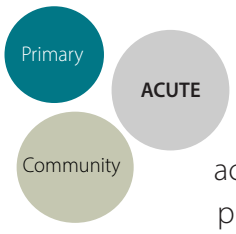
What is the big picture?

PRIMARY CARE NETWORKS
in an integrated system of care

Many people in BC can't get a family doctor or the full range of care they need. Patients and doctors have a hard time navigating the system. GPs are under stress, and the threat of burnout is real. Meanwhile, hospitals are facing unsustainable pressures.

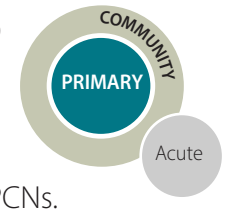
It's why family doctors, divisions of family practice, health authorities and provincial partners are creating an integrated system of primary and community care across BC, enabled by **Patient Medical Homes** (PMHs) and **Primary Care Networks** (PCNs).

Transforming the health care system



TRADITIONAL HEALTH CARE SYSTEM
Central focus: Episodic, acute / hospital care. Siloed primary & community care.

RE-DESIGNED, INTEGRATED SYSTEM OF CARE
Central focus: Robust primary care enabled by PMHs, teams and community supports in PCNs.



GPs are linked with a broader network of support. Patients get comprehensive service that is convenient.

Better for patients.
Better for providers.
Better for our resources.

FOR DOCTORS

- Eases the burden of doing it all alone.
- Increases supports for patients with complex health needs.
- Allows GPs to focus on patient relationships and addressing difficult diagnostic dilemmas.

You are freed up to do work you love to do, and what brought you into the medical profession in the first place.

FOR PATIENTS

- Increases attachment to a primary care provider.
- Coordinates care and services for easier access.
- Increases access to care in the community and links to a broad range of services.
- Improves support for vulnerable individuals.

FOR THE SYSTEM

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

GPSC
General Practice Services Committee

What is a PMH and PCN?

Connecting Patients and GPs to a **COMMUNITY OF SUPPORT**

PATIENT MEDICAL HOMES (THE DOCTOR'S OFFICE)

A Patient Medical Home (PMH) is a family practice supported to work at its full potential.

The core of the model is longitudinal care – including supports through teams – with the doctor's office at the centre of primary care.

There are 12 key attributes in what an ideal practice can deliver and how it can best be supported.

When these attributes are achieved, patients have access to continuous, comprehensive and coordinated care through their GP and linked teams and networks.

CONNECTING PATIENT MEDICAL HOMES WITH PRIMARY CARE NETWORKS

As the PMH represents the work within the doctor's office, the PCN is the system change.

To create a PCN, a network of PMHs in a defined geographic area are linked with primary care and community services that are delivered by a health authority and other organizations and services within that community.

Physicians work with teams of allied health professionals and other health care providers.

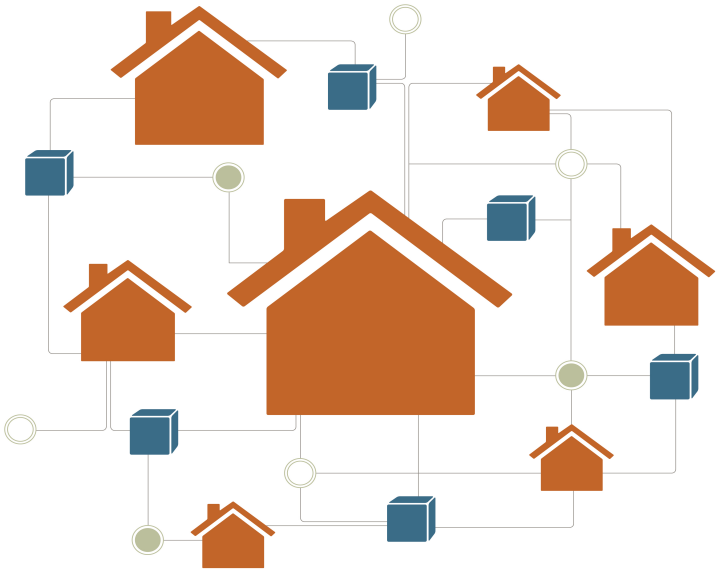
Everyone can work to their strengths, support and rely on each other, and patients get the best care.

GPs are supported to expand services to meet the needs of patients in their practices.

Partners collaboratively provide access for people who do not have a GP.

PCNs provide these eight attributes:

- Access and attachment to quality primary care
- Extended hours
- Same day access to urgent care
- Advice & information
- Comprehensive primary care
- Culturally safe care
- Coordinated care
- Clear communication



A Proven Model of Care. Read more at **www.gpscbc.ca**