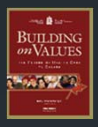


"…..I cannot say often enough: that the status quo is not an option."

Commissioner Roy Romanow, from the final report of the *Commission of the Future of Health Care in Canada*, 2002.

Who I am…

- Primary care physician—recently retired
- 30 years in general practice—all forms of primary care
- Office-based family medicine
- Obstetrics, ER, Surgical assists, Walk-in/After hours clinics
- Interdisciplinary team in chronic pain management
- Lifetime preventive health orientation
- 4 provinces (22 years in BC)
- No conflicts of interest

On Creating a cost-effective system of primary and community care built around interdisciplinary teams

Select Standing Committee on Health.
Kamloops, July 6, 2016

It's time: interdisciplinary teams in primary care….

A long held vision—To enhance the quality of primary care with a team approach:

Conceptual introduction in the USA: American Academy of Pediatrics (1967)

In Canada: CFPC-- The Medical Home (2011)

In BC: GPSC-- Visioning Statement (2016)

CFPC's "The Medical Home"

Includes the concept of interdisciplinary team in primary care

- To be patient centered, with a whole person orientation
- To have a physician-directed family practice
- To assemble and coordinate a team of health care providers and community services
- To provide timely and comprehensive care to all ages within the context of their family and community
- To improve support for acute care, chronic conditions and special needs

Assumptions

- The "Medical Home" as synonymous with interdisciplinary teams in primary care
- Interdisciplinary teams may include several health care professionals–referred to as "physician helpers/extenders" or "physician assistants" (not Physician Assistants (PAs) !).
  - Nurses
  - Nurse Practitioners
  - Midwives
  - Social Workers
  - Nutritionists
  - Physical Therapists
  - Counselors/Psychologists
  - Kinesiologists

So, if interdisciplinary health teams are now well endorsed….

Why are they not significantly embraced in primary care in BC today?

At Least 4 Barriers

Barrier One:

- Primary Care Physicians cannot delegate…

Yet most everyone else does it…

- Nurses, Pharmacists, Lawyers, Engineers, Accountants, Mechanics, Bankers……. most professionals all DO IT !

They Delegate Duties:

- Give the simpler, less skill-requiring duties to someone else
- Delegation saves money to both the customer and the professional
- It allows more overall work to get done
- It allows more difficult work to be given to the most qualified professional, while not wasting their time doing lower-skilled work

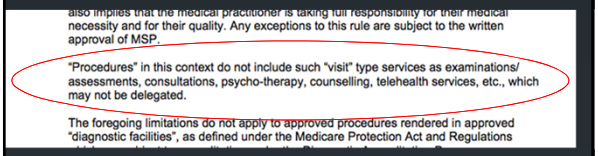
Doctors Would Love to Delegate….

- Basic procedures, basic clinical assessments, routine follow-ups, most forms, renewals….

….But They Can't.

The Guide to Fees precludes it.

… even if the doctor was to take full medical and legal responsibility for that delegation.



also implies that the medical practitioner is taking full responsibility for their medical necessity and for their quality. Any exceptions to this rule are subject to the written approval of MSP.

"Procedures" in this context do not include such "visit" type services as examinations/ assessments, consultations, psycho-therapy, counselling, telehealth services, etc., which may not be delegated.

The foregoing limitations do not apply to approved procedures rendered in approved "diagnostic facilities", as defined under the Medicare Protection Act and Regulations

"…visit type services….may not be delegated."

Another Barrier to Delegation

- Interdisciplinary team members may need to be approved for duties delegated to them that may be out of their scope of practice.

CRNBC Scope of Practice For Nurse Practitioners

- Page 7: "Nurse practitioners may provide care outside the scope of practice:

Where a formal ***delegation*** process is in place. To date, no activities for nurse practitioners have been approved for delegation. Therefore, nurse practitioners are not authorized to carry out any activity outside the scope of practice of nurse practitioners.
(Delegation under the Health Professions Act requires an agreement between the College of Physicians and Surgeons of BC and CRNBC)."

Delegation: Necessary and Workable

- If a multidisciplinary team is to develop as a comprehensive primary care "medical home", duties will have to be delegated to allied medical team professionals.
- The family physician would remain responsible for the patient medically and legally, and would take responsibility for appropriate delegation.
- A change in the Preamble of the Guide to Fees would need be a consideration of Doctors of BC Tariff Committee, the Medical Services Commission and/or the GPSC.
- The College of Physicians and Surgeons of BC would have to be consulted as well as other team professionals' licensing bodies.

Barrier Two:

- The Daily Volume Visit Cap

How The Volume Cap is Applied

- MSP payments are discounted by 50% and then eliminated when a primary care physician tries to see more than 50 patients in a day.
- This discount is waived for physicians working in underserviced areas (eligible for NIA premiums)
- Specialists are not similarly restricted

Has the Cap Outlived its Intended Purpose?

ii) The total of all billings under the codes listed in i), that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. When such a daily total exceeds 50 the practitioner's payment on these codes for that day will be discounted. Moreover, when a daily total exceeds 65, a further payment discount will be made:

Daily Ranges (for an individual practitioner for any single calendar day)	Discount Rate	Payment Rate
0 to 50	0%	100%
51 to 65	50%	50%
66 and greater	100%	0%

iii) Payment discounts will not be applied to services rendered in communities that are/were receiving NIA premiums as of December 15, 2002.

If the Volume Cap was Eliminated:

- A primary care practice could pay for the interdisciplinary team members to see delegated patients
- A given primary care practice could increase its capacity in daily visits, numbers of patients in the practice, and the numbers of services it provides
- Morale and interest in primary care would increase
- All the benefits of the "Medical Home" concept could apply

Barrier Three:

- Lack of sustained system support

On system support:

- "If there is a lack of system support for everyone on the team—including a lack of appropriate funding, a lack of clarity or even disagreement among team members about their roles and responsibilities, or if the responsibilities assigned do not match the knowledge and skillsets of those assigned to carry them out—the chances increase that a team will be dysfunctional and will not produce the anticipated benefits for the patients being served."

If There was Sustained System Support:

- Interdisciplinary teams could be reliably formed and sustained
- Heirarchies could be established within these medical homes to preserve their functionality
- The quality and quantity of primary care services would improve for an entire population
- Family physicians could reassert their important role in community primary care delivery
- Primary care physician morale would increase, and physician burnout would decrease
- Interest in primary care as a career would also increase

Barrier Four:

- Increasing competition and encroachment into primary care by other health care professionals

On professional encroachment

- Despite the family physician being recognized as the most trusted, skilled and most qualified primary health care provider, many other professionals are wanting to provide or replace physician services, such as:
  - pharmacists
  - nurse practitioners
  - chiropractors
  - naturopaths

If only Family Physicians are qualified to direct a “Medical Home”:

- The broad training and experience of a family physician could best be utilized to hire and then determine the priorities of an interdisciplinary health care team
- The training and experience of a family physician would maintain the broad community base of the “medical home”
- The science-based training of a family physician would maximize evidence-based best practices applied to a given population of patients
- The central role of the family physician in the patient-physician relationship is preserved

Interdisciplinary teams in primary care:

Removing the barriers—mostly policy changes.
12 summary points:

Summary

- The “patient’s medical home” remains a widely endorsed concept that embraces a multidisciplinary team of various health professionals to improve quality of care and reduce costs (with decreased ER utilizations and hospitalizations)

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- The context of any given family practice would dictate the number and kind of "physician extenders" to create a multidisciplinary team (specialty nurses, NPs, midwives, counselors, social workers, dieticians, etc.)

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- The family physician remains the best qualified, experienced, and most respected health professional to coordinate and direct an interdisciplinary "medical home"
- The context of any given family practice would dictate the number and kind of "physician extenders" to create a multidisciplinary team, (specialty nurses, NPs, midwives, counselors, social workers, dieticians, etc.)
- These "physician extenders" already widely exist in most communities—no new training programs required

Summary (continued)

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- Changing the Preamble to the Guide to Fees regarding payment for "delegatable" duties requires consideration by the Doctors of BC Tariff Committee
- The College of Physicians and Surgeons of BC would also have to approve primary care physicians to delegate duties to allied health providers

Summary (continued)

- If more primary care duties are "delegatable" to other health professional team members, the daily capacity of a medical home could easily exceed 50 patients per day, requiring a review of the fee cap on daily GP services as well.

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- If the capacity of GP offices could increase with the removal of these restrictions, the GP for Me initiative may also be solved in short order
- To succeed long term, system and financial support for interdisciplinary teams and the "medical home" must be sustained
- The unique qualifications of the family physician as an interdisciplinary team leader must be reinforced

So…
Are we ready to change the status quo?

References

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- https://www.crnbc.ca/Standards/Lists/StandardResources/688ScopeforNPs.pdf Scope of Practice for Nurse Practitioners, College of Registered Nurses of British Columbia. January 2016: p.7
- Guide to Fees: General Practice p.6-1 https://www.doctorsofbc.ca/sites/default/files/feeguide1apr2016.pdf
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- http://www.gpscbc.ca/who-we-are/about-gpsc
- https://www.doctorsofbc.ca/system/files/visioning_engagement_report_final.pdf

Background Reference Material

(Relevant quotes from these sources:)

Family Practice as "The Medical Home": Definition

- "It is the central hub for the timely provision and coordination of a comprehensive menu of health and medical services patients need."
- "It is where ***a team or network of caregivers, including nurses, physician assistants, and other health professionals work together with the patient's personal family physician to provide and coordinate a comprehensive range of medical and health services required by each person."***
- "It is where patient-doctor, patient-nurse, and other therapeutic relationships are developed and strengthened over time, enabling the best possible outcomes for each person, the practice population, and the community being served."

Upholds Principles of Family Medicine

1) The family physician is a skilled clinician, with a wide range of expertise in common problems of patients in the community, skilled at dealing with ambiguity and uncertainty, with an approach to health care based on the best scientific evidence available, while empowering patients to take charge of their own health care.

Upholds Four Principles of Family Medicine

1. The family physician is a skilled clinician, with a wide range of expertise in common problems of patients in the community, skilled at dealing with ambiguity and uncertainty, with an approach to health care based on the best scientific evidence available, while empowering patients to take charge of their own health care.

These attributes make **the family physician the most qualified primary health care provider to direct a "medical home."**

Upholds Four Principles of Family Medicine

- **2) Family medicine is a community-based discipline.**
- Family physicians work in several settings and are part of a community network of health care providers, both as collaborating team members or as team leaders. They very familiar with, and use specialists referrals, community resources and further investigations judiciously.

Upholds Four Principles of Family Medicine

- **3) The family physician is a valuable resource to a defined community and practice population.**
- Family physicians have effective strategies for self-directed, lifelong learning; They are familiar with and advocate public policy that promotes their patient's health; They accept responsibility for wise stewardship of scarce resources; and they consider the needs of both the individual and the community.

Upholds Four Principles of Family Medicine

- **4) The patient-physician relationship is central to the role of the family physician.**
- This relationship is essentially a covenant—a promise, by physicians, to be faithful to their commitment to patients' wellbeing, and to advocate for their health, whether or not patients are able to follow through on their commitments.
- Repeated physician contacts with patients builds trust and promotes the healing power of these interactions.

The Patient's Medical Home-- Relevant Goals (of 10 listed)

A Patient's Medical Home will:

- (#2): …ensure that every patient has a personal family physician who will be the Most Responsible Provider (MRP) of his our her medical care.
- Family physicians remain the most trusted, valued, skilled, and qualified health care professional in the lives of Canadians, and can deliver primary care services in a variety of settings.

The Patient's Medical Home-- Relevant Goals

A Patient's Medical Home will:

- (#3): …offer its patients a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician working together with peer physicians, nurses, and others.
- The composition of these teams may vary, although the personal family physician and nurse should form the core of most Medical Home teams/networks, along with the roles of others…. these should support and complement--but not replace--those of the family physician, and enhance continuity of care.

The Patient's Medical Home-- Relevant Goals

A Patient's Medical Home will:

- (#5): ……provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs, from injury prevention and health promotion, to the effects that social determinants have on health, such as poverty, homelessness, job loss, culture, age, and gender.

The Patient's Medical Home-- Relevant Goals

- (more on #5): "A more comprehensive "basket of services" can lead to better outcomes for all, including vulnerable populations. Not only does a wider range of services provided by primary care practitioners result in better health outcomes, it does so at lower cost."

http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/Publications_PDFs/2004%20Pediatrics.pdf (pp. 1494, 1497)
http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/FMH_A_Vision_for_Canada.pdf (p.36)

Family Practice: The Patient's Medical Home-- Relevant Goals

A Patient's Medical Home will:

- #10: ..be strongly supported i) internally, through governance and management structures defined by each practice and ii) supported externally by all stakeholders, including governments, the public, and other medical and health professions across Canada. Health system support, including funding, should be available to support all members of the health professional team in each patient's Medical Home.
- The "Medical Home" is a flexible construct, not a "one size fits all solution"; it varies with the setting (urban, rural, remote, etc).

The Patient's Medical Home-- Relevant Goals

- More #10: Every PMH should have an organizational plan in place, and include opportunities for patient input.
- PMH's are only achievable with the participation and support of the many stakeholders throughout the system (family physicians, other physicians, other health professionals, all levels of government, and Canadians themselves.
- The sustainability of Canada's health care system depends on ensuring a strong primary care and family practice foundation.

Cost savings?

- "…Through significant investment in patient-centred (multidisciplinary) "Medical Homes", costs were recouped in the first year by shifting utilization patterns, particularly away from the use of emergency care.
- Patients with continuity of care provided in a primary care setting (such as a multidisciplinary medical home) were associated with reduced hospitalization rates.
- Appropriate secure remuneration must be in place not only for the family physicians, but for all members of the PMH Team.

http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf, pp. 53, 54

NPs: A natural fit as a physician extender?

- Widely touted to be trained to do "80%" of what a GP can do.
- Not many in BC as yet
- Many prefer to work independently from GPs
- Lots of nurses out there

General Practice Services Committee (GPSC) (inception 2002)

- A Partnership between the Ministry of Health and the Doctors of BC to support comprehensive primary care
- Launched to improve
- patient care
- doctor job satisfaction and low morale
- Interest in family medicine as a career
- Divisions of Family Practice
- A GP for Me (2013)

The Future of Primary Care: BC's GPs share their thoughts

- All GPs consulted over 3 months July-Sept, 2015
- The Visioning Steering Committee:
- 6 division physicians
- 4 GPSC representatives
- 2 from the Ministry of Health
- 2 from the Doctors of BC
- 1 Society of GPs of BC representative
- 1 Health Authority representative
- Report released in early April 2016

Highlights from The Executive Summary:

- Every patient should have the opportunity to part of a family practice that serves as that patient's "medical home"

Highlights from The Executive Summary:

- GPs continue to endorse autonomy and "generalism", providing a full scope of services within a coordinated multidisciplinary team

"Physicians see the scope of family practice as expanding in the future, with a much greater percentage seeing themselves providing the full scope of services in their clinic or team. This includes networking with other GPs, as well as working collaboratively with multidisciplinary team members (nurses, counsellors, physiotherapists, dietitians, etc) and specialists both inside and outside of the practice."

Highlights from The Executive Summary:

- Alignment between key partners are important underpinnings for the transformation and sustainment of primary care in BC

https://www.doctorsofbc.ca/system/files/visioning_engagement_report_final.pdf p.4

Highlights from the Report:

- GPs feel comfortable with "quarterbacking"--coordinating, integrating, liaising, and collaborating with specialists and other health care professionals, especially if care was delivered in a multidisciplinary setting

"The majority of GPs already know how to lead and employ staff teams in their offices efficiently as small businesses. To maintain the sense of autonomy, and to provide an efficient health care service, the majority of the health care team should be lead and employed by the general practitioner."

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- Most GPs see themselves less likely to provide a full range of services in the future (on their own)
- Most GPs felt they would be the cornerstone and a team leader in any team-based care

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