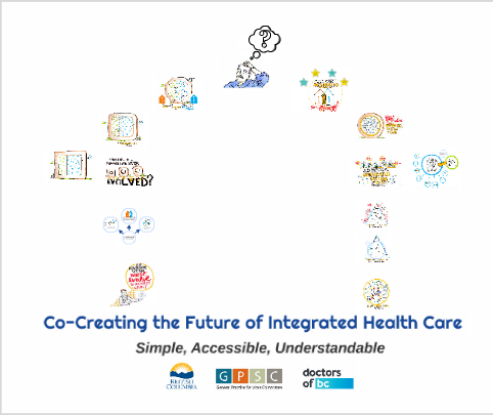
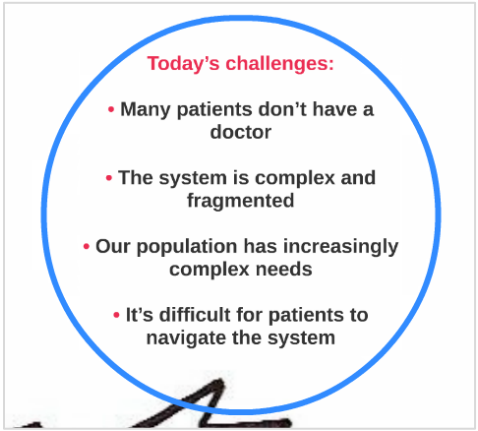
Co-Creating the Future of Integrated Health Care

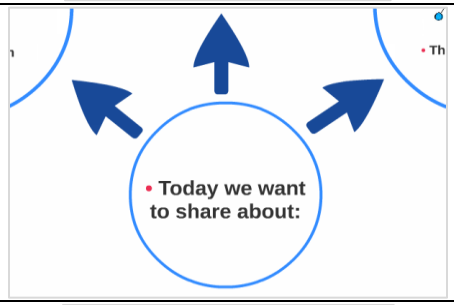
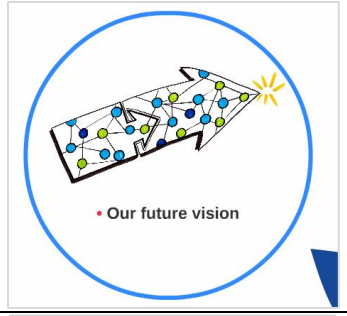
General Practice Services Committee

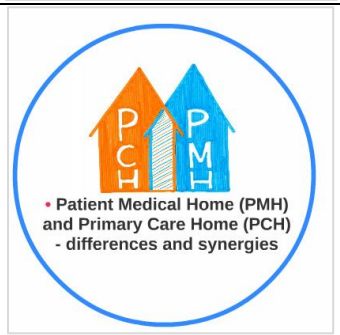
The text below accompanies a Prezi presentation entitled *Co-Creating the Future of Integrated Health Care*. The topic column will guide you through the presentation. There are several places where visuals home in to highlight a point. Each new topic line item represents progression through the Prezi. Please click your mouse at the end of each section to advance through the presentation.

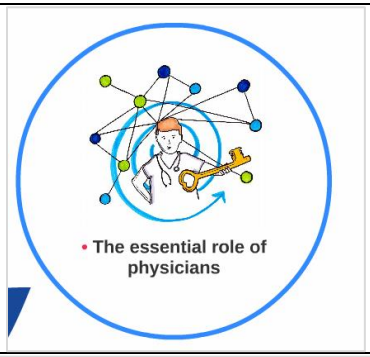
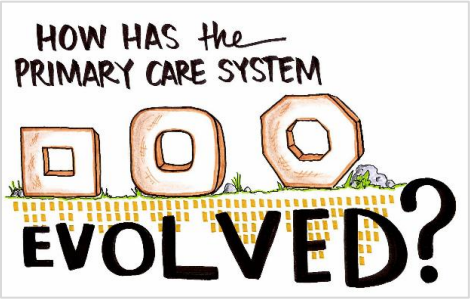
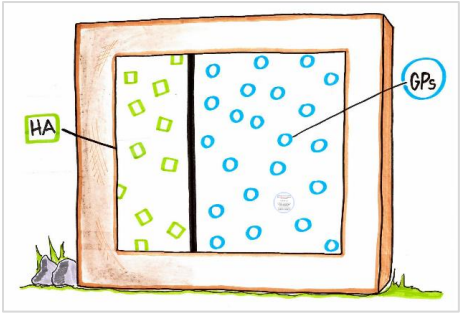
Topic	Notes

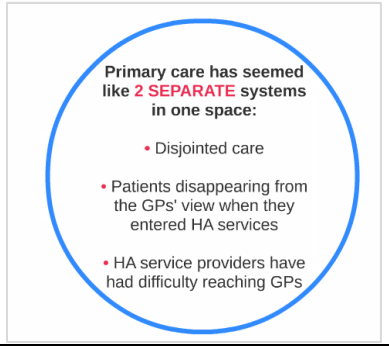
	- Over the past years, all of us together have worked to improve primary care. Collectively, we have made great strides in communities around BC.
	- Doctors have benefitted. Patients have benefitted. But there is still much more we can do.
	- Last year, the GPSC heard from more than 1,700 family doctors as part of its visioning work. Family doctors said that:
	  ○ They value providing longitudinal care to patients and having relationships with them.
	  ○ They want to provide a broad scope of services, but need support from colleagues and the system to do that.
	  ○ And, doctors recognize the value of working in a team with other providers and the need to coordinate care for patients through offices.
	- Changes need to occur for doctors to be able to provide access to high quality primary care for all patients.
	- Doctors were clear that any health delivery model must put the patient first and at the same time, pay attention to physician wellness and professional satisfaction, as well as develop any new models in response to local needs and realities.
	Doctors' input was brought forward to the Ministry and Doctors of BC, will continue to work towards those changes both through and alongside the GPSC.
	- We are on the cusp of the most significant health care transformation in our lifetime.
	- Together, we are about to co-create the future of integrated health care.

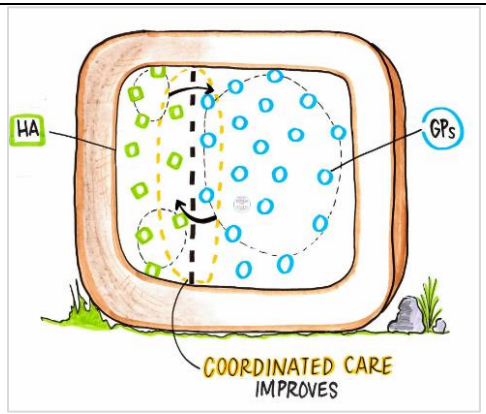
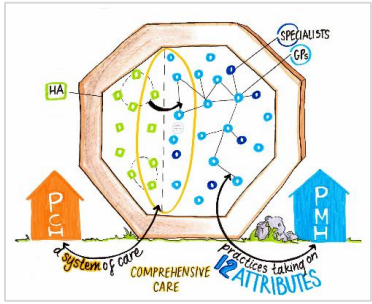
	- While there have been many improvements in recent years, today's primary care system faces some significant challenges that are familiar:
	  ○ Many patients don't have a family doctor, although A GP for Me has attached more than 100,000 patients.
	  ○ The system is complex and fragmented. It's difficult for patients and their providers to navigate the system.
	  ○ Our population is aging and has increasingly complex needs.
	  ○ And, GPs are not always provided with information about care their patients receive outside their practices, even though patients get most of their care through GP offices.

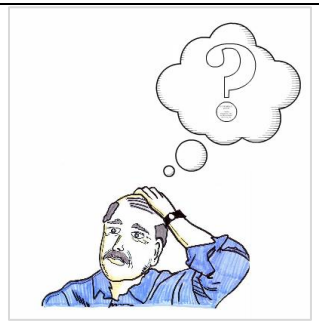
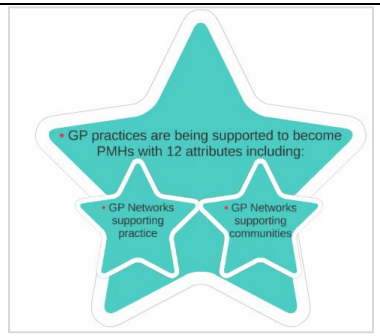
	- Building on all the foundational work of the GPSC and Divisions and all the work of our partners, it's time for our health care system to evolve to the next level.
	- Which leads us to the GPSC's strategic direction.
	- Our vision for the future. The GPSC vision represents the shared vision of the committee partners: the Ministry, Doctors of BC, and health authorities.

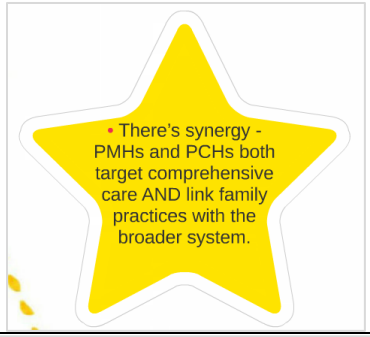
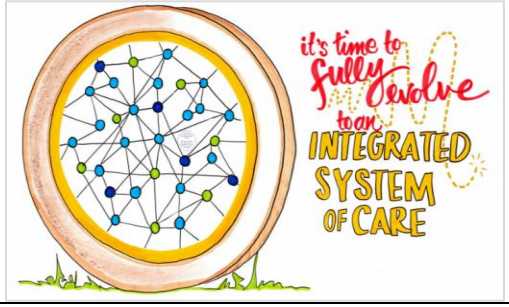
	- It centres on two main areas of focus:
	  ○ the Primary Care Home, and
	  ○ the Patient Medical Home.
	- You can see there is considerable overlap. These two related concepts will drive all we do.

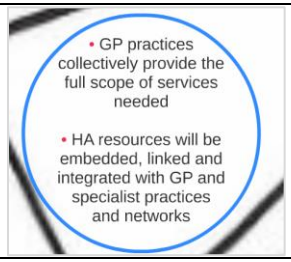
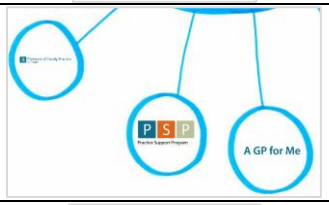
	- And, of course, the essential role that as family doctors hold in the evolution of primary care. The family doctor is the lynchpin.
	- To move to the next level, we're going build on where we've been. - These symbols – the square, the rounded square and the octagon represent different stages in the evolution of the primary care system.
	- This diagram represents our primary care system in the community as you could say it existed in the days before Divisions of Family Practice, and before the days of the health authorities' IPCC work. - Traditionally, patients have received most of their care from family doctors, represented here by the blue circles. - Some patients would also access health authority services in the community, like home and community care, or mental health and addictions support. There are also primary care services such as public health, primary care clinics, and health prevention. That's represented by the green squares. - There's a solid line down the middle because there was limited coordination of the two, and not a lot of information-sharing.

	- In many communities, it seemed like there were 2 SEPARATE systems in one space. That resulted in:
	  - Disjointed care, and
	  - Patients disappearing from their GPs' view when they entered health authority services.
	  - Also, health authorities have had challenges connecting with GPs, to either access or share information about their patients.

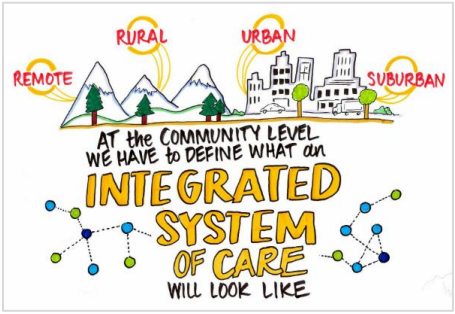
	- Over the past several years, there have been a number of initiatives aimed at better linking these two systems. So now we have a permeable line, to recognize that there has been some information going back and forth, as well as improved patient flow. - While those initial links between GPs and health authorities were happening, the GPSC was focused on helping family doctors connect with each other through Divisions of Family Practice. That's what the dotted oval on the GP side indicates- those links and that collaboration that's been occurring. - At the same time, the health authorities were doing their own work: to integrate their services – such as home and community care – and strengthen the linkages across the system. That integration is represented by the black dotted circles on the health authority side. - The creation of divisions and the CSCs have given GPs and health authorities a space to work on creating ways to improve patient care in their communities. That's what we see in the yellow circle.
	- While primary care linkages are improving, we are at a place in many communities where it can still seem like we have two separate systems.
	- Now is when we change that. - The concepts of the Patient Medical Home and the Primary Care Home will feed into a linked system of comprehensive care that brings together GPs, specialists and health authority services, making it easier for patients to access care.
	- We'll work to increase partnerships to: o Develop resources and o Better link services.

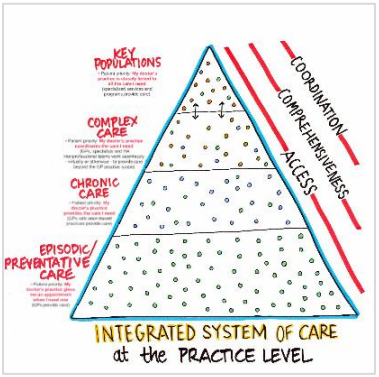
	- We need to do this, for ourselves and also for patients. Right now, we have a system that confuses patients.
	- Policies, procedures, silos and bureaucracy are in the way. We can't continue to add more patient navigators to guide patients through a complex system.
	- The Primary Care Home and the Patient Medical Home are beginning to move us towards integrated primary care.
	- GP practices are being supported to achieve the 12 attributes of a Patient Medical Home. In a sense we could say that we are supporting the practices from the inside out, to build a strong foundation and to be better able to link with the broader system.

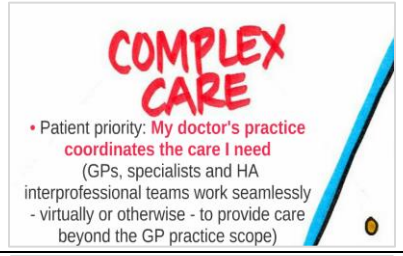
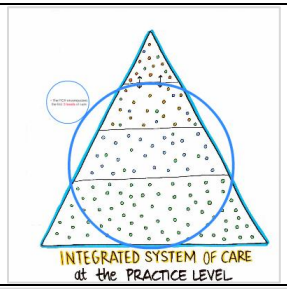
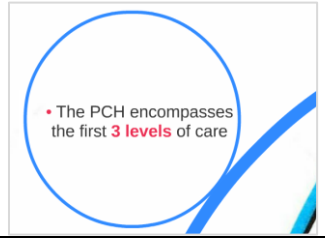
	- GPSC and Shared Care will further support Divisions of Family Practice in partnering with health authorities, specialists and service providers to better link services to create primary care homes in their communities. - This is similar to supporting the physician practices from the outside reaching inward, by wrapping services around the patient and better linking with the Patient Medical Home.
	- A Primary Care Home expands upon the Patient Medical Home in its fully realized form. The linkages with health authorities and community-based services create a system of integrated care.
	- There's synergy – Patient Medical Homes and Primary Care Homes both target comprehensive care and more fully link family practices with the broader system.
	- So, it's time for us to fully evolve to an integrated system of care.

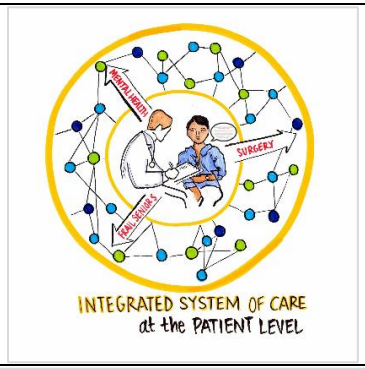
	- As Patient Medical Homes, GP practices will collectively provide the full scope of primary care services. For example, if one GP provides prenatal care but does not deliver babies, then by linking with another GP in their network that does offer that service, the patient's full maternity care is covered. - As part of Primary Care Homes, health authority services will be embedded, linked and integrated with GP and specialist practices and networks.
	- In providing integrated care, GPs, specialist and health authority providers have clear, efficient connections that make sense for providing optimal patient care. - Transforming primary care at the system level is the natural progression to the work we've been doing.
	- From province-wide changes…
	- To community and practice-based improvements through enablers such as fee incentives, EMR optimization, and in-practice coaching…
	- To initiatives like A GP for Me and Residential Care, and working with other collaborative committees like the Shared Care Committee. That foundation will support the next stage, eventually working with specialists and the Specialist Services Committee.

	- One seamless system of care that brings together GPs, specialists, specialized services like supports for frail seniors, and health authority interprofessional teams.

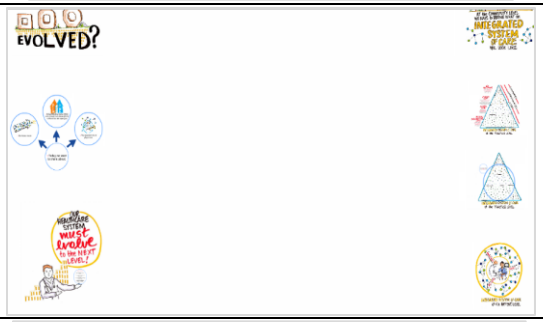
	- At the community level, we have to define what an integrated system of care will look like. It's going to vary depending on the needs of that community, and whether the community is rural, urban, suburban or remote. What region of the province it's located in is also likely to be a factor.
	- The GPSC will support divisions in leading the way in two areas:
	  ○ first, helping to identify what the physicians in their community need to achieve the Patient Medical Home vision, and
	  ○ second, in partnering with their health authority to define what Primary Care Homes look like in their communities and bringing those to life.

	- Let's take a look at an integrated primary care system at the practice level. - This triangle illustrates typical categories of patient care, with the most common, Episodic and Preventative Care, at the bottom. Moving up to caring for patients with chronic illnesses, then up further to the smaller group of patients that suffer from complex conditions. Finally, at the top, we're moving out of typical primary care into specialized services and patients can move in and out of that top tier. - With an integrated care system, the GP is the Most Responsible Provider for all four of those levels. They are either the provider or the access point to care. The fully realized Patient Medical Home or Primary Care Home has the support it needs to care for all the patients in the first three levels, and has linkages with the specialized services needed to provide the care for the most needy patients at that top level. - The result? Comprehensive patient care. Information and services are not fragmented. The GP's practice is involved in coordination of care at every stage. - Now, we've spoken about how this new system streamlines things for those who provide care. Let's take a look at how it affects a patient.
	- At the episodic and preventative care level, what the patient wants and needs is timely access to their GP. - An integrated system helps create GP capacity so the patient result is: My doctor's practice gives me an appointment when I need one and works with me to proactively take care of my health.

	- Patients with chronic care needs may benefit from services provided by someone other than their GP who is part of the team in the practice. Even for services a GP could provide, say diabetes management, if the practice has a nurse with training in that area, they can help patients manage ongoing care AND spend more time doing it while providing more in-depth care and freeing up some GP time. - Here, the patient result to team-based care is: My doctor's practice and team provides the care I need.
	- In the complex care tier, of course, are patients with multiple conditions or who require a specialist's care. - For them, the result of an integrated system is: My doctor's practice coordinates the care I need. Most of their care is still provided within the practice, however. - They have this experience because GPs, specialists and interprofessional teams work seamlessly to provide care.
	- When patients move out of primary care and into specialized services or acute care, with the current system, it's likely the GP will not be linked well into the patient's care and progress. - So the result for the patient is: My doctor's practice is closely linked to all the care I need. And the patient can seamlessly move back into the practice as their need for specialized services or acute care diminishes. - It's a seamless, holistic approach.
	- The integrated system is the primary care home.
	- The Primary Care Home encompasses the first three levels of care.

	- An integrated system of care at the patient level is about the GP and patient relationship. Whether the patient might need surgery, mental health supports or care as a frail senior…

	- All paths and information lead to and from the Patient Medical Home. Patients are able to have confidence, thinking:
	  ○ My GP knows the whole story of my care!
	  ○ I don't need to worry about following where I am in multiple lineups or on waitlists!
	  ○ Everything is linked! – my records, my care plan, my care providers.

	
	- Change takes everyone. For the past several years, you've been hearing about – and living – the benefits of collaboration. - Now, we're expanding on that. The GPSC is acting on the priorities family doctors highlighted in the visioning process. - To make it happen, it's time for us all to work together in an even deeper way and become part of the evolution.

	- We must break down barriers so patients experience one system of seamless care.
	- Create capacity so all patients have access to primary care.
	- Simplify how the system works, so patients understand how to access care.
	- And support physicians in providing and coordinating the range of care their patients need.
	- This is an exciting time. We are not talking about a project or an initiative. It's something we've never seen before. - It's a system-wide change of the system itself, with every partner in that system galvanized to make change happen. - BC's new primary care system will be simple, accessible and understandable. - It will be a sustainable system we can all be proud of.