker and would allow them to work at the top of their scope. A social worker in the Interior noted "*This change is significant to me because I really value the autonomy in my role. Because I'm not employed by the Health Authority, I can be incredibly dynamic in meeting the needs of the community I serve. For example, if one community is experiencing a crisis, I can provide support right away. It's a much more gratifying way to work, and the non-profit trusts my skills and judgment in providing the best benefits to the community. I really see the value in having a Social Worker available to the general public. The change that I have been able to effect in people's life and healthcare has been striking.*"

> "The most significant change I've experienced since starting the role is that I've moved from the job description to developing an idea of how the role can meet community needs. When I first started, the cooperative knew that they wanted a Social Worker who could do counselling, but no doctors had worked directly with a Social Worker before, and there is limited access to social workers in the community without being a client of a particular agency (Mental health clients can see a social work at mental health, people who are inpatients of the hospital can see the hospital social worker, etc.). This role has been constantly evolving and will hopefully continue to evolve to support the health of the clients."
>
> - Social Worker, Interior

> "My experience with the social worker was really good. She has helped me with all sorts of things from helping me fill out forms to helping me deal with the grief of my mother passing. I am going through quite a few things. I am dealing with my daughter's father being diagnosed with ALS. It is a big help for me counselling-wise and just bouncing things off her. I think I am able to see her as much as I want to. She is great because I can just text her or call her if you have a crisis. I seem to be able to get in as soon as she is available."

- Patient, Interior

"We do assessments on all patients and refer them to the social worker if needed. The social worker has been a phenomenal addition to our health care team. Someone who requires one hour of time to navigate long-term disability and mental health forms, which would have been by the doctor, can now see the doctor for 10 minutes and the social worker spends 30-60 minutes doing a thorough assessment and working on paperwork for the patient. The patient is supported in a more timely fashion and is getting better outcomes. "

- Nurse, Interior

Strategy: Nurse in Practice Increasing Access and Providing Physician Support

Rationale

Triaging patients is critical but time-consuming. Nurses are able to triage within a primary care setting, increasing access for patients and in turn supporting the FP in a practice. Improved quality of life and reduced burnout for the FP were achieved by adding a nurse in practice to primary care teams. Nurses triaged patients that need quicker access to care, and took care of more time consuming tasks like patient education about nutrition of lifestyle.

Description of Strategy

Including a nurse in practice led to improved access to care for the patients as the nurse triaged and as a result reduced wait times for patients to access care. Patients found it easier to make appointment with the nurse than the FP. As a result, patients had more opportunities to see a care provider at their FP's office, so they did not go to the Emergency Department. One patient indicated that it used to take two to three weeks to book an appointment, and he would wait 30 to 60 minutes for a scheduled appointment. With the nurse, the patient waited only 10 minutes.

Having a nurse in practice allowed for increased efficiency and was often appreciated by patients. Nurses in practice added support for physicians by reducing the time that the doctor would spend with patients. Some FP visits were shorter because the nurse could do assessments. Nurse also supported physicians by providing individual and group visits, and education for patients once the FP had made a plan for the patient's care. FPs saved time and were able to focus on the medical aspects of care and FP work-life balance improved. One nurse reported seeing patients one on one, doing presentations for groups of 12-14 as well as meeting with small groups of 3-4 people who can then support each other and educate them in areas such as areas of focus include dietary, osteoarthritis, and healthy heart.

Seniors, complex care patients and mental health patients particularly benefited from this strategy, as access improved to FPs and nurses provided additional support.

Change description	Outcomes
Quality of relationships • Patients felt comfortable seeing a nurse for things that they would have seen a doctor for before. • Nurses took care of issues that did not require the doctor and spent more time with patients. • Nurses gained awareness of a particular FP's style of practice and therefore knew how to respect their practice flow. This improved the relationship between FPs and nurses as they learned each other's strengths and styles. Coordination of care • Nurse triaged patients so the FP could have more focused visits. • Nurse saw patients and took care of standard patient concerns. Nurse flagged the doctor if the patient needed to be seen urgently. • Nurses summarized patient information and gave the full picture of the patient's health to the FP. • Nurses educated the patients and followed up on lifestyle changes. Awareness • FPs had an increased awareness of patients' full medical history that the patient might not have had the time to cover with the FP. • FP became aware that nurses are good communicators and educators. • Nurse asked questions to draw out what could be causing the health issues.	Provider experience • Huge impact on people at the point of no return (e.g. someone about to get diabetes or at the verge of suicide). • Patient-centered care encouraged patients to connect with extended community resources that could support healthy living rather than health management. • Nurse summarized the concerns and gave the FPs a full picture of patients' health. This ensured that patients had the best healthcare and outcomes possible. • Collaborative approach allowed the team to go through patient panels together. • Patients learned about the role of a nurse in a care team. • Physicians had a better work/life balance. • Nurse in practice initiative allowed patients to sit down with the nurses and tell their history in detail instead of being rushed. • Reduced the load on FP's to avoid burnout. Patient experience • Patients felt comfortable with the RN to discuss causes of health issues. With a nurse in practice the patient felt that they have a better quality of care and that their concerns as a patient were not dismissed. • Accessibility and faster service for patients. • Faster access to care as it was easy to get appointments with the nurse.

Main Themes

Access to care

Triaging patients helped practices increase access and reduce wait times. One patient shared that being seen more quickly and having more time with a health care provider resulted in an incredible quality of care. Multiple patients also reported to shorter wait times at the clinic due to having a nurse in practice. Patients also reported that it was easier to get an appointment to see a nurse and the nurse could often take care of the problem and then call the doctor in if it

was something that required medical attention. One patient said *"The most significant change since having a nurse in practice is that it's the first time I've been able to access a service like this. I have encountered the idea in other places and through reading about medical practice. It makes so much sense to have a constellation of medical people in a clinic, helping. It is possible that before this I would not have done anything about my minor health concerns.*" Another patient said "*I think the most significant change since having a nurse in my doctor's clinic is that access has improved. Otherwise I might have been waiting for a week to see a doctor because they are booked up. The nurses prep me for whatever I am seeing the doctor for – I see them first. Having the nurses here is excellent."*

> "Our health care team is more balanced and holistic now. The MOA takes all calls and does a telephone triage. Even if the doctors are booking two to three weeks in advance and are unavailable, I can see them as a nurse to do an assessment and make a plan, so the doctor can have a shorter visit and write a prescription. These patients would previously have been turned away, as it was hard to get someone in with appointments booked every 15 minutes."
>
> - Nurse, Interior

Physician support

Nurses in practice were responsible for a variety of tasks, including triage, wound care, and patient education for maintaining health or changing lifestyle.

Due to different training, physicians and nurses had different perspectives; a physician had a more medical perspective while the nurse provided education and support about a wide range of medical conditions to support overall health and lifestyle changes. Adding a nurse to the team provided patients with more comprehensive health education and enabled the physician to move on to see the next patient in the office. This created a better workflow within the clinic.

Patients also indicated that nurses translated and helped communicate their concerns to the doctor, so they were more confident in their communication. A nurse in practice said *"The most significant change I've experienced is that as part of the clinic team, as the clinic nurse, I have the ability to spend extra time with patients, so they can express their various health concerns and I can summarize them so that the doctor can decide on the appropriate course of action."* As a result of the work of the nurse, physicians were not rushed during an explanation with a patient, and did not fall behind with other patients. This also reduced physician burnout.

An FP described the significance of having a nurse in practice: *"The most significant change for me since starting to work with a nurse in practice is that my work life balance has substantially improved. I spend fewer hours working at home. I'm able better meet the demand to see people in a more timely fashion when they're sick, and the nurse can even assist with illness assessment for urgent problems when my schedule is already full. I feel like feel like my patients are getting more comprehensive and timely medical care. The patients have told us that they appreciate being able to sit down with the nurse and talk about things without time pressure."*

Strategy: Nurse in Practice Increasing Proactive, Patient-centered Care

Rationale

FPs have limited time to spend with patients. Nurses in practice are able to spend additional time with the patients to discuss the whole picture of their healthcare needs in order to provide proactive and patient-centered care to the patients. Nurses educated patients on lifestyle changes and answered questions about their test results.

Description of Strategy

Including a nurse on primary care team resulted in improved continuity of care as well as proactive care, especially for those patients with chronic conditions and seniors. With a nurse in practice, patients received more whole-person, proactive care. Patients also received more support for health-related tasks such as palliative paperwork. Patients were able to receive health care services locally, without having to travel to other towns (e.g. hearing screenings, STI screening and contraceptives, pelvic exams, foot care, advanced wound care) due to having a nurse in practice. Some nurses visited patients in their homes. Patients were more aware of their health information when they had more time to review their results, ask questions, and receive guidance on lifestyle changes for diet and heart health. Nurses in practice also collected data to support initiatives like senior home detox. Frail patients, prenatal and youth, seniors, mental health patients and end of life patients most benefited from having a nurse in practice.

Change description	Outcomes
Quality of relationships • Changed patient's relationship with the FP's office where the office was proactive about health issues rather than the patient presenting them with a problem. Awareness • Awareness in patients of the difference between the nursing and medical model of care. Coordination of care • Patients not referred out as often for concerns that clinic didn't have the capacity to see (such as wound care). • Patient communicated to the nurse the matters that required care and the nurse communicated that more effectively to the FP. Other	Provider experience • More patients were seen at the clinic rather than being referred to the nearest hospital, as it is difficult for frail and elderly patients to access. • Patients experienced high quality care quickly. • Patients had a better understanding of their test results. • Patients felt respected and supported. This led to patients spending healthier lives as seniors. • Patients had the opportunity to ask questions and think through the options after meeting nurse in practice. In one case, 2 out of 3 patients were able to make less aggressive decisions related to "do

Change description	Outcomes
• Patients who lived far away from the hospital could get most of their health care needs looked at the clinic. • Nurses coordinated care with other AHPs such as social worker. • Reduced the calling around that a patient has to do in order to follow up on various appointments. • Patients who had previously only had 10 mins with their FP and sometimes did not get to process what they were hearing spent time with the nurse.	not resuscitate" orders. Patients felt more confident in their decisions. • Patients trusted the RN to follow up. • RN became aware of different physician's approach to treating patients. Patient Experience • Improvement in quality of care for the patient. • Patients had access to nurses and the nurse spent more time with them and helped them understand the changes in their life style required for healthy living.

Main Themes

Patient centred care

Adding a nurse in practice allowed patients to receive whole-person comprehensive care.

Patients described that having a nurse in practice has resulted in proactive care by their provider. One couple of patients reported that their full health information had never been shared with them before, but the nurse went over everything and explained what it all meant, which was significant to them. The nurse also provided diet advice and other educational information for continuing heart health. One patient in the Interior said "What struck us about having a nurse in practice is that it's probably the first time in our relationship with a family physician that the physician's office has been proactive about health issues, rather than us presenting them with a problem. We were phoned and asked to come in to talk about our health. During our first meeting, the doctor had the nurse join us as part of an appointment. We've seen the nurse twice since she started a year or so ago. The most significant change for us is that our full health information has never been shared with us before- this time we saw results of our blood tests for the first time ever, not just cholesterol or other highlights. The nurse went over everything and explained what it all meant."

Strategy: Transition from Solo to Group Practice

Rationale

In a solo practice, the FP is responsible for all aspect of a patient's care. This can be a very time consuming process and can also drastically increase the FP's responsibilities. FPs transitioned from a solo to group practice to reduce their workload and give them a better work-life balance, maintain health services to patients, and enable them to recruit new physicians.

Description of Strategy

This strategy supported the transition of physicians practicing solo to add other physicians to their practice or join another group practice. In another example, physicians joined together with midwives to provide obstetric care throughout a remote community. A solo practice refers to an FP who provides care to their own panel of patients and is solely responsible for all the functions associated with the practice. In a group practice two or more FPs can provide medical care to the patients and share their responsibilities and other expenses.

One FP indicated that group practice allows the sustainability of care in community. Before joining a group practice each physician used to handle her or his own obstetric patients 24/7, 365 days per year and name a second physician in case of illness or being away. Now a group of 5 physicians work 24-hour shifts, and during that shift, handle all obstetric care in the hospital. An Office Manager also reported two solo physicians joining their practice due to the EMR integration and because a multi-physician clinic was more appealing.

Change descriptions	Outcomes
Partnerships • A group of 5 physicians work 24 hr. on-call shifts handled all obstetric care in the hospital. Coordination of care • PSP worker offered support through the PSP peer mentor program to clinics to augment their EMR functionality. • FP stated that increase in the number of walk-in clinics would decrease costs and increase the quality of service in the ER. • Office Manager helped utilize EMR and found ways that would allow the FP to work how the FP wanted, and use functions of the EMR that he was unfamiliar with, such as histograms. Other • Division executive worked with a number of practices to help introduce LPNs and pharmacists into the care teams. • FP lobbied alongside midwife colleagues for a maternity care hard call system. • FP moved from paper to EMR.	Provider experience • Physicians saw the benefits of PMH for smaller clinics, with close networks to serve patients even when physicians were on leave. • Physician had a better work/life balance and their enjoyment of family practice was restored. • Older physicians could continue their practice without leaving patients without physicians. • The move to EMR made the practice look more attractive for recruitment. Clinic attracted one locum FP and two solo physicians who had previously been working on their own. Moving into a multi-physician clinic was appealing for them. Provider experience and access • FP and team had great ideas of how to arrange a rotating walk-in clinic and approached the hospital about using space, but didn't have the data needed to support their request. Other • EMR system was a timesaver and the clinic had attracted young physicians. EMR was used to refill prescriptions automatically and send to the local pharmacy.

Main Themes

Sustainability of Care in Community

Working in a group practice allowed for sustainable care, especially in smaller and more remote communities. Group practices also attracted new recruits where solo practices could not.

One FP providing group maternity care stated *"The most significant change for me was my own personal learning about working with a group. The whole process was so much slower than I ever could have imagined, yet once we had the basic principles and a deeper understanding of the perceptions of the problem from each perspective, we were able to create stable delivery of maternity care with a robust system that can survive past the retirement of aging physicians and other challenges our community faces. This is significant to me in a philosophical way because the delivery of care to women has been a priority my entire life. Labour and delivery are moments in which we experience ourselves as truly powerful, and to support women when they are most vulnerable and powerful is a profound part of my life as a caregiver."*

Work-Life Balance for FPs

A move to group practice resulted in reduced workload for physicians as well as better access and care for the patients. FPs work life balance was improved by working in a group. One FP stated, *"The most significant change I experienced moving to a group practice is that it restored my enjoyment of family practice. I can now do the best part of my job- taking care of patients- while greatly reducing the unpleasant administrative aspects. Patients are hugely appreciative that they still have a physician. Thousands of people in this city have lost physicians to retirement and ill health. I enjoy the collegiality of a group practice and find working with them quite pleasurable."* Older physicians thinking about retiring kept practicing and FPs in the group clinic shared the responsibility, which decreased their workload. A PSP worker commented that *"The most significant change was that rather than the two physicians retiring and potentially leaving thousands of orphan patients, many of them over 65, in the community, he had the opportunity to move to a group clinic and find a physician to take over his wife's practice. It's wonderful to know what a difference this has made in his life."*

Strategy: Improving access to mental health care for children and youth

Rationale

Accessing support for mental health care can be daunting task for youth and can often be a barrier, as some youth may not want their families to know about the help they are seeking. FPs wanted more seamless support for mental health for youth, from the FP's office, to crisis management in the hospital, to care within Child and Youth Mental Health (CYMH) and the Ministry of Children and Family Development (MCFD).

Description of Strategy

FPs increased their collaboration with other providers of care and support for child and youth mental health and provided primary care services in community settings. The Docs in School program helped students who had experienced challenges navigating the healthcare system to receive physical and mental health care.

Change description	Outcomes
Gatekeeping/referrals • FP wanted to see more seamless support for mental health for youth, from FP's office, to crisis management in the hospital, to care within Child and Youth Mental Health (CYMH) and the Ministry of Children and Family Development (MCFD). Number of partnerships • FP worked as a team with school counsellors and teachers, and to reach out to Child and Youth Mental Health (CYMH) when needed. CYMH also did intake at the school. Other: • Docs in School program helped those students that experienced challenges navigating the healthcare system for physical and mental health.	Access • Docs in School program de-stigmatized ideas about accessing health care and healthcare professionals. • FP felt supported and was able to follow up if the students continued the care. Provider Experience • Educational evening organized to collaborate with primary care providers, counsellors, social workers from child and youth mental health (CYMH) and the Ministry of Children and Family Development (MCFD). Positive, culminating in a collaborative presentation by all parties with much engagement and sharing of resources and goodwill. Provider experience and access • FP and his team (PMH initiative) were able to build on relationships with other professionals such as CYMH, MCFD, ambulance services, the hospital, school counsellors, RCMP, FamilySmart, and drug and alcohol counsellors and etc. who had been involved in collaborative care for child and youth mental health through Local Action Team. Secondary Outcomes • Students who wanted privacy from their families could access a doctor and wraparound care including Child and Youth Mental Health (CYMH) during school. • Strategy improved relationships between various organizations involved in mental health support for youth.

Change description	Outcomes
	• Changes were seen as physicians worked together on local community programs.

Main Themes

Collaboration

FPs collaborated with community agencies and provided service in a community setting to improve child and youth mental health. One FP who is no longer practicing wanted to bring new information about Adverse Childhood Experiences (ACEs) and people recovering from trauma into the mainstream of primary care and how the community thinks about health. He joined the PMH committee for child and youth mental health. The committee designed a workshop to explain ACEs and the science behind it and also started looking at opportunities to build relationships with others working on child and youth mental health to develop collaborative approaches. This included primary care providers, counsellors, social workers from child and youth mental health (CYMH) and the Ministry of Children and Family Development (MCFD). An educational evening was organized to address an issue that had come forward: fragmentation between MCFD, CYMH and primary care providers. This collaborative event was intended in equip new physicians and other primary care providers with tools they might need to better manage and support the youth they are seeing.

One FP who was heavily involved in PMH planning felt their community was progressing on important changes that otherwise would not have happened. Physicians started to work together on local community programs and had avenues to do that. Their voice as physicians was being registered, and they had this opportunity through PMH funding. An FP stated that *"I find it refreshing to work as a team- there is a lot of support and good will for one another, and many people, from FPs, NPs, division staff and people from Child and Youth Mental Health and MCFD have become part of the team. There's an alignment happening between the groups that brings comfort and health over the long-term."*

Access to care

Offering primary care that supports child and youth mental health in a community setting increased access for young people.

The Docs in School program de-stigmatized ideas about accessing health care and that health professional were not accessible. The Docs in School program at school helped those students that experienced challenges navigating the healthcare system for physical and mental health at school. Programs like Docs in School helped students to learn about self-advocacy to access health care, whether or not their parents visited health care professionals. Accessing health care required certain actions, like finding a medical professional, making an appointment, and arranging transportation, that at times can be an obstacle for students. Sometimes the students were afraid to access the services, as they did not want their families to know. Through the Docs in School program, students can access a doctor and wraparound care including Child and Youth Mental Health (CYMH) during school. One FP noted that *"The most significant change for me was the work we did on seamless care, creating medical access for youth at two high schools, working with the local First Nation to build trust with people seeking care, and improving coordination with CYMH. It's been painful to watch people who have*

suffered because of trauma in their childhood, and who haven't developed the skills and modeling to become more effective parents themselves. I have witnessed the cycle of adversity in my career and want to mitigate the impact of mental health and drug abuse. Children are born as innocent, beautiful creatures and need to have the best chance possible."

A local school principal stated, *"The most significant change for me was that a barrier was removed for students accessing healthcare because the care was onsite at the school. I feel the program made a difference to our students and increased their comfort and confidence in accessing the care they need to support their physical and mental health."*

Strategy: Using EMR to improve practice and care

Rationale

Sharing patient information between various service providers can help the FP to provide proactive care to the patient and this can be achieved by using electronic medical records. FPs used EMR to improve communication between different members of their team, supporting all team members to work at the top of their scope. The EMR was also used to involve patients in their own care.

Description of Strategy

An electronic medical record (EMR) is a computer-based patient record specific to a family health team or group practice. EMRs were used to improve communication between team members and support productivity. Setting up an EMR system and improving the use of EMRs enhanced primary care practices and care. Effective use of an EMR resulted in better patient care from shared information between team members. In addition, technical support increased interest in functions such as visual representations of the information in an EMR, such as histograms, that aid in interpreting and understanding data and which can improve proactive care planning. EMR can be particularly useful in clinical settings where there are a number of doctors, nurses, dietitians, pharmacists, and other health care professionals.

FPs used their EMR to identify a patient population within their panel for proactive care. Complex care patients taking various medications and receiving care from various professionals benefited by use of EMR for identifying polypharmacy. Solo physicians wishing to join a group practice set up an EMR system in their practice. Practices with an EMR were able to recruit physicians to take over the practice. Divisions also expressed a need for shared access to EMR data to identify a patient population within EMR panels that would benefit from proactive care, and ultimately, to enable community planning based on information about the patient population.

Change description	Outcomes
Partnerships • Use of EMR enabled FPs to move to a group practice. Coordination of care	Provider Experience • Physician had a better work/life balance and their enjoyment of family practice was restored.

Change description	Outcomes
• PSP peer mentor program offered support to augment the EMR functionality. • Use of EMR helped the polypharmacy team to coordinate care and come up with a common plan to treat patient. • Office Manager helped utilize EMR and found ways that would allow the FP to work how the FP wanted. Other • Divisions expressed desire for a shared data repository, where FPs could view live, read-only patient information, or fully merge EMRs.	• Older physician was able to continue their practice without leaving patients without physicians. • The move to EMR made a practice look more attractive for recruitment. • EMR system was a timesaver and attracted young physicians. • EMR was used to refill prescriptions automatically and send them to the local pharmacy. • Patients were more involved in their care/treatment.

Main Themes

Efficiency and Proactive Care

One FP in a group practice commented that "[t]he majority of physicians moved to the same EMR as part of the restructuring, which has been hugely beneficial in allowing us to share patient files…" EMR use helped to ensure timely and appropriate filling of prescriptions both for community care and to reduce polypharmacy. In one practice that proactively identified patients where polypharmacy may be an issue, the FP said that *"[t]he pharmacist makes notes right in the EMR using his own account, so that I have a record that stays in my patient's chart. I can also send a note to the pharmacist about changes to medication while we're meeting."* According to another FP discussing patient care in general, "*It's worth it because of the convenience of form templates, accessing data in a hurry, and using the features to refill prescriptions automatically and send to the local pharmacy. The EMR is a huge timesaver."*

Recruitment

Having EMR technology available in a practice made practices more efficient and attractive to new physicians, supporting recruitment and retention. One FP in the Interior commented, *"As a result of moving to an EMR, we were able to attract a young physician to take over my wife's practice. I was able to join a group practice, and the young physician joining me was keen to be part of a group practice. The clinic I moved to has six other family physicians, all younger than me, who are excellent colleagues and physicians. A nurse practitioner started a week ago. It's a busy, well-run office. I've reduced my time in the clinic from 4 days to 3 days per week. I've got my life back, and I'm enjoying myself. It was difficult but it is worth it- a year and a half down the road, I'm happy with the EMR."* Having an EMR in place also supported physicians to stay longer in practice, as described by a PSP Coordinator: *"We are addressing a generational shift and helping retiring physicians keep up with technology and evolve, resulting in them staying in practice longer."*

Data Integration

In areas where FPs work in a number of roles in private practice, hospitals and residential care, data integration is also being addressed to facilitate improved access to information to allow for better patient care. One Division is leading an initiative to integrate data, described here by a lead FP: "*We started by working with physicians to get their perspectives and input, and we also asked the vendor to propose an efficient way of data sharing. We all use the same EMR in our region, which is unique. Our hopes were to either share a data repository, where we could view live, read-only patient information, or fully merge all 5 of our EMRs.*"

What's Working, Enablers, and Challenges

What is Working

Physicians and Allied Health Professionals Working at Top of Scope

Health care practitioners and patients expressed the importance of professionals working at the top of their scope. Providers felt more professional satisfaction undertaking the challenging work matched to their interests, and patients appreciated knowing that each provider would give them the maximum focus and time possible in their role. Enabling providers to work at the top of their scope was achieved in several ways: by building teams with complementary roles, and by improving the use of EMR to proactively work with patients on their overall health over time.

Role clarity and good communication including high levels of trust were key to FPs and allied health professionals working together, respecting one another's scope of work and being comfortable with medico-legal risk.

Proactive, Patient-Centred Care

Where EMRs have been used to share information among providers, communication about patient information improved and care was more focused on the overall wellbeing of patients, for example with vaccination and reducing polypharmacy. Through appointments with different practitioners such as nurses, patients expressed a sense that they were being listened to and able to spend more time going through their full history and list of concerns. More proactive care on the part of the provider also led to patients becoming true partners in their care. Patients observed that when they knew the team members they were seeing had time to hear their concerns, they were more likely to have a valuable interaction that met their overall health needs and allowed them to consider their own health holistically.

Improved Relationships in the Health Care System

Relationships between FPs within a community and between FPs and other service providers were cited as both an enabler to providing more seamless care and a source of professional satisfaction for physicians who felt more confident about the full course of care for more complex patients and supported by additional capacity including access to expertise. FPs and divisions also expressed that stronger relationships with other providers and agencies gave them a greater sense of ownership and engagement.

Changes that increased connections between providers and services for child and youth mental health improved access and led to problems being caught or treated earlier, improving health outcomes and quality of life, and some readers noted that this has the potential to reduce overall health care costs. In a practice that supported community dialogue about the needs and wants of the community, they successfully influenced a local medical imaging provider to improve their hours and upgrade their equipment.

Support and Enablers

Funding

Funding was required to support two main functions:

1. Planning and administration for PMHs including funding for physician participation, and staff support for planning, data management and analysis, and project management and administration;
2. Ongoing operation of PMHs including overhead, administration and allied health professional time.

Those practices that had access to a blended compensation model indicated that this was a significant enabler to building a PMH. One FP indicated that introduction of the blended funding model was the most significant change in their community. He noted that where fee for service funding forced physicians to do work that could have been done by allied health professionals in order to get paid, the new model supported FPs and created a greater appetite to work with patients in a different way to ensure that their health care needs were met.

> "Three years ago, FPs were leaving full-service family practice in our community and we were at a grave risk of not being able to deliver primary care to a significant part of our population. The Division of Family Practice was the driving force in addressing the crisis, and we called on assistance from the Deputy Minister of Health and our local MLA. Since then, we've shifted to a blended compensation model that combines fee for service with population-based funding, introduced interprofessional teams, and improved our ability to recruit and retain physicians."
>
> - FP, North

Electronic Medical Records

Effective use of EMRs was identified as fundamental enablers to working as a team, providing proactive care, and providing data needed for planning.

Practice Support Program

Stories often reflected the importance of training, support and mentorship in supporting the shift to a PMH model. PSP Coordinators and Peer Mentors provided support on a variety of topics:

1. Setting up an EMR
2. Optimizing EMR use
3. Using EMR for proactive care

4. Team-based care
5. Transitioning from solo to group practice

Challenges and Gaps in the System

Time and Resources for Planning and Administration

Overall, moving to a PMH model required a high level of engagement of FPs and divisions. Limited information was provided about PMH models and little evidence was available about which models would provide the best care, environment for FPs and sustainable funding. Physicians found challenges to setting up PMH committees and finding time to provide input into the planning and administration process. Multiple physicians identified the time required for meetings and other planning related to the PMH as an issue. In addition to the time away from practice required to participate in administrative functions, a number of physicians indicated that they do not enjoy administrative work and felt that increasing the time spent on administrative tasks distracted them from focusing on patient care, often identified as one of the more rewarding aspects of their job. Increased administrative work was also cited as a detractor from their work life balance.

Physicians expressed frustration at the sheer amount of bureaucracy involved with change and time delays that exceeded their initial expectations. Physicians indicated that while they wanted to be involved in decisions about their work and the system in which they operated, they do not want a second profession as administrators.

> "I was so impressed with how many physicians have carved out time to be part of the PMH project and I think that we really need to recognize the deep involvement of physicians in our division and recognize that the problem isn't that physicians aren't engaged. They are very engaged, but we don't want to be administrators, and it's unfair to ask us to be a driving force."
>
> - FP, Vancouver Coastal

> "It's key to have physicians involved in planning, but they cannot realistically close their practice and come to meetings as often as they need to take place, sometimes for a full day at a time. We need to find a better way to ask physicians for their advice."
>
> - FP, Interior

> "We had serious difficulty moving between silos. It was difficult to communicate, coordinate and move things forward when the groups couldn't work together"
>
> - FP, Vancouver Coastal

"PMH is still misunderstood as a concept. I found it frustrating that despite several meetings emails, info packets PMH remained poorly understood. We tried but I don't believe we achieved a good understanding within our community or among our physicians. In our community, we've always had 5 or 6 clinics, some referring between clinics based on expertise. This practice is in itself a group of PMHs but we never got to the point of expanding or improving each PMH or the network."

- FP, Vancouver Coastal

Culture Shift

Physicians newer to practice noted that while they were trained to work in a team-based environment, the reality of most primary care practices is that team-based care is still considered new and does not fit into the current workflow. There is a transition period for physicians already in practice to plan for these changes and to accept practicing in new ways, while making practices more appealing to new physicians.

While working in teams resulted in positive changes, some health care professionals noted that they enjoy their specializations such as wound care, mental health or community health nursing, and may not wish to become generalists serving in the primary care system. There may need to be space in the system for those who prefer not to work in more general roles.

Divisions played a key role in engaging FPs, providing or supporting access to resources and building a culture of interprofessional collaboration and more consistent EMR practices.

Costs and Funding Model

Physicians reviewing the stories found aspects of the PMH model appealing but raised questions about the funding models supporting the initiatives. Uncertainty about the sustainability of funding, workloads and ongoing administration was raised as a barrier that concerned physicians.

Some physicians paid through professional consultation fees were not paid if a patient did not attend an appointment, but still had to pay a team member such as a nurse or pharmacist if they were scheduled to work during that time. In order to sustain a practice and recruit and retain FPs, physicians expressed the need for funding models that could support their in-clinic work, while offering the opportunity to access interprofessional teams to provide the full breadth of health care services.

"I was paid through the professional consultation fee, 14077, so my work was funded. Our complex patients are dealing with mental health and mobility issues, and patients would occasionally not show up for their appointments. This would mean that I couldn't bill for the time and the pharmacist was not doing anything during that appointment time."

-FP, Interior

Team-based Care Models

Introducing team-based care through patient medical homes in a primary care setting involved testing various models, including allied health care practitioners being hired directly into practices, such as in some nurse in practice projects, while others depended on health care practitioners paid by a health authority or other source, such as with community pharmacists and some nurse in practice models. FPs also worked in community settings such as schools. Each model had its own advantages and challenges, and certain key issues arose consistently, regardless of the model. The main needs were for:

a. A sustainable funding model;
b. Addressing discrepancies in human resource practices for different providers working in the same team but hired within different administrative systems, including scheduling, hierarchies, professional duties, and salary levels;
c. Strong interprofessional practices including role clarification and interprofessional communication.

Information Management in Electronic Medical Records

The main tool for storing patient records in primary care is through an electronic medical record (EMR). In addition to storing patient information, a Patient Medical Home model generally requires information to be managed and shared among team members, including FPs, administrators and allied health care professionals.

Technical and policy barriers to sharing patient information including history, labs and imaging, were identified as significant barriers to working as a team across professions or facilities, and to providing proactive patient care. This appeared in several forms:

a. In most communities, primary care physicians did not have a common EMR across practices nor did the various EMRs in use have the capacity to share access between different kind of health care practitioners working as a team;
b. Privacy policies did not support data sharing between facilities, for example a hospital and physician's office, and between FPs and allied health professionals;
c. Not all primary care physicians use EMRs, and some Health Authority services still faxed information, including in the areas of public health and home care nursing, causing physicians to use paper and fax workarounds that were time consuming and inefficient;
d. While considerable work had been done to support physicians to optimize their EMR use to enable more proactive patient care, many practices either didn't record data in a way that served data analysis across more than one practitioner or didn't have the capacity to pull data in a format that could be analyzed systematically to enhance the quality of care and understand population health and needs;
e. EMR vendors have the potential to impact the quality of patient care through the features that they do or don't support, and whether and how they provide training, but are not responsible to public health mandates.

As a result of patient information not being recorded consistently or shared effectively, the use of data to support PMH planning and administration planning was at times limited.

> "Many physicians recognized the importance of home detox, but there was no appetite at the health authority level without solid data. They indicated that they felt volume of people impacted by this issue is low, while physicians felt that it was higher than it presented."
>
> - FP, Vancouver Coastal

EMR has associated costs, including monthly fees, investments in hardware, and ongoing computer issues. Sometimes the EMR cannot do what the physicians have envisioned and sometimes cannot capture complex situation. Difference in various EMR systems can also prevent proper integration and sharing the information across different systems.

> "There were two doctors, one wanting to retire, and the other thinking about retiring. They had struggled with the transition to EMR for six months. During the assessment, I learned that they were unhappy working with their EMR, which was affecting their workflow. I worried that they might shut their door and stop practicing altogether."
>
> - Office Manager, Interior

> "Another challenge has been in the area of information sharing--while we are working to restructure in relation to health authority personnel, we have run up against different policies such as PIPA and FOIPPA which have prevented us from sharing information electronically using our EMRs. The majority of physicians moved to the same EMR as part of the restructuring, which has been hugely beneficial in allowing us to share patient files, but the health authority still faxes information, including in the areas of public health and home care nursing, causing us to use paper and fax workarounds that are time consuming and inefficient. We'd like to see a patient-centred medical record."
>
> - FP, Interior

> "We've experienced two significant barriers: the additional work to overcome using different systems for electronic medical records (EMR), and the time required for meetings and other planning related to the PMH. We've worked through the EMR issues by sending faxes to the server and directly into Oscar. Our communication with the team is quite good because we meet every two weeks, which is a must for us to get to know each other and share our perspectives on what needs to be done, and why. However, sessional fees do not compensate us on par with other work that we do, so we spend a lot of volunteer time on meetings."
>
> - FP, Vancouver Coastal

"The EMR does a good job of noting contraindications, but not for complicated issues like kidney function."

- FP, Interior

Recommendations

Based on changes identified as most significant to providers, patients and administrators, it is recommended that GPSC consider the following priorities:

Prioritize Support for EMR-ready Practices

a) Ensure that EMRs are set up to support appropriate team access to patient records;

b) Work toward shared access or integration of data to enable providers to access complete and up to date patient information regardless of their location in a private practice, hospital or other point of care;

c) Support physicians in paper-based practices to transition to EMR;

d) Implement consistent data entry processes so that EMR data can be used at a bigger scale to support proactive care, use of algorithms, understanding of population health and better allocation of resources throughout the health care system.

Support Planning and Administration

a) Provide sufficient funding and resources to support physicians to participate in planning and administration;

b) Ensure that FPs have access to training in planning and administration if desired;

c) Support FPs to develop leadership skills;

d) Provide access to data to support evidence-informed decision-making.

Continue Building a Culture of Interprofessional Collaboration

a) Provide training in interprofessional collaboration, ensuring that team members have a solid understanding of role clarification and interprofessional communication;

b) Ensure that fees and compensation models support PMH models including co-location, referrals, and primary care in community settings as a normal part of care;

c) Provide funding and logistical support to involve community partners and providers in planning;

d) Provide evidence about PMH models of care including benefits and costs.

Address Funding and HR within PMH Model

a) Match fees and compensation models to PMH goals and functions;

b) Identify how PMH models will fund:

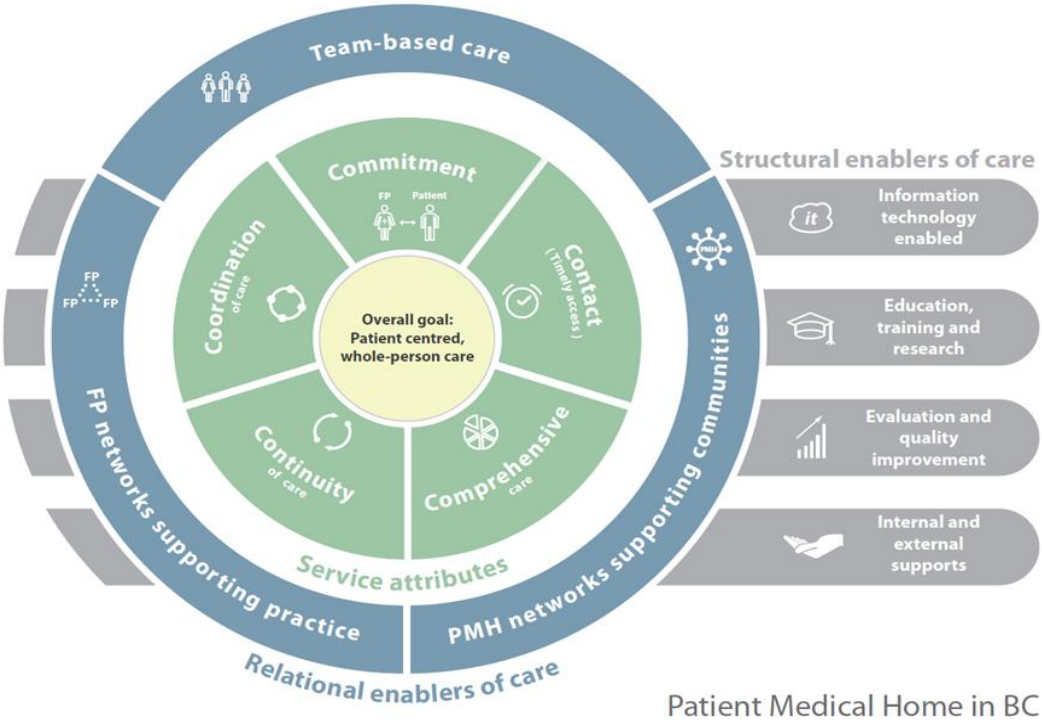
    a. Overhead
    b. Administration
    c. Allied health professional time

c) Support human resource planning and management in private practices as well as partnerships with public health agencies.

Appendix 1: Vision for the Patient Medical Home

The General Practice Services Committee (GPSC) set out a vision to enable access to quality primary health care that effectively meets the needs of patients and populations in BC. A key approach has been the implementation of the Patient Medical Home (PMH) model of family practice. The PMH positions family practice at the centre of an integrated system of primary and community care. The PMH emphasises the use of a team-based care approach to deliver patient-centered care and enhance the quality of care. Patients have timely access to a primary care provider and coordinated, continuous and comprehensive care.

The GPSC has identified the following 12 attributes of the PMH model as key to achieve the overall goal of patient centered, whole-person care. The image below outlines these attributes.



For more descriptions of the PMH attributes visit the GPSC webpage here.

Appendix 2: GPSC PMH Outcome Areas

Patient Experience

Patient experience refers to the patient's cumulative evaluation of their journey with the healthcare system. It is the quality and value of all of the interactions—direct and indirect, clinical and non-clinical— across the entire continuum of care and includes health care processes, patient-provider interactions, involvement in decision-making, support for self-care and overall ratings of care.[1]

Access

Ease with which health services are reached. Accessibility is the extent to which individuals can easily obtain the care when and where they need. Accessibility aims to ensure there are not physical, financial or psychological barriers to receiving information, care and treatment.[2]

Physician Experience

Physician satisfaction with their professional experience including interpersonal, remunerative and clinical aspects, as well as the relationship between professional life and personal health and wellbeing.

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[1] Wolf et al. (2014). *Defining Patient Experience*. Patient Experience Journal, 1, 1, pp 7 – 9.
[2] BCPSQC Health Quality Matrix

Cost

Optimal use of resources to yield maximum benefits and results. Cost is about delivery of services to improve health of British Columbians by maximizing capacity and avoiding waste in the health system. Health care services are considered in light of value for money or providing the maximum amount of positive impact on the health of British Columbians.[3]

[3] Adapted from BCPSQC Health Quality Matrix