

Patient Medical Homes, Primary Care Networks and an Integrated System of Care

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September 27, 2018

Outline of presentation

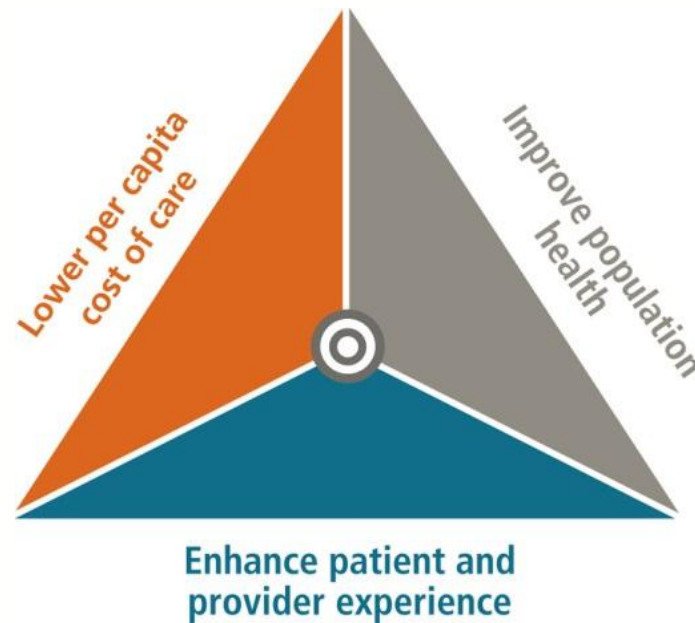
- Context- Primary care, GPSC and JCCs
- Why is change needed?
- Patient Medical Home/Primary Care Networks
- IMIT as key enabler of system change
- Understand IMIT needs from Primary and Community care perspective
- Discussion

Joint Collaborative Committees



General Practice Services Committee

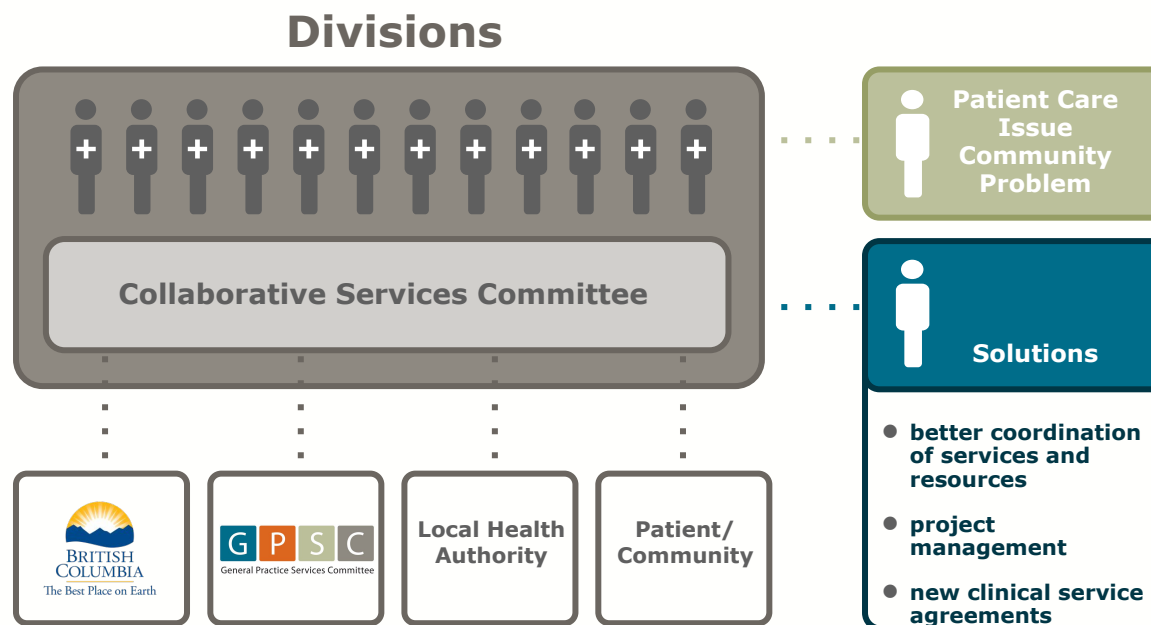
Triple Aim:



Divisions of Family Practice



Collaborative Services Committee (CSC)



Our reality, today

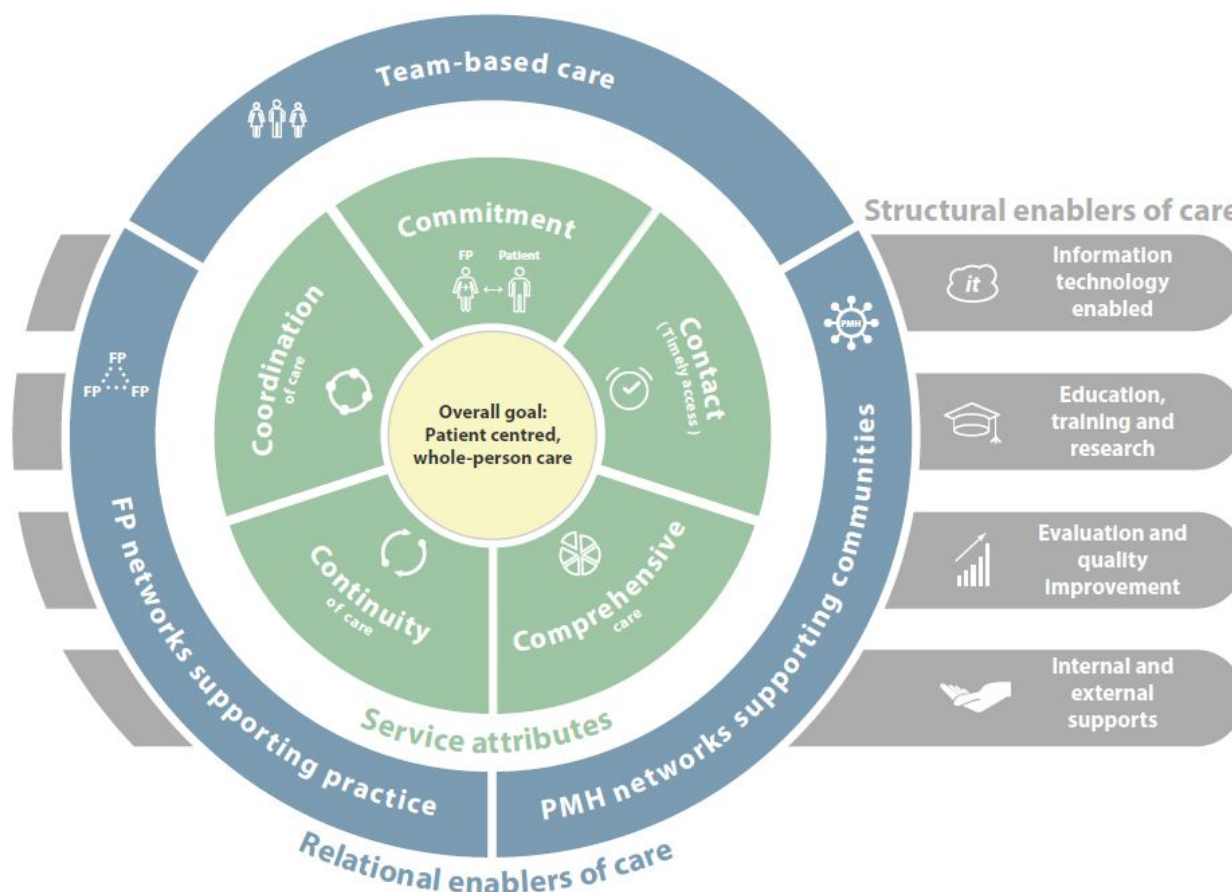
- The number of patients needing care goes up, their needs are more complex.
- The number of family doctors is declining.
- We cannot meet the needs of the population.



GPSC vision

- To enable access to quality primary health care that effectively meets the needs of patients and populations in BC, using the patient medical home to form the foundation for care delivery within a broader, integrated system of primary and community care.

Patient medical home (PMH)



Benefits of a Patient's Medical Home

A Literature Summary of 115 Articles | 2017 Update



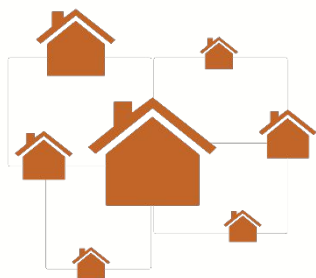
PMH: Key areas of work



Panel
management



Team-based
care

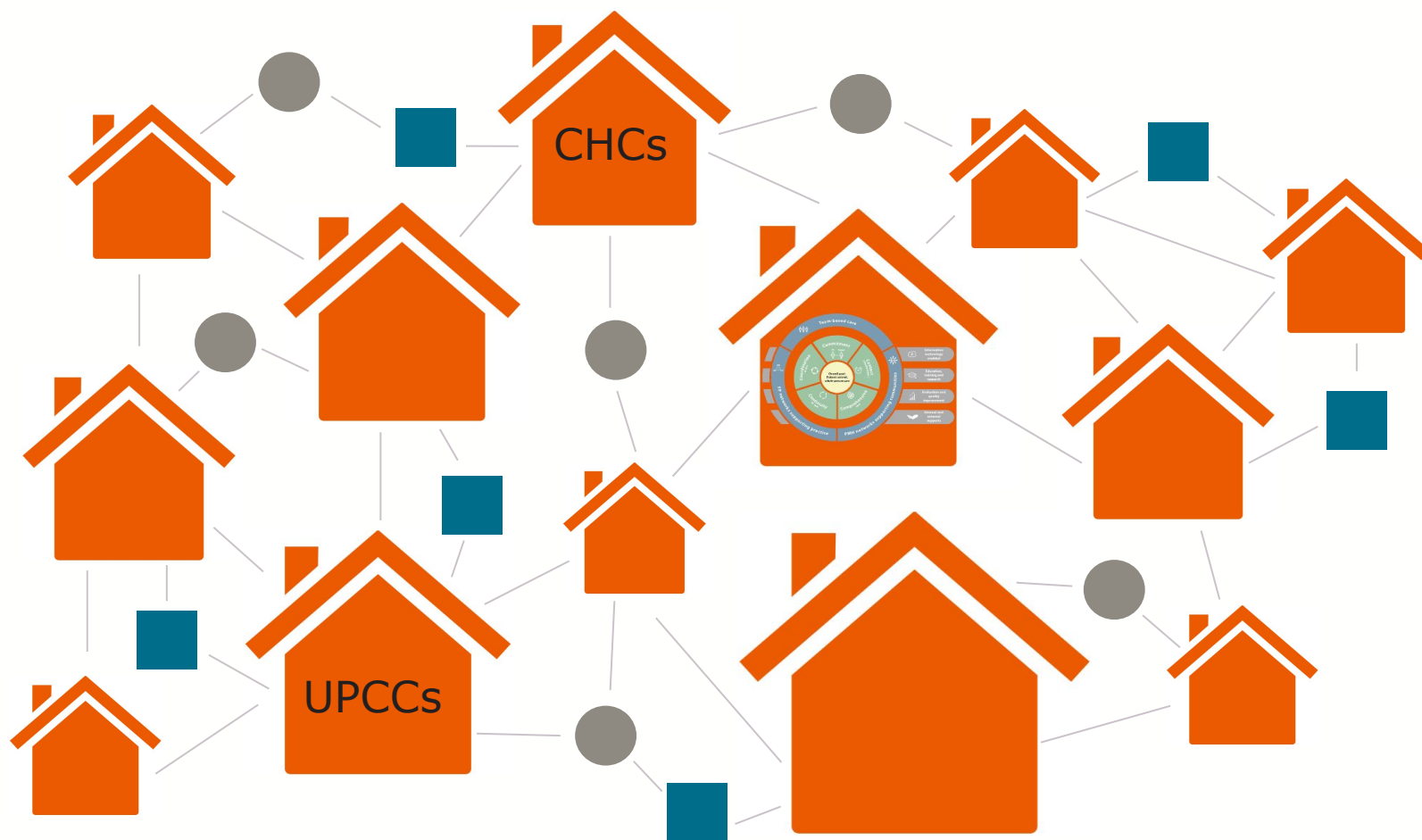


Physician
networks



Primary care
networks

Primary Care Networks (PCN)



PCN attributes

Access & attachment to quality primary care

Extended hours

Same day access to urgent care

Advice & information

Comprehensive primary care

Culturally safe care

Coordinated care

Clear communication

PCN design will include implementation and sustainment of the following functions:

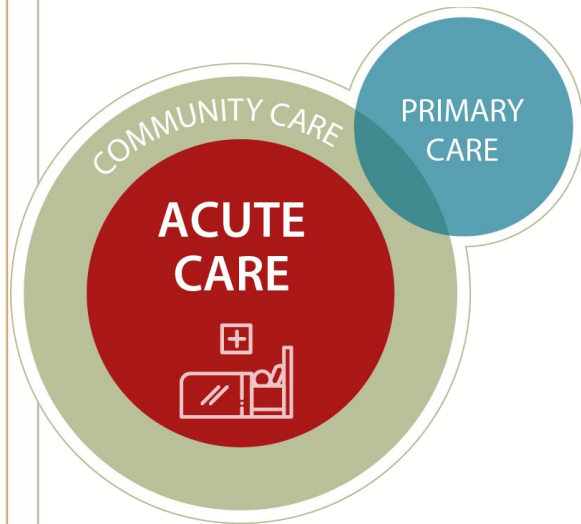
- a. Interdisciplinary team care (in-practice and network) to optimal scope of practice;
- b. Technology-enabled solutions with virtual care embedded into daily operations to link patients and providers (e.g. home health monitoring);
- c. Informational continuity (e.g. appropriate information sharing, single patient health record) and management continuity (e.g. longitudinal care planning, integrated team planning, team-based case management), including working towards linked electronic medical records;

Moving to an Integrated System

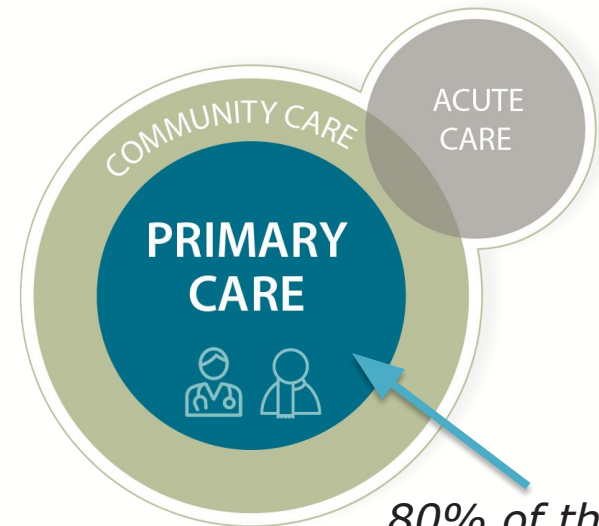
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Institutional
HA-operated
services



*80% of the
population*

Patient-centered
GP-directed
services

System Foundation of Primary Care

- Helps prevent illness and death...
- Associated with a more equitable distribution of health in populations." - *Barbara Starfield (2005)*
- "...Available evidence confirms improved population health outcomes and equity, more appropriate utilization of services, user satisfaction and lower costs in health systems with a strong primary care orientation." - *Atun R (2004)*
- "...the more higher-care-needs patients were attached to a primary care practice, the lower the costs were for the overall health care system (for the total of medical services, hospital services, and drugs). - *Hollander (2009)*

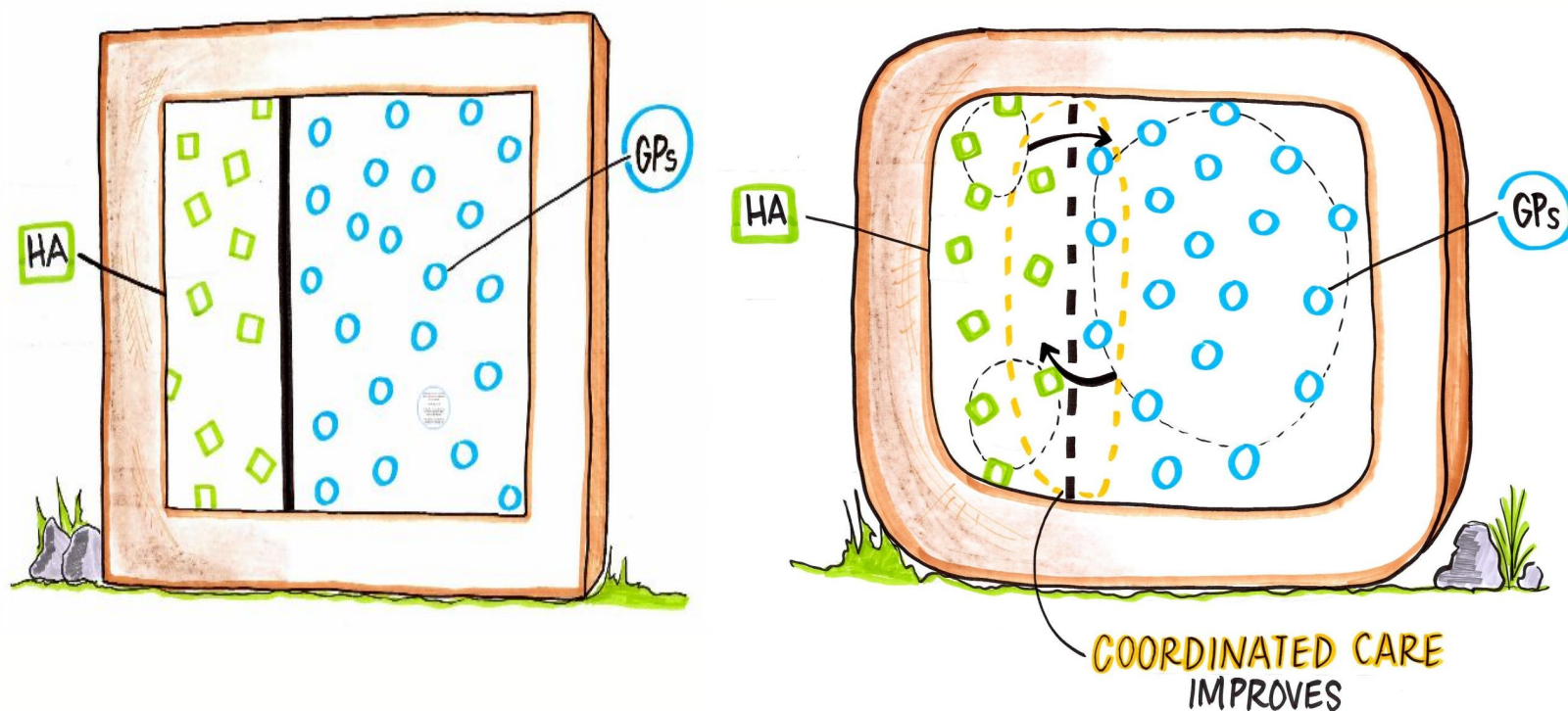
Working with our Specialist Colleagues

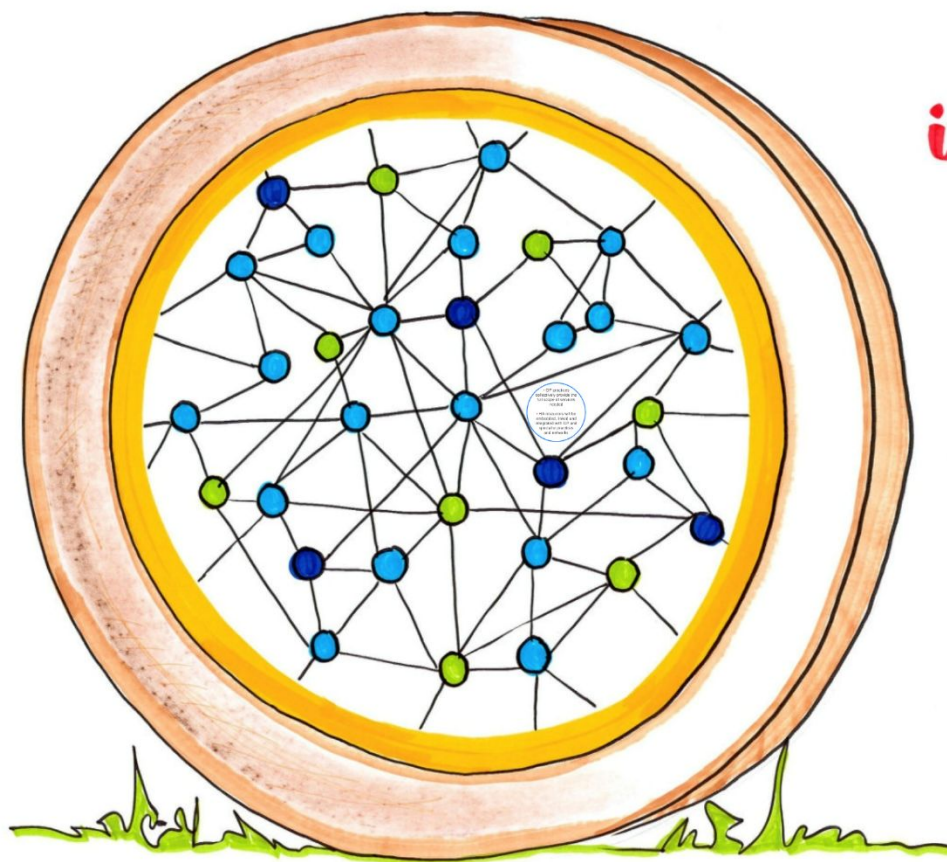


Why change?

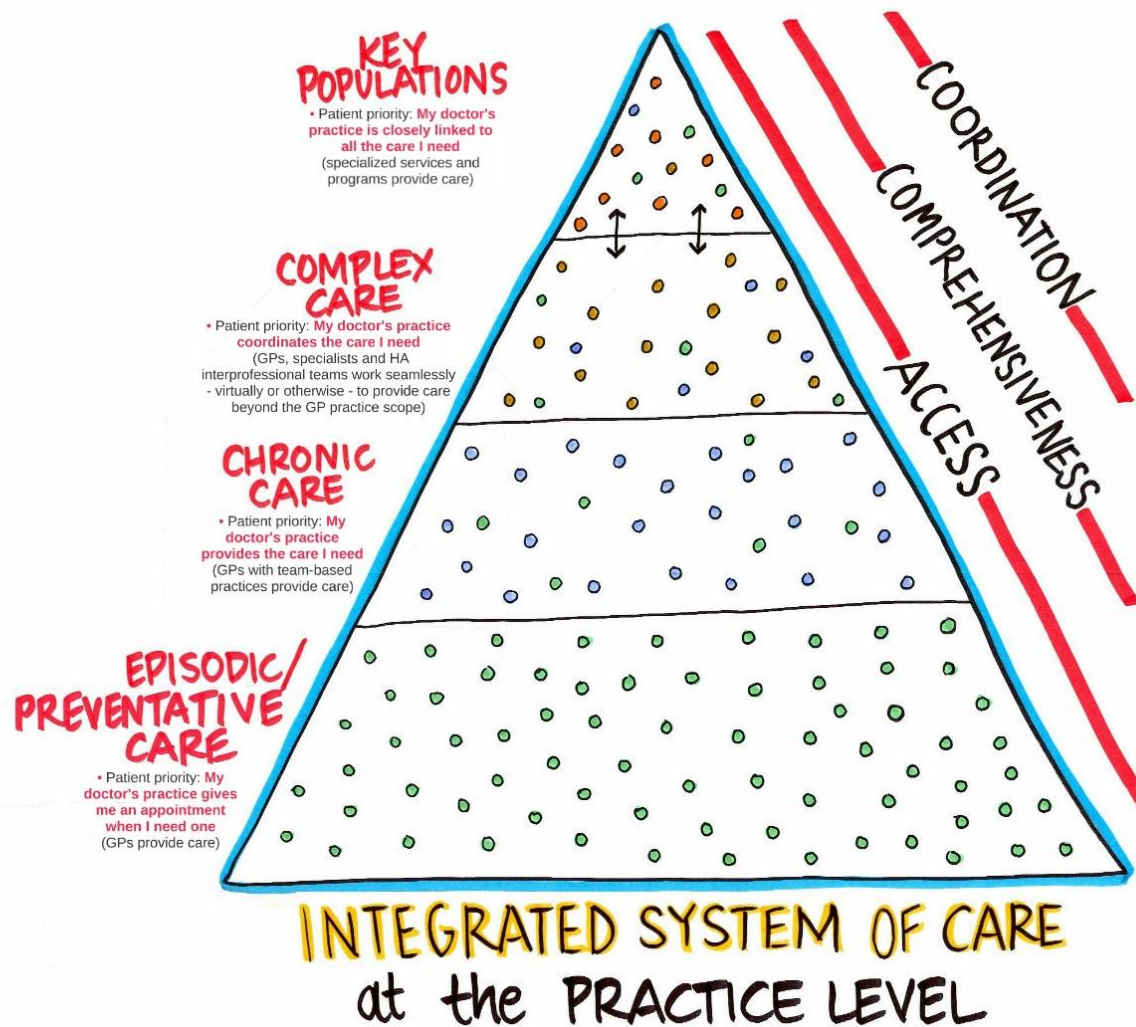


Our Current System





it's time to
fully evolve
to an
**INTEGRATED
SYSTEM
OF CARE**



Patient perspective



Current Context in Primary Care

- Many siloed systems across the sector.
Providers can't see each other's records, even within teams.
- Lots of faxing, phoning, mail, text, email.
- Patients can see very little, if anything.
- Very few patients have access to virtual care interactions.
- Uncertainty around consent, permission, agreements for data sharing.
- Billing model doesn't well support team-based care, new electronic interactions.



Examples of Current Issues

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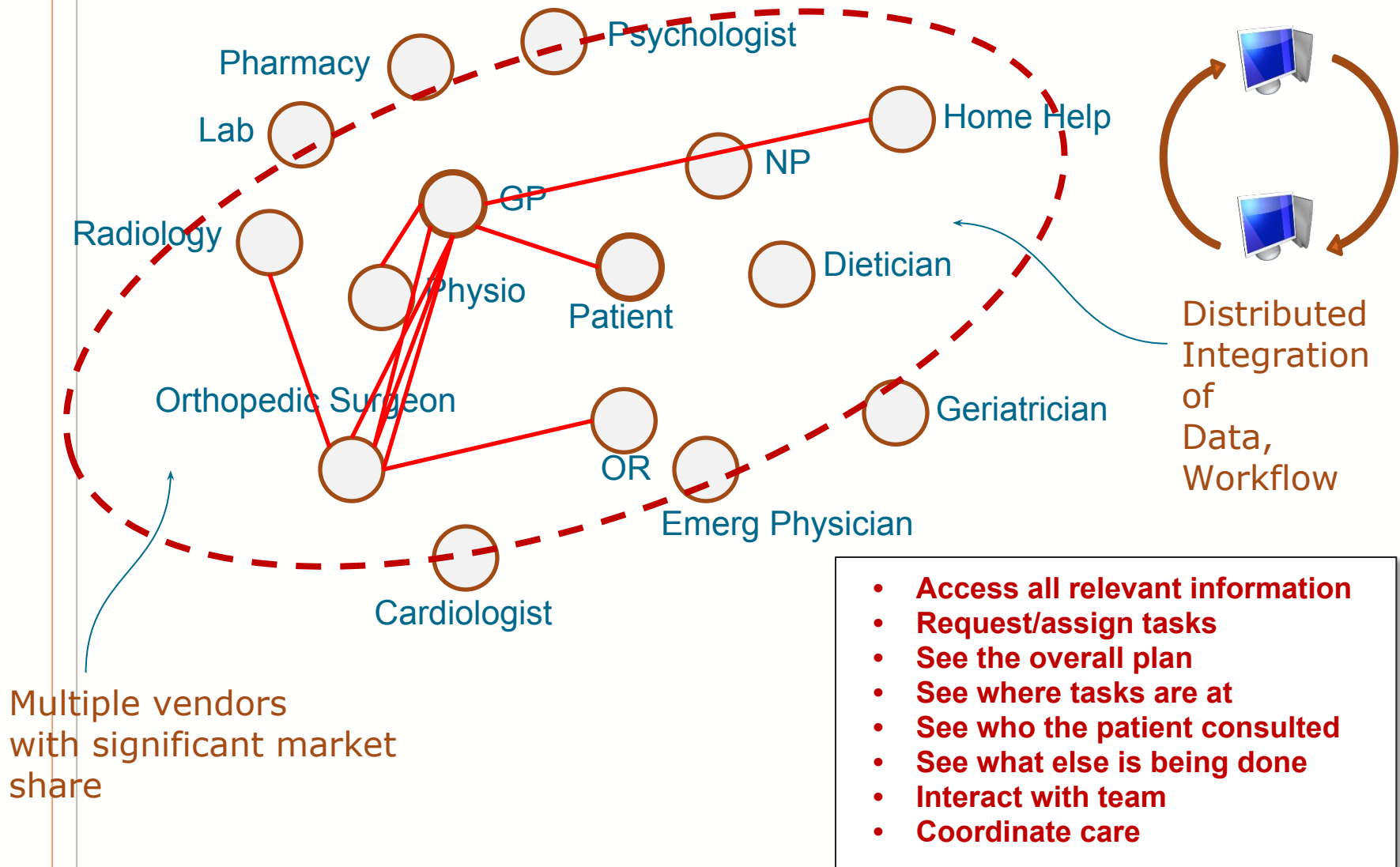


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- Accessing & sharing information – summary, goals/targets, reports, results, care plans
- Avoiding being overwhelmed by information
- Interacting with patient, sharing/receiving info & advice with patient
- Patient engagement, self-management
- Coordinating team-based care, communicating with the team
- Managing referrals, orders, scheduling
- Managing workflow within the practice
- Knowing who's dealt with what already – tasks, results
- Dealing with forms, guidelines
- Decision support
- QI within practice & across wider team

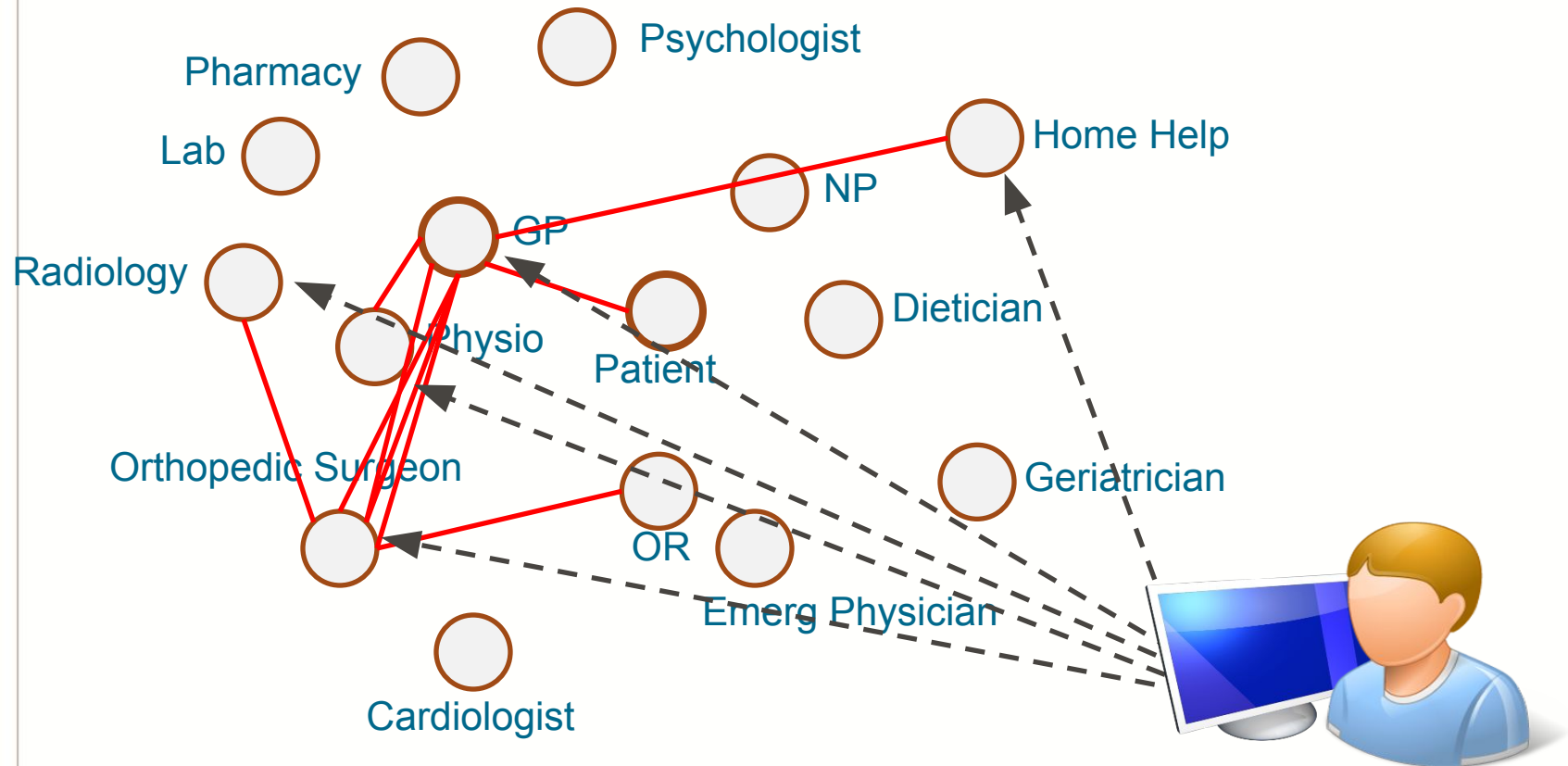
Patient's Journey

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Patient's Perspective

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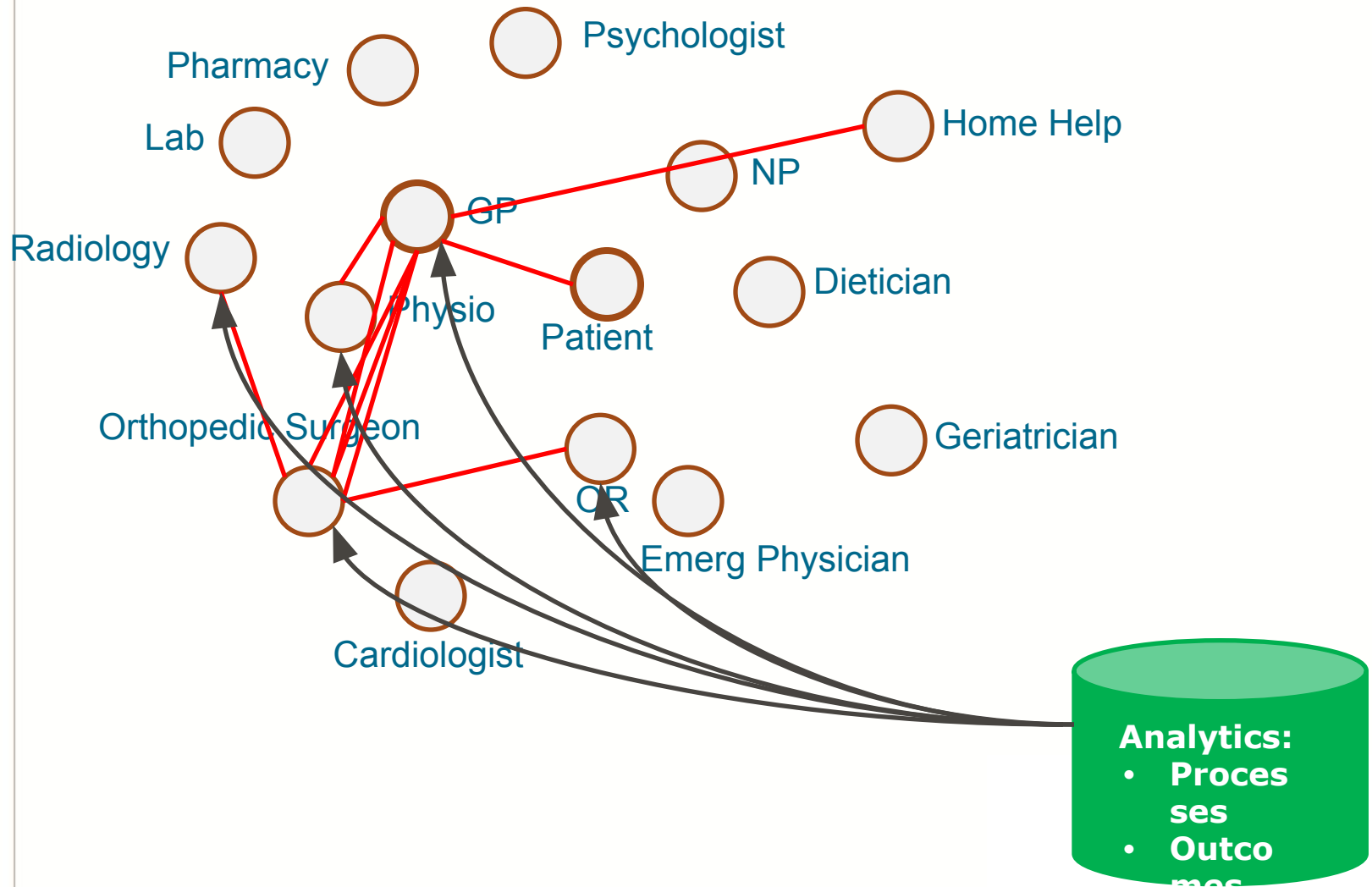
- Access to all records
- Interact with the whole team
- Participate in workflow
- Contribute data, PREMs, PROMs
- Control access to information

System Planner's Perspective

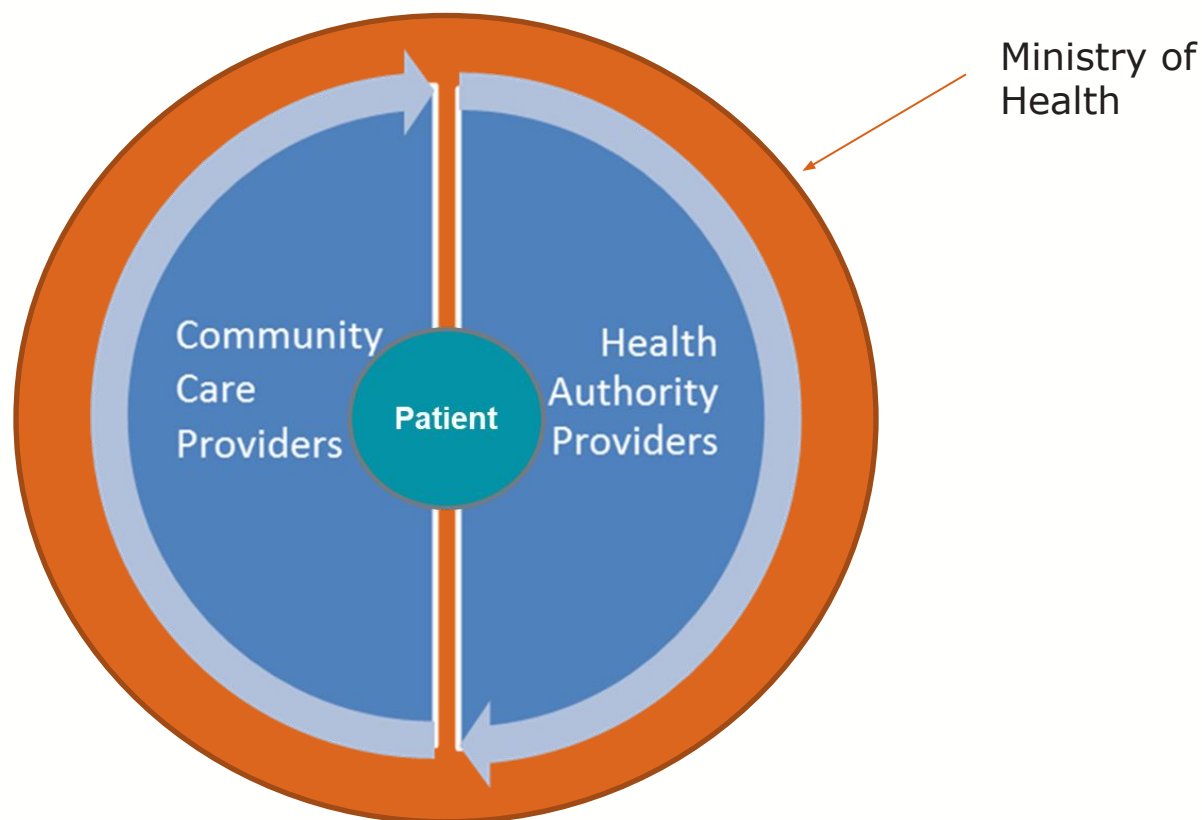
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The Health Sector



History

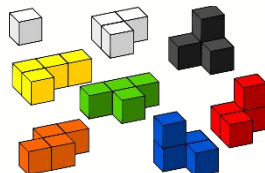
- PITO program created through 2007 PMA
- Mandate to implement EMRs in community physician practices
- MSAs with major EMR vendors
- The PPN was created at the same time through BCCSS (Telus).
- Mandate expanded over time to include change management and meaningful use.
- Program ended in 2014 with no further plans to support community IM/IT provincially

What is the DTO today?



Current PC Context - Technical

- **>95% EMR uptake, but very challenging to work with:**
 - No provincial oversight or ability for MDs to have leverage on contracts and expectations
 - Increasing costs for support, making overhead unmanageable
 - Extreme difficulty in switching EMR vendors or merging databases
- **2-way messaging *within* some vendors, but not *between***
- **Emerging QI tooling – PSP: HDC, Telus**
- **Access to data held in other systems:**
 - Some patient portals available but no provincial strategy– Excelleris, IHA MyHealthPortal, RelayHealth, Telus PHR, KindredPHR, individual EMRs
 - Provider portals – Excelleris; CareConnect, UCI starting to reach into community in some areas
 - Remote login to hospital systems (Cerner, Meditech) for those with privileges
 - Meds: PharmaNet (med list only, no ePrescribing, not integrated)
 - Public Health: Panorama, PARIS, MOIS
- **eReferral, eConsult: limited to IHA and NH**



Why aren't we there yet?

Based on feedback:

- Historical top-down approach; vendors excluded; vendors have their own roadmaps, pan-Canadian views
- Lack of business drivers for vendors
- Work historically progressed in multiple silos with lack of provincial direction – MoH, HA's, DoBC; competing, even contradictory, requests to vendors
- It's not just about HIE, it's also about supporting the *processes* of care delivery ("workflow")
- Long history of "projects", "pilots"
- Need for a single voice for Community providers in IM/IT



Roadmap

1. **Longer-term Strategic View**
2. Short-term Tactical View



Harmonized
Privacy Legislation

Nobody holds
Entire Record

Supportive
Payment Model

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Care
coordination,
workflow

Committee

Reporting,
Analytics

Identity,
Relationships

Role-based
Access Control

Coding

Security,
Authentication

Event
Notification

Examples:

- Within your practice
- Across the patient's journey
- Across populations
- Around specific interventions
- Learning system →
feedback into workflows, guidelines
- What appointments have already been made?
- Results carrying followup automated followup

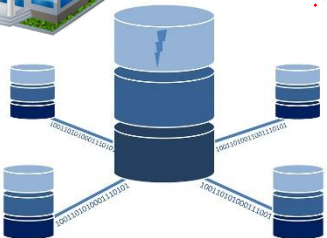
Integrated with E

Retrieve records,
data ("pull")

IHE XDS



Web-based apps,
decision support,
other systems



Regional repositories, ?EMRs



Patient portals, PHRs, apps



EMRs, hospital systems

Roadmap

1. Longer-term Strategic View
2. **Short-term Tactical View**



Focus on Standards

Guidelines around privacy framework

Billing code discussions



Provincial work on Shared Care Plans;
Care coordination using messaging

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Emerging QI tools from HDC, CPCSSN, Telus; PSP dashboard

IHA/NHA leading interoperability with
CDX
Clinical Data eXchange

Identity –
Provider Location
Registry integration

Secure network,
Authentication

PharmaNet integration
(Meditech, Cerner,
CareConnect)



Your EMR:
Improved integration

Log into portal/CIS;
Launch CareConnect in
context from EMR

Bi-directional cross-vendor
messaging

Structured data (eg. ECG)

Some can
upload content
to portal, CIS

Access info;
- eReferral, eConsult
- Clinical summaries
- Narrative care plans
- Notifications



CareConnect
UCI, other portals
Cerner, Meditech



Patient portals, PHRs



EMRs, hospital systems

Challenges & Risks

- Patient records access, interaction needs attention
- Primary Care transformation strategy and surgical strategy at risk as they have limited access to information and no plan or mechanism to adequately address (currently using fax and phone)
- Large CIS investment but little in community; arguable whether CIS helps community care
- Current lack of strategy or drivers towards solution for the platform ecosystem target state
- Existing policy & funding barriers, regional decisions largely block progress
- EMR vendor governance is a top priority
- Current IM/IT governance essentially excludes community

For Patients – enable patient tools to access & contribute to their records:

Policy, funding and common approach to enable patients to:

- Access records wherever they reside, collect their own records into a PHR, pull records from other systems as desired, share with others.
- Contribute to the record in other systems, submit forms, participate in 2-way communication with their care team.

For Providers – ready access to data and information (unstructured at start):

Policy, funding and common approach to enable providers to:

- Communicate with patients & care team, share contributions to record, coordinate care, distribute updates, send to repositories.
- Collect PREMs, PROMs, assessments; rudimentary orders.
- Migrate records between systems.
- See live record in GP and other systems from Emerg, walk-in clinics, and across the care team; retrieve content on demand.

Summary



Short-term

- Mainly human-readable data
- 2-way communication
- Transitional use of portals
- eReferral
- eConsult
- Clinical summaries
- Narrative shared care plans

Longer-term

- Distributed data access
→ virtual single record
- Machine-readable data
- Managed workflow
- Seamless ecosystem of EMRs, portals, virtual care
- Embedded decision support
- Advanced analytics



How do we make the future of PMH/PCN successful?

1. Show providers that **we are doing something!**
2. It won't be successful without broad IM/IT support, clear mandate and funding.
3. Need to co-create the future through collaboration between clinicians and IT professionals.
4. Need a governance structure for community IM/IT, outside of the traditional institutional framework, that is in partnership with the JCCs
5. Need core sector-wide HIE infrastructure
6. Need to address policy issues related to compensation, P&S, EMR vendor market, sector-wide leadership and governance.

West Coast Trail,
Vancouver Island, British Columbia



“

If you want to travel fast,
travel alone.

If you want to travel far,
travel together.

”

Thank You

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