SharedCare
Partners for Patients

Coordinated Seniors Care Initiative

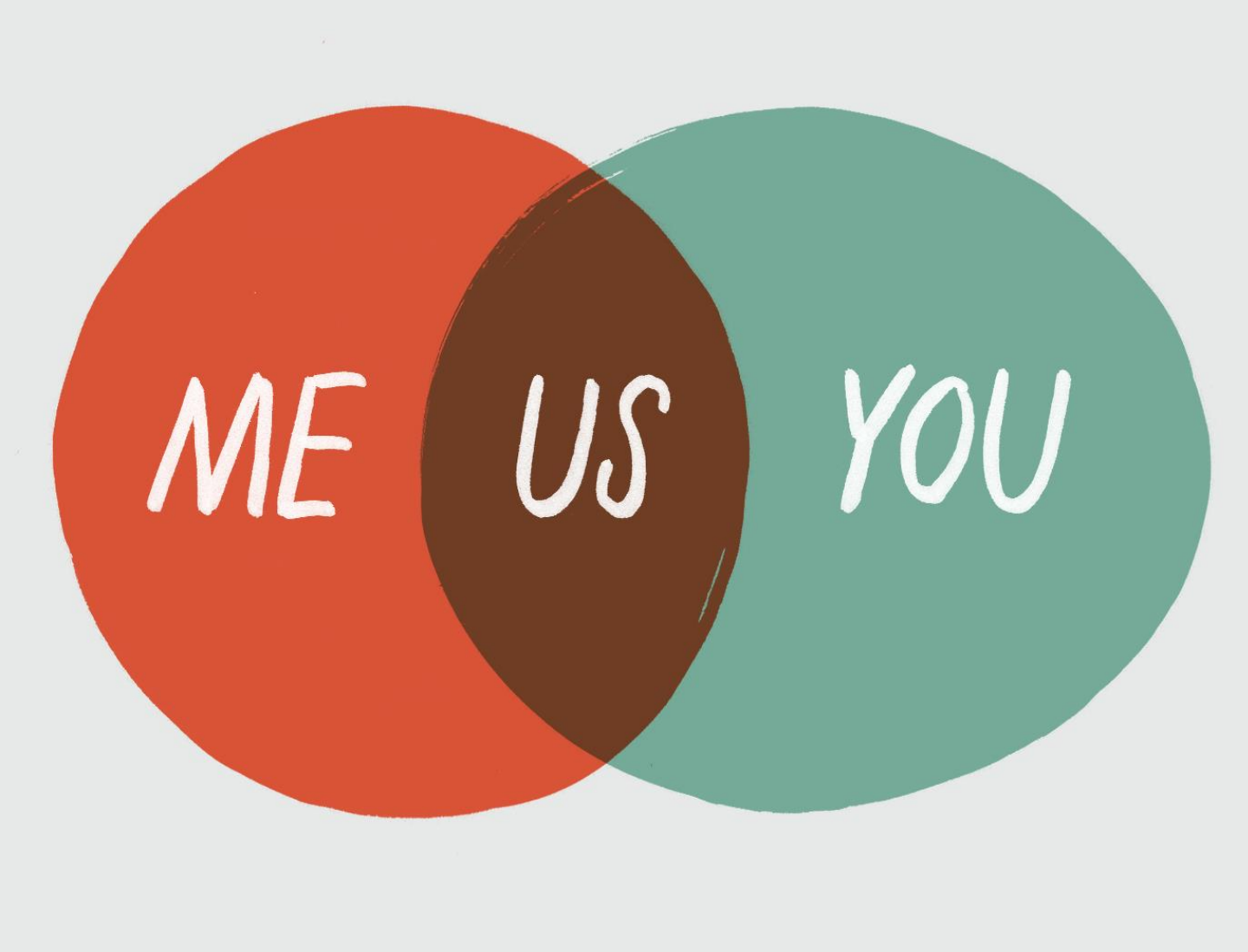
Completing the Circle of Care: Specialists + PMHs + PCNs

October 29th, 2018

BRITISH COLUMBIA

doctors of bc

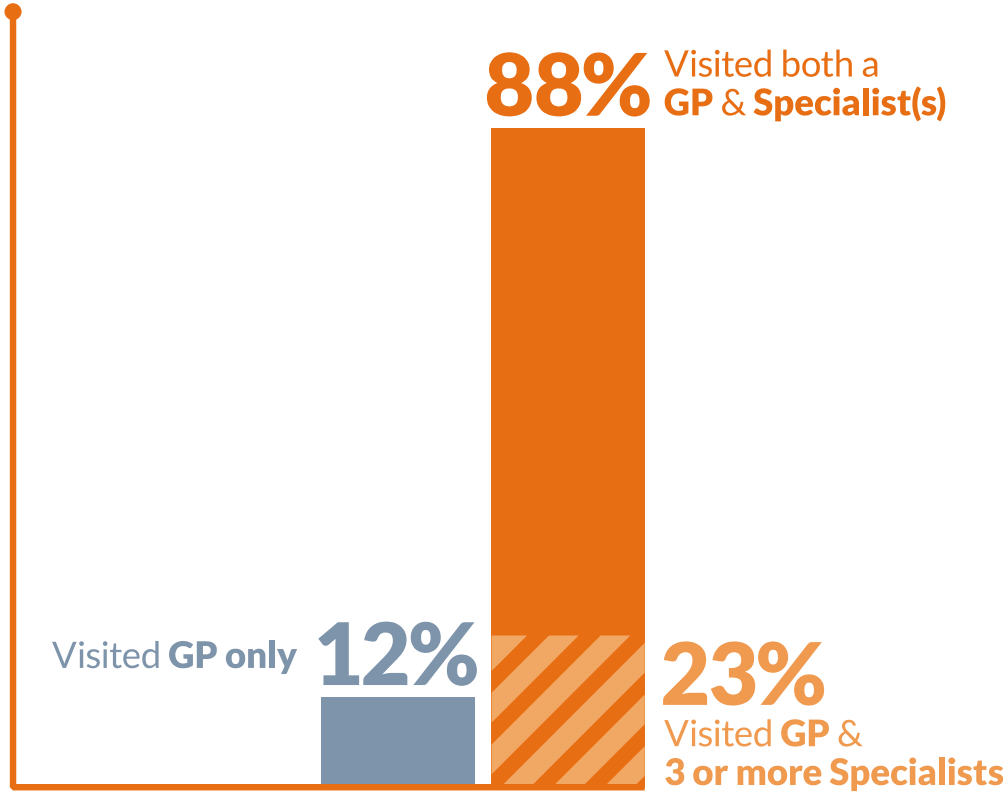
A Collaborative Culture of



Relationship-Based Care

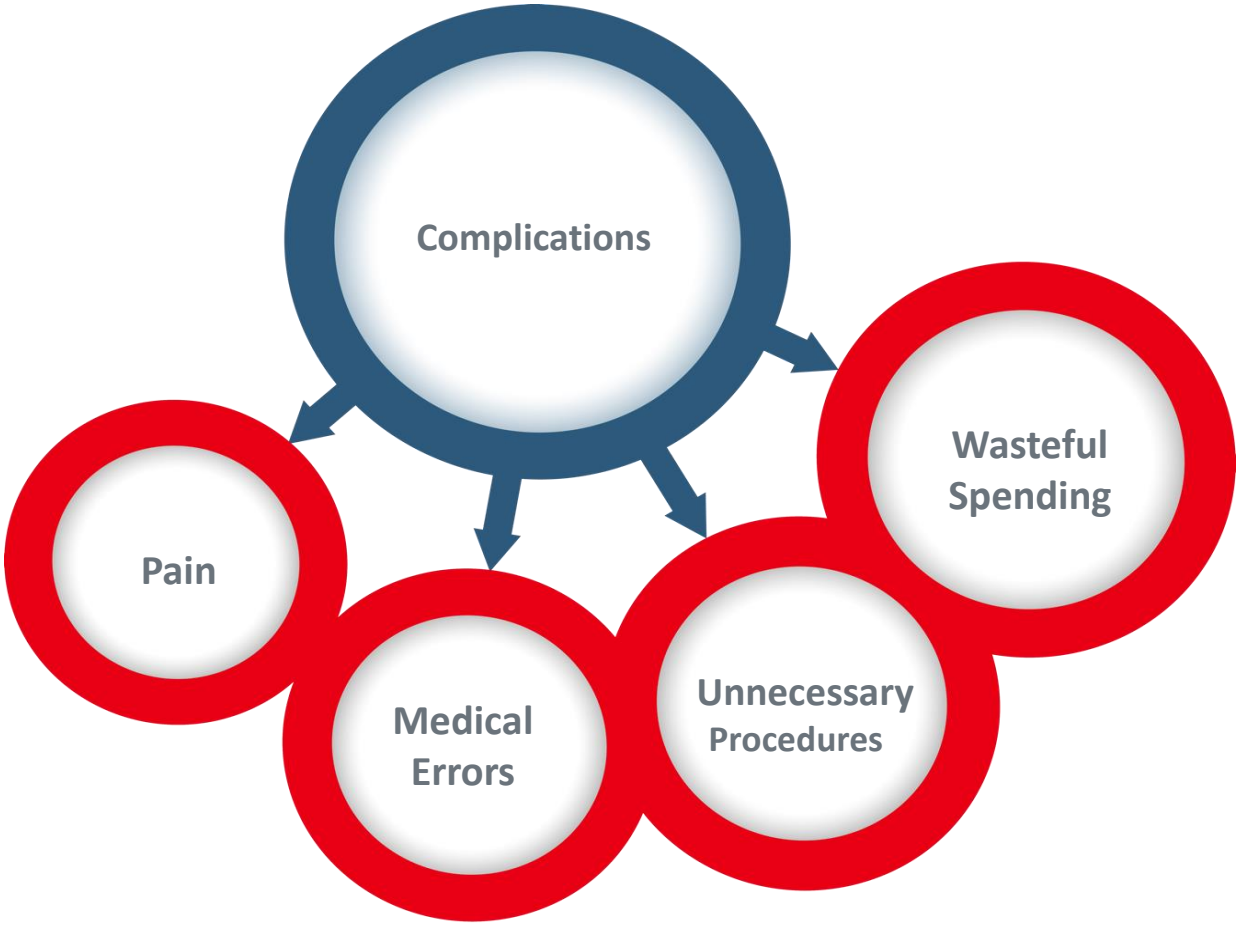
There are **950,000** Older Adults in BC …

… **832,883** had an MSP visit



*PPhRR Evaluation Administrative Dataset (includes all people 65+ and service data from BC MOH Client Roster, MSP, PharmaNet, DAD, NACRS, Home and Community Care, Vital Stats, RAI Continuing Care and Home Care)

The Impact of Uncoordinated Care



Canada ranks 9th out of 11 countries in the Commonwealth Fund 'Mirror, Mirror 2017' report on measures of access, effectiveness, safety, coordination, equity, efficiency and patient-centredness

What we learned from Frail Seniors Prototypes (Fall 2016)

STRENGTHS	CHALLENGES
Collaboration with HAs and local community partners	Fragmented system of care
Inclusion of patients & caregivers	Inadequate communication re Knowledge Translation, Transitions in Care
Increased awareness of existing resources	Social Determinants of Health Issues: Food, Transportation, inadequate income and shelter = POVERTY
Virtual Care	Inadequate Service Funding: Inconsistent providers, lack of culturally sensitive care, language barriers
Polypharmacy Risk Reduction	Lack of IM/IT systems integration: Fragmented Pt Medical Record

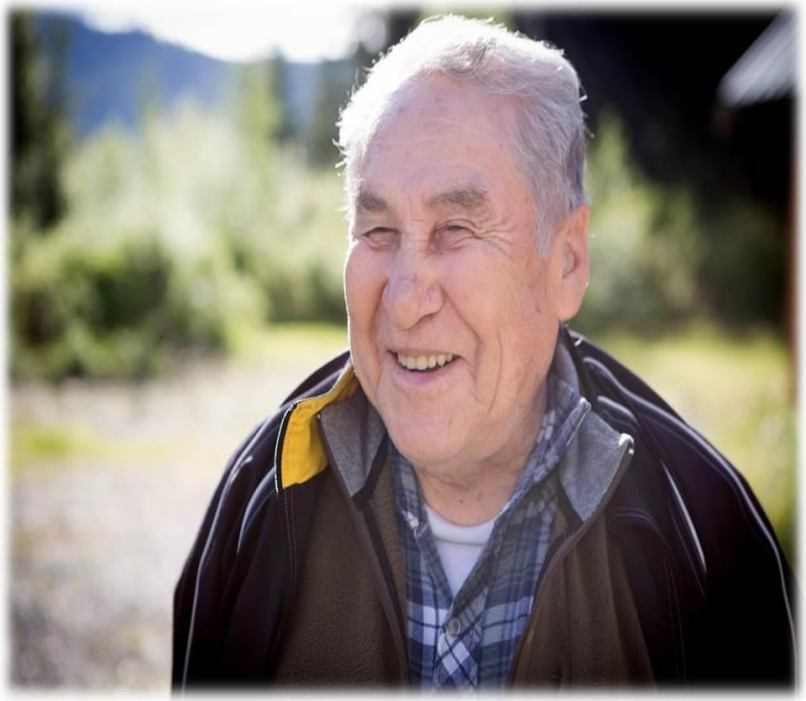
Critical benefit of Shared Care work

New & improved relationships achieve better results for patients & providers

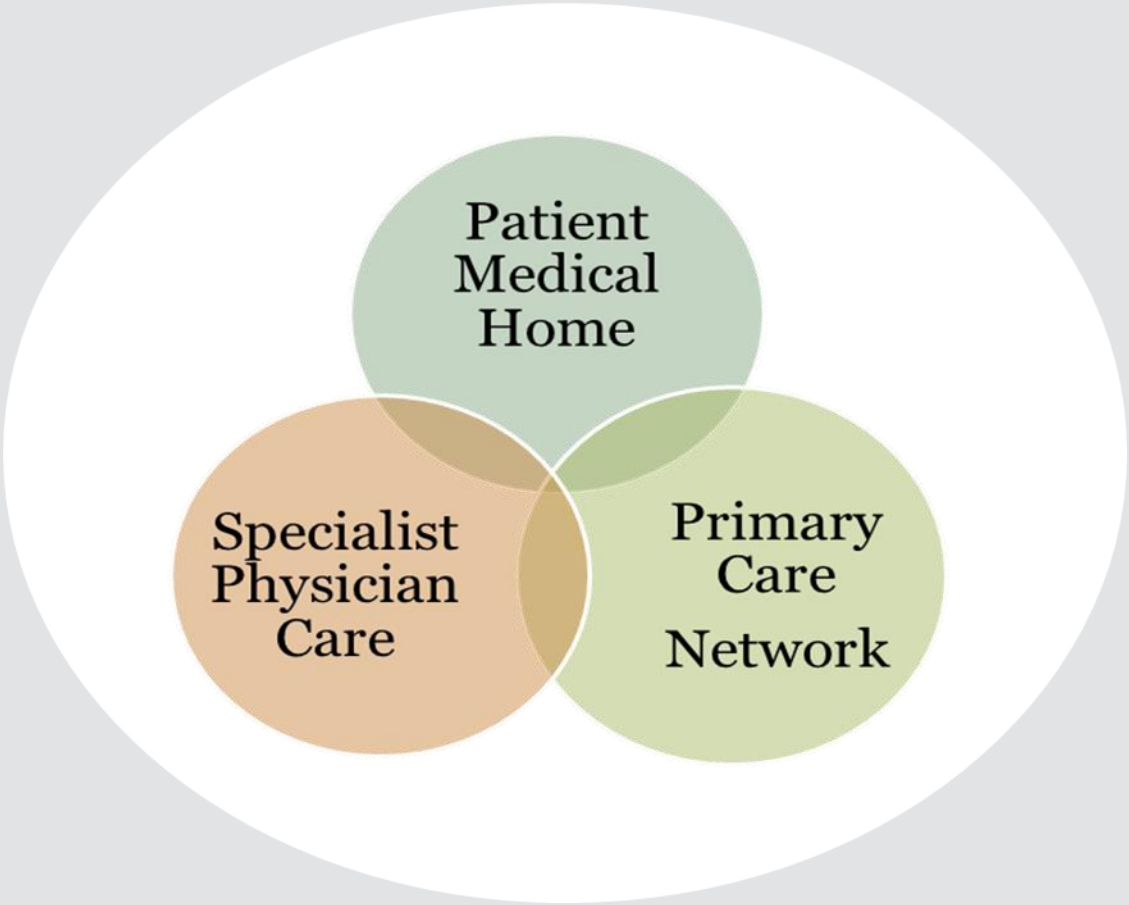
Where we want to go now:
Completing the Circle of Care

- Coordination of care for older adults with complex conditions by involving SPs, GP's with Focused Practice, GPs and other Allied Care Providers.

- Alignment with PMHs and PCNs



Specialists + PMH + PCNs =



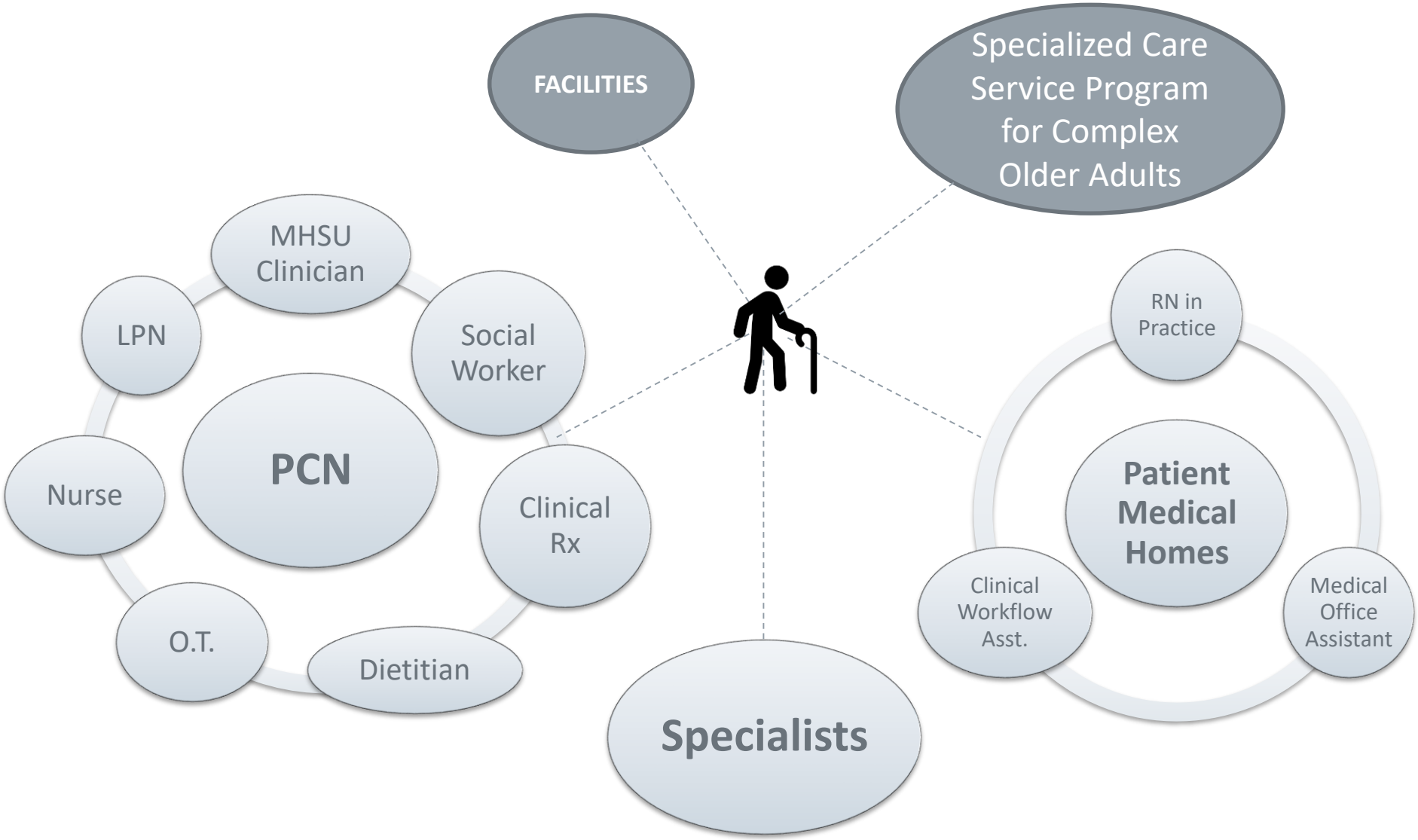
Coordinated System of Care

Principles of Coordinated Care

1. Track and Manage all Referrals
2. Support Team-Based Care & Organization of Resources
3. Know & Manage your Patients
4. Enable Access to Continuity of Care Information
5. Provide Collaborative Care Management & Support during transitions in care
6. Measure & Improve Performance on Indicators of these Principles

The Medical Neighbourhood

- Specialists are integral to care teams, especially for those with complex conditions
- Other health system experiences show benefits of early engagement of specialists in system change
- Opportunity for Shared Care/Specialist Services collaboration

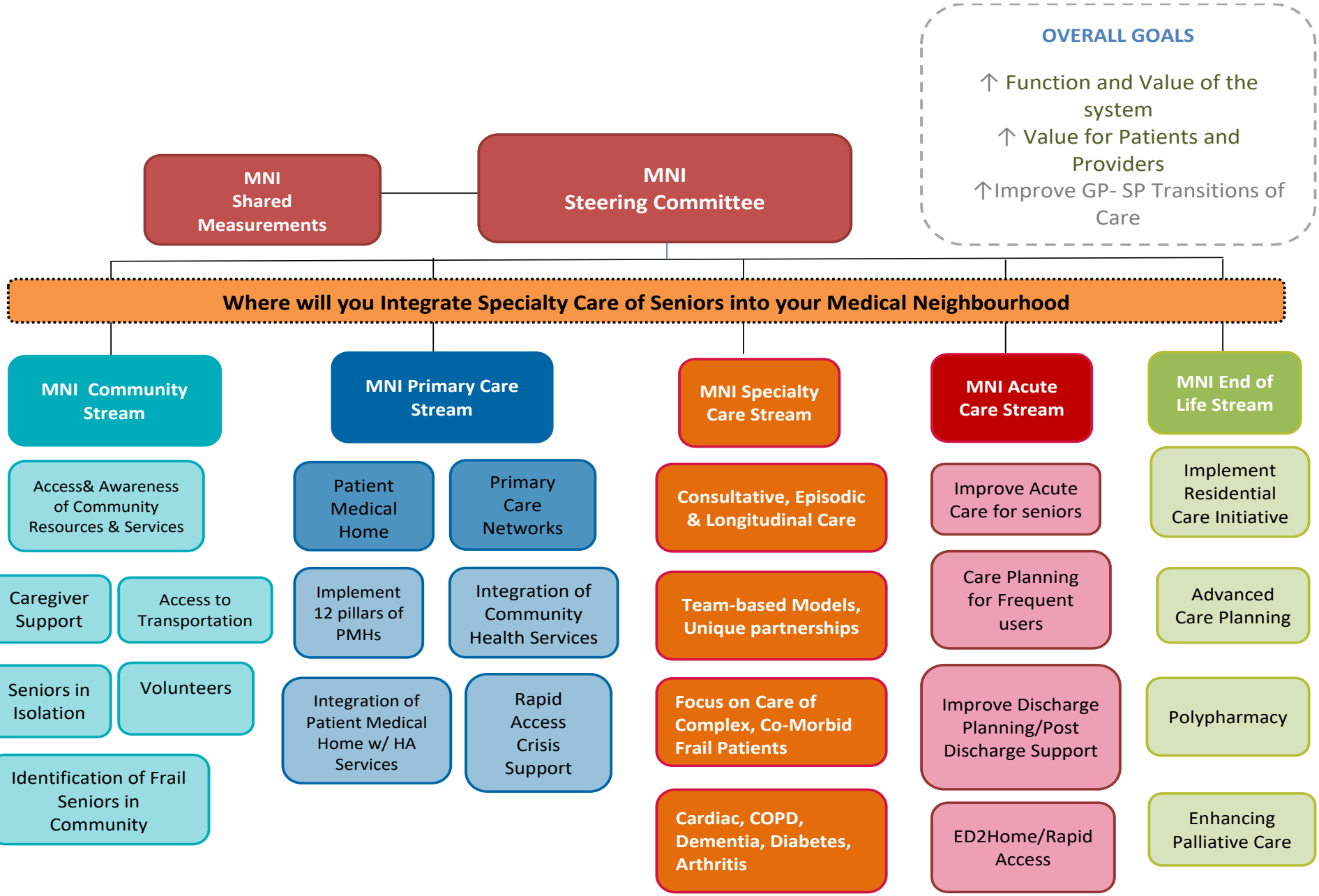


Coordinated System of Care

Patient Medical Home Attributes:	Primary Care Network Attributes:	Principles of Coordinated Care
Patient centred, whole person-care: Care is easily navigated and centered on the needs of the patient, family, and community.	Process for ensuring all people in a community have access to quality primary care, and are attached within a PCN	Track and Manage all Referrals Between Providers to Improve Care Transitions
Commitment (A personal family physician): A Patient's Medical Home (PMH) will ensure that patients have access to a personal family physician (or in some cases a NP) who will be the most responsible provider (MRP) of his or her medical care.	Provision of extended hours of care including early mornings, evenings and weekends.	Support Team-Based Care and Organization of Resources
Contact (Timely access): Patients are able to access their own family physician or PMH team on the same day if needed. Patients know how to appropriately access advice and care on a 24/7 basis.	Provision of same day access for urgently needed care through the PCN or an Urgent Primary Care Centre.	Know and Manage your Patients
Comprehensive care: The PMH provides delivery of, and linkages to comprehensive services.	Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.	Enable Access to Continuity of Care Information
Continuity of care: Longitudinal relationships support patient care across the continuum of patient care, spanning all settings.	Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.	Provide Collaborative Care Management and Support to Patients Moving Between Providers and Services
Coordination of care: The PMH is the hub for the coordination of care through informational continuity and personal relationships and networks with other PMHs, inter-professional team members within and linked to the practice, and linkages to speciality and specialized services across the care domains.	Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.	Measure and Improve Performance on Indicators of these Principles
Team-based care: The PMH generally includes more than one FP working with an expanded inter-professional team within the practice, and / or linked to the practice, with a focus on person-focused relationship-based care.	Care is culturally safe and appropriate.	
FP networks supporting practice: FPs are part of a clinical network working together to meet the comprehensive care needs of their patients and the patients of other PMHs in the community including extended hours of service, cross coverage, and/or on-call.		
PMH networks supporting communities: The PMHs are networked through the Divisions of Family Practice (or other similar community care service organization where Divisions may not exist) to enable better coordination, partnership and integration with health authority and non-governmental community services (Primary Care Home), and the broader system of health care.		
Information technology enabled: Physicians, providers, and staff in the practice are IT enabled, including optimized EMR use and data collection methods to inform quality improvements in patient care and practice workflow.		
Education, training and research: The PMH promotes mentoring, peer coaching for continuing professional development, training and research.		

Cross-Initiative Alignment Opportunities

Integrate with your existing streams of work



How will we Do This?

The Challenge:

Coordinating Care for Moderately Complex Patients

- Moderately complex patients often require multiple Specialist physicians to provide consultative, episodic or longitudinal care. The challenge is to effectively coordinate care among all providers for a seamless experience.

- Also, for these patients, families are often actively involved in daily care, but not recognized as part of the care team.

The Opportunity:

Align with Patient Medical Homes & Primary Care Networks

- The Shared Care Committee is allocating resources for interested communities to better connect Specialist physicians to other providers and family caregivers, to create a Coordinated System of Care for older adults with multiple complex conditions.

- There are many opportunities to improve outcomes and the experience of care for these patients, their families and their providers.

Who Can Become Involved?

- Communities selected for developing PCNs **OR** communities who have interest in improving care coordination for complex adults.

Supports Offered:

- Project development, project management, physician engagement, and other improvement activities
- Community Partnership Coaching
- Participation in Provincial Learning Sessions
- Principles of Care-based evaluation

We're interested – What are the next steps?

- Email Margaret English, Lead, Shared Care Committee menglish@doctorsofbc.ca
- Participate in a call with the Shared Care team to learn more about initiative objectives and supports available.
- Participate in optional pre-EOI coaching session to focus your approach and identify outcomes for your community.
- Complete an EOI to outline your proposal and which specialists and stakeholders will be involved.