Building the business case for allied health care professionals in family physician practices in British Columbia

The benefits of interprofessional collaboration include improved patient self-care and more effective use of resources.

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As outlined in a 2009 College of Family Physicians of Canada (CFPC) discussion paper, "Patient-Centred Primary Care: Bring It On Home," the concept of the Patient's Medical Home[1] is built around the ongoing relationship between the patient and the patient's family doctor, and requires the following key supports:

1. Patients have personal family physicians who provide and direct their medical care.
2. Care is for the patient as a whole.
3. Care is coordinated, continuous, and comprehensive with patients having access to an interprofessional team.
4. There is enhanced access for appointments.
5. The practice includes well-supported information technology, including electronic medical records.
6. Remuneration supports the model of care.
7. Quality improvement and patient safety are key objectives.

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Research shows that while the services of other health professionals are of value, it is the continuity of care provided by personal primary care or family physicians that results in the best population health outcomes.[2] A team approach has the potential to expand care in family physician practices from primarily "illness care" to care that promotes healthy lifestyles, disease prevention, and screening. The collaborative multidisciplinary team can provide patients with the appropriate lifelong support to better manage their chronic diseases and to maintain and improve their overall health status.

A recent report[3] states that when interprofessional collaboration is fostered and supported, positive outcomes have been observed in terms of improved patient self-care; improved health care provider satisfaction, knowledge, skills, and practice behaviors; broader range of services; better access, shorter wait times, and more effective use of resources.

Barriers to interprofessional collaboration in BC

In BC only some patients have access to a coordinated and collaborative primary care team that includes family physicians, nurses (RNs, LPNs), nurse practitioners, physician assistants, and other health care professionals. However, some barriers need to be addressed for the interdisciplinary team model to become a reality in most family physician practices. There are four main issues:

1. Clarification of scope of practice and roles
2. Information sharing
3. Infrastructure
4. Funding

1. Clarification of scope of practice and roles

Creating a high-functioning team requires more than co-locating professionals. Our disconnected way of practising in silos will require reframing and outside-the-box thinking to enable a group of professionals to truly work as a team for patients with complex and unique requirements. Development of interactive team care protocols and change management will be needed to build high-functioning teams, as will education on the respective scopes of practice and roles of various team members. Each member of the team must have clear responsibilities and contribute his or her unique skills and expertise to the care of the patient.[4]

All members of the team need to be well informed of the activities of other team members, and handoffs need to occur in a manner that is

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seamless to the patient. The composition of any given multidisciplinary team must be determined at the local level based on a needs assessment of the individual practice/clinic. While administrative team leadership may be provided by a team member from any of a number of disciplines, clinical leadership should continue to be provided by a family physician, who remains the most responsible provider with the broadest scope of clinical practice.

2. Information sharing

Ideally, appropriate patient information and interdisciplinary communication is supported by team collaboration and co-location, where possible, and by a single, shared electronic medical record with multiple layers of security to ensure privacy. Regardless of where team members are located physically, robust communication strategies are required to ensure all team members operate with the most current and complete patient information. Further, patient privacy and custodial responsibilities must be clearly delineated through information-sharing agreements that ensure compliance with the relevant privacy legislation and professional standards of practice.

The recent cancellation of the Physician Information Technology Office and the shift to one-time funding to reach level-three meaningful use of an EMR, with no commitment to ongoing support, leaves a level of uncertainty in the minds of many BC family physicians regarding their ability to attain a high-functioning integrated electronic health records system.

3. Infrastructure

Co-location of primary care team members allows for robust and highly effective teams, promotes direct communication and collaboration, and provides a one-stop-shopping experience for patients. However, the vast majority of primary care in BC is delivered in physician-owned offices and clinics. This represents a private investment of several hundreds of millions of dollars in physical infrastructure and significant business operating costs. Many existing physician clinics were not designed with larger teams in mind, and limited space makes the co-location of other professionals impractical or impossible.

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The move to support on-site multidisciplinary team-based care must leverage the already massive investment in infrastructure by using suitable existing community-based family practices. The most cost-effective approach to holistic health care delivery would be to build on what is already in place by expanding existing clinic infrastructure rather than fracturing care by developing new, stand-alone entities disconnected from family practices. This approach could include virtual teams that work through a supported community network, provided appropriate information sharing is addressed.

4. Funding

In BC, the vast majority of family physicians are compensated by the fee-for-service (FFS) method. While over the past 10 years the General Practice Services Committee has introduced limited block funding in the form of chronic disease management and complex care incentives, current billing rules for FFS practices do not generally support team-based care.

The restrictive preamble rules about the delegation of a medical act to allied health professionals and the rule requiring a face-to-face physician-patient visit discourage allied health professionals from practising to full scope of practice and impede efficient team care since no revenues (i.e., billings) are generated unless the patient is also seen by the physician. In addition, the existence of the high-volume low-intensity patient limits for family physicians in larger communities restricts the number of physician visits that can be billed to MSP on any calendar day. This places a cap on the ability to expand capacity under the current FFS model.

To encourage and support multidisciplinary teams within FP practices, the BC Ministry of Health, the Medical Services Plan, Doctors of BC, and the Society of General Practitioners of BC must collaborate on updating the preamble to fees to reflect the changing landscape of care provider scopes of practice and support models of care that allow family physicians to incorporate allied health professionals into their practices.

Population-based funding models have been reported to have the potential to expand practice capacity because they enable the use of funds to hire allied health professionals who can then provide time-consuming nonmedical services and free up the physician to see additional patients in the practice. A limited number of sites using this model were initially introduced in BC in 2000 through Health Canada's Primary Health Care Tran-

sition Fund. While there is the ability to track the health status of the practice population due to required reporting, the administration of this model is quite complex. More than half of the initial sites have not continued to operate for a variety of reasons. The benefits reported by those sites that remain in operation, including the flexibility to support different ways to provide patient care, have not been fully evaluated to determine the per capita cost and the impact on system and patient outcomes.

Existing sites supported by population-based funding need to be fully evaluated to determine efficiency and cost-effectiveness. This evaluation must also include the costs of administration, mostly borne by the health authorities. If the evaluation is positive, the BC Ministry of Health and the health authorities need to reconsider the current restricted access to this payment model. The per capita rates for these sites are calculated based on patient illness burden and reflect family physician billings under FFS, and as such would benefit from any changes made to the rules for fee-for-service billing that would better support the integration of allied health professionals into FFS family practices.

Building the business case for the future

To see the CFPC vision of a family practice serving as a Patient's Medical Home become a reality and ensure that the citizens of BC receive the care they need in their communities, the issues listed here must be addressed.

While a co-located multidisciplinary team is often touted as ideal, the reality of family practice in BC with its significant number of solo and two-physician offices does not support the embedding of allied health professionals directly into most, or even many, family physician practices. To support the expansion and spread of collaborative interdisciplinary team care in family practice in BC, the barriers need to be reviewed and addressed through innovative funding options. These funding options need to be long-term to give all members of the primary care teams some assurance of stability and ongoing practice viability.

Newly trained family physicians are less willing to go into solo and small-group practices as many have been trained in group practices in multidisciplinary settings. They have seen the benefits to patients as well as the professional satisfaction and life balance of their teachers. Shifting to a multi-FP, team-based model can entice newly graduating family physicians into the longitudinal model of care and support a sustainable primary community care system.

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