Primary Health Care Charter

A Collaborative Approach

BRITISH COLUMBIA
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Executive Summary

The Primary Health Care Charter (the Charter) sets the direction, targets and outcomes to support the creation of a strong, sustainable, accessible and effective primary health care system in B.C. Primary health care provides first-contact access for each new need, long-term comprehensive care that is patient-centred, and coordination when care must be sought elsewhere.

There is great potential in primary health care to improve the health of the population and contribute to the sustainability of the health care system. To reach that potential, all partners for a healthy population must work together. To support such collaboration, this provincial charter for primary health care was co-developed with many partners to capture the activity, experimentation and successes of the last five years, and to set strategic direction to move forward.

The work outlined in the Primary Health Care Charter supports the B.C. government's *Five Great Goals for a Golden Decade*. The Charter describes primary health care challenges, identifies priorities, and establishes outcome measures to set the strategic direction of the Ministry of Health with the regional health authorities. Developing the Charter collaboratively has resulted in clear direction and priorities that each health authority will translate into its plans, and the Ministry of Health will use in developing its long-term integrated strategic plan for B.C.'s health care system. In addition, the Charter sets out a strategic agenda for other key stakeholders who want to align their efforts with a systems approach.

Currently, family physicians constitute the largest workforce in primary health care. Therefore, the current B.C. government/BCMA agreement (the Agreement) is a significant part of the Charter's context. Components of the Agreement align with and support each of the Charter's seven priorities outlined below. The Agreement also includes dedicated change-management funding. The Practice Support Program teams, funded through the Agreement, which include physician champions, will work in partnership with local family physicians and health authorities staff in realigning health care services to attain better health outcomes and improve providers' professional satisfaction. The Agreement contains a planned investment in information management/information technology (IM/IT) for primary health care. IM/IT is critical to successfully implementing the Charter, and supports activities in the seven priority areas.

To achieve measurable progress in each priority area, it is imperative for the health system to focus on a small number of high-impact, system-wide initiatives and achieve the desired system shifts and health outcomes. The infrastructure initiatives that support work in the seven priority areas include implementing integrated health network teams with patients as partners as the basic philosophy.

Achieving system-wide improvements in B.C. requires a multi-faceted strategy–no one solution will provide the kind of system shift we require to meet changing patient needs. When identifying solutions, we must take into

consideration urban/rural realities, supply and skills of health care professionals, and public expectations and attitudes. Based on the analysis of existing challenges and strengths, the following seven priorities have been established:

1. Improved access to primary health care
2. Increased access to primary maternity care
3. Increased chronic disease prevention
4. Enhanced management of chronic diseases
5. Improved coordination and management of co-morbidities
6. Improved care for the frail elderly
7. Enhanced end-of-life care

These priority areas knit together with a focus on priority populations: maternity patients, people at risk for or living with chronic conditions, the frail elderly, people living with mental ill health and addictions, aboriginal people, and people approaching end-of-life.

Developing the Charter has supported and stimulated an exchange of information among a broad stakeholder group. The alignment of governmental and non-governmental strategic plans is an encouraging sign. It will facilitate implementation of the Charter and ultimately ensure its success.

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Introduction

There is great potential in primary health care to improve the health of the population and contribute to the sustainability of the health care system. To reach that potential, all partners for a healthy population must work together. To support such collaboration, this provincial charter for primary health care was co-developed with many partners to capture the activity, experimentation and successes of the last five years, and to set strategic direction to move forward.

A modern health system is one that supports British Columbians across their life span[1] to:

- **stay healthy** - achieve and maintain optimal health and wellness;
- **get better** - improve health after an acute event, or move to a better plateau in a chronic condition;
- **live with disease** - minimize deterioration of health and successfully manage a long-term condition; and
- **cope with end of life** - relieve suffering and improve quality of life, and maintain health and wellness of family/caregivers.

The Primary Health Care Charter (the Charter) reflects the growing prevalence and impact of chronic disease, and places strong emphasis on populations living with chronic disease and those at risk. The Ministry of Health's Service Plan, the Medical Services Division's Strategic Plan, health authority plans and the B.C. government/British Columbia Medical Association negotiated agreement have all underscored the need to shift the system from an acute/episodic orientation towards planned/proactive care.

This document sets the strategic provincial direction, based on an analysis of B.C. data, the experience of health authorities, physicians and other health professionals and an analysis of international literature and evidence. B.C. has also hosted exchanges with the U.K., U.S., Australia, New Zealand, Denmark and Ireland to understand best practices in primary health care in those countries.

The Charter sets out the following principles and methods that define and reflect the work in and for British Columbia:

- Improving patient health outcomes will drive what we do.
- Patients and families assume the role of partners in their care.
- A population-based approach will ensure inequities and needs are identified and addressed.
- We will re-orient health services to align with the patient's journey through a patient-centred, integrated health system.
- Family physicians are the cornerstone of primary health care. They are part of a broader community network and professional team that includes nurse practitioners, public health staff, community nurses, midwives, pharmacists, mental health professionals, clinical counsellors, physiotherapists, chiropractors, home and community care workers, dietitians, specialists, and many other health professionals and non-governmental organizations who work as a team with patients and their extended families.

[1] B.C. Ministry of Health, *2006/07 – 2008/09 Service Plan*, Budget, 2006.

- Patients should receive accessible, appropriate, efficient, effective, safe quality care at the right time in the right setting by the right provider.
- Patients and their clinicians must receive key information to make informed decisions at the point of care, and decision support also must be available for managing patient populations.
- We will implement the Expanded Chronic Care Model[2] through structured collaborative approaches because this model has derived the best results in clinical improvement and system change in B.C.

This Charter outlines primary health care challenges, identifies priorities and establishes outcome measures to set the strategic direction of the Ministry of Health with the regional health authorities. Developing the Charter collaboratively has resulted in clear direction and priorities that each health authority will translate into its plans, and the Ministry of Health will use in developing its long-term integrated strategic plan for B.C.'s health care system. In addition, the Charter sets out a strategic agenda for other key stakeholders who want to align their efforts with a systems approach.

The Primary Health Care Charter paints a picture to support systems transformation, focused on improved access and patient outcomes across their lifespan. Developmental work and implementing best practices are initial key initiatives to build momentum for systems transformation. The 2008 version of the Primary Health Care Charter will document and respond to projections and analysis of population need, growth in health care spending, and overall impact of the Charter on those projections. The magnitude of the shifts required for meaningful systems transformation to result in meeting patient and population needs, in seven priority areas, will be identified as system stretch targets.

The Charter identifies key system and structural changes that will drive the needed change but does not prescribe to any health authority, health professional or organization how best to implement the priorities at a detailed level. Coordinated, collaborative system redesign and ongoing practice support will enable the change. The result will be front-line professionals and decision-makers, supported in their jurisdictions, who are responding, innovating and getting results because they are best placed to do so.

All co-developers of the Charter will have an opportunity to contribute to the Primary Health Care Charter annual progress reports, which will be published in the spring of each year. The Charter itself will be revised annually, based on results and to reflect new evidence. To assist with this formative and summative evaluation work, we will solicit access to research supports in partnership with provincial research teams.

[2] The Expanded Chronic Care Model (ECCM) is an integration of the principles of population health promotion and the Chronic Care Model developed by the Group Health Cooperative and the Institute for Healthcare Improvement. This model is designed to guide teams taking action to improve quality. The model suggests improvements in population health and clinical outcomes are a product of productive relationships between an informed, activated patient and a prepared, proactive practice team in the context of their communities. See: Barr, Victoria, S. Robinson, B. Marin-Link, L. Underhill, A. Dotts, D., Ravensdale and D.Salivaras. *The Expanded Chronic Care Model: An Integration of Concepts and Strategies From Population Health Promotion and the Chronic Care Model,* Hospital Quarterly, 7(1), 2003. A summary of the *Expanded Chronic Care Model* is available at www.primaryhealthcarebc.ca.

Our Aim: A Strong, Effective, Accessible and Sustainable Primary Health Care System

The Primary Health Care Charter sets the direction, targets and outcomes that will create a strong, sustainable, accessible and effective primary health care system in B.C.

Medical literature acknowledges the affect of primary health care on population health:

> Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care, which are:
>
> - First contact access for each new need
> - Long-term person-focused care
> - Comprehensive care for most health needs
> - Coordinated care when it must be sought elsewhere

The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies. The means by which primary care improves health have been identified, thus suggesting ways to improve overall health and reduce differences in health across major population subgroups.[3]

[3] Starfield, Barbara; Shi, Leiyu; MacInko, James. Contribution of Primary Care to Health Systems and Health, *The Milbank Quarterly*, 83(3), September 2005.

Our Intended Outcomes

BRITISH COLUMBIANS CAN EXPECT:

- a primary health care system that helps British Columbians stay healthy, get better, manage chronic conditions and die with dignity
- improved confidence to be partners in their own care, and in the primary health care system
- access to a primary health care provider who provides continuity of care within a coordinated system that includes a variety of health professionals and health services
- reduced need for contact with the acute care system
- improved quality of care for populations who currently experience lower health status or gaps in care
- new investments into the primary health care system that will result in measurable patient benefit

PROVIDERS CAN EXPECT:

- to be valued and listened to as an important part of a primary health care team

THE HEALTH SYSTEM CAN EXPECT:

- increased health care system sustainability due to decreased demand for emergency and acute care resources.

Background and Challenges

Analysis of health issues facing British Columbia that may be affected by quality improvement in primary health care takes place within a larger strategic context. The work outlined in the Charter supports the B.C. government's F*ive Great Goals for a Golden Decade*,[4] and is more specifically linked to the Ministry of Health's service plan goals:

- improved health and wellness for British Columbians
- high quality patient care
- a sustainable, affordable, publicly funded health system

Primary health care is considered a key strategy that will contribute and deliver improvement in these goal areas. Primary health care also aligns with and supports other initiatives such HealthLines Services BC. HealthLines Services BC, under the Emergency Health Services Commission (bringing together BC NurseLine and other BC HealthGuide resources, Dial-A-Dietitian and bcbedline), is intended to enhance individual control over health, health care and quality of life. Other examples of aligned initiatives are ActNow BC, B.C.'s Active Aging Plan, and the provincial framework for end-of-life care. These initiatives, and others, create a platform to make significant progress in primary health care. Jurisdictions around the world face the challenge of linking strategies and creating effective ways to address the significant challenges of aging populations, the growing burden of chronic disease and the need to strengthen primary health care.

Primary health care is a key health service and it is crucial that all British Columbians have access to its benefits. According to a Statistics Canada Survey in 2003, 89.3 per cent of British Columbians aged 12 and over had a regular family physician, 7.7 per cent had not looked for a family physician and 2.9 per cent (101,700 people) had not been able to find a regular medical doctor.[5] In addition, many British Columbians do not have same-day access to their own primary health care provider, thus compromising the benefits of primary health care. This lack of same-day access contributes to emergency room use by people with non-urgent symptoms who would be better served by primary health care, delays appropriate management and contributes to duplication of services.

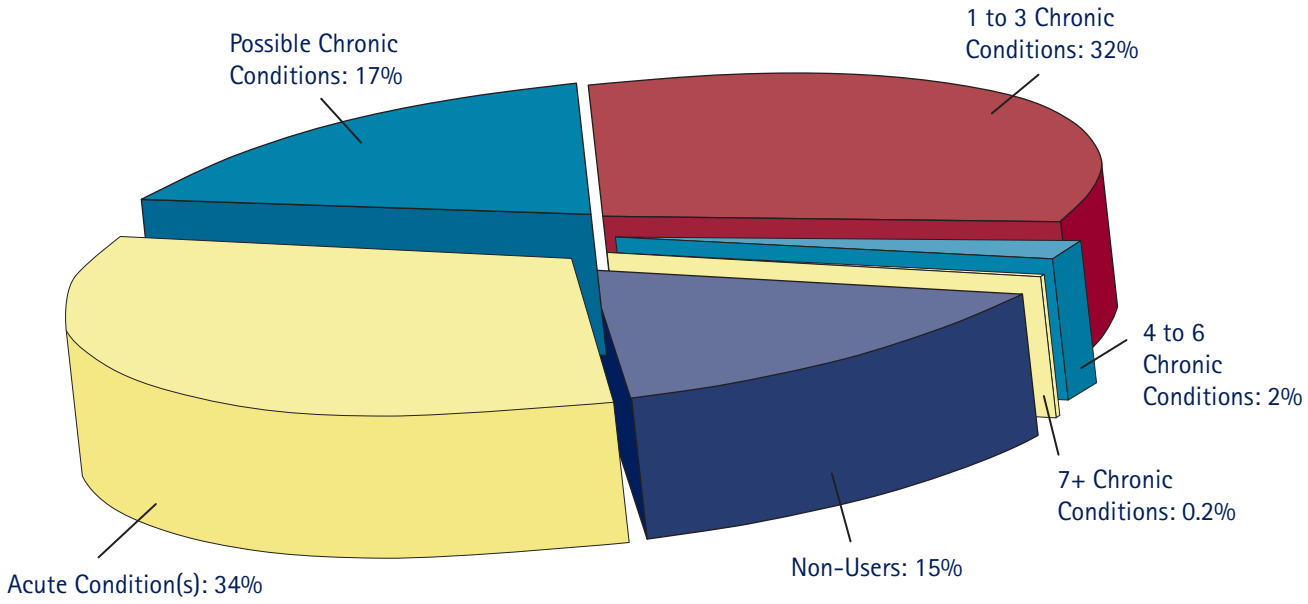
Access to primary maternity care is crucial to the women of this province. The number of primary health care providers delivering babies has continued to fall in each of the last nine years for which data is available. As a result, B.C. women are experiencing more difficulty accessing primary health care for pregnancy, birth and post-natal periods. The introduction of midwives has only partially mitigated the access problem because of the small number in practice.

4 www.bcbudget.gov.bc.ca/2005_Sept_Update/stplan/default.htm#FiveGreatGoals

5 www.statcan.ca/Daily/English/040615/d040615b.htm

Despite the available supports in most communities to help individuals stay healthy, approximately one in three British Columbians now has at least one confirmed chronic condition (Figure 1). Some specific examples in 2005/06 include almost 700,000 individuals with hypertension, over 350,000 individuals with asthma and just over 250,000 patients with diabetes.[6] The prevalence rates of chronic conditions, such as diabetes, are continuing to grow. For example, in 2005/06 there were over 26,000 new cases of diabetes diagnosed in B.C.[7] This trend can be seen across developed countries with an aging demographic.

Figure 1: Population by Health Status, B.C., 2005/06



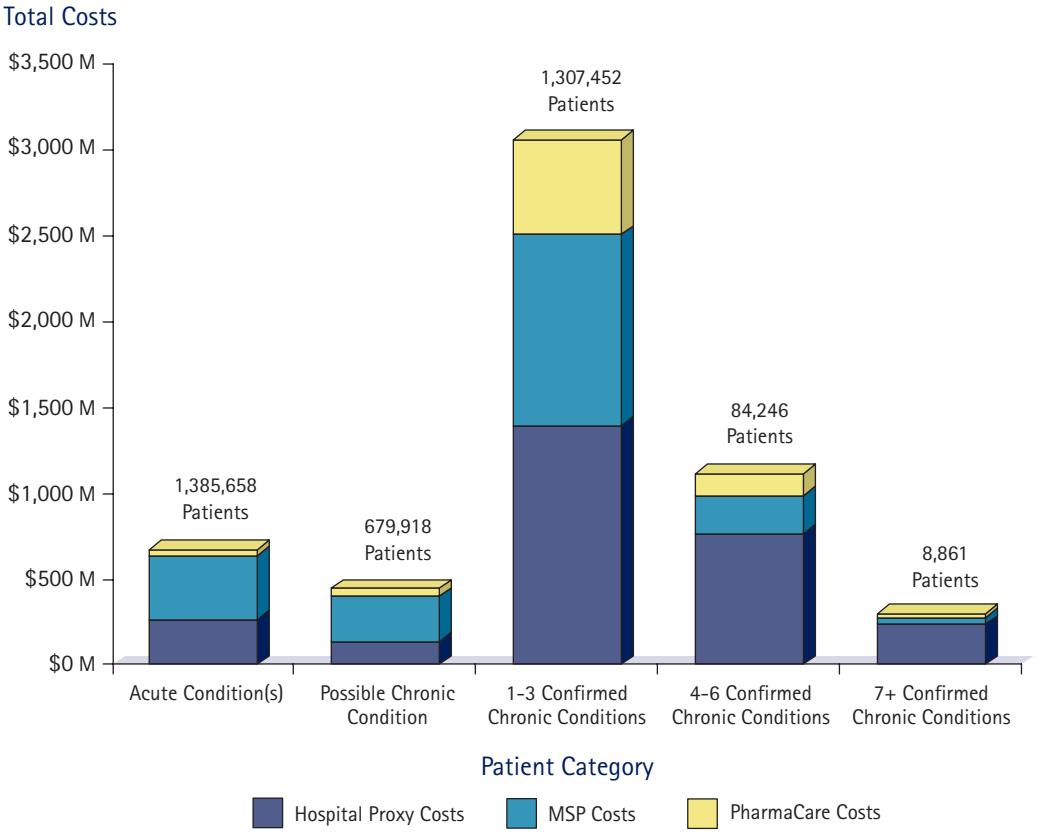
Source: Medical Services Plan (MSP) and Discharge Abstract Database (DAD) data, 2005/06.

6 B.C. Ministry of Health, Medical Services Division. Chronic Disease Registers, 2005/06.

7 Ibid.

Figure 2 shows MSP, PharmaCare, and Acute Care expenditures in B.C. in 2005/06, categorized by health status. While people with chronic conditions represent approximately 34 per cent of the B.C. population, these individuals consume approximately 80 per cent of the combined MSP, PharmaCare, and Acute Care budgets. The cost per patient rises dramatically with increasing co-morbidity (see Figure 3). Nationally, one in three Canadians report in surveys that they have at least one chronic health condition, and more than one-third of this group reports multiple long-term health problems. The proportions are similar across the country, although somewhat higher in the Atlantic region.[8]

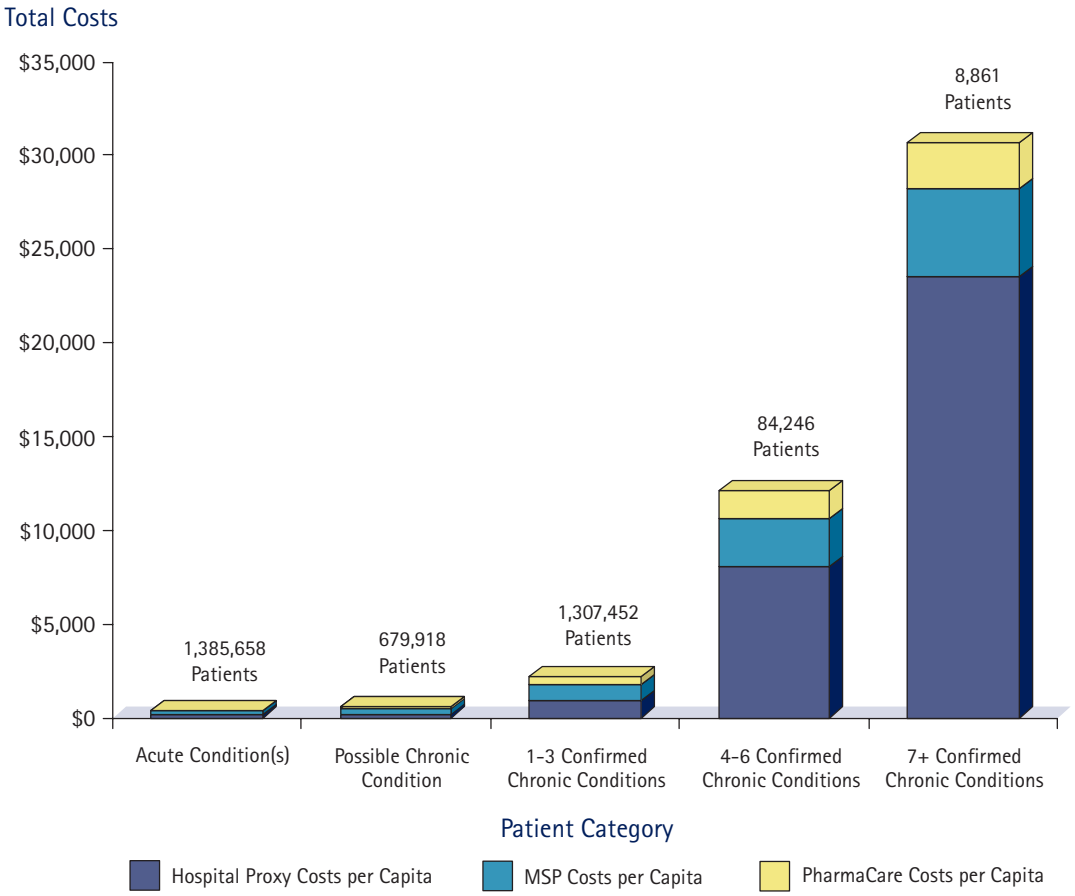
Figure 2: Acute Care, MSP and PharmaCare Expenditures by Health Status, B.C., 2005/06



Source: Discharge Abstract Database (DAD), Medical Services Plan (MSP) and Pharmacare data, 2005/06.

[8] Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005 cited by Health Council of Canada. *Why Health Care Renewal Matters: Lessons from Diabetes*, March 2007.

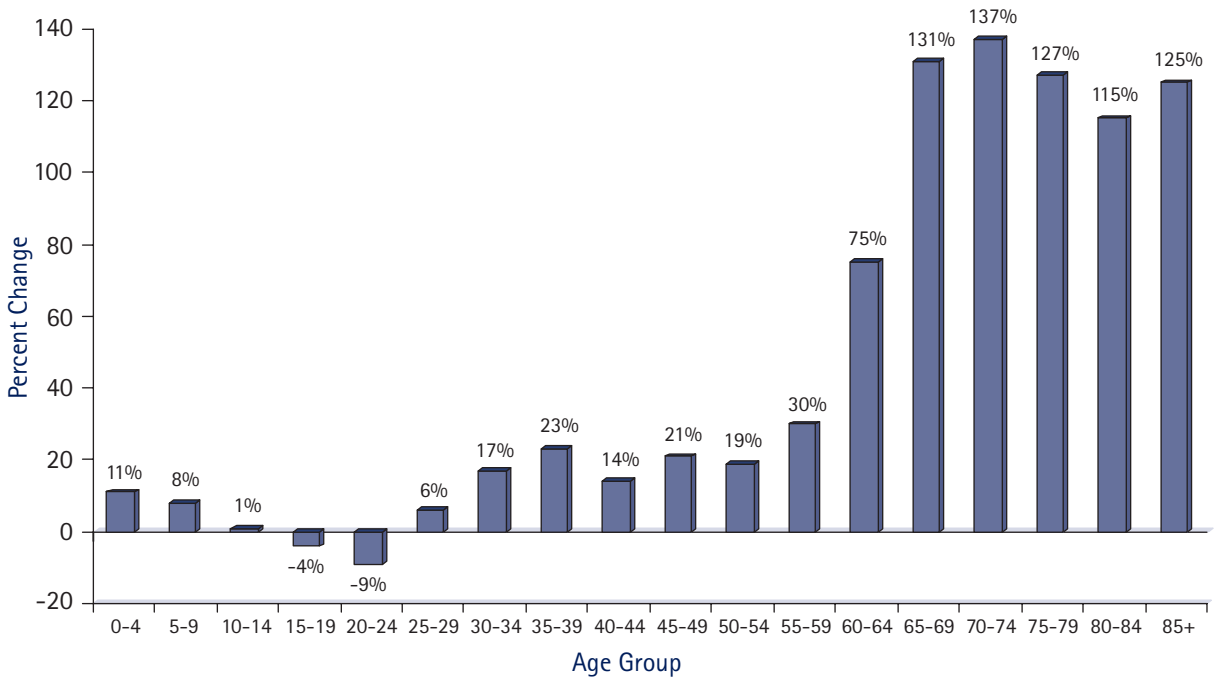
Figure 3: Cost per Patient by Health Status, B.C., 2005/06



Source: Discharge Abstract Database (DAD), Medical Services Plan (MSP) and Pharmacare data, 2005/06.

In general, people with no chronic conditions are younger and people with confirmed chronic conditions are middle-aged and older. British Columbia's population is expected to grow by 31 per cent over the next 25 years, and during this period, the seniors population is projected to grow over 100 per cent (Figure 4). Managing chronic disease is, therefore, a significant issue that affects British Columbians' quality of life and the sustainability of the publicly funded health system into the future.

Figure 4: Projected Population Growth by Age Group, B.C., 2005/06 to 2030/31



Source: Population estimates from PEOPLE31, BCSTATS.

As a result of the shifting demographic towards an older age group, it is projected that the prevalence of chronic conditions could increase 58 per cent over the next 25 years. Along with the aging population, the associated costs could conservatively increase by 79 per cent, even without factoring in inflation or changes in disease patterns.[9]

British Columbia has established a number of evidence-based guidelines and protocols for managing chronic conditions. However, delivery of care according to these guidelines has been low. For example, in 2005/06, 44 per cent of people with diabetes received the recommended care according to B.C.'s guideline for diabetes.[9] Such a gap in care contributes to disease complications and co-morbidities. This results in less than optimal quality of life for many patients, professional dissatisfaction among family physicians and health professionals, and avoidable, expensive emergency room and hospital bed utilization. This is a systems problem experienced by many jurisdictions in developed countries. In B.C., the 2006 Agreement addressed this issue by providing incentives to physicians who practise according to the guidelines. Early evaluation of these incentives has shown a dramatic improvement in the age standardized mortality ratio for patients with congestive heart failure.[9]

Clinical practice guidelines often focus on a single chronic disease, which does not reflect reality for patients with multiple chronic conditions.[10] This is especially true for older seniors. As elders advance in years, they become more at risk of being psychologically and physically overwhelmed by the collective impact of their diseases on their quality of life. Improvement, such as a more planned, coordinated and supported approach to care, could prevent adverse outcomes, increase patients' capability to manage their own care, and prevent or delay frailty.

At the end-of-life, more than 90 per cent of deaths occur as the result of end-stage and/or chronic health conditions, such as cardiovascular or respiratory disease or cancer.[11] Although most of these deaths are expected, approximately 60 per cent of British Columbians die in hospital.[12] With appropriate backup, primary health care providers (family physicians and other health professionals) could play a greater role in delivering end-of-life care.

While primary health care plays an important role in keeping British Columbians as healthy as possible, many factors other than health care services also determine health. These include socio-economic status, social supports and education. Health, or lack of it, is not distributed evenly across the population. Primary health

9 B.C. Ministry of Health, Medical Services Division. *Chronic Disease Projection Analysis*, March 2007, (2007-064).

10 American Medical Association. *Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases Implications for Pay for Performance*, 294 (6) August, 2005.

11 B.C. Ministry of Health. *A Provincial Framework for End-of-life Care*, May 2006.

12 Ibid.

13 Belanger A, Martel L., Berthelot JM, Wilkins, R. Gender Differences in Disability-free Life Expectancies for Selected Risk Factors and Chronic Conditions in Canada, *Journal of Women and Aging*, 14(2), 2002.

14 Wilkins, R., Berthelot, J.M. and Ng, E. Trends in Mortality by Neighbourhood Income in Urban Canada from 1971 to 1996, *Health Reports*, 13, 2002.

15 Vancouver Island Health Authority Chief Medical Health Officer . *The Best of Times, the Worst of Times: A Review of the Health Status and Social Determinats of Health for Vancouver Island Health Authority*, Vancouver Island Health Authority, 2006.

care plays a role in blunting the impacts of non-medical determinants of health and reducing health inequities. There is evidence that this role can be strengthened.[13,14,15] Internationally, a socio-economic gradient in health, with health improving as income and education increases can be seen even in wealthy countries.[16] This difference exists even when accounting for behavioural or lifestyle factors such as smoking.[17] In some health areas, such as diabetes, the gap in health appears to be widening.[18] Local data demonstrates there is an income gradient in health in B.C. The gradient can be seen among children and the elderly but is most marked among the working population. Age-related chronic conditions, such as heart disease, tend to show up earlier among lower-income groups.[19] Analysis of the 2003 Canadian Community Health Survey data for B.C. shows that people with lower incomes are more likely to develop chronic disease at an earlier age, as compared with higher-income earners. This may make them more vulnerable to experiencing the complications of these diseases by living with the diseases over a longer period of time. In addition, chronic disease rates are higher among females, single parents, adults with less than secondary school education, and people who are widowed, separated/divorced, have a permanent disability, or receive social assistance.[20] Of particular concern are the inequities in health experienced by aboriginal people. Aboriginal people have a life expectancy seven and a half years shorter than the rest of the population in B.C. In his landmark 2001 report on the *Health and Well-being of Aboriginal People of British Columbia*, B.C.'s Provincial Health Officer identified eight strategic initiatives, including primary health care, that should be targeted to improve the health of aboriginal people.[21] Initiatives in the Charter will accelerate the work already underway in B.C. to further close health inequity gaps.

Just as the general population is aging, so is the healthcare workforce. Maintaining an adequate supply and balance of health professionals and workers will be challenging. Despite B.C.'s position of having a comparatively stable and above-average supply of physicians when compared to the rest of Canada, retaining and recruiting family physicians remains a significant concern to family physicians and their professional associations. Retaining and recruiting family physicians is a complex human resource issue. It is not a simply a matter of the number of family physicians, but also an issue of the changing profile of the work, and work design. Human resource planning is also a concern for other health professions. In addition, there are a number of barriers to enabling team care that must be explored and resolved.[22]

16 Starfield, Barbara. Equity in Health, *Journal of the Canadian Medical Association*, February 2000.

17 Belanger A, Martel L., Berthelot JM, Wilkins, R. Gender Differences in Disability-free Life Expectancies for Selected Risk Factors and Chronic Conditions in Canada, *Journal of Women and Aging*, 14(2), 2002.

18 Wilkins, R., Berthelot, J.M. and Ng, E. Trends in Mortality by Neighbourhood Income in Urban Canada from 1971 to 1996, *Health Reports*, 13, 2002.

19 Vancouver Island Health Authority Chief Medical Health Officer . *The Best of Times, the Worst of Times: A Review of the Health Status and Social Determinats of Health for Vancouver Island Health Authority*, Vancouver Island Health Authority, 2006.

20 Ibid.

21 British Columbia Provincial Health Officer. *Report on the Health of British Columbians. Provincial Health Officer's Annual Report 2001. The Health and Well-being of Aboriginal People in British Columbia*, Ministry of Health Planning. 2002.

22 British Columbia Medical Association. *Enhancing Multidisciplinary Care in B.C.*, October 2005.

Clinical and management decisions should be made based on clinical data and evidence. Currently, most primary health care practices do not have computers or software to schedule advanced or same-day access, recall for planned care, or build patient registries to identify whether individuals in a patient population are receiving recommended care. Barriers to information management, such as privacy interpretations and the current lack of technology, training and support in primary health care offices, must be rapidly solved.

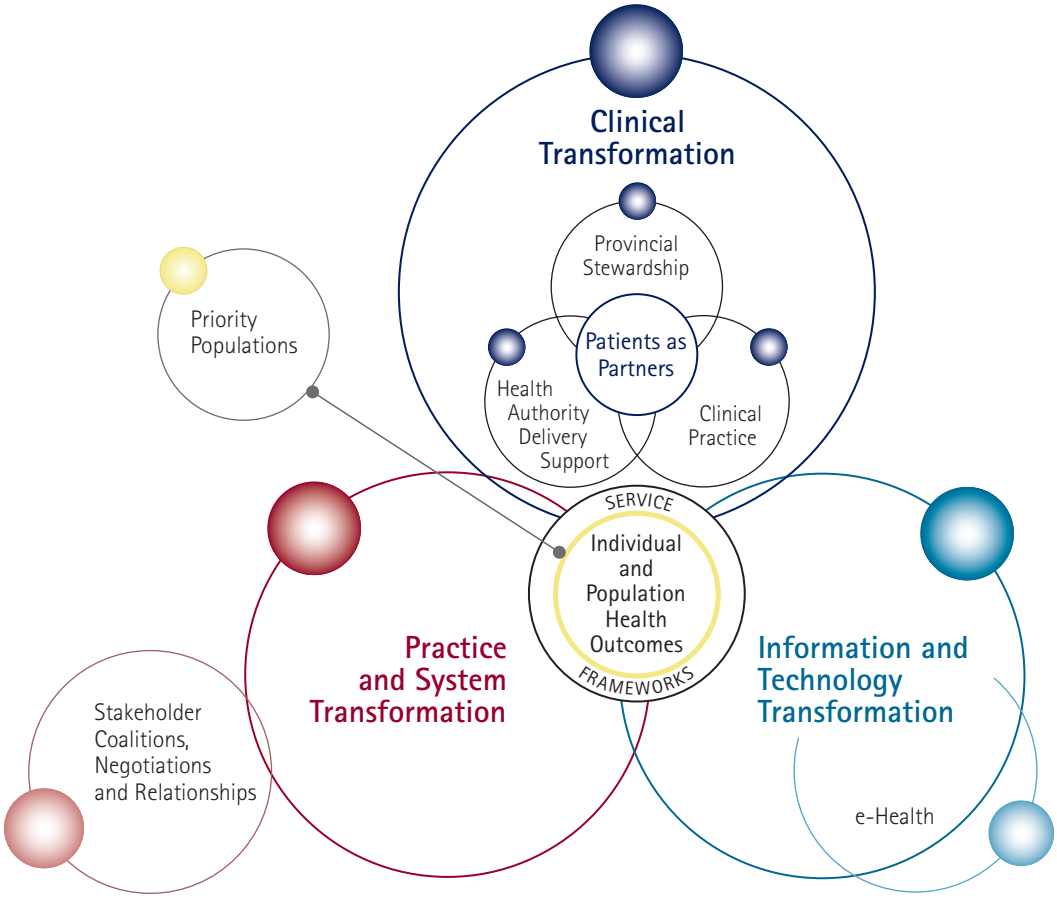
Finally, our current system supports passive patients rather than patients as partners in their own care. This system problem typically results in services designed around the needs of health professionals and facilities rather than patients. As a result, patients often do not have sufficient information and supports to make decisions about their health and implement changes.

System Transformation

5.1 Context

Addressing the challenges described above requires a system-level response. This document sets the direction for primary health care within this context. The Charter links to and supports a number of strategic plans within government and within the broader stakeholder community. Likewise, aligning specific initiatives within those plans supports the system-wide commitment to the transformation described in the Charter. Figure 5 suggests that, to achieve the desired results of improved individual and population health outcomes, efforts must be focused on transforming three areas: clinical care, practice and system design, and information technology.

Figure 5: Transformation Strategies for Primary Health Care



This primary health care transformation model outlines the Charter's component objectives and guiding principles:

- The Primary Health Care Charter aims to improve **individual and population health outcomes**. Value for patients is the central premise of the Charter's agenda. Value for patients is multidimensional and includes timeliness and accuracy of diagnosis and treatment, recovery time, quality of life, and emotional wellbeing over the duration of a medical condition. Maximizing the cost effectiveness or benefits of a single episode or intervention is not sufficient. In economic terms, value for patients could be understood as the health outcome per dollar of cost expended in addressing the integrated care of a patient's particular medical condition over the full cycle of care.[23]
- The focus on **priority populations** recognizes that targeted approaches for high-risk populations will reduce inequities and yield the greatest overall benefit.
- **Clinical transformation** identifies the most significant gaps in care, and outlines quality improvement initiatives across a wide range of stakeholders to close the gaps to improve outcomes for patients.
- **Practice and system transformation** proposes mechanisms to align funding and business models (such as group practice and team care) to the needs of the population.
- **Information and technology transformation** identifies initiatives to provide health care information that is accessible, when and where it is needed.
- **Stakeholder coalitions, negotiations and relationships** recognize that system change requires the active involvement of many stakeholders.

Moving forward on these transformation strategies requires focused attention and commitment to identified priorities. Currently, family physicians constitute the largest workforce in primary health care. Therefore, the current B.C. government/BCMA agreement (the Agreement) is a significant part of the Charter's context. Components of the Agreement align with and support each of the seven priorities described in the Charter. In addition, the Agreement includes dedicated practice support funding for family physicians and their office staff to identify and work toward goals for improved patient care and outcomes relevant to their own local practice populations. The Practice Support Program teams, funded through the Agreement, which include physician champions, will work in partnership with local family physicians and health authorities staff in realigning health care services to attain better health outcomes, and to improve providers' professional satisfaction.

The Agreement also contains a planned investment in information management/information technology (IM/IT) for primary health care. IM/IT is critical to successfully implementing the Charter, and supports activities in the seven priority areas described in detail in Section 6: Key Initiatives. The Physician Information Technology Office

[23] This idea and content is taken from Porter and Teisberg. *Redefining Health Care*, 2006.

is facilitating implementation of the Agreement's IM/IT component in alignment with the overall provincial eHealth strategy. In concert with existing initiatives, such as the provincial Chronic Disease Management (CDM) Toolkit, PITO's IM/IT supports for family physicians will enable improved clinical management and decision support at point-of-care and population levels. Both of these are essential to monitoring and improving primary health care's progress toward the health outcome and system goals outlined in the Charter.

Developing the Charter has supported and stimulated an exchange of information among a broad stakeholder group. The alignment of governmental and non-governmental strategic plans is an encouraging sign. It will facilitate implementation of the Charter and ultimately ensure its success.

5.2 Methodology

Over the past five years, primary health care quality improvement initiatives have used a methodology that focuses on the patient population. An analysis of the population's needs is paired with an evidence review to determine care gaps and opportunities for improvement. This approach underpins the Charter and will remain a key element of change management.

The approach described in the Charter is founded on evidence-based best practices for quality improvement in primary health care.[24] It has been refined over the past five years, based on international primary health care experiences, and the experience of B.C. physicians, health professionals and health authorities involved in structured local, regional and provincial quality improvement initiatives. This approach provides an adaptable, evolutionary, and collaborative model involving top-down (system redesign) and bottom-up (practice redesign) components. The goal is to leverage these approaches and learnings at a sustainable, system-wide level over the coming years. The system redesign components will focus on realignment of health care services, strategy, legislation and policy, provincially and regionally, to better support effective primary health care. The practice redesign components will focus on supporting family physicians, their practice staff and other health professionals to innovate, improve and sustain practice changes that result in better professional satisfaction and improved patient health outcomes. Large-scale system change is complex and difficult to achieve. It is essential to implement initiatives in dynamic and flexible ways to accommodate new learnings and evidence, build on successes, and make "course corrections" if applied strategies do not achieve the expected measurable improvements in a reasonable timeframe.

The health authorities will be leaders in further developing and building supportive community environments for the required system change, linked to collaborative initiatives underway with the BCMA, the broader physician community and community organizations. Implementing the Charter requires building on and coordinating with existing health authority quality-improvement initiatives

[24] See: Barr, Victoria, S. Robinson, B. Marin-Link, L. Underhill, A. Dotts, D., Ravensdale and D.Salivaras. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. *Hospital Quarterly*, 7(1), 2003 and the Institute for Healthcare Improvement's quality improvement models (www.ihi.org). A summary of the Expanded Chronic Care Model is available at www.primaryhealthcarebc.ca.

and physician-engagement processes. These changes can only occur and be sustained when health authorities, the Ministry of Health and other major stakeholders remove barriers, align policies and provide supports.

The Charter has identified seven priority areas for primary health care system change that are described in detail in the following section. However, regardless of the priority area, a foundation or infrastructure is required to successfully implement the change. This infrastructure is critical to the success of the changes and is made up of the following cross-system initiatives:

- establish regional practice support teams
- provide local learning sessions with follow-up action periods
- implement integrated health network teams in a staged or phased approach
- realign secondary and tertiary services
- build supports for patients as partners
- provide technology to support critical primary health care functions
- ensure a supportive policy environment

Establish regional practice support teams. Regional Practice Support Program teams will provide expertise for clinical, practice and IM/IT transformation, using a collaborative approach. The regional teams will engage with family physicians and other health professionals to introduce and embed evidence-based changes. Teams will comprise clinical and practice-management peer champions[25], health authority coordinators, and IM/IT support experts. They will provide direct support and peer mentoring for family physicians, their practice staff and other health care professionals to engage in clinical and practice changes for improving care for priority patient populations. In partnership with family physicians, the teams will work within the local community to integrate primary health care and realign health authority services to better support family physicians, primary health care workers, and the communities and patients they serve.

Provide local learning sessions with follow-up action periods. Sessions will be made available to family physicians, specialists, medical office assistants (MOAs), family-practice nurses, nurse practitioners and other primary health care providers. Learning session topics will be specific to local priority-population needs such as:

- implementing the Expanded Chronic Care Model
- improvement in clinical process and outcomes for specific at-risk or chronic-disease patient groups
- implementing shared and team care
- improved access (e.g., advanced access scheduling, a technique that improves the availability of same day appointments)
- providing culturally safe care
- conducting group visits for clinical care and education

To launch learning sessions and introduce the Practice Support Program teams, a series of 20 one-day Practice Support Program (PSP) workshops have been scheduled across B.C. These PSP workshops are being held between

[25] A peer champion is an experienced local leader who supports people undertaking similar changes. For example, a medical office assistant (MOA) peer champion might be a MOA who has experience in implementing expanded roles or different scheduling systems and acts as a resource and support to other MOAs taking on similar changes.

May 1 and June 14, 2007, and are designed to reach up to 1000 physicians and their medical office assistants. The workshops will provide an opportunity to learn about many practice-enhancement related topics, such as the new funding incentives and the training and support opportunities available through regional practice-support teams led by the health authorities. The workshops will be delivered jointly by the General Practice Services Committee, the Ministry of Health, the BCMA, and each health authority's practice support team. Participants will have the opportunity to discuss their individual practice situations with fellow physicians and medical office assistants, and to identify areas of interest for future workshops and where additional support is required.

Implement integrated health network teams in a staged or phased approach, with patients as partners as the philosophy.[26] The goal is to design and implement integrated health network teams that shift the patient experience away from multiple, fractured services to a patient-centred experience focused on supporting the central role of patients in staying healthy and managing their condition(s). These networks will typically serve a geographic community that links family physicians with existing health authority and community resources. It also adds other key resources to improve coordinated community care through an integrated team of providers wrapped around high-need priority patient populations, and providing functions such as:

- patient self self-management training and groups
- patient education
- life coaching and solution-focused counselling
- group clinical visits
- effective linkage to home and community care, medical specialists, and local hospital transition-home teams
- community development and social supports capacity.

The initial focus of integrated health networks will be to improve care for priority populations with specific chronic conditions or co-morbidities. There is substantive evidence that, if patients in these priority populations receive recommended and planned care, there is a direct correlation to reductions in ER use, hospitalizations, and re-hospitalizations, among other benefits. An integrated health network is the mechanism to support and formalize the critical links between community organizations and resources with primary health care and to re-align health authority and specialist services to integrate with primary health care. Improving population-health outcomes is the key that drives the development and implementation of each network.

Realign secondary and tertiary services. Health authorities will further realign their services for better integration among primary health care, mental health, home and community care, and other services to meet the needs of the population and improve outcomes. In addition, medical specialist, laboratory and imaging services will also need to be aligned for better integration with primary health care.

[26] This key idea and content is taken from Porter and Teisberg, *Redefining Health Care*, 2006 who proposed a similar idea of Integrated Practice Units.

Build supports for patients as partners. Primary health care providers and organizations will develop and implement additional ways to support the central role of patients as partners in their own care.

- Develop and implement evidence-based self-management support for **patients** (and their families/caregivers) across all regions of the province, including supports for improving health literacy. Particular attention will be given to investigating the infrastructure requirements to maintain and spread the self-management training in aboriginal communities.
- Maintain existing self-management supports aimed at building **provider** capacity to support patient self-management.
- Develop and deliver policies, provider education and regional supports in efforts to implement a patient as partner **systems** approach.

Provide technology to support critical primary health care functions. Incremental improvements will be supported in the context of the provincial eHealth strategy and the 2006 Government/BCMA Agreement. Key areas of focus include:

- scheduling for advanced access and monitoring improvements in access
- patient registries to identify and manage priority populations within primary health care practices, and to coordinate delivery of appropriate services and health-system planning across larger geographic areas
- "rule-based" recall to support planned care according to evidence-based clinical best practices
- clinical templates and flowsheets for point-of-care access to clinical guidelines and evidence-based best practices
- decision support for patients, providers and health-system planners at point-of-care, whole practice, community, regional and provincial levels
- data analysis and reports of clinical process measures and clinical outcomes, based on clinical evidence and priority measures identified in this Charter
- integration with, and support of, B.C. eHealth initiatives to enable electronic medical records (EMRs) in primary health care provider offices, and access to key clinical and administrative data to support patient care (e.g., patient lab and medication profiles, medical summaries, referrals/consultations, hospital discharge abstracts)

Ensure a supportive policy environment. Creating local changes to improve care and outcomes for patients is most easily done in an environment where public policies support the desired changes. This requires an active feedback mechanism and communication between the people and organizations doing the quality improvement, and the people and organizations creating and maintaining the policies to support change. The range of policy-area supports include information management, protection of privacy, and professional scopes of practice. An illustrative example, arising from the Charter stakeholder consultation, is a request that government, educators, service providers and professional associations be brought together to assess primary health care educational issues and barriers, such as availability of training and clinical preceptorships, in order to develop collaborative policies and strategies to address them.

Key Initiatives: Target Areas for System Change

The Charter has identified seven priority areas for primary health care system change. To achieve measurable progress on each priority area, it is imperative for the health system to focus on a small number of high-impact, system-wide initiatives and achieve the desired system shifts and health outcomes. The methodology section above described the cross-system initiatives that will support improvement in the seven priority areas. These are critical but not sufficient to the success of the changes to be introduced in the Charter's seven priority areas that will be described in more detail in the following sections.

Given the system challenges and trends described previously, achieving system-wide improvements in B.C. requires a multi-faceted strategy – no one solution will provide the kind of system shift we require to meet changing patient needs. When identifying solutions, we must take into consideration urban/rural realities, supply and skills of health care professionals, and public expectations and attitudes. Based on the analysis of existing challenges and strengths, the following seven priorities have been established:

1. Improved access to primary health care
2. Increased access to primary maternity care
3. Increased chronic disease prevention
4. Enhanced management of chronic diseases
5. Improved coordination and management of co-morbidities
6. Improved care for the frail elderly
7. Enhanced end-of-life care

These priority areas knit together with a focus on priority populations: maternity patients, people at risk for or living with chronic conditions, the frail elderly, people living with mental ill health and addictions, aboriginal people, and people approaching end-of-life.

For each of the seven priorities, the Charter provides some background information to describe the care gap and the logical underpinnings for the direction being promoted. This is followed by the key initial initiatives that will be continued or developed over the coming year with results listed for March 2008.

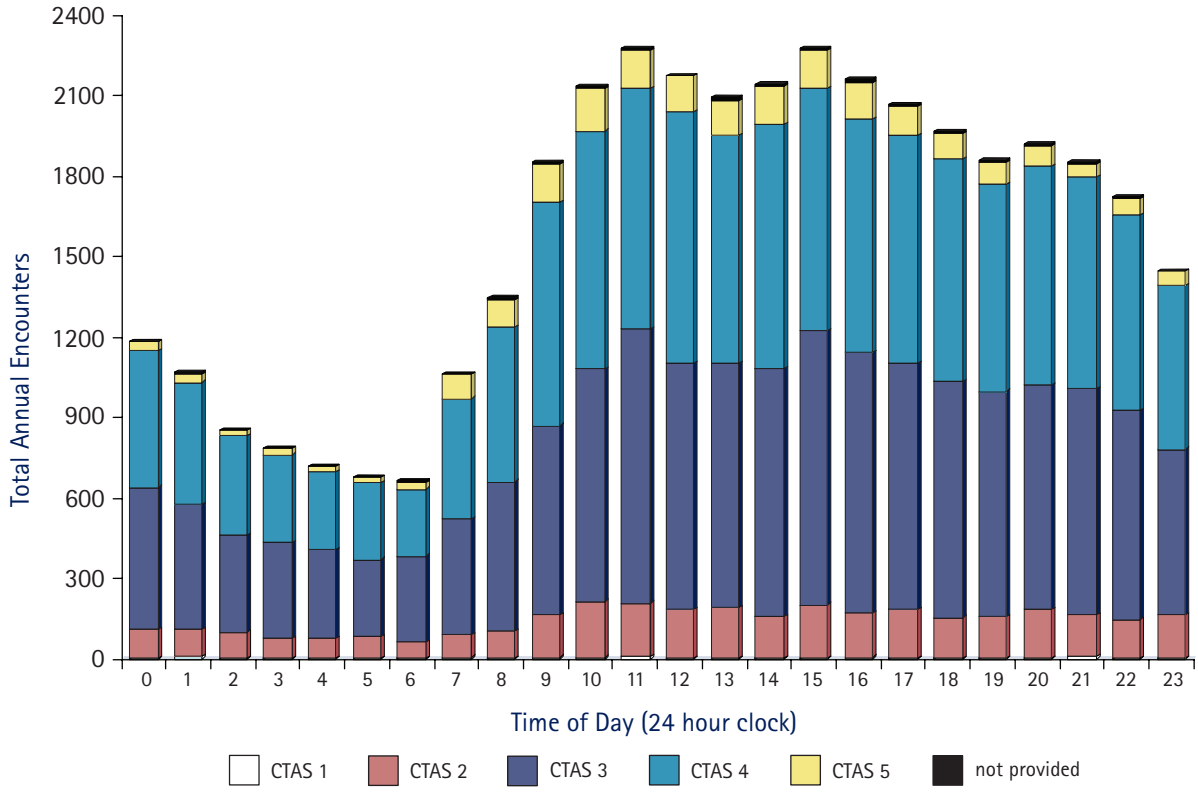
6.1 Access to Primary Health Care

Timely access to health care is a significant concern that affects many areas of the health system, including primary health care. The College of Family Physicians of Canada (CFPC) reports that, when people cannot find a family physician, they will be more vulnerable to long waits throughout the rest of the system and will be less satisfied with the system overall. The CFPC has also identified underserved populations who have disproportionate difficulties in access. These include those living in rural, remote, and inner-city areas, and people living with barriers due to disability, language, culture, or lack of education.[27] The primary health care community is concerned that people living with mental illness and/or addictions might find accessing primary health care particularly difficult. People with relatively non-urgent symptoms make up a large proportion of users of

[27] College of Family Physicians of Canada. *Family Medicine in Canada: Vision for the Future*. November 2004.

emergency rooms in B.C. hospitals, often appearing in the emergency rooms during the day between 9:00 a.m. and 9:00 p.m. (see Figure 6, particularly CTAS levels 4 & 5 which are less urgent). We must understand this concern and commit to finding solutions to integrate care for this population.

Figure 6: Emergency Room Encounters by Time of Day, VIHA Royal Jubilee, 2005/06[28]



Source: Vancouver Island Health Authority.

[28] CTAS scores are a scale to indicate urgency from 1 the most urgent to 5 the least urgent.

Work by Barbara Starfield indicates policy change that encourages physicians to practice in underserved areas improves access and reduces major causes of death, disorders, and disparities in health across major population subgroups.[29]

A recent Commonwealth Fund survey compared same-day access to physicians and emergency room use for several countries, including Canada. The use of emergency rooms for non-emergencies was higher in countries with the lowest rates of same day access. Canada had the lowest rate of same day access and the highest rate of waits of six days or more.[30] Advanced or open-access scheduling is one solution for improving access to primary health care. It can increase same-day access to care providers by collapsing the variety of appointments on a provider's schedule and leaving approximately 70 per cent of the schedule open at the start of each day. By ensuring access to a patient's own provider and using the patient's own health record, service duplication and miscommunication can be reduced.

Currently, British Columbia has a number of regulated health professionals who function as primary health care providers with first contact access. Family physicians are, and will continue to be, central to B.C.'s primary health care system. While still small in number, midwives and nurse practitioners increase capacity and options for access to primary health care for British Columbians; and, like physicians, they are connected to a wide range of other care providers within the primary health care system. All of these providers have a role to play in achieving the outcomes set out in the Primary Health Care Charter. The building of broader interdisciplinary teams will be a key focus in future iterations of the Charter.

The 2006 negotiated agreement between the B.C. government and the BCMA is foundational to the current Charter, and the source of a number of key initiatives in the seven priority areas, including access. As a whole, the Agreement represents a $422 million investment in family physicians. This will have a positive impact on patient care and health outcomes, and support physician recruitment and retention. In addition, there are a number of ongoing financial incentives and benefit programs designed to improve access to primary health care in rural areas. Examples include the rural retention program, the GP locum program, and the rural continuing medical education program.

Initial Key Initiatives for 2007/08

- Update regional mapping and identify health inequities and gaps related to access to primary health care (building on the Centre for Health Services and Policy Research January 2005 report, *Planning for Renewal: Mapping primary health care in British Columbia*[31]) and complete an analysis of the policy implications for increasing access.
- Implement the $10 million initiative, through the 2006 Agreement, to attract and retain additional family physicians in group practices in areas of the province with demonstrated need. Solo practice would be considered for remote and rural areas.

29 Starfield, Barbara; Shi, Leiyu; MacInko, James. Contribution of Primary Care to Health Systems and Health, *The Milbank Quarterly*, 83(3), September 2005.

30 *New Commonwealth Fund Survey Spotlights Strengths and Gaps of Health Care Systems in U.S., Canada, the U.K. and Other Nations*, October 2004.

31 Watson DE, Kruegar H, Mooney D, Black C. *Planning for Renewal: Mapping Primary Health Care in British Columbia*, Centre for Health Services and Policy Research, January 2005.

This initiative is available for qualified general practitioners within ten years of licensure to practice and includes student debt forgiveness and financial assistance to set up a practice.

- Develop a provincial physician-supply plan, integrated with the provincial health human-resource plan, based on projected patient needs.
- The Practice Support Program teams will offer family physicians change packages and support in adopting advanced or open-access scheduling to improve the availability of same day access to service.

Results by March 2008

- net increase in the number of family physicians establishing practices in underserved areas
- increase in the proportion of practices with advanced or open access in each region

Looking Forward to 2017

The long-term goal is to ensure that all British Columbians will have timely, local access to a primary health care provider or network to meet their health care needs. Indicators and milestones will be established over the coming year to effectively track progress toward this goal.

6.2 Access to Primary Maternity Care

There are over 40,000 births in B.C. each year. Providing maternity care for pregnant women is an important component of primary health care. In many ways maternity care is a health-promotion and disease-prevention service with the objective of having a healthy mother and child, and preventing complications during pregnancy and delivery.

Family physicians are challenged in providing maternity care by a number of factors, such as increased complexity due to increasing maternal age at first birth, and limited surgical back-up and staffing support in rural and remote areas. As a result, over the past nine years, the percentage of births delivered by family physicians has dropped from 59 per cent in 1997/98 to 45 per cent in 2005/06.[32] During the same period, the number of family physicians delivering babies dropped from 1743 to 829, a 47.6 per cent decline.[33] Midwifery numbers (currently 102 practising)[34] are inadequate to fill the gap in the short term, and the use of obstetricians for primary maternity care (205 practising in 2005/06)[35] is unsustainable and costly. It is estimated that in 2005/06, midwives have cared for approximately 3,000 mothers and newborns, or 7.3 per cent of deliveries in B.C.[36]

Under the 2004 agreement, the Maternity Care Enhancement Project gathered evidence, consulted stakeholders, and produced the report: *Supporting Local Collaborative Care Models for Sustainable Maternity Care*

32 B.C. Ministry of Health, Medical Services Division. *Chronic Disease Projection Analysis*, March 2007, (2007-064).

33 B.C. Ministry of Health, Medical Services Division, based on 14014 fee item.

34 College of Midwives of B.C. *List of Registrants*. www.cmbc.bc.ca. January 2007.

35 B.C. Ministry of Health, Medical Services Division. *MSP Information Resource Manual*. Table 1-1, p. 12, 2005/06.

36 B.C. Ministry of Health, Medical Services Division. *MSP Knowledge Base (version 0.99). By Client Location – Detail for B.C. (including non-residents)*, March 2006 (YTD) and *Ministry of Health Knowledge Base (version 2.6) Birth Volumes and Rates for B.C.*, 2004.

in British Columbia. The recommendations included supporting the development of a woman-centered care pathway, collaborative care models, practitioner sustainability, quality monitoring and provider education.[37] The Charter builds on this continuing work, as well as, other documents such as the First Nations Health Plan.

Initial Key Initiatives for 2007/08

- Continue to implement and evaluate initiatives to encourage family physicians to provide primary maternity care services. This includes the Maternity Care Network Payment that supports family physicians in moving to group maternity practice to help prevent burnout (by working as a team, at least one physician is always available to deliver their patients). Also, the Obstetrical Care Premium has been introduced to encourage and support low- to moderate-volume delivery practice by providing additional payments for the first 25 deliveries in a calendar year.
- Improve regional and provincial supports for women and their family physicians. These supports will include rapid access to specialist care, links to midwives, and links to other health authority services such as public health and mental health.
- Provide increased training and support to primary health care maternity providers and family physicians wishing to return to obstetrical care by a variety of means including training at B.C. Women's Hospital and regional health authority sites, and the use of telehealth and simulated education. This is supported by $1 million funding under the 2006 Agreement.
- Create opportunities for collaboration among system stakeholders, such as the B.C. Reproductive Care Program, the health authorities, colleges, and the Primary Health Care Charter team, to leverage opportunities for working together, focusing initially on removing barriers to collaborative care among midwives, family physicians, nurse practitioners and others.
- Continue development and implementation, by the B.C. Reproductive Care Program and health authorities, of the patient-centred maternity care pathway.
- Develop a strategy to increase the number of perinatal care providers (including midwives and perinatal nurses) and monitor health human resource trends to assess progress.
- Continue the development of the Aboriginal Maternity Care Plan to increase access to high quality maternity care for women in aboriginal communities.

Results by March 2008

- increase in the proportion of births delivered by primary health care providers

[37] www.healthservices.gov.bc.ca/cdm/practitioners/mcep_recommend_dec2004.pdf.

Looking Forward to 2017

The long-term goal is that all British Columbians requiring maternity care will have timely, local access to a primary maternity provider or network. Indicators and milestones will be established over the coming year to effectively track progress toward this goal.

6.3 Chronic Disease Prevention

Family physicians have long shown a commitment to clinical prevention. They have been guided by the evidence base developed by the Canadian Task Force on Preventive Health Care, whose recommendations cover preventive services from prenatal and infant care to immunization, prevention of injuries and chronic diseases. The province of B.C. funds a range of clinical prevention services such cancer screening for cervical, breast and colon cancer. The province is committed to increasing effective prevention in primary health care, as evidenced by the new prevention fee allocation and the development of new prevention guidelines. While there is an interest in ensuring that prevention is increased for all ages (e.g., the performance expectation with the health authorities regarding immunization rates), there is a particular interest in the prevention of chronic diseases because prevention is the first step in effective chronic disease management.

A key response to the demographic trends of increasingly older populations with more chronic diseases is to invest in strategies that will prevent or delay the onset of chronic diseases. A growing body of evidence indicates this is possible. According to the World Health Organization, 80 per cent of some chronic diseases, such as type 2 diabetes, can be prevented.[38] Specific research has found that moderate exercise and diet control among overweight people with pre-diabetes (impaired glucose tolerance) reduces the likelihood of developing diabetes by more than 50 per cent.[39] Cardiovascular disease is still the most

[38] World Health Organization. *Preventing Chronic Diseases a Vital Investment*, 2005.

[39] Tuomilehto J, Lindstrom J, Eriksson JG, et al. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. *New England Journal of Medicine*, 344, 2001.

common cause of morbidity and mortality in Canada. In an encouraging trend, B.C. has seen a major reduction (50 per cent) in cardiovascular disease mortality in the last twenty years.[40]

Many chronic diseases, such as diabetes and cardiovascular disease, have similar risk factors. Addressing these common risk factors (reducing tobacco use, healthy eating, and being active) is the underlying logic for the recent cross-government initiative – ActNow BC – and for the strategies of non-governmental organizations such as the BC Healthy Living Alliance. This supports the second of the B.C. government's *Five Great Goals for a Golden Decade*: lead the way in North America in healthy living and physical fitness. In addition, early detection (e.g., cervical, breast and colon cancer screening) can also aid in disease management and can improve outcomes.

Development of chronic disease is a complex process that occurs over time. Likewise, prevention of chronic disease is a complex and multi-faceted endeavour that requires efforts of many partners. Primary health care has a key role to play. Encouragingly, evidence shows that changing physician behaviour towards prevention requires the same set of supports shown to be effective in B.C. for chronic disease management. These include information systems, training and coaching, support networks, feedback of results and comparators, and dedicated fees.

Initial Key Initiatives for 2007/08

- Develop and implement technology-enabled guidelines to address the primary prevention of cardiovascular disease. The guidelines, to be developed by the government/BCMA Guidelines and Protocols Committee (GPAC), will identify interventions most effectively delivered by primary health care providers and supported by community resources and lifestyle experts, such as dietitians and organizations such as the BC Healthy Living Alliance.
- Develop and implement a prevention-incentive payment for family physicians focused on cardiovascular risk reduction. Starting in April 2007, five per cent of annual fund allocation through the 2006 Agreement is to be allocated to an incentive for family physicians to conduct cardiovascular risk assessments and create action plans with their patients (men aged 40-49 and women aged 50 to 59).
- As part of B.C.'s Transformative Change Accord, work with the First Nations Inuit Health Branch, first nations service providers and health authorities will begin to implement an integrated and culturally-appropriate approach to chronic disease prevention and management.

[40] Heart and Stroke Foundation of Canada. *The Growing Burden of Heat Disease and Stroke in Canada*, 2003.

Results by March 2008

- identification of the proportion of physicians providing recommended preventive services linked to the new prevention incentive

Looking Forward to 2017

The long-term goal is that all British Columbians will have access to evidence-based clinical prevention in primary health care where there is sufficient evidence of effectiveness. Indicators and milestones will be established over the coming year to effectively track progress toward this goal. Primary health care has a role to play with the province attaining its broader ActNow BC goals related to: tobacco use, physical activity, eating fruits and vegetables, and prevalence of overweight and obesity.

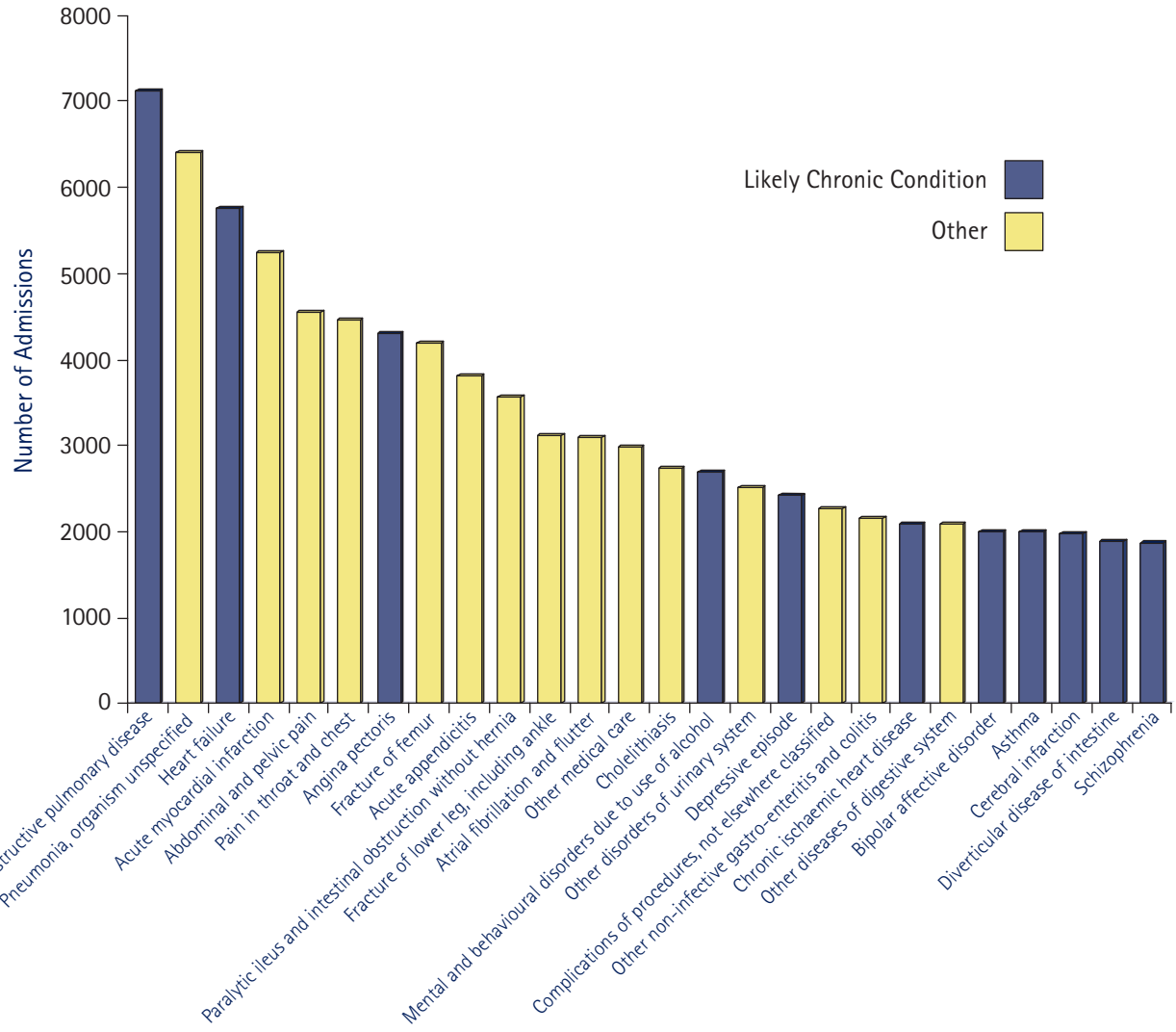
6.4 Chronic Disease Management

Chronic conditions affect over one in three British Columbians.

B.C.'s changing demographics reflect an increasingly older population with a higher prevalence of chronic illnesses that persist over a long period of time. Often, patients first develop a chronic condition in middle age and accumulate additional chronic diseases as they move into their senior years.

The significant projected increases in chronic disease prevalence for conditions such as diabetes will bring with them an associated growth in costs, especially in hospital care. Chronic conditions also play a significant role in emergency room volumes. For example, in 2005/06 chronic obstructive pulmonary disease (COPD) was the leading reason for hospital stays for patients admitted via an emergency room (Figure 7).

Figure 7: Hospital Admissions by Most Responsible Diagnosis (ICD10) where the Patient was admitted through ER, B.C., 2005/06



Source: Discharge Abstract Database (DAD), 2005/06.

This highlights that, in addition to the direct costs associated with chronic conditions, complications of chronic conditions are also significant. In 2005/06 for example, 60 per cent of lower limb amputations were performed on people with diabetes.[41]

British Columbia has been actively engaged in chronic disease quality-improvement initiatives for the last several years. Encouragingly, evidence shows that chronic disease management can have a positive impact on patient outcomes. For example, early results show that B.C. chronic disease management initiatives underway for patients living with congestive heart failure (CHF) have reduced the mortality rate.

During the summer of 2006, the Medical Services Division completed an analysis in partnership with the GPSC, B.C.'s health authorities, and other stakeholders to identify specific chronic conditions for which the greatest opportunities existed to improve the quality of the services delivered and the outcomes for patients. This analysis was supported by research such as the Centre for Health Services and Policy Research report on chronic conditions.[42] The following priority medical conditions, diseases and co-morbidities were identified:

- cardiovascular disease (hypertension, diabetes mellitus, ischemic heart disease, congestive heart failure, cerebrovascular disease – strokes and TIAs – chronic kidney disease, disorders of lipoid metabolism)
- depression
- musculoskeletal (osteoarthritis & fractures related to osteoporosis, lower back pain)
- respiratory ailments (asthma, chronic obstructive pulmonary disease, acute lower respiratory tract infection)

Approaches for evidence-based effective management of individual chronic diseases are well documented and evaluated. Approaches for each priority disease and co-morbidity cluster would include:

- developing a patient register;
- analyzing potential gaps in care;
- developing clinical practice guidelines and/or service frameworks to articulate evidence-based care;
- implementing specific initiatives with patient health-outcome targets, with supports such as IT systems, coaching, training, and feedback; and
- specific supports for self-management, particularly for populations experiencing health inequities, such as aboriginal people.

Over the past five years, B.C. has made in-roads in closing care gaps by implementing the Expanded Chronic Care Model[43] through structured collaboratives and introducing physician incentives. B.C. has taken a leadership role in developing collaborative, evidence-based approaches to managing diabetes and congestive heart failure, and supporting pioneering work in patient self-management. We need to expand this work to include the majority of patients in B.C. with these chronic diseases, and to cover the management of the other priority chronic diseases.

41 B.C. Ministry of Health, Medical Services Division. *Chronic Disease Projection Analysis*, March 2007, (2007-064).

42 Centre for Health Services and Policy Research. *Chronic Conditions and Co-morbidity Among Residents of British Columbia*, February 2005.

43 Barr, Victoria, S. Robinson, B. Marin-Link, L. Underhill, A. Dotts, D., Ravensdale and D.Salivaras. The Expanded Chronic Care Model: An Integration of Concepts and Strategies From Population Health Promotion and the Chronic Care Model. *Hospital Quarterly*, 7(1), 2003. A summary of the Expanded Chronic Care Model is available at www.primaryhealthcarebc.ca.

Initial Key Initiatives for 2007/08

- Continue to support and evaluate improved clinical management of single diseases: diabetes, congestive heart failure and hypertension (with consideration of other diseases in the future), including payment of family physician incentives to provide recommended care for patients with diabetes, congestive heart failure and hypertension.
- Develop and disseminate electronically-enabled clinical practice guidelines for osteo-arthritis, osteoporosis, and asthma.
- Complete development of the musculoskeletal (osteoarthritis, rheumatoid arthritis and osteoporosis), and COPD service framework[44] as a collaboration of community stakeholders and explore the utility of service frameworks to impact chronic disease outcomes. Start implementing the COPD service framework in the Central Okanagan and share lessons learned with provincial stakeholders. Explore opportunities to implement the musculoskeletal service framework.
- Further align health authorities' services, such as home nursing care and nutrition support services, to better collaborate with primary health care providers and to meet the needs of the population.
- Link data collection for asthma, chronic obstructive pulmonary disease, and stroke in all emergency departments to the implementation of stroke and asthma protocols and primary health care initiatives.
- Implement decision-support technology (e.g., the enhanced Web-based CDM Toolkit that will support the guidelines listed above. This information system will evolve to the electronic medical record (EMR) and eHealth).
- Improve the utility of physician profiles for chronic disease quality improvement. Add drug and hospitalization data to the physician profiles and identify health-outcome data elements for the physician profiles.
- Conduct an evidence review and population health data analysis to assist health authorities and other stakeholders in strategic planning (e.g., strategies for targeting services to those most at-risk).

Results by March 2008

- increase in the proportion of patients with diabetes receiving two A1C tests per year
- increase in the proportion of patients with congestive heart failure on ACE or ARB drug therapies
- increase in the proportion of patients with congestive heart failure on beta-blocker therapy
- baseline emergency room data for asthma and chronic obstructive pulmonary is available
- service frameworks are assessed for their potential to impact patient outcomes

[44] The service framework (SF) approach, a new person-centred planning approach for health system integration, was conceived in the spring of 2005 as a vehicle for looking at systems improvement from a broader perspective. Service frameworks represent a person-centred approach to improving health outcomes across the conventional boundaries of the health system. SFs present a high-level picture of optimal care that people should expect to see, based on evidence from the literature and best practices drawn from experts, including health professionals, care providers and patients. SFs do not attempt to prescribe how care would be provided. This must be determined locally according to local priorities and capacity. Rather, SFs offer a menu of priority, action-oriented recommendations that allow all stakeholders to define how they will contribute to improved services and better outcomes. In applying SFs to various chronic diseases, there will be many recommendations in common.

Looking Forward to 2017

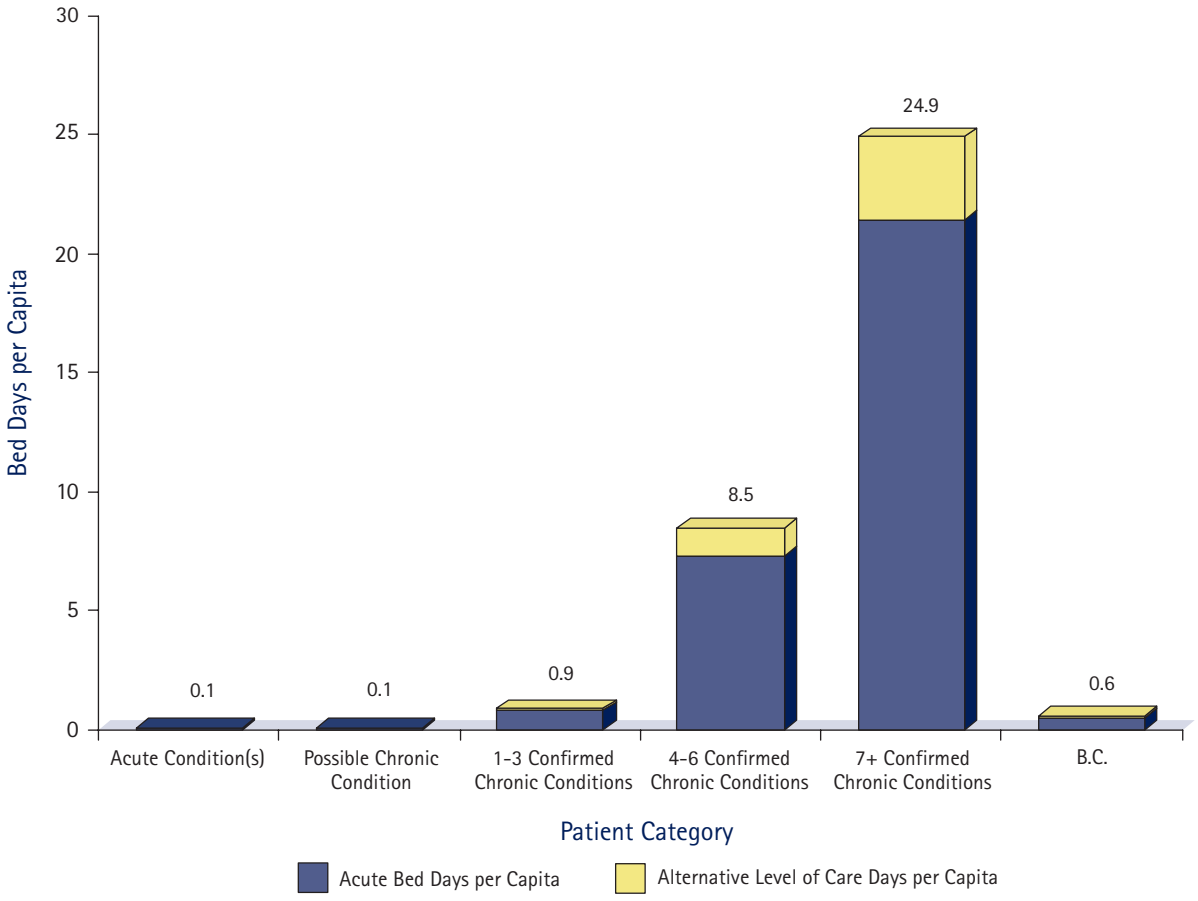
The long-term goal is that the majority of British Columbians who have a single chronic disease will receive guideline-directed care that minimizes or delays disease progression and development of complications. Indicators and milestones will be established over the coming year to effectively track progress toward this goal.

6.5 Management of Co-Morbidities[45]

The use of guidelines to treat individual diseases is effective; however, as the patient grows older it is not uncommon for the individual to have a combination of diseases that potentially involves multiple medication prescriptions. This can bring about increasing problems associated with poly-pharmacy and adverse drug effects. In addition, mental health concerns may add further difficulty, as can chronic pain. This level of complexity requires thoughtful planning and care coordination by the family physician, medical specialists and other health care professionals. It also requires the full involvement of patients and, often, their families. Patients are faced with issues around quality of life, comfort, functioning, and choices with difficult trade-offs. Increasing co-morbidity is also associated with a higher cost per patient (recall Figure 3). In 2005/06, there were over 92,000 patients in B.C. (recall Figure 2) who had four or more chronic diseases, and these patients had much longer hospital stays (Figure 8) than patients with fewer than four chronic diseases.

[45] Key ideas for this section are taken from M.E. Tinetti and T. Fried, *The End of the Disease Era*, 2004.

Figure 8: Hospital Bed Days per Person by Health Status, B.C., 2005/06



Source: Discharge Abstract Database (DAD), 2005/06.

Clinical decision-making in these situations should be based on informed patient goals and thoughtfully-crafted treatment plans, rather than the prescriptive treatment often associated with individual diseases. Health services must be organized to support family physicians in taking the time to develop these plans in collaboration with the patient, their support network, and other health care providers. Health services, where medically needed, should take the form of shared care among medical specialists and family physicians. Patient education and services should be re-oriented from multiple, single-disease clinics to integrated health network teams.

The B.C. government/BCMA Agreement has focused on this area by committing to a complex care fee, in addition to the payment for a regular office visit, for patients with two or more chronic diseases. This will be supported by enhanced clinical decision support through the eHealth strategy, and by a provincial collaborative on providing complex care. In addition to this support for family physicians, some health authorities have piloted case management for planning and coordination of care, and assisting patients to navigate the system.

Initial Key Initiatives for 2007/08

- Develop, implement and begin ongoing evaluation of integrated health network teams in each regional health authority (see page 17).
- Strengthen case coordination and management of transitions between primary health care and hospital care. Evaluate different models of case management and transition management linked to primary health care for utility and impact.
- Implement and evaluate the family physician incentive for complex care for patients living with two or more chronic conditions.
- Strengthen collaboration and shared care between specialist and family physicians for complex patients.
- Further align health authorities' services, such as home nursing care and nutrition support services, to better collaborate with primary health care providers and to meet the needs of the population.
- Analyze opportunities (and related policy, funding and integration issues) for supporting patients with co-morbidities through the evolving role of community pharmacists.
- Given a specific patient population and its needs, develop a framework and method to analyze when and how an expanded, integrated, primary health care network team would affect patient outcomes, and what barriers and solutions exist to this team care. This may include methods on how to determine who is the right provider and when is the right time. For example, given a particular patient population, before a new team member is hired we need a tool to understand if adding a chronic disease nurse, physiotherapist, counsellor or other provider would have the biggest potential positive impact on patient outcomes.

Results by March 2008

- initiation and initial evaluation of integrated health network teams in each regional health authority

Looking Forward to 2017

The long-term goal is that all British Columbians who have multiple co-morbidities will have thoughtfully-crafted care plans created by an integrated proactive team with their input. The plan will mitigate against the combined impact of the co-morbidities and reduce unintended consequences, such as poly-pharmacy or communication delays during transitions, that might result in from uncoordinated care. Indicators and milestones will be established over the coming year to effectively track progress toward this goal.

6.6 Frail Elderly

The frail elderly are a population group with significant needs. The focus of care with the frail elderly population is on function and quality of life, including symptom control. Coordinated patient-centred team planning, including advanced care-planning, is central to the care of the frail elderly. It is important to determine care expectations of all involved. The preferred care location is usually in the community, and it is recognized that the hospital environment, even during a decline in health, can be adverse for the frail elderly population. Cognitive impairment may add additional challenges to supporting self-management and family and caregiver supports.

Initial Key Initiatives for 2007/08

- Continue to implement and evaluate incentive payments to family physicians for conferencing with patients living in a facility or in the community, their family members, and other health professionals.
- Expand the seniors at risk/frail elderly collaborative, currently underway in three areas of the province, to enhance coordination and continuity of care for seniors most at risk.
- Further align additional health authorities' services, such as home nursing care, to better collaborate with primary health care providers and to meet the needs of the population.
- Develop and disseminate electronically-enabled clinical practice guidelines for cognitive impairment.

- Complete development of the dementia service framework and explore opportunities to test implementation of the service framework in one region.

Results for March 2008

- increase coordination of interdisciplinary care, tracked by the uptake of the facility patient conference fee, and of the community patient conference fee (e.g., per cent of patients who have had a conferencing fee billed on their behalf linked to their service utilization and outcomes)
- reduction in visits to emergency departments by patients aged 75 and over due to de-stabilization in the community or in residential care

Looking Forward to 2017

The long-term goal is that all British Columbians who are seniors-at-risk or frail will have thoughtfully-crafted care plans, created by an integrated proactive team with patients' and their caregivers' input. Indicators and milestones will be established over the coming year to effectively track progress toward this goal.

6.7 End-of-life Care

End-of-life, in this Charter, relates to a number of populations with varying trajectories of decline in health and function to a final terminal stage. End-of-life care, therefore, relates across the age span and can reflect single diseases, including cancers, or populations with complex co-morbid and/or age-related decline. The goals of end-of-life care at the terminal stage of life are the same for any age and varying conditions. Compassionate care, including symptom management, is a critical part of the primary health care continuum. The demographic shifts in aging and the shifts in chronic disease patterns have affected end-of-life care, as have other changes in society and medicine. More than 90 per cent of deaths in B.C. now occur due to end-stage or chronic disease.[46] Approximately 60 per cent of people in B.C. die in hospital, even though the provincial end-of-life framework reports the large majority of people would prefer to die at home near their family and friends.[47] The framework covers the full range of end-of-life services and states primary health care providers, with appropriate backup, could play greater roles in end-of-life care. Primary health care providers are seen as key in preparing patients and families for death and the decisions that will be required, and as part of the team managing pain and symptoms with appropriate specialist support.

46 B.C. Ministry of Health. *A Provincial Framework for End-of-Life Care.* May 2006.

47 Ibid.

Initial Key Initiatives for 2007/08

- Continue implementation and evaluation of incentive payments to family physicians for conferencing with patients living in a facility or in the community, their family members, and other health professionals.
- GPAC will review how to integrate the process and decision support required in the transition from active management to end-of-life care, for its chronic disease guidelines.
- Include end-of-life recommendations in the service frameworks that are under development (COPD, dementia, musculoskeletal).

Results for March 2008

- development of primary health care supports of the Ministry Service Plan objective to increase the per centage of natural deaths occurring in settings outside hospital (home, residential care, hospice)

Looking Forward to 2017

The long-term goal is that all British Columbians who are facing end-of-life will receive competent, compassionate and respectful care. Primary health care providers will work closely with other stakeholders to support death with dignity and comfort in the setting that best meets the needs of patients and family caregivers. Indicators and milestones will be established over the coming year to effectively track progress toward this goal.

Collaboration and Participation: Making It All Work Together

In facing up to and tackling the challenges presented by B.C.'s demographic and disease trends, population health inequities, and changes in health care provider demographics and work profiles, it is clear the system must make shifts that can only be achieved collaboratively. The health care system encompasses a number of partners, including British Columbians (patients and families) and their communities, each of which has a critical role and responsibility. Stakeholder groups who have been involved in the co-development and review of this Charter include:

- B.C.'s Ministry of Health
- Regional Health Authorities
- Provincial Health Services Authority
- British Columbia Medical Association
- General Practice Services Committee
- Society of General Practitioners
- Guidelines and Protocols Advisory Committee
- HealthLines Services BC
- B.C. Pharmacy Association
- Dietitians of Canada, B.C. Region
- College of Physicians and Surgeons
- British Columbia College of Family Physicians
- College of Registered Nurses of B.C.
- College of Midwives of B.C.
- College of Pharmacists of B.C.
- UBC Faculty of Medicine, School of Nursing and Continuing Medical Education
- Centre for Health Services and Policy Research
- UVic Centre on Aging
- Michael Smith Foundation for Health Research
- Healthy Heart Society
- Heart and Stroke Foundation of B.C. and Yukon
- Canadian Diabetes Association
- Osteoporosis Society Canada, B.C. Division
- Alzheimer Society of B.C.
- B.C. Lung Association
- The Arthritis Society, B.C. and Yukon Division
- B.C. Healthy Living Alliance
- Pacific Blue Cross
- College of Dietitians of British Columbia

B.C. has the partnerships and infrastructure to accelerate the required system shift, and many elements are already in place. Legislation, governance, investment, media, human resources and research are all powerful enablers of improved health outcomes and a sustainable health system. However, individually, these enablers are limited in scope and influence. Collaboration works because of the contribution of each organization's sphere of influence and acceptance of responsibility. It is only by collaboration and participation towards a greater whole that we will reach the desired results.

Ministry of
Health