General Practice Services Committee

Report to Divisions of Family Practice – Moving Forward Together: Supporting Team-based Care and Networks in Community

Background

On November 3rd, 2017, the GPSC's Incentives Working Group (IWG) and the Team-based Care Task Group (TBC TG) met with Divisions and health authority partners to discuss emerging ideas for supporting Patient Medical Homes (PMH) and Primary Care Networks (PCN). These emerging ideas had evolved from a variety of sources, including GPSC Visioning, working group and GPSC discussions, A GP for Me reports, and GPSC Summit discussions.

Informed by feedback from Divisions and health authority partners, the IWG and the TBC TG convened on November 6th, 2017 to prioritize emerging ideas and to develop a plan for moving forward.

This report provides a summary of the discussions and the priorities which were identified at the November 3rd and 6th events.

November 3rd Event – Feedback from Divisional and Health Authority Partners

Opportunities & Challenges

Participants were highly engaged and provided thoughtful insight and feedback on the opportunities and challenges of implementing team-based and networked care. In addition, many participants expressed appreciation for the opportunity to provide input at this stage of the planning process.

The table below summarizes the key topic areas discussed at the November 3rd event.

Topics	Discussion/Details
Primary Care Network (PCN) focus areas. See Appendix 1 for PCN focus areas	Divisional and health authority representatives shared a variety of activities, in which they are currently involved in, which were aligned with PCN focus areas. Overall, there was general support for the eight PCN focus areas. There was a consensus that having clearly stated expectations are helpful in the future development of PCNs.
Value proposition for physicians	A priority expressed by many participants was the need to have a clearly articulated value proposition for PMHs and PCNs in order to facilitate effective engagement with local physicians. Participants generally agreed that it was important to focus on local issues to enhance buy-in from physicians.
Resources for and integration of team members	Many participants expressed the need for more resources to pay for extra clinicians, both physicians and allied health providers, as well as staff support for business and administration relating to team-based and networked practice models. Some participants also shared various challenges they encountered when

Topics	Discussion/Details
	integrating health authority employed nurses and cited issues such as differing priorities, frequent turnover, differing reporting/accountability structures, and lack of access to EMR systems as barriers to optimal integration.
Long-term funding	Many participants expressed their desire for long-term funding to support their PMH and PCN related work. There was general agreement that a reliance on grant/short-term/pilot project funding is not sustainable even if projects show good results.
Governance of PCN	Many participants inquired about potential governance models for PCNs. There was general agreement that future governance models should enable local divisions to work with health authorities to co-design PCNs and shared strategic plans for their communities.

Emerging Ideas to Support PMHs and PCNs

Participants also had an opportunity to provide feedback on a number of emerging ideas for supporting PMHs and PCNs.

The table below summarizes their feedback.

Emerging Idea	Discussion/Details
Redesign and streamline current GPSC incentives	Participants generally supported the idea of redesigning the current GPSC complex care, chronic disease management, palliative care, and mental health incentives to better support working in a team-based care environment and to decrease billing complexity.
New attachment billing code	There was limited support for introducing a new attachment billing code.
Compensation for foundational PMH activities	Many participants identified the need to support and compensate physicians for foundational work needed for PMH and team-based care, such as panel management, using practice data for QI, and team building and management activities (e.g. team huddles). This foundational PMH work aligns with the basic building blocks of the PMH ("10 Building Blocks of High-performing Primary Care").
Change management	Participants agreed that divisions would need support in the change management activities needed for participating in, preparing for, managing, and reinforcing changes toward PMHs and PCNs.
Create a network participation incentive	Participants expressed interest in creating a new network incentive to incentivize involvement in PCNs. Some participants suggested that a network incentive would need a system to equitably remunerate physicians for various levels of participation and that the current Residential Care Initiative may be an appropriate model.
Reward progress toward PMH, using PMH practice characteristics matrix as a framework	There was little support for using the practice characteristics framework as a tool for incentive compensation. Some participants were concerned that tying the framework to remuneration may risk physician disengagement from the practice tool.

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November 6th Event – IWG and TBC TG Meeting

On November 6th, 2017, the Incentive Working Group (IWG) and the Team-based Care Task Group (TBC TG) convened to prioritize emerging ideas and to develop a plan for moving forward. Based on feedback from the November 3rd event, the IWG and TBC TG agreed to focus their efforts on four priorities.

The priorities are summarized in the table below.

Priorities	Discussion/Details	Potential Next Steps
Value proposition for physicians	IWG and TBC TG members agreed that it is important to develop and communicate a value proposition to encourage physicians to become involved in team-based and networked care in their communities. This value proposition should be evidence-based.	Provide physicians with examples of business models that allow for support of team-based care in the current fee-for-service environment.
Redesign and streamline current GPSC incentives (complex care, CDM, palliative and mental health fees)	IWG and TBC TG members agreed that the future redesign of GPSC incentives should: • Reduce administrative burden • Incentivize team-based care by supporting the delegation of services to appropriate non-physician providers • Consider non-monetary incentives to encourage change • Simplify billing process • Measure complexity based on patient functionality Members recognized that any changes to GPSC incentives will need to consider auditing implications and the challenge of measuring patient complexity and functionality.	Undertake analysis and modeling regarding collapsing incentive fees to better support working in a team-based environment and to decrease administrative burden.
Support physician participation in a network	IWG and TBC TG members supported moving toward a networked model where care is shared in a community in order to facilitate the provision of comprehensive primary care services to more patients. To encourage physician involvement in such networks, members generally supported the creation of a new network incentive. Members discussed a number of key considerations: • Making network incentive payable to network rather than individual physicians • Allowing some communities to combine network incentive with other networks (e.g. residential, hospital, maternity care) • Funding allocated based on a point system or score card	Define expectations and resources associated with developing a new network participation incentive. Explore the option of allowing this to be combined with other network incentive fees administered at the community level.

Priorities	Discussion/Details	Potential Next Steps
	• Network participation as a portal to access additional resources such as allied health providers • Ensure clear deliverables and expectations for network incentive	
Compensate physicians for time required for foundational PMH work	IWG and TBC TG members supported compensating physicians for time spent on foundation PMH activities such as panel management, quality improvement, and managing a health care team. Key considerations discussed included: • Differentiating between upfront PMH activities (early in PMH transition process) and ongoing PMH activities. • Ensuring incentive payments are aligned with the work of the Practice Support Program (PSP) and Community Partnerships and Integration (CPI). • Identifying infrastructure needs for shared care and the sharing of patient information.	Future planning to consider PSP and CPI supports for foundational PMH development.
Other Next Steps: • Conduct cost analyses to estimate resources required for options above. • Test ideas with physician focus groups. • Define governance model of PCNs. • Determine the extent to which resources should be targeted or made available to all physicians, and/or phased.		

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Appendix 1 – PCN Focus Areas

As outlined in the Ministry of Health (MoH) policy papers, primary care networks (PCNs) will be established across BC to provide quality primary care services to the population of local communities and, as required, coordinate access to specialized services.

A PCN is a network of family practices and health authority primary care clinics in a defined geography linked with primary care services delivered by a health authority and other community-based organizations and services.

GPSC has defined 12 attributes of a patient medical home. Key attributes include the provision of timely access to comprehensive, coordinated primary care through team-based care and networks. In order to establish PMHs and PCNs, there will be new resources targeted to enhance team-based care in support of the initial PCN focus areas. The implementation of PCNs will include support for divisions, or groups of family physicians where no divisions exist, to co-design and develop local solutions to create PCNs with health authority partners.

The table below describes the current PCN focus areas, as well as the related PMH service attribute.

PCN Focus Area	Related to PMH Service Attribute
1. Process for ensuring all people in a community have access to quality primary care, and are attached within a PCN.	Commitment
2. Provision of extended hours of care including early mornings, evenings and weekends.	Contact
3. Provision of same day access for urgently needed care.	Contact
4. Access to advice and information virtually (e.g. online, text, e-mail) and face to face.	Continuity
5. Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.	Comprehensive
6. Culturally appropriate service.	Patient-centred care
7. Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.	Coordination
8. Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.	Coordination