

The Big Picture

TRANSFORMING BC'S HEALTH CARE SYSTEM

From a traditional system that is episodic and siloed.

Many people in BC can't get a family doctor or timely access to the full range of care they need. GPs are under stress and the threat of burnout is real. Meanwhile, hospitals are facing unsustainable pressures.

To a new system that is robust and integrated.

It's why doctors, divisions of family practice, health authorities and provincial partners are working to create an integrated system of care across BC, where patients have access to quality primary health care that effectively meets their needs.

THE FOUNDATION

Together, PMHs and PCNs position primary care at the centre of an integrated health care system.



PATIENT MEDICAL HOME (PMH)

A family physician practice operating at an ideal level where patients get the majority of their care and GPs focus on diagnoses, patient relationships and longitudinal care.

PRIMARY CARE NETWORK (PCN)

A clinical network of primary providers in a geographic area who work together in new ways to expand team-based supports for GPs and patients.





BETTER FOR PHYSICIANS

- Shifts focus to diagnoses and patient relationships.
- Brings services together around GPs and patients.
- Eases the burden of doing it alone.
- Attracts and retains GPs.

BETTER FOR PATIENTS

- Increases attachment to a primary care provider.
- Increases access to a broad range of services.
- · Coordinates care and services.

BETTER FOR THE SYSTEM

- Maximizes health care roles and resources.
- · Reduces hospital visits.
- Builds sustainable, quality health care.



Patient Medical Homes

How can I give the best care to my patients?

Where can I get some help? How can I make my practice run better?



A patient medical home brings more supports into a family practice to increase your ability to care for patients.

A patient medical home (PMH) is a family physician practice where patients get the majority of their care. It builds on what GPs are already doing, and takes the practice to the next level. GPs get more consistent support from teams, networks, and clinical services in the community and use data to inform decisions.



PATIENTS Have a relationship

Have a relationship with a GP and access to the best care.



FAMILY DOCTORS
Spend time on diagnoses,
patient relationships and
longitudinal care.

A PMH helps GPs to get relief from caring for patients alone, which can help avoid burnout, and make the most of practice resources, time, and capacity.

Four key changes create a patient medical home:

- 1. Greater use of EMR data to plan care and supports.
- 2. Team support from allied health professionals and other providers.
- 3. Physician networks for peer and patient support.
- 4. Being part of a primary care network.



THE BIG PICTURE

Helps a practice operate at an ideal level, which in turn creates a strong foundation for primary care networks in the community.

Get Involved

The creation of patient medical homes is an emerging area of work in BC. You and your practice team can get started by identifying supports you need for your patients through the process of panel management.

Frees you up to do the work you love to do, and for what brought you into the medical profession in the first place.



Use EMR data to know and plan for your patients' needs. Identify teambased supports that would help you.

Connect with other GPs to plan for mutual patient supports.

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Primary Care Networks

I need support for a patient. Where can I send her? How will I know what happens to my patient?



As part of a primary care network, you have access to a supportive team of health care providers and services outside of the practice to expand care for your patients.

A primary care network (PCN) is a clinical network of providers in a geographic area where patients receive expanded, comprehensive care and improved access to primary care. PCNs include GPs in patient medical homes (PMHs), allied health care providers, health authority services and community health services. Everyone works together to provide all of the primary care services for the local population.



PATIENTS

Get timely, comprehensive, coordinated care outside of the doctor's office when needed, arranged by the GP.



FAMILY DOCTORS

Have convenient access to a supportive network of people and services for expanded patient care.

PCNs reorganize the way everyone works together by:

- Strengthening teamwork, communication and links.
 - Bringing services together around GPs and patients.
 - Creating capacity in a community to increase access.

You get more support to do your job, including:

- Direct access to an array of clinical services.
- Team-based care supports for patients.
- Connections with other parts of the system.



THE BIG PICTURE

Makes the whole community stronger, which in turn supports GPs to care for patients and create patient medical homes.

Get Involved

Divisions of family practice and health authority and community partners have started the work to create PCNs in some BC communities. Other communities will follow.

Participate in a supportive network of local primary care services to increase comprehensive care



Use EMR data to know and plan for your patients' needs. Work with other GPs and use collective data to identify teambased needs.

Work with divisions and CSCs to plan community supports.

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The Difference

PATIENT MEDICAL HOMES and PRIMARY CARE NETWORKS

	PATIENT MEDICAL HOME (PMH) Frees you up to do the work you love to do, and for what brought you into the medical profession in the first place.	PRIMARY CARE NETWORK (PCN) Get access to the right care for your patients, quickly and conveniently.
PATIENT CARE	Patients get the majority of their care and have an ongoing relationship with a GP.	Patients receive expanded, comprehensive care and improved access to primary care.
WHERE	A family physician practice, or community health centre or health authority clinic.	A clinical network of primary care providers in a geographic area.
PROVIDER	The most responsible provider, usually a family doctor who is supported by a team, directs care in the practice and into the community.	Includes all primary care providers: GPs or NPs in PMHs, allied health providers, health authority services and community health services.
PROVIDER FOCUS	GPs focus on diagnoses, patient relationships, and longitudinal care, with expanded support from teams and networks as needed.	Providers bring team-based services together around GPs and patients in PMHs to enable access, and to better support complex care and vulnerable patient needs.
ROLE IN PATIENT ACCESS	GPs manage patient practice panels and take on new patients when there is capacity to do so.	Networks provide primary care services for the local population and build capacity in the community.
KEY CHANGE	A practice operates with greater use of EMR data, more teams and networks, and better access to clinical services in a community.	Primary care providers work together in new ways and to their strengths, through increased teamwork, communication and linkages.
RESPONSIBILTY	Family doctor(s) with their practice teams.	Divisions of family practices, health authority and community partners.
BETTER FOR PATIENTS	Access to timely, coordinated and comprehensive care that meets patients' range of needs.	
BETTER FOR FAMILY DOCTORS	 Be relieved of caring for all patient needs alone. Avoid burnout. Make the most of practice resources, time and capacity. 	 Access an array of clinical supports and services outside of the practice. Be connected to other parts of the system. Provide better access to care for patients.

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Makes the whole community stronger, which in turn supports GPs to care for patients and create patient medical homes.