HEALTH AUTHORITY BOARD SESSION

April 3, 2007

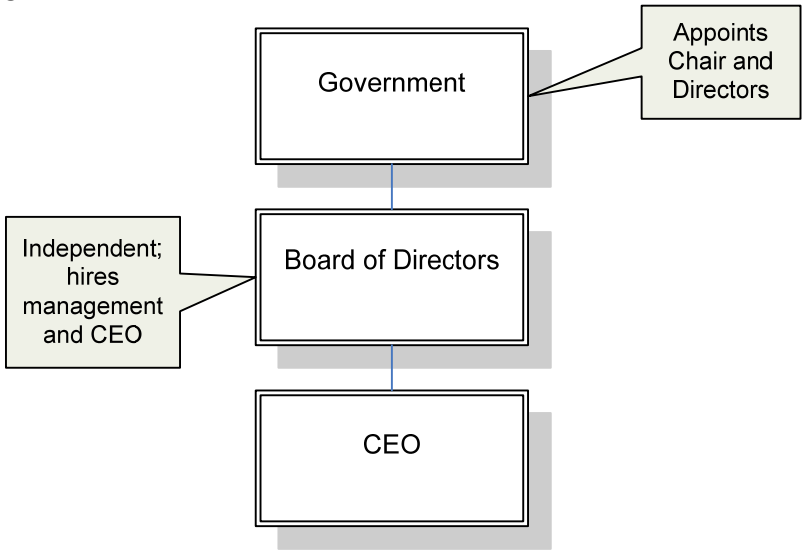
Introduction

On April 3rd, 2007, 28 Health Authority Board Members came together in Vancouver at the Pan Pacific Hotel for a one-day Conversation on Health workshop. They discussed sustainability, governance, technology and infrastructure planning processes, and had the opportunity to raise any issues they wanted to in a open discussion section.

The session was not intended to develop consensus on any of the issues. Therefore, while the following notes capture the range of views articulated during the session, they do not reflect a decision or recommendation on which solution or direction to follow.

Governance

Health Authorities are established as Boards through a typical Board governance structure:



Ideally, this structure divides responsibilities as follows:

- Government: develops broad strategies, policies, targets for outcomes, and provides the tools and resources to do the job.
- Health authority boards: somewhat at arm's length from government and responsible for delivering health care to established targets within a given budget. Also provides advice on direction and strategies.

Generally speaking, health authorities see the current structure of six health authorities managed by boards appointed by government as being significantly more effective than the structure of the early 90s. In particular, the current focus on accountability through performance agreements is seen as a positive step. That being said, health authorities raised a number of issues which need to be addressed to take greatest advantage of this structure and to make it work on behalf of the people of British Columbia.

Performance Management

- The current letter of expectation appears to set clear performance measures without equally clear benchmarks, making it challenging to plan for, or achieve, the measures established. The letter of expectation appears to place more decision making authority in the Ministry, affecting the overall governance structure.

- The letter of expectation has moved from a high level directional document to much more detailed instruction, which has inconsistencies with a Board model of governance.
- Representatives from the Provincial Health Services Authority were not as deeply concerned with issues related to governance.

Control and management of health authority communications and operations

- Concern was expressed that Government appears to be increasing control of health authority communications, making it difficult for health authorities to manage issues that arise within their jurisdiction, and to manage strategies and approaches to communications. Boards need to be governing bodies, and not have the role of advisory bodies.
- Since many individual health cases are raised in the House, the Minister, and consequently the Ministry, are drawn into debates around issues that belong more properly within the purview of the health authorities. This issues management approach also tends to detract government and the Ministry of Health from consideration of long-term and complex policy questions. Health authorities recommend that these issues be referred back to the health authorities rather than continuing the debate in the House or through the media.
- There is some concern that a number of overall governance responsibilities continue to lie outside of health authority responsibility, but have a large impact on health authority operations and performance (for example, delivery of primary care). There was a recommendation that there be a review of the overall responsibilities for health across government and health authorities. This review would include a question of whether the responsibilities are within the purview of the right department or organization.
- The stronger the governance responsibilities of Boards, the more likely they will be to attract and retain world-class management personnel.

Long term planning

- Health authorities are concerned that long-term health planning is complicated by the political reality of four-year terms of office. As a result, it is difficult to look forward past the four-year timeframe to make effective long-term plans.

Board appointment process

- Recent changes to the Board appointment process have seen responsibility for this within government shift to a departmental

role. Some health authorities have experienced a delay in approvals. Furthermore, there is a concern that grouping health authority appointments with other government appointments will undermine the overall importance put to health authority board appointments.
- Government should continue to focus on quality of Board appointments.

Collaboration with government departments and other health authorities

- Health authorities find the internal government departmental structure inconsistent with working effectively for patients. They advocate for more interaction between government departments.
- There is a strong desire for improved collaboration and communication between health authorities. A secretariat devoted to this purpose would help to ensure that this happens. Areas of collaboration discussed include: board orientation and development, discussion of common issues, and sharing of best practices and governance.
- There is a place for continued discussions between health authority board chairs and the Minister to allow for open and frank debates.
- There needs to be a mechanism to facilitate policy and legislative change within government to allow health authorities to implement innovations and changes. Often these policy and legislative changes take too much time to help health authorities meet their business goals.
- Health authorities need an opportunity to discuss with government strategies and policies under development. In addition, health authorities need to discuss with government their resource requirements in terms of implementation of government strategies to ensure that this can be done effectively.

Solutions

- Government, with health authorities, could investigate a Crown corporation model of governance, which has an enhanced ability to do long-term planning, and would include the Ministry of Health and health authorities. There was a suggestion that this may result in a more coherent governance and accountability framework and would isolate government from day to day issues management and operations.

- The Board structure overall is seen as a positive experience, but Board members sent a strong message that government needs to allow Boards to govern their health authorities without detailed management by government or the Ministry of Health.

Sustainability

Principles

- Sustainability needs to be defined. Furthermore, the Ministry should identify the goals of sustainability based on public input. This would inform the sustainability strategy.
- We must start focusing on long-term issues, and not on the short term. The health care system cannot be managed focusing on the short term.

Planning, measuring and paying based on health outcomes

- The funding formula needs to reflect the complexity and needs of the health care system. For example, practitioners need to be accountable for their patient outcomes, not just the process. To do this, we need to improve our approach to measuring outcomes. Similarly, we need to move to a longer-term planning and budget cycle.
- Evidence-based care and practice are not fully maximized. A Danish study demonstrated that evidence based care in type 2 Diabetes can have a significant impact on costs and savings. Similarly, the Vancouver Island Health Authority chronic disease management initiatives are a successful example of how evidence-based medicine can be designed such that tools can be brought to health professionals. Health authorities could collaborate on evidence based care, and could be given the mandate to develop best practices in a certain area, then disseminate the information to other health authorities.
- If we can prove through economic evidence that the private system can do it better and cheaper than the public system, then we will consider a role for the private system.
- A focus on patient safety will help to reduce costs.
- We need a province-wide initiative to change lifestyles and the environment (for example, improving water quality). This will help us to shift from a focus on treatment to a focus on prevention. For example, the province needs to look at ways to encourage responsibility for our own health through incentives and disincentives for desirable and undesirable habits and behaviours. Any such initiatives should be based on proven outcomes. One successful model of prevention is the anti-smoking campaign. We should also consider incentives for organizations to encourage wellness programs.
- In terms of end of life care, we need to decide when we die.
- We need to align how we pay physicians with our goals and their outcomes. The existing fee for service system encourages

physicians to increase appointments while health authorities are trying to ensure value for money. Some argue that salaried physicians cost less and achieve better outcomes because doctors are paid to take care of patients for the full year.

- We need to step up and respond to aboriginal health needs by focusing on health outcomes. To do this, we have to pay attention to the determinants of health and work with partners involved with those determinants.
- We should consider moving towards a greater share user-pay model for non-medically necessary services. In addition, we should consider allowing patients to pay for diagnostic tests. We should assume that there will be a safety net for essential services and for non-essential services we could consider other models of delivery. First we need to define what is essential. Alternate funding and delivery models should be defined for excluded services.
- Doctors should be able to advertise for the non-medically necessary or non-essential services or advice they can provide and how these will be provided (for example through user fees).

Scope of Services

- It needs to be made clear what basic services the public health care system will provide, and which it will not. What is considered "medically necessary" under the *Canada Health Act*? The system cannot be all things to all people and we do not have a clear understanding of what is essential. Any shift in the expectations, therefore, will take time, perhaps a generation, and will therefore need a commitment from government to make bold moves and a phase-in plan to ensure success.
- A focus on health outcomes will need to be accompanied by a discussion of ethics. For example, an obese patient may be told that they will not receive a hip or knee replacement until they lose weight, because a healthy weight will result in a positive health outcome from the procedure.
- A primary health care team is considered to be a key in building long-term relationships with patients and families. This, in turn, ensures compliance with complex instructions at home which improves health outcomes. Primary and chronic care are linked and seen as among the most important areas on which we should focus. As a result, primary care providers should be brought into the system.
- If a service is perceived as free, then demand will increase.
- We do need to redefine health care, but we also need equal rigour and leadership to address other determinants of health.

- Health authorities need to get out of all business unrelated to health and focus on core health service delivery.

Health Human Resources

- Government needs to strengthen its stewardship role in dealing with health professionals so that interest groups are not responsible for making decisions.
- The competition for skilled health professionals is global. Health authorities, and the province, need to focus on acquiring the right skills in the right place at the right time. This requires international recruitment efforts. Similarly, we need to have a plan to ensure that we can fully utilize the health human resources we have (for example, training international health professionals to practice in their chosen profession more quickly). We need to break down barriers from health professional associations and immigration to recruit and retain health professionals from other countries and get them working in their profession sooner. Incentives to assist recruitment, for example through signing bonuses, moving costs, would help to address this need.
- More education is not the answer. We need to review what level of practitioner we require, and consider laddering professions to meet the different requirements. For example, a laddering approach may include initial schooling, a move to practice, then later deciding on an area of interest, returning to school at that point to complete a program of interest.
- We need to incorporate a culture of change that requires practitioners to undertake ongoing education and could include an ongoing review of capabilities (for example, similar to an accountant peer review).
- Health professionals want more personal time while they are practicing.
- It is difficult for rural and remote areas to compete for practitioners, resulting in some units (for example Intensive Care Units) being shut down for lack of staff.

Scope of Practice

- The scope of practice should be expanded for certain professions, including nurse practitioners and licensed practical nurses.
- There should be incentives for doctors to hire nurses or other professionals to do some of their tasks.

Funding

- There is not enough money on the public table to fund and sustain the current system.
- There are quite a few inefficiencies in the current methodologies and practices, and these are being rectified. While these incremental changes have been made, we need a fundamental change to truly influence cost savings. The service delivery model needs to shift in order to realize any future savings.
- There is a lot of funding available in the form of gifts, donations and contributions, but we need improved mechanisms to allow the giving of gifts.
- We should be more open to allow communities to fund medical and diagnostic equipment through taxation.

Technology and Infrastructure Planning Processes

Integrated Information Technology

- Technology needs to be used and funded to drive change to prescribed standards and protocols.
- Participants support an overall strategic vision for information technology (IT), developed by the Province and by health authorities. The vision needs to move away from old style IT conservatism, which is preventing health authorities from achieving its goals, to use of IT as an enabler of change.
- Health authorities support a move to an integrated IT environment. To do this, leadership at a provincial level is required and collaboration provincially and federally must be improved. Furthermore, within health authorities there should be a focus on integration.
- Currently, there are different planning processes within health authorities. However, more consistency is required and the Ministry of Health has a clear role in making this happen, including setting common ground rules and standards, providing provincial funding assessments based on need, and improving strategic planning. Some effort needs to be undertaken to understand those IT planning processes which need to be managed provincially.
- Core capabilities should be identified within the infrastructure to identify opportunities for improved products, processes and outcomes. Improvements and solutions, however, should be looked for within and outside of British Columbia.
- Opportunities for centralized services should be explored, such as the health care card. Electronic health records are seen as a key to transforming the system. A business case should be developed for centralized shared services in this area.
- Health authorities acknowledge that when the budget is tight, IT investment and planning are the first to get cut. Dedicated funding might alleviate this problem.

Capital Investment

- We need to look to real estate professionals to assist with managing valuable assets. It is possible that the university model for infrastructure management and revenue generation may offer some possibilities.
- Public-private partnerships should be explored. This would be helped with more communication and education.

Infrastructure planning

- Planning needs to be longer term and better coordinated, based on cost effective outcomes and driving towards change. The vision needs to be structured so it can be operationalized and it needs to be properly financed. To build this plan and the vision, we need to first think about the kind of health care system we need, then IT and infrastructure become a means to that end, and flexibility can be built into the system.
- We should encourage increased collaboration provincially and federally in the area of capital asset and infrastructure planning and management. In addition, there should be defined protocols and standards between health authorities.
- Old and aging infrastructure is creating undue operating expenses and some of these investments are not conducive to safe practices.
- Standards of care should be established for infrastructure design. Furthermore, processes could be developed that understand needs and match needs with capacity.
- While health authorities agree that more beds are needed, they are not necessarily required in hospitals. For example, health authorities could investigate the expansion of services at existing facilities (such as expanded elderly care facilities rather than moving the elderly to the ER for treatment).
- Infrastructure should be built for the future, understanding the need for flexibility while still meeting standards. For example, flexible and modular designs may enable health authorities to respond to changing needs and technology using their same infrastructure.
- IT and infrastructure are strategic components of the business of health care. As a result, health authorities should own these assets and manage them to ensure they benefit health authorities.
- The cycle time from planning to occupancy of new facilities should be reduced by half.

Open Discussion

Health care system

- There is a need to focus on creating an environment for change that will move us to a model that is more patient-centric and more efficient. There are a number of ideas on how this may be done:
    - The Minister and the Ministry must create the environment for culture change.
    - There should be incentives to encourage change other than just financial.
    - We should move to a patient centric system (for example through the use of self serve and web portals) which empowers patients.
    - Primary care should be a focus of the new model as the gatekeeper to the system: the current approach needs to change and we need to develop incentives to encourage that change.
    - We should look at innovations that manage demand.
    - We should consider taking better advantage of nurse practitioners.
    - Patients should be funded, not beds or visits. And the attitude to patients should change (they should not be considered a "cost").
    - De-politicize the issues, and involve everyone.
    - Find three bold decisions or actions from the Conversation on Health Report (not a hundred little ones).
    - We need to work towards a system that runs itself by encouraging a creative environment that identifies its own needs and finds solutions.
    - We need to find alternatives to the transactional approach to compensation.
    - Clinical care has been left by boards to doctors while it is our responsibility.
    - Need broader view not just a critical care view? Entire life cycle view is needed.
- A performance management culture should be encouraged:
    - The planning process should focus on future trends beyond 2008 to achieve a long-term plan (5-7 years).
    - This will require moving from a culture of non-accountability to culture more focused on measurable results.

    - Ask directors and managers what goals they have and how these aligned with service delivery. Then develop key performance measures and a means to track and correct actions. Actions need to be followed up rigorously. There needs to be consequences for not following goals and strategic direction, and the approach needs to be coordinated province wide.
    - Need a stronger emphasis on quality in performance agreement and letter of expectations.
    - Need more of an outcomes approach from whole life cycle of care.
    - We don't collect enough data on quality issues.
- Innovation should be encouraged:
    - We are slow to adopt best practices.
    - We need to identify and empower innovators.
    - There has to be some investment in innovation through long-term commitment and funding.
    - Use alternative technology approaches for service delivery.
    - Enhancements to core service could be source of revenue.
    - We do not look enough at what is happening around the world.
- We need constraints on the use of system:
    - The *Canada Health Act* has created expectations that cannot be met: We need to stop idea we fund everything.
    - We need public discussion on expectations of Canada Health Act.
    - Identify what "public health" is: stop stretching the meaning of the Act and decrease the influence of lobbyists.
    - Public expects every doctor to be "Marcus Welby".
    - How can we educate the public they have a contribution plan and not a defined benefit plan.
- People are "blind" to fact that 40% of existing system is private.

Health professional and health authority culture

- We need to create the # 1 place to work in BC health sector.
- Issues with management hierarchy:
    - Span of control is still too large: 50 – 100 direct reports.
    - Create environment where management is rewarded for engaging staff (what are you doing to make things better each day).
- Empowerment to encourage innovation and change, which doesn't cost money, it actually saves money in the long run

    - Empower those staff who want to be innovator (getting to maybe).
    - Find ways to assist our fabulous collection of health professionals in dealing with their front line issues.
    - Focus on the people who deliver health care. What are the "proof points" for the culture change that is needed or wanted.
    - Focus on development of collaborative teams: Develop comfort with "matrix" approach.
    - Redefinition of everyone's role so everyone is encouraged to implement local change.
    - Engage physicians with managers: Co-management of change process (has developed accountability because they are accountable to other doctors).
    - Established regional management boards to ensure a regional voice.
    - Engage all staff in change management: understand and tap into health care professionals' motivation (it is not just dollars), and create systems that influence their motivation.
    - Board members should be champions of health care professionals. The real motivation of health care professionals is to help the patient.
    - Give people more choice in their working conditions, something which should start and perhaps be managed by the Ministry.
    - Raise the level of appreciation and recognition.
    - Find leaders who go in and find out what people want.
    - We need to create a system that encourages quality information (look at Vancouver Coastal model): the system should not be punitive, focuses on improvement, and taps into values (teamwork, holistic view, focus on those you serve).
    - Need common vision of what quality means.
    - Need to feel empowered is hard in a regulated environment. The challenge is to push authority downwards and provide recognition. Need front line managers to do more recognition and bring this closer to the front lines.
    - Build respect at all levels.
- Clarity of roles:
    - Match these with ability to act effectively.

- How physicians operate within system needs to change to allow system to operate more effectively for both system and doctors.

Disease Prevention and Health Promotion

- Encourage self-care through care protocols and regulations to improve health, such as: bicycle helmets; no surgery until certain health conditions achieved; or more active interventions with caring response or non interventions.
- Engage the education system as early as possible and continue education throughout on self responsibility for one's own health.
- Acknowledge and understand the barriers to behaviour change.
- Give a report on key health measures to province: the Ministry should then encourage change in behaviour.
- Get incentives for patients to stay within chronic disease management limits.
- Review incentives to use health resources effectively: abuse is presently rewarded.

Funding Model and bargaining

- Need a change in the funding model for primary care, for example by having salaried nurses and funding for the patient, not visits. How nurse practitioners and clinic doctors get paid is critical to change.
- Bring the medical and nursing professions to one table to be involved in change process, then engage in an integrated bargaining approach. Single representation will result in a focussed approach.
- Look at a fee for service approach.
- Move to a block funding system and ensure funding to meet future requirements.

Pressures

- Auditor General Report on Infection is a Red Flag and we need to look at this issue.
- 50% of our money spent in the community. We need to look at more opportunity and more vehicles for this, for example, home care in rural areas.
- Quality issues are not just in hospital, they are in community.

- Chronic care management consumes lots of money and will likely increase due to changes in demographics. We need a new methodology for chronic care, for example through a one stop shop, or a team based approach with appropriate leads. We should consider funding things that presently fall outside fee for service for chronic care.
- Importance of child care right from birth: Public primary care needs to be available strongly encouraged (see the Australian model).
- We need to visit and improve the mental health plan in the province.
- We need to look at demographic trends with an emphasis on immigration issues in order to identify the health trends.

Health Human Resources

- There is too much "one offing" in human resource strategy.
- The shortage of health professionals is a world wide problem.
- We need to focus on recruitment and retention of health care professionals.
- We are not funding all of the right skills.
- It costs more to train nurses and doctors and we are therefore limited by budget.
- Too many nurse practitioners are winding up in institutions and not enough in primary care.
- Scope of practice changes are going well.
- Remove roadblocks for certifying international health practitioners, for example, allow international medical practitioners into the health care system on a trial basis.
- How can we capitalize on folks who are retiring.

Inter-ministry collaboration

- We need to coordinate all government activities to focus on the social determinants of health. For example, we need to understand the relationship between health and homelessness.