



The BC Ministry of Health Services' Service Plan maps out the Province's strategic course for health system reform towards a more affordable and sustainable public health care system that is patient centred, provides accessible high quality service, and results in improved patient health and wellness. The Service Plan reflects the government's first priority – patient care. In this update, the Service Plan is used to measure the progress made over the past 12 months in improving the management of chronic disease in the province and to identify next steps.

### Building The System We Want – Working With Partners to Support Patients

BC's Health Authorities and other health system partners, such as doctors, deliver the majority of the province's health programs and services.

The BC Ministry of Health Services has been working with partners to optimize chronic disease management by providing the following leadership and support:

#### Direction

BC's current health care system is well designed to support acute and episodic care, but changes are needed in order to better support the complex task of managing chronic diseases. Following extensive consultation with multiple stakeholders, agreement was reached on the barriers to progress and what must be done to remove them (see *Improving Chronic Disease Management: A Powerful Business Case for Congestive Heart Failure* and *Improving Chronic Disease Management: A Compelling Business Case for Diabetes*).

The Expanded Chronic Care Model was selected to guide BC health system re-organization as research from other jurisdictions has shown that its implementation resulted in improved quality of chronic care, patient outcomes, professional satisfaction, and ultimately, overall system cost reductions. A consensus was reached among many stakeholders who are now actively working to achieve the agreed system objectives.

“ We are very fortunate in British Columbia – partnerships that span the entire health care system have emerged to support the nearly one million British Columbians who are living with chronic diseases. The successes we are seeing in chronic disease management and reform of our health system is the result of the active commitment of a host of people: the Ministers, those working in various branches of the Ministries, health authorities, doctors, nurses and other disciplines, a number of professional organizations and stakeholder groups. Building a health system that is responsive to 21<sup>st</sup> century realities is challenging work, especially in our current environment of tight fiscal restraint. But the deep commitment and dedication that I have seen from all the partners can only result in an improved health system and better patient care. ”

*Dr. Penny Ballem, Deputy Minister  
Ministry of Health Services*

“Shifting a health system towards one that prevents the preventable and stops the worsening of disease may not be a simple task, but it is a crucial one. As with all major system changes, there will be small gains at first, but success will build as the new ways of doing things become established. The health system has expressed that it wants to improve how chronic disease is managed. We have a clear direction and our energies are focusing on the implementation currently underway.”

*Stephen Brown,  
Assistant Deputy Minister  
Medical & Pharmaceutical Services,  
Ministry of Health Services*

## Best Practice Information

With an excellent reputation for developing evidence-based clinical guidelines, the MPS/BCMA Guidelines and Protocols Advisory Committee (GPAC) is supporting multi-faceted strategies for embedding best practices into clinical work.

In addition to developing guidelines for diabetes, asthma, hypertension, hepatitis B & C, and congestive heart failure, GPAC has also introduced patient care flow sheets and patient information guides to BC's practitioners. Flow sheets are valuable tools for summarizing the care patients have received, and for planning future care. An example familiar to BC practitioners is the prenatal flow sheet.

Clinical guidelines, and accompanying patient care flow sheets and patient guides, for chronic kidney disease and depression are slated for completion in 2003.

Provincial Working Groups have been working on a number of initiatives to support clinical guideline implementation. For example, under the leadership of Dr. Adeera Levin, Director of the BC Renal Agency, a lab strategy is currently underway that will see BC laboratories reporting estimated glomerular filtration rate (GFR) in addition to serum creatinine for a more accurate measure of kidney function.

## Data

Identifying the population of patients with chronic disease is the foundation of improving the health system - it makes it possible to accurately monitor the quality of care provided and population health status. To date, diabetes, hypertension and congestive heart failure patient registers have been developed. Asthma, osteo/rheumatoid arthritis, and chronic kidney disease patient registers will be completed later this year.

Identification of patient populations has enabled the Ministry to develop the following products -- which have helped establish health system acknowledgment that improving chronic care is a priority:

- Provincial disease prevalence and incidence rates indicate a diabetes epidemic. Currently, 196,467 British Columbians have been diagnosed with diabetes, and this number is expected to increase 90% by 2010.
- Business cases provided compelling evidence that improved diabetes and congestive heart failure management could save BC's health system approximately \$34 million and \$25 million, respectively, in three years.
- Annual report cards for the first time have established BC's true burden of diabetes and congestive heart failure (re: morbidity, mortality and health care utilization). Importantly, the performance measures indicate a significant performance gap exists – diabetes and congestive heart failure care in BC falls well below evidence based clinical guidelines standards.

These products will also be available for asthma, chronic kidney disease, and osteo/rheumatoid arthritis management once patient registers are completed.

Health authorities need data to make service delivery management decisions. Doctors need data to help them self-evaluate their clinical practice. To support this:

- Report card data are available to Health Authorities at both the health region and health service delivery area level of analysis
- Through the Ministry's CDM Secure Web site for practitioners, BC doctors can now obtain a list of their patients who have been diagnosed with diabetes or congestive heart failure, and a report on the extent to which the care they provided is consistent with BC clinical guideline recommendations. By the end of the year, the secure website will have physician reminder and patient recall functionality.

## Research Backing

Patient surveys were conducted to obtain patient input on improving BC's chronic care system. The Ministry and the Vancouver Island Health Authority completed a Diabetes Patient Survey that assessed patient satisfaction with services received, and the burden of the disease on their daily life. Osteoarthritis and Rheumatoid Arthritis Patient Surveys are currently being developed as a joint project of the Ministry, Arthritis Society of BC and Yukon, and Arthritis Research Center of Canada.

This CDM data and research backing assists the health care system in *knowing our patients*. This is essential to patient-centred care, ensuring that individuals receive the necessary tests and treatment known to prevent exacerbation and complications of their disease, and participate in self-management strategies that help maintain or improve their health.

The Ministry completed a survey of BC's top 89 physicians providing optimal diabetes care, and reported on how they achieved this level of care. In addition, the Ministry, the BC Renal Agency and the BC College of Family Physicians are working together to survey BC doctors' knowledge of chronic kidney disease best practices.

The Ministry is a partner in the Western Health Information Collaborative, which is developing chronic disease data standards (minimum data sets, information interchange messages, and data definitions) to support primary health care team clinical decision-making.

The Ministry's CDM website receives over 350 hits daily. Requests for information or resources have come from other Canadian jurisdictions and from as far away as Nigeria and Australia. The Ministry receives many patient e-mails through the website regarding specific concerns or enquiries about chronic disease management.

[www.healthservices.gov.bc.ca/cdm](http://www.healthservices.gov.bc.ca/cdm)

“There was a wonderful sense of teamwork and excitement about improving heart failure. I am really optimistic that the collaborative will have a profound impact on the lives of patients with heart failure and on the people who provide their health care. I am envious of the close working relationship among health professionals, the provincial government, and the local health authorities. In this environment, everything is possible.”

*Dr. Ruth Medak,  
Oregon Professional Medical  
Review Society,  
CHF Collaborative  
Faculty Coach*

## Linking Partners to Create Best Practice Networks

Learning Session One of BC's first ever Province-Wide Structured Collaborative on Congestive Heart Failure (sponsored by the Healthy Heart Society) took place on May 26-27, 2003. Physician-led teams of health care professionals from each health region participated in interactive professional development on implementing best practice into clinical workflow, use of flow sheets for planned patient visits, and monitoring their performance.

Collaborative participants regularly share information through an electronic listserv and conference calls, and have access to specialist knowledge and clinical practice redesign expertise. Health authorities have worked hard in providing clinical teams with the support needed to ensure alignment of activities and resources to achieve maximum success. Learning Session Two is scheduled for October 2003.

Under the leadership of the BC Medical Association, physician-led teams will be able to participate in planning and implementing optimal diabetes care. This collaborative is made possible through a Ministry of Health Services grant and will build on the experiences of the CHF Collaborative. This collaborative is generating considerable excitement, with Learning Session One slated for early 2004.

## Developing Expertise

People who have a chronic disease live with their condition twenty-four hours a day. For example, they need to make daily decisions and take action to control pain and fatigue, use medications properly, and incorporate diet, exercise and stress reduction into their daily routines. Many people need support and education on how to become experts in managing these complexities, and the health system is making the changes needed to bring this support to them.

The Ministry is helping empower patients to become experts in managing their health in a number of ways. The Ministry's CDM Website currently contains patient information on diabetes, congestive heart failure, hypertension and asthma. It also links to valuable resources, including BC Nurseline, BC HealthGuide, BC Dial-A-Dietician, and the University of Victoria's evidence-based Chronic Disease Self Management Program (CDSMP). Through the Health Canada/Primary Health Care Transition Fund, the Ministry has provided \$.9 million to help health authorities make the CDSMP available in more communities across the province.

Supporting clinical practice enhancement is a priority. Through Ministry of Health Services grants, the BC College of Family Physicians, the College of Physicians and Surgeons of BC, and the UBC Faculty of Medicine, Division of Continuing Medical Education are designing and delivering professional development to support BC physicians enhance skills in practice self-evaluation, patient self-management leadership and training, and using web-based and personal digital assistant (PDA) information technology in clinical practice, respectively.

To achieve maximum benefit, these initiatives will operate as a coordinated strategy, with initial focus on reducing the burden of diabetes. The strategy will first roll out as part of the BCMA-Led Provincial Diabetes Mellitus Structured Collaborative, and then expand to other professional development opportunities.

## **Aligning Performance with Incentives**

Preliminary results of the February 2002 Full Service Family Practice Survey reported BC general practitioners' concerns regarding challenges they face in providing comprehensive health care. In response, starting September 1, 2003, BC GPs are eligible to receive an annual \$75 payment per year for each patient with a confirmed diagnosis of diabetes mellitus and/or congestive heart failure whose care is managed to BC clinical guideline standards.

This 2 year pilot project is part of the *Full Service Family Practice Incentive Program*, a joint Ministry of Health Services, BC Medical Association and Society of General Practitioners of BC initiative funded through the \$20 million Subsidiary Agreement for General Practitioners, November 2002.

Aligning performance with incentives, making chronic disease management professional development available, and developing best practice networks are key components to increasing the chronic disease management capacity of primary health care services in this province.

The activities described in this update aim to create a culture of change, and provide the infrastructure needed to support change. B.C. physicians and people living with chronic disease have shared their success stories (which are available on the Ministry's CDM website) of how they have incorporated the components of optimal chronic care for maximum benefit.

## How is Progress Measured?

Key to improving BC's health care system is measuring and reporting health system performance. The Chronic Disease Management Initiative is measuring 3 levels of performance – examples of indicators include:

<b>LEVEL 1</b>	<b>Shifting the Health System/Clinical Practice Redesign</b>
	<p>% of BC Physicians:</p> <ul style="list-style-type: none"> <li>• participating in Structured Collaboratives</li> <li>• requesting Secure CDM Website Access</li> <li>• claiming Full Service Family Practice Incentive payment for treating patients according to evidence based guidelines</li> <li>• participating in professional development:             <ul style="list-style-type: none"> <li>- Practice Self-Evaluation</li> <li>- Information Technology in Clinical Practice</li> <li>- Patient Self-Management</li> </ul> </li> </ul>
<b>LEVEL 2</b>	<b>Patient Care Managed to Clinical Best Practice Standards</b>
	<p>CHF - % of patients receiving:</p> <ul style="list-style-type: none"> <li>• care according to guidelines</li> <li>• ACE-1 (or ARB)</li> <li>• ARB, Beta Blockers, Diuretic, Digoxin</li> <li>• LV ejection fraction by ECHO or RNV</li> </ul> <p>Diabetes - % of patients receiving</p> <ul style="list-style-type: none"> <li>• care according to guidelines</li> <li>• at least: 2 HBA1c tests per year</li> <li>• one eye exam within 2 years</li> <li>• one microalbumin test per year</li> <li>• one lipid test within 3 years</li> </ul>
<b>LEVEL 3</b>	<b>Improved Patient Health Outcomes</b>
	<ul style="list-style-type: none"> <li>• Age standardized mortality rate</li> <li>• Years of potential life lost</li> </ul> <p>CHF - % of patients:</p> <ul style="list-style-type: none"> <li>• re-admitted to hospital within: &lt;15 days, 31-45 days, 46-60 days, 61 or more days</li> </ul> <p>Diabetes - % of patients with:</p> <ul style="list-style-type: none"> <li>• diabetes co-morbid conditions (diabetic retinopathy, nephropathy, end stage renal disease, stroke, heart attack, hypertension)</li> <li>• surgery for disorders of the retina and cataracts, amputations of toes, feet or lower limb amputation, coronary artery bypass surgery, or dialysis for any reason</li> </ul>