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Proposal for Renewal of Family Practice - Blueprint for Quality and Sustainability

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This submission proposes a conceptual model with innovative payment reform for Family Physicians to strengthen primary care as the foundation of an integrated health care system, based on quality and value to achieve the Quadruple Aim.

1. Payment reform: Independent Family Practitioners
   FFS Fee Schedule redesign as a comprehensive package of *incentives aligned to goals of quality, value, safety, and sustainability.*

2. Integrated delivery system for patient-centered care:
   Accountable Care networks of community Family Physicians and Specialists connected with acute care facilities and community care.

Vision: Best care for all, sustainable per capita cost, healthy population (*Triple Aim*), + delivered by healthy physicians in a vibrant profession (*Quadruple Aim*)

Values: Care Excellence, Equitable, Sustainability

Goals

1. **Sustainability of Family Practice as the foundation of strong primary care and a patient-centered, integrated health system**

   a) Ensure that every British Columbian can have access to a Family Physician, especially vulnerable populations including elderly and people with chronic diseases and complex conditions.
   b) Incentives and resources to support the provision of first contact, comprehensive, coordinated, and continuous medical services by family physicians.
   c) Recruitment and retention of Independent Family Practitioners.
   d) Healthcare delivery system reforms to support collaboration with Family Physicians for integration of patient-centered care, improve communication and efficiency.

2. **Achieving the *Quadruple Aim***

   a) Care quality and improved patient outcomes.

b) Sustainability of total costs by decreasing avoidable hospitalizations and ER visits, reducing system fragmentation, waste, duplication, unnecessary and inappropriate (e.g. non-evidence-based) services.
c) Improved population health.
d) Reduce physician burnout, improve professional satisfaction and wellness.

We propose a comprehensive strategy aligned with payment reform to achieve the "Quadruple aim", by strengthening Family Practice as the cornerstone of Canada's publicly funded healthcare system.

Family physicians empower their patients to receive patient-centered, integrated, and safe care across the health system.

There is strong evidence that a strong primary care system

a) improves Quality and patient experience
   Lower mortality and morbidity
   Better patient satisfaction (trust and adherence)
   Decrease ED use, hospitalizations
b) lowers per capita costs
c) improves population health
   Higher life expectancy
   Improve functioning and quality of life
   Equity

This is the Triple Aim.

FFS payment reforms are aligned with defined goals and measurable objectives.

The purpose of system reform is to enable Family Physicians to practice a high standard of medicine with professional satisfaction and fair economic reward.

Well-designed incentives along with delivery system reforms that enable sustainability of the medical workforce, reduce physician burnout and risk of medical errors, are key to achieving the *Quadruple Aim*.

Principles

- Based on Quality and Value
- Sustainability of total health system costs
- Doctor-patient relationship at the center of primary care
- Primary care is based on a whole-person orientation, not single-diseases based.
- Patient's right to privacy, confidentiality, and informed consent
- Professionalism: excellence/standards, ethics, autonomy
- Accountability is to the patient (Hippocratic Oath), not only to government/HA/payer
- "Team-based care": can be either co-located or virtual; the physician is the medical leader; clear role and responsibilities of team members is based on training, for best patient outcomes

- Learning health system: physicians-led for continuous improvement, to promote evidence-based policies and practices in the health care delivery system.

Measurable Objectives

1. Support for Independent Family Physicians (FP) providing comprehensive, longitudinal primary care for vulnerable patients with complex, chronic diseases must focus on:

   a) ***Recruitment*** - new FPs to join or take over practices, locum coverage.

   b) ***Retention*** - support FPs to continue practising and mentor younger/new FPs**.**

   c) ***Prevent Physician Burnout*** - by addressing root causes including inadequate FP fees; reducing bureaucracy/administration that are unnecessary and onerous; improving work-life balance with flexibility and autonomy for FPs. Collaborative on call coverage for night and weekend calls, and for holidays is vital to 24/7 accessibility.

2. Reform the ***payment system*** for GPs in BC that supports high quality, safety, and value for better health outcomes.

   - Incentives for the 4 pillars of primary care: <u>first contact, comprehensive, continuous, coordinated</u> under a <u>longitudinal doctor-patient relationship</u>.

   - ***Quality dimensions: safe, effective, patient-centered, timely, efficient, equitable***.

   - Key to sustainability of the Health Care system: reduce total health care costs, budget neutral, targeted funding for Community longitudinal GPs, evidence-based policy evaluation for continuous improvement.

3. Integration of primary care by Community Family Physicians with acute care/ER, community care, mental health services, and public health with coordination of ***accountable care.***

   - Family Physician as <u>Most Responsible Physician (MRP)</u> in the community.

   - <u>Patient *panels/registry*</u>

4. Control total costs by strengthening primary care

   - Timely access to primary care services including preventive care, diagnosis, and treatment to prevent complications and delays, decrease ***Emergency Dept.*** use for <u>ambulatory-sensitive conditions (ASC)</u> and preventable ***hospitalizations***.

   - Fewer diagnostic tests, specialty consults, and investigations with prevention and good primary care.

- Reduce fragmentation, waste, duplication, unnecessary services, inefficient bureaucracy and onerous processes that divert physician attention from clinical care.

5. Family Physicians play a key role in medical leadership, education, research

    - Engagement of Family Physicians in medical education, training and mentorship for undergraduate, postgraduate students, continuing medical education.

    - Support for Leadership training and professional development

    - Opportunities and resources for practice-based research and evaluation.

A Strategic Framework for Quality and Value in Family Practice

Structure:

- A Family doctor for every British Columbian as the foundation of primary care and patient-centered, integrated health care system.

- Accountability: Community Family Physician as MRP, patient registry/panel.

- Choice and flexibility in practice size and type (group, solo), full-time or part-time, office and staff.

- Independent Family Physician networks: on-call coverage 24/7 access to urgent care, with EMR access to on call physicians, locum coverage, administrative or technology support, and virtual care.

- Accountable care networks: integration of Family Physicians with specialists, acute care/Emergency Dept/ urgent care centers, community services (pharmacists, allied health professionals, home care, social worker, etc.).

Process:

- 4 Functions of Primary Care, roles and responsibilities

- Family Physician as the head of primary care teams, as first-contact for the diagnosis, evaluation and management of acute and chronic medical conditions.

- Team-based care: high-functioning teams have defined roles and responsibilities based on appropriate training and competency, good communication and coordination.

- Empowered Family Physicians practicing good medicine, as strong patient advocates and engaged leaders working collaboratively for a learning health system.

- Incentives that value Family physicians' broad clinical expertise and training, and are based on time and complexity of services.

Four Functions of Primary Care

- The Community Family physician as the ***Most Responsible Physician (MRP)*** is accountable for the provision of whole-patient care, under a trusted longitudinal patient-physician relationship. The Family physician maintains a longitudinal patient record with a Problem List including medical conditions, medications, allergies, etc.

- **First contact** in the health system: The unique ***Gatekeeper*** *role* of Canadian Family Physicians includes provision of timely access to *diagnosis and treatment* of acute and chronic diseases. The Family physician manages the majority (80%) of common conditions, and is responsible for arranging referrals to specialist consultants when required.

- **Comprehensive care** includes the diagnosis, treatment and ongoing management of *acute and multiple chronic conditions, mental health, preventive care, screening* of high-risk populations across all age groups.

- **Continuity of care** across settings and over time, with appropriate follow-up of episodes of care.

- **Coordination of care** include arranging diagnostic services, referrals to specialists, acute care centers, urgent care centers/emergency department, other health professionals in the community, ensuring follow-up for continuous care.

Team-based care may be co-located or virtual, requires *clear roles and responsibilities,* including accountabilities (to whom and for what), with good communication. The Family physician is the leader of the primary care team that includes the patient/family, and coordinates care with specialists and services by other health professionals that is integrated across the health system.

FFS Payment Reform: Valuing Family Physicians

Special payments for Family physician as MRP for the provision of comprehensive, longitudinal, and coordination of services in addition to episodic care, with access to 24/7 on-call coverage.

These payments are designed as incentives to recognize the increased time and complexity of services, as well as the added responsibilities as MRP caring for patients with complex, chronic conditions.

The redesigned fee structure incentivizes the provision of clinical care for complex, multiple chronic conditions; minimizes redundant bureaucracy/forms that take away from patient time.

Notes:

- Replaces the Complex Care fee and CDM incentive fees for single diseases.
- Special and enhanced fees are not available to non-MRP GPs providing only episodic care, eg in walk-in-clinics.
- Virtual care billings only available to MRP Family Physicians who know the patient.

Special Payment for MRP provision of Longitudinal and Coordination services

Patient Registry or Panel:

a) The patient chooses/designates the MRP Family Physician, renewed annually.

b) Family Physician maintains a registry or list of active patients as "panel".

Responsibilities include Administrative tasks, case management (non-direct patient care)

- Maintaining the Longitudinal patient record with Problem List (medical diagnoses, medications, allergies, past surgeries and hospitalizations, obstetrical history, family history, smoking/drugs, social history).
- Documentation using SOAP progress notes
- Preventive care, screening (pap, etc.), vaccination record, eg. flu/Prevnar/shingles shots, etc.
- Chronic Diseases Management, using Guideline-based care
- Annual visit/care planning for complex patients
- Review of Lab/diagnostic imaging reports, Specialist letters, forms, etc.
- Referral letters to specialists and follow-up
- Communications with ER/acute care for patient hospital admission, and post-discharge follow-up
- On-call coverage 24/7, EMR access for call group physicians

Annual Payment per patient (paid monthly) based on age and complexity/comorbidities

Level 1: $60	age <50 no chronic conditions
Level 2: $120	age 50-69, or 1-3 chronic conditions
Level 3: $240	age 70 plus, or >3 chronic conditions, frail, dementia

Comprehensive Care Enhanced Fees:

The comprehensive office/virtual visit fees enable the Family Physician as MRP to deliver high-quality care to more complex patients. The enhanced payments compensate for the increased time necessary to address multiple issues during a single visit, especially for patients with complex, chronic diseases/co-morbidities. Increasing the number of prolonged visits for mental health counselling allowable per year and for complex medical problems are critical to the care of highly complex patients, especially with the extreme shortages of psychiatrists, internists, and geriatricians in the community.

These enhanced fees are based on the average time required for proper evaluation and management of complex patients, based on the patient's age and number of co-morbidities/chronic conditions grouped into 3 levels of complexity (simple, intermediate, high). This enables Family Physicians to provide whole-patient care addressing multiple patient complaints including acute and chronic conditions that may be interconnected. In particular, provision of safe care must be timely in order to reduce risks of complications and exacerbation of diseases, while avoiding the need for multiple appointments.

Office/virtual fee per visit, *based on* ***Age/Complexity/# Chronic conditions***

Level 1: $ 50	age <50, 1 chronic condition, Low complexity
Level 2: $ 75	age 50-69, or 2-3 chronic conditions, Intermediate complexity
Level 3: $ 90	age 70 plus, or >3 chronic conditions, frail/dementia, high complexity

Office/virtual fee, prolonged visit based on time

Complex medical visit	$90	>20 minutes (start/stop times)
Mental health counselling up to 12 times/year	$90	>20 minutes (start/stop times)
CPX/complex care plan	$180	>40 min with care plan
First visit for complex new patient.	$90	>20 min (start/stop times)

Multiple issues per visit (acute episodes)

After the first issue (basic fee), $30 per additional issue, up to ***maximum 3 per visit***.
SOAP documentation per issue with ICD codes

Conference call (virtual or in-person) fee: by time eg. $50 every 15 min

For hospitalized patients following admission, discharge planning.
Include: MRP Family physician, hospital MRP/specialists/hospitalist/care coordinator.