GP Update

GPSC
General Practice Services Committee

A QUARTERLY NEWSLETTER FROM THE GPSC

FALL 2017

Patient medical homes in rural BC

The introduction of the BC patient medical home last year prompted many rural GPs to reflect on how they are currently working, including working in teams to deliver integrated services and whole-person care that wraps around patients.

"Many small rural communities are ahead of the curve and doing this work very well, out of necessity," says Dr Rebecca Lindley, Chair of the Rural and Remote Division of Family Practice. She explains that working together and being creative is what health care providers in small communities do to make the most of scarce resources, optimize capacity, and minimize the impact of provider departures from the community.

Health care providers and patients in rural communities must also contend with challenges such as weather, geography, limited resources, and services available only at a distance. These challenges are particularly acute for rural GPs and others providing outreach services to remote communities. In this context, collaborative, creative approaches have been integral to supporting patients and colleagues. These approaches also provide valuable learnings for physicians and partners across the province who are working toward the patient medical home model in their communities.

In addition to working in teams, many rural GPs and other health care providers work as generalists across the full spectrum of services, including primary, community, acute, residential, palliative, maternity, surgical, and other specialized care. So patients may see the same rural care team for a minor illness, acute emergency care, speciality care, home care, or palliative care. The result is patients have access to a team, and care is usually well-coordinated within a community.

The model – the combination of teams and services provided – may look different from one rural community to the next, depending on geography, socioeconomic factors, and available resources and services.

"While there are improvements to be made, the experiences of rural communities can contribute insights to the enrichment of patient medical homes right across the province," says Dr Lindley. "The enablers and supports that are needed to improve patient medical homes in rural areas may be very different from the resources needed in larger areas and must be individualized to each community."

What's working well in rural communities?

(Note: The following provides a rural perspective and is not intended to preclude the same being true for physicians in non-rural and remote settings.)

Patient medical homes extend beyond primary care. In many small rural communities, primary care is not a separate system and is well-integrated with acute and community care services.

Patient-centred, whole-person care comes naturally. Strong patient-provider relationships often enable rural teams to wrap services around patients. Most providers live in the community, interact often with patients, and know their issues well. Care is grounded in local community and culture.

Continued on p.2

what's **inside**

Now available: Summit report

The summary report from the GPSC Spring Summit, which took place June 19 - 20, 2017, is available online. The Summit Summary captures the highlights of the event in a web-based format, featuring learnings and recommendations shared by presenters and attendees. Readers can peruse an overview of each session, listen to audio recordings, see photos of presenters and participants, and read a summary of feedback provided by attendees.

We hope this event reporting format is engaging and informative. To view the summary, visit **gpscsummit-summary2017.com**.

Dr Paul Grundy with Dr Brenda Hefford at the GPSC Spring Summit in Vancouver.

Patient medical home: A broader perspective

In June, family doctors and various Ministry of Health, health authority, and Doctors of BC representatives gathered for the GPSC Spring Summit, which focused on progress and future steps toward establishing the patient medical home in BC. Keynote speaker Dr Paul Grundy, IBM's Chief Medical Officer and Global Director for Health Care Transformation, opened the event, sharing his perspectives on the international emergence of patient-centred medical homes as the foundation for primary care transformation. Dr Grundy commended BC doctors and their partners for the progress they've made and their contribution to worldwide learning on primary care transformation. A summary of key themes of his remarks are below.

Work in BC is part of an emerging worldwide trend built on early and continuing success. The patient-centred medical home is a "wonderful experiment" that is unfolding in several US states, Canadian provinces, and other parts of the world, from Denmark to New Zealand. Grundy cited examples from Michigan, Vermont, and Jersey, England where team-based care and innovative repurposing of existing resources are supporting the patient medical home.

BC is on its way and should celebrate success to date. The BC patient medical home model "one of the best examples [Grundy's] seen of putting the pieces together."

Continued on p.4

Patient medical homes in rural BC *Continued from p.1*

Comprehensive care and team-based care go hand in hand. Integrated, inter-professional teams of generalist providers (e.g., GPs, MOAs, nurse practitioners, nurses, mental health providers, social workers) can deliver comprehensive, full-spectrum care to patients and the community. Teams often look after patients collectively, sometimes without individually-defined patient panels. Providers work together to provide continuous care for patients when other team members are providing acute services or travelling to remote areas outside their community.

Commitment extends to the community as well as patients. In many rural communities, small populations and geography foster a sense of awareness and closeness between providers and the community. With this in mind, many rural providers have committed not only to care of their patients but also of their health care team and the health and the wellness of the entire community.

> *"My life is better in team-based care because I have these people wrapped around me, as well as wrapped around patients. We wrap around each other.*
>
> – Dr Jel Coward, Rural and Remote Division of Family Practice, Pemberton chapter

Coordination of care generally works well within a community. Smaller communities provide unique opportunities for providers to get to know each other, and often they can pick up the phone or walk down the hall to discuss patient care with their colleagues.

Patients usually know where and how to appropriately access care, but it looks different from one community to another. Often, creative approaches are used to give patients access to services when and where they need them. For example, in many communities, the ER is an appropriate place for patients seeking after-hours non-emergency primary care.

Moving forward

With team-based care and integration of services in place for many, family doctors in rural environments offer a unique perspective on what is working well and what enablers are needed to further enhance the patient medical home in rural communities.

Many family doctors across BC have experienced close, collegial, and team-based relationships similar to those in rural communities. The work toward full realization of the patient medical home model has the potential to reinvigorate a sense of medical communities across the province, to enable doctors to rediscover the joy in practice, and to enhance patient care.

Upcoming GPSC fee changes

As of October 1, 2017, some of GPSC's incentive fees are changing in response to physician feedback collected during the visioning consultations, and to support the strategic objectives of the patient medical home model.

The GPSC incentives are changing to support physicians in practice to improve access to care and services for their patients. Fees will be simplified and aligned, modified to enable team-based care, and some fees initially connected to the time-limited A GP for Me initiative will be transitioned. Throughout these changes, the overall budget for GPSC incentives will remain the same.

Continued on p.3

Upcoming GPSC fee changes *Continued from p.2*

Current	Change
GP with Specialty Training Urgent Telephone Advice Fee G14021	
Payable to a GP with specialty training for urgent communication regarding assessment and management of a patient. Only eligible for requests initiated by a specialist or a GP.	Effective July 1, 2017: Expand the eligibility for fee G14021 to include requests for urgent telephone advice initiated by an allied care provider.
Chronic Disease Management G14050, G14051, G14052, G14053	
One of the two required visits must be in-person with the FP and one may be a group medical visit or by telephone with the FP or nurse (G14079 and G14076 may be delegated).	Effective October 1, 2017: Allow one of the two required visits to include an in-person visit with a college certified allied care provider. (See G140YY for details of new ACP visit tracking code)
Allied Care Provider Visit G140YY	
	Effective October 1, 2017: Allow a college certified allied care provider to provide one of the visits required for GPSC chronic disease management. Submission of this $0.00 fee by the family physician indicates an in-person visit was provided by a college certified allied care provider working within the family physician's practice where the family physician has accepted responsibility for the provision of that care.
Planning Visits for Complex Care G14033 and G14075, Mental Health G14043, and Palliative Care G14063	
Varied requirements for whether a same day visit service must or may be billed on the same day as the planning incentives.	Effective October 1, 2017: Allow the option for a same day visit service to be billed on the same day as the planning visit fee for any reason.
Varied requirements for whether the 30-minute total planning time must take place all on one day.	Effective October 1, 2017: Allow for the required 30-minute planning time to not all have to take place on one day and enable appropriate non-face-to-face planning tasks to be undertaken by a college certified allied care provider working within the physician practice.
Varied requirements for whether all or majority of the 30-minute planning time must be face-to-face.	Effective October 1, 2017: Require the majority of the 30 minutes to be face-to-face across all planning incentives.
Mental Health Management G14044, G14045, G14046, G14047, G14048	
Fees do not allow delivery by videoconferencing	Effective October 1, 2017: Allow delivery by videoconferencing to align with the current MSP counselling telehealth visits.
Telephone/Email Follow Up Management G14079	
Restricted to patients for whom a GPSC planning fee has been billed. Can be delegated to AHPs, including MOAs.	Effective October 1, 2017: Fee no longer available. Physicians who have submitted G14070 can bill G14076 GP-Patient Telephone Management for a clinical telephone discussion with any of their patients.
GP-Patient Telephone Management G14076	
Current value is $15.	Effective October 1, 2017: Increase the value to $20 to better reflect relativity to a base office visit.
GP-Patient Email/Text/Telephone Medical Advice Relay G140XX	
	Effective October 1, 2017: Create a new GP-patient email/text/telephone medical advice relay fee (G140XX), applicable to all patients and delegable to AHPs, including MOAs. Set the new G140XX to $7 to better align with comparable Fee for Service INR fee G00043 (value of $6.83).
GP with Specialty Training Telephone Patient Management G14023	
Currently pays $20/15 minutes or portion thereof.	Effective October 1, 2017: Align G14023 with the GP-Patient telephone fee G14076 by making both worth $20 and deleting the per 15 minute component.
GP Attachment Participation G14070/71, Frailty Complex Care G14075, Telephone Management G14076, Allied Care Provider Conference G14077	
Labeled "attachment" fee codes to support A GP for Me.	Effective October 1, 2017: Delete "attachment" from the fee code names as A GP for Me has completed. Effective October 1, 2017: Rename Attachment Complex Care Management G14075 to GP Frailty Complex Care Planning and Management. Effective October 1, 2017: Rename Attachment Telephone Management G14076 to GP-Patient Telephone Management. Effective October 1, 2017: Rename Attachment Patient Conference G14077 to GP-Allied Care Provider Conference. Effective January 1, 2018: Rename the GP Attachment Participation Portal G14070/71 to GPSC Portal. For information about fees that are accessible through participation in the portal please see the **FAQs** online.
Unattached Complex/High Needs Patient Attachment Fee G14074	
Compensates for the time, intensity and complexity of integrating a new patient with high needs into a family physician's practice.	Effective October 1, 2017: Fee no longer available. For other GPSC incentive fees that support the care of complex patients, please see the **FAQs** online.
GP Facility Patient Conference G14015, GP Community Patient Conference G14016, GP Acute Care Discharge Conference G14017	
These fees compensate for conferencing with allied care providers to improve patient care and continuity.	Effective January 1, 2018: Fees no longer available. For other GPSC fees that support conferencing please see the **FAQs** online.

For more information, including FAQs and a downloadable summary chart, visit **gpscbc.ca/news**.

Patient medical home: A broader perspective *Continued from p.2*

He noted the strength of the BC landscape, where significant social infrastructure is in place that enables partners to consider how to integrate a patient medical home into communities, and sees much of what has enabled success elsewhere happening in BC.

Family doctors are central to integrated care. Primary care providers are central to integrated care in all health care systems. Grundy reminded family doctors that "there is no system of care that works very well in the world without you as the foundation of that system."

Change must be physician-informed and physician-driven. Changes must be rooted in a common set of principles and priorities that came from doctors themselves. If imposed or legislated, efforts will fail, he said, advising partners to ask primary care doctors, "How can you change your practice? You tell us what you want to do." He encouraged physicians to own the journey: "Stand up and say, 'This is important for me and for my patients.'"

Key enablers are integral to success. Payment reforms, use of data, improved communication/patient engagement, and tools for physicians are some key enablers for success of patient medical homes. However, Grundy stressed that tools must support and enhance—rather than replace—the relationships that are vital to the work to transform the primary care system through the patient medical home.

To read a full-length version of this article, visit **gpscbc.ca/news**.

Finding a way to have it all

"In the past it was impossible to find time to make patient visits at nursing homes," says Dr Margaret Myslek, a family physician in Oliver. "Afternoons ran too late. Mornings were too busy. As a result, they rarely happened. And I felt helpless."

All that changed last year when Dr Myslek adopted a new office practice, which put rapid access appointment blocks into her calendar two to three days per week. Patients with simple issues that can be solved in five minutes are now routinely booked into these spots.

Dr Myslek had tried rapid access before, but says it only became successful with proper staff training, followed by patient training. "When patients are prepped to know this is a short appointment, they understand and are delighted we can slip them in."

Patients at Oliver's two residential care homes are equally delighted. By making her office more efficient, Dr Myslek has been able to regularly schedule a Friday morning block every two weeks to visit patients at McKinney Place and Sunnybank Retirement Centre.

"These regular visits have made such a huge difference," says Michelle Larose, LPN at McKinney Place. "Residents worry a great deal and are anxious if they don't know when the doctor is coming. It's wonderful now. The patient feels validated."

Not only are the patients happier, but it has made care at the facilities much more efficient, and allowed for continuity of care. "We can help patients prioritize lists of what they'd like to talk to the doctor about ahead of time, which is much more efficient."

Facilities also have documentation ready, and have the right staff available. "If we know they're coming, we can make sure patients are up, awake and their family can be there too," explains Alexander Brockholm, assistant manager at McKinney Place. Both facilities noted that there is less remote filling of prescriptions, and by taking care of small issues on site, larger ones can be avoided.

Communication is key. McKinney Place keeps a communications notebook where patient notes are left for physicians. "But, the missing piece that made this ineffective was knowing when the physicians would come," says Brockholm.

To aid in communication, Dr Myslek's office makes a reminder phone call the day before she visits a care home.

These visits have not added any extra time to her work schedule. "The biggest win for me is that I can do more by being more efficient, and I'm less tired at the end of the week," says Myslek. "I'm thrilled."

Some residents at Sunnybank now come down to the office on Friday mornings, not for an appointment but just to say hello to Dr Myslek. "It's therapeutic for them to know she's there at a regular time, and they will be cared for if they need it," explains Penny Spink, care coordinator at the facility.

"Dr Myslek comes for the morning, but even if a physician could come for half an hour every other week of dedicated time, it would be great. It's so much more efficient," says Brockholm. "This system works, and we are all delighted."

To learn more about the South Okanagan Similkameen Division of Family Practice, visit **divisionsbc.ca/sos**.

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GP Update is produced by the General Practice Services Committee (GPSC), one of four joint collaborative committees that represent a partnership of the government of BC and Doctors of BC.

The GPSC strengthens full-service family practice and comprehensive patient care in BC with its programs and initiatives. For more information, visit **gpscbc.ca.**