Special Report

RISQy Business (Relationships, Incentives, Supports, and Quality): Evolution of the British Columbia Model of Primary Care (Patient-Centered Medical Home)

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Abstract

In 2002, the British Columbia Ministry of Health and the British Columbia Medical Association (now Doctors of BC) came together to form the British Columbia General Practice Services Committee to bring about transformative change in primary care in British Columbia, Canada. This committee's approach to primary care was to respond to an operational problem—the decline of family practice in British Columbia—with an operational solution—assist general practitioners to provide better care by introducing new incentive fees into the fee-for-service payment schedule, and by providing additional training to general practitioners. This may be referred to as a "soft power" approach, which can be summarized in the abbreviation RISQ: focus on Relationships; provide Incentives for general practitioners to spend more time with their patients and provide guidelines-based care; Support general practitioners by developing learning modules to improve their practices; and, through the incentive payments and learning modules, provide better Quality care to patients and improved satisfaction to physicians. There are many similarities between the British Columbian approach to primary care and the US patient-centered medical home.

Introduction

This paper presents an analysis and firsthand account of a major change initiative regarding primary care in British Columbia (BC), Canada. Fundamental to the approach adopted was the focus on the acronym RISQ, as follows: Relationships between funders and providers; the payment of Incentives to allow family physicians or general practitioners (GPs) to spend more time with patients and provide guidelines-based care; the provision of Support and additional help to GPs to improve their practices; and a focus on the Quality of care provided to patients. The patient-centered medical home (PCMH) model from the US has not been widely adopted in BC. However, what is simply referred to in BC as "primary care" has many similarities to the PCMH.

An overview of the PCMH indicates that it has five key characteristics.[1] These characteristics and how they are reflected in primary care in BC are as follows:

1. Practice Organization: There is a range of solo and group practice organizations in primary care in BC.
2. Health Information Technology: The British Columbia Medical Association (BCMA) (now Doctors of BC)[a] and the BC Ministry of Health are providing financial assistance and training support to GPs to encourage them to adopt electronic medical records. More than 70% of BC GPs have now adopted electronic medical records.
3. Quality Care: A training program composed of several modules is available to GPs to train them on how to increase office efficiency and the quality of patient care.
4. Patient-Centered Care: General practitioners in BC provide patient-centered care and have wide discretion to provide the care they believe best benefits the patient. They do not have oversight of their clinical decisions by private insurers. An incentive payment system allows GPs to take more time to plan and care for their patients.
5. Family Medicine: All GPs or family physicians are trained in family medicine.

More detailed typologies of the features and principles of the PCMH are presented by Epperly.[2] Again, with the exception that some organizations are solo practitioners, essentially all of the components of these typologies exist in the BC primary care model.

This article outlines how BC moved from an acrimonious relationship between the BC Ministry of Health and the BCMA to one of joint cooperation and collaboration with a primary focus on the well-being of patients. Thus, it involved a major change in organizational culture from a bureaucratic control model based on centralized authority, organizational processes, respect for hierarchy, and adherence to rules, to a culture with an emphasis on flexibility, teams, and broad participation by a range of actors, and in terms of the competing values framework, from a hierarchal culture to a team culture.[3]

Background and Context

For most major initiatives, one can readily obtain information about *what* the initiative is and *how* it works: what are its component parts and how they fit together, how the initiative

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is related to its context, and so on. What is often harder to determine is *why* the initiative works the way it does, why it was developed in a certain way, why it is successful or not, and why it is or is not sustainable. In this article, we try to shed light on the more intangible factors related to why the General Practice Services Committee (GPSC), whose mandate is to find solutions to support and to sustain full-service family practice in BC, has been successful and works the way it does. (For an overview of the GPSC, see Cavers et al[4] and Mazowita and Cavers.[5]) This involves an examination of basic values and beliefs about human behavior. It also relates to organizational behavior and the willingness to take risks. What is often not fully appreciated is the profound effect that values and philosophy can have on organizations. For example, Deber et al[6] show how government philosophy and policy can have an impact on operational issues, such as how service delivery is funded. If government sees itself as primarily a purchaser of service, risk will be off-loaded to care provider organizations by adopting funding options such as capitation diagnosis-related groups and tendering. Alternatively, if government sees itself as a steward of the health care system working in partnership with care provider organizations, it may fund them on a negotiated budget, or fee-for-service, basis.

In terms of funding for physicians, BC has funded, and continues to fund, GPs primarily on a fee-for-service basis. GPs bill the Medical Services Plan, which is funded by the government. Payment is rapid (most often within one month to six weeks), but is subject to retrospective audit. There are also some sessional payments (usually blended with fee-for-service) provided for specific populations. BC has not adopted capitation payments for GPs except for a few small experiments. Also, salaried positions have not been offered for full-service GPs for many years.

To provide some context, BC is Canada's most westerly province.[7] It is bounded on the south by the US, on the east by the province of Alberta, on the north by the Yukon Territory and parts of Alaska, and on the west by the Pacific Ocean. The province has a population of approximately 4.4 million inhabitants and is some 364,800 square miles (slightly larger than the square miles of California, Oregon, and Washington State combined).

BC is a multicultural province with representation from a variety of racial and ethnic groups. The following data are presented from statistical tables produced by BC Stats, the province's central statistical agency.[7] Approximately 50% of the population live in the Vancouver and lower mainland areas. The 2 largest ethnic groups in BC are Chinese (with approximately 250,000 people indicating this as their mother tongue) and East Indian (with more than 180,000 people indicating this as their mother tongue). Population density declines as one moves from the Vancouver area to the north and east. A large part of the province could be described as small town and rural and, in the north, even remote. (The population density for BC is some 4.8 persons per square kilometer.) This is true for many Canadian provinces. Canada's population is about one-tenth of that of the US, and BC's population is approximately 13% of that of Canada. The median annual household income in BC in 2006 was $46,472 CAD, and the average age of its citizens in 2011 was 41.9 years.

Regarding GP income, BCMA indicates that in Fiscal year 2011/12 (ie, April 1, 2011 to March 31, 2012) the average income for all GPs was $199,512 CAD. To estimate income for regularly practicing GPs, the BCMA also uses a second estimate that excludes part-time GPs. For Fiscal year 2011/12, this cut-off point was $82,500. Thus, for GPs with incomes greater than $82,500 CAD, the average annual income, based on claims made to the BC Medical Service Plan, was $255,522 CAD (unpublished data [DM]).

In accordance with the Canadian Constitution, the provision of health services is a provincial responsibility. Provincial and federal taxes are collected by the federal government, which provides health funding to the provinces through the Canada Health Transfer. Physician services and hospital services are single-payer, insured services and, thus, residents of BC generally receive medical and hospital services without a charge or user fee. No other services are insured services and, thus, there is a complex set of rules regarding copayments for drugs, long-term care, and other allied health services. In the 1990s, the focus in the US was on integrated service delivery systems, through managed care organizations or health maintenance organizations, whereas much of the focus in Canada was on enhancing and improving primary care services. However, more recently, primary care has become an important component of the health reforms in the US. In summary, the GPSC was established as a collaborative partnership of government and the medical profession to bring about transformative change to primary care in BC.

In the 1980s and 1990s, BC was well known for its acrimonious relationship between the government and the BCMA, punctuated by short periods of relative peace. The characteristics of this relationship were focused on comparative power and money. Who was more powerful, government officials or BCMA representatives? How much money could the BCMA extract from the government for its members? In the late 1990s, government tried to cap the overall income of physicians to restrain cost escalation. Physicians countered with Reduced Activity Days, in which they provided less service as a response to having their incomes capped in order to stay within their caps.

These tensions culminated in a 2002 arbitration award, which was rejected by the government. The government subsequently awarded physicians an additional $392 million CAD but believed that it got nothing additional for their money. Physicians, in turn, were upset with the whole process and the government's rejection of the third-party arbitration award. New leaderships emerged in key positions at the government's BC Ministry of Health and at the BCMA, and this ultimately led to the emergence of the GPSC (unpublished data [DM]).

Initial Development of the General Practice Services Committee (2002-2007)

In the 1990s and early 2000s, the BC Ministry of Health Services was, as were other health ministries across Canada, grappling with how to improve primary care. It was also facing a disillusioned and dispirited workforce of family physicians, or GPs, who were retiring early, leaving their practices to become hospitalists or emergency room physicians, or moving to special interest health clinics. Thus, there were intensive discussions about primary care reform between the government and the BCMA. The main catalyst for change was the clear decline in

the number of GPs working in traditional family practice and the resulting negative effects this would have on access to, and the quality of, care for British Columbians (unpublished data [DM]). There were two points or incidents that were critical and set the course for the emergence of the GPSC.

First, during one set of heated discussions in the early 2000s, a BCMA representative (DM) metaphorically cut the Gordian knot of how to enhance primary care in BC when he blurted out in frustration, "Why don't you just pay us to do what you want us to do?" There was silence in the room. After a long pause, the government representatives said, "Let us think about that," and later agreed to have further discussions on this approach. This was a major breakthrough.

Once the notion of paying GPs to provide enhanced primary care was on the table, a second point solidified the future direction to be taken. It was suggested that instead of being mired in administrative and ideologic discussions, future discussions should be focused on how best to meet the needs of patients, and all future administrative and policy discussions should be framed regarding how they can help patients. This patient-focused care approach solidified the evolution of the BC model to primary care transformation.

The solution was to address operational problems related to how primary care would be provided, and how the decline in full-service family practice could be reversed, by an operational solution. Thus, unlike other jurisdictions, which have sought *structural* solutions such as various forms of community clinics and group practices, BC opted for an *operational* solution that would build on and enhance existing structures and mechanisms. Although there are many legitimate criticisms of fee-for-service medicine, the fee schedule is, nevertheless, an excellent incentive mechanism that can be used to shape behavior and track activities.

The vehicle to be used to bring about the transformation of primary care in BC, in accordance with the two foundational concepts of "pay us to do what you want us to do" and the clear focus on the patient, was the GPSC, a joint committee of government and the medical profession, with representatives from the regional health authorities.

Relationships

A first critical step was to begin to repair the damage in the relationship between GPs and government. The GPSC determined that it wanted to build positive relationships with GPs. To do this, they staged, in 2004 and 2005, a series of Professional Quality Improvement Days to obtain the views of GPs and to allow them to vent their frustrations. These consultations were held with some 1000 GPs across the province. The key finding from these consultations was that the exodus from full-service family practice was real but could be stopped if GPs felt valued, were paid appropriately for their work, and had adequate ongoing training and support to provide good care for the increasingly complex patient population that is typical in the province. In effect, they said, "Value us, pay us, train us, and support us to provide good care." The consultations were often tense and acrimonious but yielded very valuable information that was used to guide the work of the GPSC into the future. Although the exodus from traditional family practice was clear and palpable, it is not possible to document directly as one cannot assign motivation to a GP's decision to retire, or to reduce stress and responsibility by working in a drop-in clinic, and so on.

Incentive Payments

The second step in the evolution of the GPSC, in accordance with the key values noted earlier of paying for what one wants and improving patient care, was to develop new incentive payments to encourage GPs to take the time to provide guidelines-based care to their patients. The GPSC created the Full Service Family Practice Incentive Program and started to focus on financial incentives. Incentives were designed to allow GPs to spend more time with their patients and to practice guidelines-based care. The intent was to shift the focus of care to a greater emphasis on patient-focused holistic care and healing, from what some have referred to as fragmented, body-parts medicine.[7,8] The financial benefit to GPs varies directly with their adoption and use of incentive payments. The average income for regularly practicing GPs from incentives alone in fiscal 2010/11 was $32,000 CAD (unpublished data [MH]).

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Support

One of the outcomes of the provincial consultations, and the third step, was the establishment of the Practice Support Program, which develops and delivers learning modules on topics of interest to GPs and can improve their day-to-day practices. Two of the most popular modules are Advanced Access, which trains GPs how to restructure their practice to shorten the wait time so patients can see their GP more quickly,[9] and Adult Mental Health, which trains GPs how to provide better care for patients with mental health issues.[10] The Practice Support Program learning modules have truly been a major success in providing GPs with paid training and support, and the evaluation results have been extremely positive.[11] A typical pattern for the peer-led training module is to have GP champions who have been trained in the model teach practicing GPs in their local communities. The learning modules are structured as three half-day learning sessions interspersed by two (approximately two-month) action periods when GPs practice what they learned at the learning session in their own GP practices.

Quality Revealed by Measurement

Both the Practice Support Program learning modules and the incentive payments are specifically designed to help provide better quality care to patients. Thus, one has the acronym RISQ (Relationships, Incentives, Supports, and Quality), and "RISQy Business" is a key guide to GPSC activities. There is an ongoing, independent evaluation of the Practice Support Program and the incentive payments initiatives, which has revealed very positive results for both initiatives.[12]

Values and Principles

Over time, from the initial base of "RISQy Business" a series of 12 values and principles has evolved to guide the work of the GPSC. These are discussed at the end of this article.

Intermediate Phase of the General Practice Service Ccommittee (2007-2010)

From 2002 to 2007, the structure, goals, and purposes of the GPSC were established, as were its initial, two main initiatives: the Full Service Family Practice Incentive Program, which provides incentive payments to GPs, and the Practice Support Program, which provides training to GPs and their medical office assistants. From 2007 to 2009, there was a rapid expansion of incentive payments. There was also an aggressive development of the initial four Practice Support Program learning modules.

Four major events occurred during this intermediate period. The first was that the GPSC established that its mode of operation would be one of aggressive, active, hands-on, strategic planning, program development, and program operations. The GPSC would not simply be a funder of new programs, or an arms-length steward of primary care. Rather, it would be an active and collaborative agent of change to transform primary care in BC.

The second major event was that an independent evaluation team was hired to evaluate the Full Service Family Practice Incentive Program and the Practice Support Program. The GPSC wanted to make evidence-based decisions and needed someone to provide them with relatively quick new knowledge development. The GPSC made it clear that it would welcome clear, objective evidence. It would build on positive results to further improve services and use the information obtained from neutral or negative results to correct the committee's activities. Thus, what made the GPSC tick in this second phase of development was a clear, active, and evidence-based strategic planning, development, and operations approach.

It became clear early on in the evaluation that the GPSC approach was relatively unique in the primary care field. The closest parallels were with a pay-for-performance initiative in England and a conceptual paper on primary care in the US.[13-15] Over time it also became clear that the GPSC model was based on different values and principles than many other initiatives in Canada and internationally. It also appeared, on the basis of research, that it could be quite a successful program.

The third major event was that an active knowledge transfer strategy was developed. It was recognized that no matter how successful a program is, it can come to naught under certain circumstances (eg, a change in leadership with different priorities). Thus, it was determined that an active program of publication and knowledge transfer would be developed. This would serve two purposes. It would inform others in the health sector who face the same challenges that BC faced in the early 2000s about a possible approach to meeting these challenges that may be helpful to them. Publication in scientific and professional journals was selected as the strategy, rather than only producing government reports for the "gray" literature. If one is taking a national and international perspective, the only knowledge that really exists about one's program is what people in other countries can find if they search MEDLINE or a similar citation source or index. In Canada, one can share government reports, and the GPSC does so, but to reach a broader audience, one needs to publish in journals that are contained in major citation and abstract databases. The second reason for knowledge transfer was to assure current and future senior officials and politicians that GPSC activities are credible and important enough to warrant publication.

The fourth event was an outgrowth of the first three noted. As part of the evaluation conducted for the GPSC, an important new finding emerged regarding the benefits of the continuity of care. It was found that for people with high care needs who had diabetes or congestive heart failure, there was an inverse relationship between the level of attachment of the patient to the provider's practice and costs. Thus, the higher the attachment, the lower the cost. This finding was validated using multivariate analyses.[16] Hollander et al's article had a major influence on policy and program development in BC and was the basis for the development of a provincial "Attachment Initiative" (described in the next section).

Moving to a Broader Corporate Approach (2010 and Onward)

In 2010, the GPSC took on 2 major new initiatives. The first initiative was the development of Divisions of Family Practice, which facilitate greater cooperation and collaboration among GPs in what evolved into more than 30 geographic areas. The Divisions of Family Practice also facilitate discussions between GPs and regional health authority representatives about how to streamline and improve the delivery of patient care. The discussions take place through Collaborative Service Committees composed of divisional physicians and health authority representatives. The second new initiative was the development of an Attachment Initiative, which seeks to find family physicians for persons who do not have them and to solidify and support the existing relationship between family physicians and their patients.

In addition, 2010 saw the beginning of an expansion in the range of incentive payments and major developments in the Practice Support Program. Several new Practice Support Program learning modules were implemented between 2010 and 2013, including learning modules on child and youth mental health, end-of-life care, and shared care (Chronic Obstructive Pulmonary Disease and Heart Failure). Thus, the GPSC has expanded and has had to make adjustments in personnel and procedures to allow it to move to the next level and operate on a larger scale. In particular, because of the success of the GPSC, Specialist Services and Shared Care Committees have been established, and there is an overall senior committee that now provides oversight to the GPSC and the other two committees.

A Brief Word on Pay for Performance

The literature on pay for performance reveals mixed results.[17-19] Although the Quality and Outcomes Framework in England does appear to have had some success, the results are also still somewhat mixed.[20-24] The term *pay for performance* can have a range of meanings. In its true sense, pay for performance relates

to payments for specific outcomes that improve the health of patients, populations, or both. The payments are to individual physicians, group practices, or clinics. However, pay for performance, in actual practice, quite often refers to payments for process, such as doing an immunization, or ordering a certain test such as for diabetes. This is best understood as pay for *activity,* not *performance.*

In terms of the GPSC, the incentive payments are a form of pay for activity compensation, similar to that found in other jurisdictions. What is unique about GPSC is that it incorporates a two-step process. It pays for activities conducted by GPs to provide guidelines-based, or enhanced, care. However, in terms of outcomes or performance, it takes the view that there are many methodologic and other shortcomings in the pay-for-performance approach when applied to individual GPs. Thus, the GPSC decided to look at performance at the system level. Is overall medical care improving? Does the GPSC approach increase value for money? On the basis of the values and beliefs that in most cases GPs will provide the best care they can when they are valued, supported, and paid reasonably, the position was taken that a more collective approach—we all sink or swim together—would be more appropriate. That is, performance was to be determined at the broader systems level, rather than at the individual GP level.

Values and Principles that Underlie the General Practice Service Committee

On the basis of the above-mentioned analysis, the 12 values and principles that underlie the activities of the GPSC are:

1. a belief in practical solutions (pay us to do what you want us to do)
2. a clear focus on the patient (all policy and program discussions are analyzed through a lens of how it will help patients)
3. the adoption of the Triple Aim approach of the Institute for Healthcare Improvement (ie, initiatives are viewed through the 3-way lens of population health, per capita costs, and the experience of care)
4. a belief that most GPs want to do well and help others
5. a belief that most GPs recognize and value ongoing training to improve their practices
6. a belief that support from the BC government and the regional health authorities reduces the clinical isolation of GPs and produces better patient outcomes
7. a belief in active, hands-on management to identify and resolve problems quickly
8. a willingness to be evaluated and to accept objective evidence—to build on positive findings and correct policy and programs if there are negative findings
9. a recognition of the importance of sharing results with others
10. a focus on collective results
11. a recognition that change is difficult and requires constant hard work to be successful
12. a belief in the value of inspired, thoughtful, transparent, and strategic leadership.

These values and principles are ingrained into the GPSC and guide day-to-day decisions, whether they relate to how a new program (eg, a new incentive, a learning module, or major initiatives such as Divisions of Family Practice) should be structured; what goals, objectives, and policies it should have; and how one deals with day-to-day operational activities. Their continued acceptance will be critical for the ongoing sustainability of the GPSC and its expansion to the Shared Care and Specialist Services Committees.

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Challenges Ahead

Although the GPSC has been well regarded, it is still vulnerable and will need ongoing support and attention to remain sustainable. A key challenge for the GPSC will be dealing with internal, external, and professional challenges by those who are not comfortable with or do not believe in a collaborative approach to health care, or who have their own agendas and/or competing approaches to promoting primary care. The GPSC's current tactics of evaluating and publishing results, engaging with stakeholders, and exchanging knowledge may need to be further expanded to build bridges to others so the GPSC can continue to develop and sustain collaboration for improved patient care.

Another challenge is that the GPSC approach gives GPs the infrastructure to provide high-quality care. Along with this comes greater responsibility to ensure quality by the BCMA and the medical profession so that the public and decision makers do not lose confidence in the GPSC approach. Related to this is the challenge of being able to adequately support the local Collaborative Services Committees composed of representatives from the Divisions of Family Practice, Regional Health Authorities, the GPSC, and the community to truly provide collaborative care.

It will also be important to ensure that the GPSC is not seen simply as a vehicle for giving more money to physicians without getting a return on the investment. The evaluation will be key to shedding light on this challenge. It will also be important to document, and make clear to decision makers, the possible cost savings and/or cost avoidance from GPSC activities for other parts of the health care system (ie, reduced hospital days), so that the GPSC is not misunderstood as being a cost add-on. A final issue will be succession. When current leaders retire or go on to other activities, care will need to be taken to ensure strong, committed, and competent new leadership. The key will be to ensure that new leaders also adhere to the 12 values and principles noted in the previous section.

The GPSC is open to new ideas and approaches and wishes to learn from others. It will make a point of trying to compare itself with other approaches to primary care and to focus on continuous quality improvement. ❖

[a] Recently, in January 2014, the BCMA changed its name to Doctors of BC. For purposes of clarity we shall still refer to the BCMA in this article as that was the name of the organization up to the end of 2013.

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In Their Own Houses

First, the sick without being pained by a separation from their families may be attended and relieved in their own houses. Secondly, the sick can in this way be assisted at a less expense to the public than at a hospital. Thirdly, those who have seen better days may be comforted without being humiliated: and all the poor receive the benefits of a charity the more refined, as it is the more secret.

— First annual report in 1813 of the Boston Dispensary, established in 1796