

## **BUILDING THE VISION IN BRITISH COLUMBIA AN UPDATE FROM THE MINISTRIES OF HEALTH**

**August 2003**

Our March 2003 issue introduced the many partners who are working together to reduce the burden of chronic disease in BC. We also provided an overview of the Expanded Chronic Care Model and an update on the work being done to implement various parts of this model on a province-wide basis. In this issue we are pleased to introduce some exciting new partnerships and innovative initiatives that focus on the task of realigning the health system for better patient outcomes.

### **SHIFTING OUR HEALTH CARE SYSTEM**

BC's population is aging. As a result, more family physicians are now caring for numerous patients with complex chronic disease. BC physicians are working hard to provide good care for their patients with chronic conditions, but they face many challenges. Our health care system has not kept up with the changing needs of British Columbians. Whereas BC's health care system is well designed to support acute and episodic care, it is not organized in a way that supports effective chronic disease management.

Our health care system needs to be redesigned towards a more patient-centered, evidence-based, and outcomes-focused approach. Many sectors of BC's health care system are taking responsibility for making these changes happen. Building the infrastructure of a new health care system has begun, and this update showcases a few of the initiatives that are helping to accelerate province-wide change.

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### **THE FIRST OF ITS KIND IN BC!**

#### **PROVINCE-WIDE STRUCTURED COLLABORATIVE ON CONGESTIVE HEART FAILURE BEGINS**

The first learning session of the Province-Wide Congestive Heart Failure (CHF) Collaborative was held on May 26-27, 2003. This 12-month quality improvement initiative is sponsored by the Healthy Heart Society and coordinated by a Steering Committee with broad representation from the health care sector. The Collaborative is designed to assist family physicians re-design their clinical practice for better patient outcomes and improved professional satisfaction.

The Collaborative on Congestive Heart Failure is based on the Institute for Health Improvement Breakthrough Series (<http://www.ihl.org/collaboratives>), and has been adapted for the BC context. Clinical practice teams participated in two days of interactive learning and knowledge sharing on the components of optimal chronic disease management. This included strategies for integrating evidence-based best practices into practice workflow and, importantly, methods for measuring the organizational change's impact on quality of care and patient health outcomes.

Clinical teams from each of the BC's health regions are participating in this Collaborative, and several new clinical teams will be joining the Collaborative during the summer. The second learning session is scheduled for October 6-7, 2003.

Over these next months, each team will be trying out the strategies they have learned, testing what works well and what needs to be modified, and sharing what they have learned with the other practice teams. The organizational changes implemented to improve congestive heart failure management will help primary care practices build the infrastructure needed for managing a variety of other chronic illnesses as well.

The Province-Wide CHF Collaborative is intended as a starting place for future collaboratives that will build disease management capacity for other chronic illnesses, such as diabetes. To this end, the collaborative will be evaluated on an on-going basis in order to inform similar initiatives implemented at both the provincial and regional level.

*"This first learning session was very successful. Participants were excited about what they learned and started to identify changes they planned to implement in their practices. Many teams have already started their first testing cycles. And we are very enthusiastic about collaborating with the McColl Institute for Healthcare Innovation", comments Liza Kallstrom of the Healthy Heart Society.*

For more information on the CHF Collaborative:  
<http://www.heart-health.org/about/hhs.html>

For highlights of the May 26-27 Learning Session:  
[http://www.healthservices.gov.bc.ca/cdm/research/chf\\_collaborative\\_may2003.pdf](http://www.healthservices.gov.bc.ca/cdm/research/chf_collaborative_may2003.pdf)

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## **MINISTRIES OF HEALTH PLANNING/SERVICES GRANTS TO BC PHYSICIAN ORGANIZATIONS FOR PROFESSIONAL DEVELOPMENT PROGRAMS**

Effective chronic disease management asks that physicians do things differently - but at the same time the health care system supports outdated approaches. BC's physicians have the experience, knowledge, and abilities to introduce innovations that will help realign our health care system for improved chronic care outcomes.

In recognition of the challenges physicians face in providing optimal chronic disease care, the Honorable Sindi Hawkins, Minister of Health Planning announced on May 30<sup>th</sup>, 2003, that the Province is investing \$2.8 million in the following professional development opportunities:

### **Initiative 1: Facilitating Self-Evaluation of Practice College of Physicians and Surgeons of British Columbia**

BC physicians strive to achieve optimal results for their patients with chronic diseases. Those efforts could be enhanced by better access to the information, practice tools, coaching and encouragement that would enable them to evaluate the care they provide and to identify for themselves areas where their practice could be improved.

Research shows that self-auditing can be an effective means to improve physician performance and professional satisfaction. The College of Physicians & Surgeons of British Columbia has the mandate to "establish, monitor and enforce standards or practice to enhance the quality of practice amongst members. This program will assist with that mandate, complementing already established programs of the College and providing physicians with further tools and experience in practice self-evaluation, enhancing the high quality care they deliver.

**Initiative 2: Interactive/Integrated Approach to Chronic Disease Self-Management for Physicians and Patients**  
**British Columbia College of Family Physicians**

Often patients do not recognize the role that lifestyle plays in contributing to the burden of illness. Many do not have the problem-solving or coping skills required to make the necessary lifestyle changes. Due to the unique relationship between patients and their physicians, maximum benefits from treatment are more likely to occur when physicians are more involved in dialoging with their patients on how they can better understand and manage their own health.

Working closely with the University of Victoria's Centre on Aging Chronic Disease Self-Management Program, this initiative will develop an integrated approach for Chronic Condition Leadership Education and Training for Family Physicians and Patient Self-Management Education. It will also explore the development of BC Chronic Disease Self-Management Guidelines aimed at improving patients' ability to monitor and manage their illness.

**Initiative 3: Diabetes Structured Collaborative**  
**British Columbia Medical Association**

The BCMA-led Diabetes Structured Collaborative is a professional development opportunity aimed at supporting changes in clinical practice that facilitate the delivery of optimal chronic disease care and patient best outcomes. Physician-led teams of health care providers will take part in interactive learning sessions on developing clinical improvement strategies appropriate to their local circumstances and resources. Teams will then apply the strategies to clinical practice, assessing the changes, and sharing what proved most successful in their practices.

People living with chronic disease can expect improved health, fewer disease-related complications, less need for hospitalization, and longer and better quality of life as a result of improved treatment and monitoring of their chronic conditions.

The Diabetes Collaborative, currently in its early planning stages, will span 12 to 15 months. The goal of the Collaborative is to identify a model for improved chronic disease management that can be applied throughout BC for better patient outcomes and increased physician professional satisfaction.

**Initiative 4: Information Technology for Chronic Care Practice**  
**UBC Faculty of Medicine, Division of Continuing Medical Education**

Medical research has generated a vast amount of evidence on chronic care best practices. Health information resources such as clinical practice guidelines, patient flow sheets, and drug interaction detailing, have been shown to effectively assist in the care of patients with complex medical needs. Unfortunately, busy physicians find it almost impossible to incorporate up-to-date knowledge into their clinical practice, let alone efficiently retrieve this information when needed. Many do not have a way to self-assess the consistency and quality of the care they provide their patients.

This initiative will help physicians integrate Internet-based and personal digital assistant (PDA) information and communication technologies into their workflow. Chronic disease management will be optimized through efficient access to "just-in-time" information for decision support; rapid update and incorporation of the latest evidence into the information technology; technology-enabled academic detailing; physician reminders for scheduled testing and patient visits; and automatic documentation for practice self-review and evaluation.

In order to achieve maximum benefit, the four initiatives will work together as one coordinated physician professional development strategy. Initial efforts will focus on reducing the burden of disease for diabetes.

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## **FULL SERVICE FAMILY PRACTICE INCENTIVE PROGRAM**

### **A JOINT INITIATIVE OF THE BC MINISTRY OF HEALTH SERVICES/PLANNING, BCMA & SOCIETY OF GENERAL PRACTITIONERS OF BC**

Providing full-service family practice is a challenge for many of BC's general practitioners. In response to the concerns expressed by BC general practitioners, the BC Ministries of Health Services and Planning, the British Columbia Medical Association, and the Society of General Practitioners of BC have developed the Full Service Family Practice Incentive Program

This Initiative is funded through a \$20 million allocation set aside for general practice services under the Subsidiary Agreement for General Practitioners, November 2002. It offers BC general practitioners the opportunity to participate in any of the following three financial incentive programs to enhance patient access to comprehensive health care:

#### **1. Structured Collaborative Participation Funding**

This funding supports physicians who wish to participate in quality improvement structured collaboratives, sanctioned by the General Practice Services Committee. Physician remuneration for time spent at learning sessions will be equivalent to the current MSC General Practice sessional rate.

#### **2. Chronic Care Practice Enhancement Incentive Pilot Project**

This incentive is being offered as a 2-year pilot project. It is aimed at supporting comprehensive, evidence-based management of congestive heart failure and diabetes. General practitioners are eligible to receive an annual payment of \$75 for each patient with a confirmed diagnosis of diabetes and/or congestive heart failure whose clinical management is consistent with the recommendations outlined in the BC Clinical Guidelines for Diabetes and/or Heart Failure. Participation in this pilot project will be on a first come, first served basis.

These two incentives align with the professional development programs described above.

#### **3. Obstetrical Care Incentive**

Obstetric care by family physicians is a vital service. To encourage and support low to moderate volumes of deliveries, general practitioners currently performing only one delivery per day will be eligible to receive a 50% bonus on the current fee-for-service payment (14104 or 14109), up to a maximum of 25 deliveries per calendar year.

The Full Service Family Practice Incentive Program represents a new approach for ensuring better patient care through full service family practice. It will be evaluated to determine its impact on quality of care and patient health outcomes.

Information on how to participate in any of the three incentives will be available on the CDM website in September 2003, <http://www.healthservices.gov.bc.ca/cdm/>

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