Collaboration in the System

Participants point to the need for more Collaboration in the System in order to improve patient care. They raised issues such as collaboration across the entire social sector, integrated and holistic care, and multi-disciplinary care in their explorations. Here is a selection of what British Columbians had to say on the subject of Collaboration in the System.

System Collaboration

Many participants talked about the apparent lack of coordination between social agencies. Social inequities cannot, they argue, be solved through health care alone. Similarly, non-profit organizations suggest that there is more that they could offer if they were more effectively integrated into the health care system and into social services generally.

One recommendation is to create a single database for all ministries so they can more effectively understand the inter-relationships between their various mandates, from criminal justice to income assistance. This is particularly valuable for working with at-risk or marginalized populations. Without a more holistic understanding of the issues facing those populations, participants argue we will waste money in trying to address problems in isolation.

First Nations say that this whole system approach is critical to finding real solutions to the complex problems facing their communities. They suggest integrating Aboriginal healing and traditional lifestyle practices with social services and the health care system would begin to address these challenges more effectively.

Participants encourage government to consider a no-wrong-door approach, whereby a citizen can walk into any service agency and find a way into the system to address their needs, including health, housing and income.

Practically, participants believe that to achieve this systemic integration you need to get ministries to start planning together. They need to understand the populations they are serving, think about how their programs link together, and focus on integrating services to improve population health and health outcomes. Many believe these measures should apply across organizations, not just to the Ministry of Health. Participants want to acknowledge that prevention and health promotion are cross-
ministry functions. They also believe that accountability for population health improvement is something that should be shared across agencies. Participants think that formalizing this shared responsibility into the accountability structure will build links across agencies and throughout the system.

…[H]ealth is a very complex issue that touches along social status, education, …housing [and so on]. But our …bureaucratic structures are not set up to consider health within that context. Now, if we started to think about health within the social determinants and tried to ensure a healthy population, our structure should enable that. And so one of the questions we should be asking [is]: are our … bureaucratic structures and how we've organized things…enabling what we're trying to accomplish, which is a healthier community? Or are they becoming barriers for us to have the conversations to build the coalitions, to understand the accountabilities and responsibilities and who's doing what?
- International Symposium, Vancouver

I still get shocked frequently by the perception that the health care system is the Ministry and the health authorities, and there are so many other players out there that have hands on levers that make differences. There's no one group that can control it and if we don't work collaboratively together at all different levels, we can't solve the problems that they would face.
- Focused Workshop Health Human Resources, Vancouver

Integrated and Holistic Care

Participants' visions of an integrated system of care share some common components: they look at the population and society they serve and design systems of care for the whole population or system; they look at patients holistically, considering their physical, mental, emotional and spiritual well-being; they integrate all social services; they focus on health promotion and disease prevention; and, they bring all health practitioners together. Models such as collaboratives, clinical microsystems (which are all of the inter-dependent health and social facilities, services, and people that provide the building blocks of care for a population where the patient is the focus), and, on a smaller scale, integrated clinics are all suggested as ways of creating a system of holistic and integrated care. Participants want to define the philosophy and services that would form the basis of this type of care, and then build it.

Participants argue that an integrated system, with a focus on prevention, health promotion and interdisciplinary care, is by its nature more efficient. As a result, they suggest that these systems, whether through clinical Microsystems or integrated community clinics, will result in savings down the road.
Administration and facilities for this type of care need to be carefully considered. Participants argue that there are some excellent examples of integrated care in operation throughout British Columbia right now, including the Healthy Heart model at St. Paul’s Hospital. They also argue that the lack of funding to certain health services has undermined a move to integrated care. As a result, they believe funding mechanisms and facilities must be changed to support integrated care.

Some participants warn that shifting from our current system, which they argue is fragmented in silos, will require a focus on change management at the top of the system and from the bottom. Many argue that health professionals are ready for this shift, but they lack the funding and administrative support to make it happen.

Similarly, participants suggest that discussions need to happen within communities to ensure that British Columbians understand the vision and can adapt to its expectations. Managing the change to this model must be structured and well planned, including consideration of the expected health outcomes and measures and tools to monitor those outcomes. Participants also suggest health professionals need to be trained differently in order to operate in an interdisciplinary fashion.

*It seems every time a conversation around health care is opened, it turns into a party verses party argument about funding or turf protection. The idea of an open conversation, collaboration and team work seem like foreign concepts to many higher level health care professionals and administrators.*

– Web Submission, Vancouver

*Multidisciplinary care is one possible solution to challenges. Multidisciplinary care is an important component of a broader primary care approach designed to meet the need for delivering increasingly comprehensive services as the population ages and the incidence of chronic illness increases. If implemented properly, Multidisciplinary care can result in better coordination of care, help to alleviate physician shortages, better maximize health care resources, and improve patient outcomes (particularly for those with chronic conditions).*

– British Columbia Medical Association, Submission

Models of Collaborative and Multidisciplinary Care

Participants often discussed models of collaborative care where the different health disciplines work together to improve the health of a patient. They suggest that integration of different health disciplines into treatment plans and facilities means more focus on patient needs and fewer barriers to their care. This also links discussions around embracing different practitioners as entry points to the health care system into primary care.
Tools discussed by participants to help make collaborative care a reality include integrated community clinics, electronic health records that practitioners can share, and an accessible database which monitors population health. New approaches to funding to encourage and support these community clinics are also needed.

In smaller communities, many feel integrated clinics can assist in promoting community stability. They would be able to measure the health of the community, identify challenges, link with social services and may even play a role on the local business council, advising on community needs and encouraging ways to promote growth and health in the community.

Participants also argue that integrated models are particularly effective for marginalized populations, such as residents of the Downtown Eastside, where citizens often find the social support and health care systems difficult to navigate, and feel the structures operate to exclude them. A more integrated system would help those citizens access services and provide the support to improve their lives. For Aboriginal people, the integration of traditional healing practices and practitioners would help make them more comfortable within the health care system. Many participants also focus on integrating alternative and complementary medicine into this model as a key to addressing chronic illness or developing and maintaining good health.

Participants also encourage consideration of smaller interdisciplinary teams intended to address specific illnesses or situations. Mobile palliative care teams are an example. These teams would be called to situations, at home or in health facilities, where they could use their collection of skills and knowledge to properly treat the patient and counsel the family in as low-stress an environment as possible.

Participants noted that barriers to collaboration and more integrated patient care involved administrative and funding models and lack of facilities. Similarly, they suggest current professional training practices may discourage integration. Participants encouraged exploring the current funding models, particularly the physician fee-for-service model, and the consideration of models which would bring new health practitioners into a practice or clinic setting. They also ask for removal of barriers, allowing other practitioners to be entry points into the health care system by permitting them to refer to specialists or order diagnostic tests. Many believe these are first steps to empowering the system to become more integrated and helping patients get the care they need.
An interprofessional approach to health care benefits patients, through decreased morbidity and wait times, and patient empowerment, as well as health professionals through increased efficiency and efficacy, and mutual respect and appreciation for the expertise of all practitioners.

- The UBC College of Health Disciplines and the Interprofessional Network of BC, Submission

Conclusion

The themes of integration and collaboration came up frequently throughout the Conversation on Heath. Participants wanted collaboration whether it was in relation to forming collaborative practices with nurse practitioners, larger integrated community clinics with a number of health practitioners from many different traditional conventional health disciplines, or seeking systemic collaboration between all social agencies in the delivery of services. While there are administrative, cultural and infrastructure barriers to implementation of this approach, many participants see collaboration and integration as a key step towards creating and maintaining good health for British Columbians.
Collaboration in the System

This chapter includes the following topics:

- **System collaboration**
- **Integrated and Holistic Care**
- **Collaborative and Multidisciplinary Care**

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### Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: **Information Technology, E-Health and Electronic Health Records** and **Health Care Models**.
System collaboration

Comments and Concerns

Need for System Collaboration
Aligning Planning
Aligning Budgets
Aligning Delivery

- Comments on the need for system collaboration:
  - There should be integration between the Ministries of Health, Education and Finance. We were there 30 years ago.
  - There are inequalities that cannot be solved by health care alone. Health care is part of the problem in inequalities and we must change it.
  - The not-for-profit sector needs a really serious look in terms of its contribution to the health system generally. We end up subsidizing the public health system in many respects. What makes us interesting is that while our transactions may be with the patient, because of the way not-for-profits work, the purpose of what we do is change in the community, change in the community's health status and so on.
  - It is shocking that there is a perception the health care system is the Ministry and the health authorities. There are so many other players out there that have hands-on levers that make differences. There is no one group that can control it and if we do not work collaboratively at all different levels, we cannot solve the problems that they would face.
  - So there are criteria for Indigenous success, including the need to think about kinship and relationality, the need to positively engage local community as well as global society and also the need for autonomy and self-management. If we are going to link them to health services, we need to think about health services that promote family and community as well as individual health status.
  - Externally imposed programs, which are mostly based on your Western biomedicine and public health, do not work very well in isolation. The assumptions are quite different than the assumptions around health in local context. They work a little better if Indigenous health workers are involved in their implementation. We need to be able to assess the quality of these different kinds of knowledge.
  - We should be working with Indigenous community members to nourish and support them in applying their local knowledge, because it will make for more
effective health systems, context is everything. Critically underlying the possibility of achieving success is developing the relationships with Indigenous communities, and relationships that build over time, that are multi-faceted, multilevel, and build trust and build relationships on a professional basis.

- It is funny that we actually have to talk about the fact that things are not dealt with in an integrated manner, that we do not think about health and education and housing as related issues that all affect one another.
- There is only so much that you can ask the system to do and the rest of it is beyond the system and about the individual and their lives.
- In Saskatchewan there is a great system of regional inter-sectoral committees that are supposed to coordinate policy. However there is very little to show for after many years of work. They keep running into traditional barriers to integration. It is tough.
- Partnerships are critical to our ability to make constructive contributions to our health care system. By working with the provincial government, health authorities, health professional associations, research funding agencies and others, our education and research activities have a broad and positive impact.
- Prevention needs to cross barriers of ministries to support functional families.
- When we are talking about linking, we do not just mean government or community agencies, we mean family, friends, and relatives too. You want to think the whole big picture here.
- Practitioners of all sorts run into social problems, but they do not necessarily know what to do or where to go. The information sent to physicians is in a thick binder, in which is buried Healthy Kids (delivered by income assistance). But it is buried so deeply that it is not accessed.
- So income assistance should be able to tell people about mental health and addictions services with some knowledge of what is available in their community and who to go to.
- Someone needs to take full responsibility for special needs children.
- If you are really pushing prevention, it moves outside of health to education and highways for example. So then it becomes the mandate, not just of health, but of every government ministry. They all should be involved in the sustainability of prevention in the health care system. That really does become a challenge.
- It is the provincial government’s job to set up necessary social networks for vulnerable populations.
• Government tends to inadvertently encourage competitive, non-communicative behaviour. For example, with the Health Innovation Fund we sought input and ideas. That is an inherently competitive process. I am not going to talk to the guy at the university, or over at the Health Authority because if he gets money, I might not. There has got to be a better way to encourage innovation than just a blanket call for proposals and a competitive process judging who is best.

• The military and provincial medical systems do not communicate.

• There needs to be linkages between the various ministries, between local governments and the primary health care, and between communities and community groups and agencies. So that is the interface, and that is where things can fall between the cracks.

• If you look at the pharmaceutical industry, one of the things they do is they motivate their members to go out and build relationships with the people that are going to make the decisions about buying their drugs or using their drugs. They literally hold them accountable for the number of contacts they have made, the level at which they have made those contacts, and how fruitful the relationships have been. That accountability for the relationship is key. It may not be the best example to use, but it has been successful.

• What we have really been not very good at is the notion of sharing best practices. We have six different health authorities who sometime collaborate on initiatives, but there is an incredible duplication of effort. We cannot afford to do that anymore in this system. We have to be able to put in the necessary infrastructure or supports to share the information.

• We will not break down ministry silos in the foreseeable future.

• Where is leadership on the notion of whole systems stewardship?

• Health is the responsibility of many agencies and ministries.

• There is a lack of resources for ministries that deal with local community engagement in remote, rural and northern communities.

• There is no teamwork within government between decision-makers and staff.

• Enquiry BC has worked.

• It is hard to break through entrenched communication methods between major players. How do we influence the political and senior ministry levels to set the goals that would be most meaningful?

• We really need to think outside the box and understand the way that everything is connected to everything else, and that social supports are particularly important.
Without a quality, accessible, flexible childcare system, you are going to have more women leaving the health care workforce.

- There are examples of where government works against itself. For example, there was work done on Aboriginal health at the same time that there was work on the new relationship. Side-by-side, these two initiatives did not square because the health one was about putting power down to the local government level, and on the Aboriginal side it was a brand new provincial level, government-to-government relationship.

- **Comments on aligning planning:**

  - We have the ActNow BC Assistant Deputy Minister’s Committee, which is focused on ensuring that all Ministries look at the outcomes that are desired for ActNow BC. Each Ministry has a responsibility to deliver something in their service plan. That is being lauded as a silo busting initiative that is showing some success.

  - Engaging data across ministries is essential to the wellbeing of a very vulnerable population. We are all involved with that challenging population, whether it is the criminal justice system, income assistance, health, or housing. It costs us huge amounts of money and we are not very good at it.

  - We need to look at multiple kinds of evidence and develop different approaches and skills to evaluate the evidence, think about the diversity of context and understand that we are not going to reduce health status inequities by looking at health services on their own.

  - We need to understand that the processes, expectations and responsibilities of a health services partnership might be a bit different.

  - There is a need to shift the approach to accountability measures for Indigenous-specific services to a more collaborative model rather than a top-down model. For example, the reporting on performance measures for Indigenous community-controlled health services is now done collaboratively and published results are published in collaboration with that sector.

  - We need to integrate at the business planning level between ministries as we develop our service plans. If the Ministry of Health is developing a service, they need to get income assistance and justice staff and management there to develop the integration with those services from the beginning. The model that is happening now is we implement a service and we undertake the implementation after the fact. The integration should be done right upfront, at the planning stage and develop the solution across the sectors.
• **Comments on aligning budgets:**

  - We have acute care pockets of funding and community pockets of funding, which is further divided into social services. Look at an integrated funding model first. Not only do we have fracturing in terms of funding, we have fracturing in terms of providers.
  
  - This goes beyond ActNow BC: the second phase of ActNow BC which would really create this inter-ministerial coordination where everyone can come and talk to their part of the solution. It is very clear that if we do not have Ministry of Finance, housing, economic development, or health there, they are all parts of the puzzle. We cannot just be pointing to one another saying it is your money.
  
  - Nobody seems to work together because they are all balancing their own budgets.
  
  - You need to make sure that the players who carry your message are adequately equipped. They need the actual dollars to carry that message forward, and they need incentives to carry that forward. You have to make an investment with those partner participants who are going to carry your message back to the grass roots.

• **Comments on aligning delivery:**

  - So on the positive side we see things like access to care being focused upon, dealing with marginalized populations, mental health, substance abuse, chronic disease prevention and management and as well as healthy living, which all make up one's health. There has also been nothing but consistent praises for that Primary Care Health Charter that has just come out.
  
  - A model of Primary Health Care is supported by interrelationships. We need to invest in those relationships and that investment takes time, commitment, and priority, and it needs to be facilitated through communication tools. We need to use tools like appreciative inquiry and build on interest based solutions. We often make decisions in health care based on positions. We should move to interest based solutions.
  
  - For seniors, we are really talking about a system that has a large number of components, from services in the community like adult day care, meals on wheels, home support, home nursing, to residential services, chronic care, assisted living, and the specialty geriatric centers. Essentially, what you have is a system that has a broad community base and is integrated horizontally that way and also has institutional components so it is integrated vertically.
• Leaders at all levels, including our own First Nations leaders and representatives, are not getting the information to the front line workers and membership in general.

• The three pillars of senior care are nutrition, mobility and social connectedness, and those three things are all outside the health system. They are systems that are beyond just health and into the area of community, transportation, housing, and so on.

• Health is a very complex issue that touches social status, education, housing, and so on. But our bureaucratic structures are not set up to consider health within that context. Now, if we started to think about health within the social determinants and tried to ensure a healthy population, our structure should enable that. So one of the questions we should be asking is whether how we have organized is enabling what we are trying to accomplish or creating barriers?

• We need to look at the notion of no wrong door. You can walk into any service provider and find a way into the health system. Those linkages are totally absent in the health care system right now. The only problem is if there are so many entry points, how do you keep the continuity and know the history of the patient. That is where information technology comes in: to improve communication across sectors. In most provinces in Canada, we do not have those lines of communications open between the social and the community and the health organizations.

• Look at the difference in how we handle health care delivery and social service delivery. Health care delivery is premised on a kind of an asset pool. We would already have your premiums paid. And we encourage you to be healthy. And if you need help, you go in and it is essentially covered. In social services, we give you a certain meager amount of money and watch you like a hawk in terms of how you spend it. We give you a rent allowance instead of letting you decide. It is all deficit-based. Imagine if we could walk into a social service on the same basis as we can walk into health services and get care in that way. And if we were to integrate to that degree. The different departments would need to communicate more effectively, and that is difficult in itself because everybody has their budget envelope.

• Too many funding jurisdictions and service boundaries make the system difficult to navigate.
Ideas and Suggestions

Need for System Collaboration
Aligning Planning
Aligning Budgets
Aligning Delivery

- Ideas about the need for system collaboration:
  - Collaboration across the health care system can contribute to improved management of disease and improved health care generally.
  - We need partnerships with all levels of government, health professionals, non-profit organizations, schools, businesses, and foreign countries.
  - You need political will and strong leadership if you want to influence all of those sectors.
  - Part of the answer is leadership at the highest political level making it a priority. ActNow BC is a really interesting example of a very heavy leadership message of, this is important in this province and it is not just the little slogan of the week. That kind of leadership helps the competing, or maybe not quite so aligned, programs and ministries to find better ways.
  - Use the Auditor General’s office to help encourage collaboration across ministries.
  - Develop a system that integrates First Nations values and traditions into a clinical approach to wellness from both directions.
  - In terms of sustainability, you have to broaden the focus to include population health rather than just intervention. You have to take a broad approach that integrates medical, health, social and economic agencies and any of those should be a point of entry into the primary care system. We need greeters, not gatekeepers, as some of our clients do not access all aspects of this system. We need some strong leadership from government to deal with this fragmented care and that leadership can go upwards to affect federal agencies. We also need strong communication and outreach programs to reach downwards as well to the general public and to clients. We have to create some sort of a value proposition to get the general public to buy into this approach.
  - Broaden the health lens to other ministries, and the Federal and local governments.
  - We need a partnership between schools, cities, health professionals and communities to promote healthy lifestyles.
  - Social services and health care should not be separated.
• There should be more collaboration between branches of the Ministry of Health and more collaboration between Health Authorities.

• We urge the provincial government, through its Conversation on Health, to take action across government ministries to improve the health and wellbeing of British Columbians. It will be a missed opportunity if the provincial government focuses solely on recommendations under the jurisdiction of the Ministry of Health.

• **Ideas about aligning planning:**

  • There should be shared responsibility for health issues and concerns (housing, employment, education, community, aboriginal affairs), including integrated health planning.

  • Commit to a bi-annual meeting (Interior Health CEO and First Nations Chiefs) to establish benchmarks of health targets to achieve the quality of life required.

  • Create a vision statement and create an inter-ministerial committee.

  • Create a side table allowing First Nations community health directors to interact with planning and integration and cultural safety of all health programs and service delivery with the Health Authority on a par with their counter-parts.

  • Develop and implement a policy framework to ensure that policies are developed collaboratively.

  • There needs to be a systems level dialogue before closures take place to ensure that there are the necessary community supports available for patients and clients.

  • There should be community level responsibility and accountability for funding and planning including housing.

  • Bring all providers into the accountability framework, perhaps through a pilot study.

  • Link the determinants of health to health care policy, advanced education and economic development.

  • We need more in-depth meetings with specific groups of experts to address special and vulnerable populations.

  • Develop communities of practice.

  • Develop a strategy for each group within vulnerable populations based on accessibility which is client-driven and includes client choice.
• Look at a broader network of community services facilitated by a co-operative structure.
• Health authorities should be engaged with municipal planning.
• The First Nations Health Blueprint must be examined by both federal and provincial governments at the same table.
• We must address federal-provincial gaps in jurisdiction and improve coordination and communication.
• Improve integration across social services.
• Empower staff and involve them in decision-making.
• Enhance local, regional and provincial networks.
• Government should lead a round-table of government ministries, non-profits, professionals and the public.
• Expand bilateral dialogues to strategic discussions with partners.
• It is important to share best practices around change management and work flow that already exist to feed into the culture shift that needs to happen. As you foster these initiatives they need to have tight evaluation models built into them.
• There should be proper urban planning that incorporates consideration of health care needs.

• Ideas about aligning budgets:
  • Merge health and social services ministries and programs and sharply increase spending on programs and services that reduce harm and crime. Increase welfare and provide more mental health and home care services and so on to reduce the pressure on hospitals.
  • The federal Government role is as a partial funder, and also a collaborator on some meaningful issues. The Federal Government has been in on some important discussions with the provincial health minister on how we can do some things together, whether it is to increase accessibility, decrease wait times, or move forward towards the next logical extension of reducing wait times, which is the wait times guarantee.
  • Align all ministry budgets around key health priorities such as prevention or health human resources.
  • Require ministries to invest in policies and programs that support populations to lead healthy lives.
• **Ideas about aligning delivery:**
  - Coordinate and utilize the many participants in the health care continuum.
  - Services should take a holistic approach, community-focused, and spend time looking at whole person.
  - Recognize and respect health programs on reserve.
  - Increase the number of partnerships between agencies (government ministries) to improve communication and services to First Nations communities.
  - Integrate federal and provincial services, particularly around Aboriginal health.
  - The Ministry of Health needs to partner with and fund non-profit organizations which provide health-related information and services, particularly for women.
  - There could be community non-government organizations that provide services around some of the other determinants of health.
  - The system needs to communicate, not deal with each episode separately.
  - Health initiatives need to be partnered with other government agencies and initiatives to address the larger picture.
  - Get beyond the turf issue.
  - Try new models and see how they work.
  - Listen to feedback.
  - Have the entire provincial health care system managed by one group.
  - Form partnerships between three levels of government to coordinate, and not duplicate services.
  - Promote discussion between unions and the health region.
  - Work co-operatively with our American and Albertan neighbours to allow for greater mobility of information and equipment.
  - Throwing money at the problems will not necessarily solve them. We need to start looking at the redundancies in the system, get people talking and working together, and efficiencies will likely begin to emerge.
Integrated and Holistic Care

Comments and Concerns

**Design and Vision**
**Change Management**
**Impacts of Integrated Care**
**Administration and Facilities**
**Costs and Funding Models**

- **Comments on design and vision:**
  - We need an approach that is going to develop not just primary care but actually clinical micro-systems. You need to determine who you are serving, what kind of problems you are serving and what you are addressing with the system.
  - Develop a system that integrates First Nations values and traditions into clinical counselors’ approaches to wellness.
  - You have to have vertical and horizontal integration, so that people are able to access all social and medical services. This is more like primary care based models, where physicians would coordinate with these other services. The trick here is the linkage and authority over these different vertical levels, so they are all part of the same system.
  - One of the opportunities is to find opportunities for collaborators in the fields without offloading. Who are the grassroots collaborators who can facilitate sustainability? BC Hospice and the Palliative Care Association, we are very cognizant of coalition development. It is done at the national level with all the end of life care coalitions. So how can the Ministry utilize its resources within the framework of the practitioners? Who are the care delivery people who know best what can be sustainable.
  - What matters is that the concept of a fully developed, integrated system of care is accepted. Then you need to look at which system makes sense in British Columbia.
  - A more integrated system of achieving health is about health promotion and disease prevention, and also about palliation, facilitating people to get to the best level care possible with wherever they are at in the disease process, and do it in the context of the system being integrated from beginning to end. This way we can plan for outcomes and costs and ensure that we have got enough providers.
  - We need a system where diagnosis, prescription, treatment and education are fully integrated.
• We need a clear understanding of what holistic means.
• We need to open the lines of communication between social, medical and health professionals and sectors.
• There is a need for multi-disciplinary services including: home care, public health, health authority programs, seniors support services, and community based programs.
• If you try to set up some clinics, they do not tend to necessarily do well. But if you set it up in networks, it actually works a lot better. The value in networks is that there are relationships between providers. You do not get structural change, you do not change people's pay cheque, so it is easier to introduce. But better inter-professional integrated practice happens when the space facilitates it, and co-location is one of the important factors. It is easier if you are on the same floor working with a colleague regardless of what your profession is than it is to go down the road, across the street, to the next province, and so on.
• People are looking at the system today saying it does not work. So it is not a conflict, they are just saying that there another model and they are throwing up a community based clinic as an alternative.
• The physicians that would be hired as the core team for a collaborative are not going to end up doing conventional physician work. The doctors that work in the clinic become a liaison between the findings of the whole professional team at that centre and the doctors in the community. So they play a supervisory role: they are supervising health planning. They interface with the physicians.
• The one-size-fits-all approach will not work across the province. Clinics need to be targeted to each area. You need to understand the population, age, and demographics. You need to think about cultural sensitivity, whether it is the South Asian community or the Aboriginal community.
• How can we make sure the resources we are spending in health care, particularly in a primary health care setting, are spent appropriately to optimize patient access to a range of inter-disciplinary practitioners?
• Do not do what the Ontario government around family health teams. They have spent hundreds of millions of dollars on it. They are all different: they do not have a standardized clinical model. There is no standard structure on who administers this type of clinic, how big the clinics are, and so on.
• The evidence does not support an integrated health care model. These models can work, so they certainly have applicability. But they do not necessarily have applicability to primary care in a sense of the general population. There does not seem to be any evidence that suggests, for example, that solo general
practitioners are much different from group practices or much different from the integrated healthcare context. The evidence suggests that solo medical practices are not an ideal model, and that it is better to have two or more physicians. This is mainly because of work load management issues. But in terms of quality of health care literature, the case for integrated health care has not been made. In fact the evidence would seem to run the other way. It is a policy in search of the evidence as opposed to the evidence trying to drive a policy.

- There are examples of integrated clinics. The Centre for Integrated Healing is a cancer centre where they do specifically cancer therapy using different modalities. They receive high dose Vitamin C from naturopathic doctors, acupuncture, counseling, nutritional counseling, and all in conjunction with chemotherapy and radiation. Maybe it is a matter of setting up more disease specific centres. But then there is a danger of not treating patients as a whole.

- Ultimately there has to be a lead agency. Even though it is multi-disciplinary and there is funding that comes from multiple places, somebody at the end of the day has to take the lead. The lead agency could have some kind of ministerial status and a pivotal place inside the government system, including sustainable funding.

- My experience of working in an integrative health care environment in Washington state is that all people involved benefit from this model of care. Physicians were grateful that naturopathic doctors could spend the time with patients to help them make the changes they needed while providing expert advice on areas of nutrition, prevention, responsible screening and supplementation etc. I was grateful to be able to consult with physicians regarding complicated cases and to refer those patients that were not responding to natural medicine. Of course, the patient was happy having the choice to see both providers in a collaborative environment.

- Our bodies and our systems are very complex and require a diverse group of practitioners to efficiently and effectively address all of the challenges the people in our society face.

- The federally funded Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) pilot project in Hamilton, Ontario points the way to true interdisciplinary health care models. The Rosedale pilot project is a very successful physician-run clinic which serves approximately 14,500 patients in the Hamilton area. Rosedale is focused on efficiency of service and inclusivity in health care provision. The range of services at Rosedale is broad. There are family physicians, nurses and nurse practitioners, chiropractors, mental health counsellors, physiotherapists, pharmacists, a breast-feeding and parenting specialist, home care coordinators as well as a range of technical and other support staff. At
Rosedale, integration is so thorough that it has become part of the work culture and occurs seamlessly.

- Multidisciplinary care is one possible solution to challenges. Multidisciplinary care is an important component of a broader primary care approach designed to meet the need for delivering increasingly comprehensive services as the population ages and the incidence of chronic illness increases. If implemented properly, multidisciplinary care can result in better coordination of care, help to alleviate physician shortages, better maximize health care resources, and improve patient outcomes (particularly for those with chronic conditions).

- Integrating massage therapists into hospitals, community health centres, educational institutions, community centres, sporting facilities, workplaces, neighbourhood houses and elsewhere would offer the benefits of massage therapy to a broader audience, producing a healthier population.

- Politicians and administrators at best guide but do not run health systems; that responsibility ultimately belongs to the practitioners, at many levels. It is important therefore that professional and related health organizations continue to have a voice in how the system is designed and developed, operationalized and evaluated.

- The non-profit sector continues to function in spite of the lack of adequate funding as a result of their knowledge of their clientele and its needs.

- There has been no recognition provincially or regionally of the key role that rehabilitation plays in the care of the elderly and those with chronic disease.

- **Comments on change management:**

  - We have this massive system in its silos, with its different funding mechanisms and lack of connection and everybody wants to go to team care. But what is going to catalyze that? What is going to make people want it? What is going to make healthcare professionals excited? Healthcare professionals are already there. They already want it and know how important it is. But they do not have the money or the power to make it happen. So you have to go back to the top and work down. You have to go to the federal government to earmark certain funds to the provinces to start the system. And then they have to give guidelines.

  - It seems every time a conversation around health care is opened, it turns into a party verses party argument about funding or turf protection. The idea of an open conversation, collaboration and team work seem like foreign concepts to many higher level health care professionals and administrators.
• We need leadership at all levels, including the highest levels, to be modeling the cooperation and collaboration.

• Let us have a collective conversation about what accountability across the country might look like.

• It is recognized around the country that we are the most successful province in terms of dealing with cancer care. It is partly because of the kind of culture that emerged that everybody was willing to work together, and that is part of the key to success. Is there a willingness to really collaborate and cooperate to make a thing happen, and get beyond the competing interests to complementary interests?

• A major challenge common to all systems appears to be integrating physicians fully into the system as core partners and people who share the same goals and the same accountabilities and the same stewardship as the overall system does. This is a vestigial problem of the way the profession is developed. In North America, it is a particularly strong tradition of independent contractors working with the system rather than being fundamentally integrated into the system like some other countries.

• There is a systemic bias within the College of Physicians and Surgeons against complementary therapies because of the threat of disciplinary action.

• **Comments on impacts of integrated care:**

  • If you have an integrated system of care, you do not have stovepipes and competing policies. It is better care for the client because you can move them through and respond to their needs more actively than if you have a whole bunch of different services and professionals where people are getting in each other's way.

  • Can we effect the model with the health human resources we actually have available?

  • At the care delivery level, acute care and home and community care aren't closely associated; palliative care programs are not typically provided to people with dementia, health records are not routinely moving with the patients as their dementia journey takes them to different health care services, the new Assisted Living program is unavailable to people with dementia, very few health care providers throughout the system have received appropriate up-to-date education about dementia...and policy, health care delivery and people's needs are not aligned.
Dementia care is provided through at least five branches of the Ministry of Health, and working together is challenging for staff who are extremely busy and working on priorities that may not be properly strategically linked.

A physician or a group of physicians cannot do it all, particularly the way the system is structured today. One thing that we found is that interdisciplinary team, not multi-disciplinary but interdisciplinary, where providers are working to the fullest scope of their practice, actually supports good outcomes, particularly around chronic conditions.

Implementation would go beyond a term of government.

Too many eggs have been put in that one basket (integration). There is some good stuff going on with the integrated primary health care networks. But this has been a pipe dream for at least ten years. We have been having the same discussion.

Doctors who are in their offices get kind of angry and bitter and lonely and blue. When they work in collaboratives, they develop personality, become engaged, get excited and actually start to do things. The highlight for most of us is actually the interpersonal socialization and the rest is all just gravy.

We have to start with a meaningful discussion at the community level that includes patients, health care providers and administrators. There is something before that: a top down direction from the ministry, including the parameters. Then you have community dialogue around those parameters. Otherwise you might end up just getting road blocked. There has to be some money aligned to the process. Then there has to be development of the criteria as to what we are trying to achieve, and perhaps some principles aligned with how that objective is achieved. To some degree people are getting tired of consultation because they feel that they have been consulted. So this whole process of the Conversation on Health will have a wealth of information that can be appropriated into this process. You can actually feed back what was heard and the expert panel will validate it.

We need to implement integrated clinics by: training health professionals differently and providing incentives for collaboration.

Multiple medical visits between many different health practitioners is tough for people with disabilities or older and poorer people.

New doctors want things like time off with their families and work life balance. So there is more than just a business incentive to have a clinic, because with more staff, there are more people available to cover for you, and this improves your quality of life.
In a multidisciplinary clinic, where you have a group of patients coming in, you do not necessarily have to have the physician see that patient on every visit. You could have a nurse practitioner, dietician or nutritionist conduct a group session where you bring in maybe 20 or 30 of your diabetic patients. And then the physician would be there as a resource for that particular visit. But the physician would still be managing the overall medications, the goals, the targets for defining good diabetic care and again we have had some experience with the diabetic with collaboratives in diabetic care in British Columbia.

- Holistic health centres could reduce costs.

- If a health system talks about bringing in inter-disciplinary practices in an unstructured way, the physician alignment and payment systems do not work. As a result, the doctors will not want these people because when they see a patient rather than the doctor, the doctor does not get paid. We have a huge disincentive working against some of our models. The nurse practitioners are leaving because they are not satisfied with the work they are doing.

- One important piece of this was looking beyond primary health care to include services provided by other ministries and community based service organizations, encompassing the wide spectrum of services, from a population health perspective, that help support folks in terms of maintaining good health, preventative health issues and treatment. So working across ministries and sectors and creating an innovative integrated service delivery model will help increase access for vulnerable populations.

- One of the advantages of a clinical micro-system is that in a sense if you can resource this appropriately you are dealing with a small system that can work within itself. Change management is less difficult if you do not have to be taking into account directives from a whole bunch of higher level agencies.

- It is possible to do the things we were all talking about, like team based care and electronic medical records, and actually make no difference to patient outcomes.

- An integrated system is better from a cost effectiveness point of view because if you have a single authority and single funding envelop, you can then be studying and looking at what are the relative distributions. If you have a lot of people, or some people with relatively low care needs in a facility that could be looked after in the community, maybe you could reallocate the resources, and in fact provide those services in the community where they want to stay at a lower cost, so you are also getting efficiencies.

- From a policy perspective, integration allows you think about the whole system of care. So if you are making policies, you can make policy about how home care is
linked to residential care is linked to specialty geriatric care and what is it that is best for the client and what is the best way to do it.

- The integrated health care system might reduce demand, because it is focused on prevention. It might move demand to more appropriate places and less into acute care. It may also actually increase demand if you get really good at your case management and you have really good networks, because there are people that are not being served now that will be served.

- If, in fact, there is any merit to the argument that there are efficiencies through an integrated system that you cannot get through a splintered system, then it is more sustainable because essentially it is a more efficient and effective system. Also you can make the tradeoffs that you need to make. That does not mean in terms of total dollars that you may not have a problem, but it is more sustainable. So if you have an integrated system, it is probably about as sustainable as you are going to get, depending on what dollars you have, and certainly more sustainable than non-integrated systems.

- There is fragmented delivery of primary care.

- An integrated system is more cost effective and efficient.

- **Comments on administration and facilities:**
  
  - The Healthy Heart model at St. Paul's Hospital links cholesterol testing with dieticians.
  
  - Integration includes community delivery models.
  
  - The Cancer Society has an admirable system. It supports people who are who are pursuing alternative medicine; they are very open and holistic, and they really follow people.
  
  - There has to be one person where the accountability and the responsibility falls on a multi-disciplinary team. One person has to have the legal liability, and it is usually a physician.
  
  - A Collaborative is a structured event that is a quality improvement model. Before funding collaboratives, put the resources into defining what the standard of care and administrative model is actually going to be. The planning has to be from a business model perspective: what is the population scope, where are they going to be in terms of transportation, and so on.
  
  - Many things in their plan for Collaboratives in Ontario were good, but they did not identify how it could be delivered effectively and efficiently, how it should be organized and administered, or what systems they could put in place. They did not develop a package to hand to the core service provider system.
• A community clinic would provide a resource centre for after-hours care, education, and support, and would take the burden off of emergency departments.

• In Australia they had their health services in a community centre with a pool and gym. There was the room where they had pregnancy prenatal care and there was the place where the elderly folks came and had access to all of their chronic disease support.

• There is a role for volunteers in an integrated centre.

• There is a similar model in terms of addressing HIV prevention needs among gay men. Previously it was all about dealing with talking about people about condoms and viruses. As holistic approaches to health and population health developed over the years, it has now been adopted into a gay men's health approach. There is a gay men's health centre in Vancouver where folks can go in and address some basic level health needs in terms of sexually transmitted diseases screening, prevention counseling, and so on. They can also get employment counseling, supported housing access and talk about how to get rid of your debt.

• There are some marginalized populations which require that you go where they are. For example, the Community Transitional Care Team provides IV antibiotic care in a community residential setting for active or recovering drug users. While they are there, income assistance workers come in to do their work, and we could bring in a range of other services to plan for their discharge and case manage them and support them after they are discharged.

• **Comments on costs and funding models:**

  • The integrated model of health care is already available at a cost.

  • In Alberta, they are trying to move forward on primary care networks. The idea behind them was to create an incentive for physicians to work more collaboratively with other people in the system. So, if you join a primary care network, you get a supplement of $50 per head, and the physicians can use that whatever the way they want. Some physicians have used it to increase the complement of other nurse practitioners and other allied health professionals. We had one case where they just pocketed the money. The supplemental pay was supposed to be to invest in improvement, but part of the problem is the money goes to the physician, not to the team.

  • What funding models would support integrated clinics and what are the factors for their success. Urban clinics appear to do well, but others do not. Is it about the
volume of patients or funding models? They need to make it a viable operation. Fee for service is very limited in a lot of ways.

- We have stopped funding pharmaceutical services, physiotherapy, most of community mental health, and many of the other practices that we now consider as part of an integrated health care system. So either those components are optional, and therefore unimportant, or the whole thrust of our health care policy to this point has been misguided. We have no appetite for funding nutritionists and physiotherapists and so on, and we are in fact progressively funding fewer of them, and yet we do have some kind of appetite for having these one stop shopping places for health care.

- We need to be realistic about cost and having a multi-disciplinary team available for every kind of health need 24 hours a day and seven days a week would actually bankrupt us.

- In the South Community project they have physicians and midwives working in the same models, spending the same time, so, until the Ministry got it organized to give them a funding model, what they did was take all of the fees and put them in a pool for everybody and divvy it up and pay everybody the same. Now the Ministry has actually put together funding that fits that model. Here is a group of people who wanted to do this and make this innovation and they took the existing system and said, well, it is going to take them a couple of years to figure out how to change it and we have this access to federal money now so let us just create our own solution.

- We do not know what integrated clinics would cost, and we have no space for building new centres. Land is highly expensive.

- The Copeman Centre has fees for holistic treatment. They have taken the whole primary health care agenda and privatized it and made it a profitable business.

- We need an administrative and funding model for collaborative health centres. We have to put the funding model there somewhere.

- Fee-for-service motivates physicians to spend as little time as possible with patients.

- You cannot take the current money from doctor compensation and pay a multi-disciplinary clinic system on the basis of no added money. Where is the funding for facilities and staffing going to come from? You have got to add some money into that system. If you want a multi-disciplinary clinic you have got to buy some bodies to staff it. The only money we are talking about in primary health care right now, the funds in the budget, is for doctors. And out of that they are already paying for the 2000 offices and staff and so on around the province.
• This is an opportunity to be as creative as possible with an envelope of money. You may get some groups who want to use naturopaths and others who do not. They should be allowed to use whatever they want. It would be community-specific. Those services will change depending on the community.

• Looking at multidisciplinary clinics, our biggest problem as physicians, particularly family physicians, is that we do not have adequate funding.

**Ideas and Suggestions**

**Design and Vision**  
**Change Management**  
**Impacts of Integrated Care**  
**Administration and Facilities**  
**Costs and Funding Models**

• **Ideas about system design and vision:**
  
  • We need to define the core: the philosophy, the guidelines and what the service is. We have to understand what services are necessary in order to fall into the category of collaborative care, or integrated care centres or whatever you want to call it.

  • There needs to be a recognition at all levels of the health care system that rehabilitation is an essential part of the system which provides value to payers and improves the function and quality of life of persons with impairments and disabilities.

  • It is time to completely redesign the model upon which our health care system is based. We should adopt a wellness model, in which the entry point for access to the health care system would be provincial wellness centres located in each community. These centres would offer a variety of services and would be supervised by medical health officers. They would be staffed by teams of nurse practitioners, nutritionists, physical therapists, kinesiologists, dental hygienists, and the like. Examples of services a wellness centre could provide include: routine dental examinations and cleaning, especially for school children; diabetic foot care; nutritional counselling and meal planning for families on fixed incomes; exercise programs and pool therapy for arthritis suffers; adult day care for seniors who live at home; a drop in centre for single, teenaged mothers; an obesity support group; and, prenatal monitoring and pregnancy management.

  • Government must foster voluntary participation in multidisciplinary care by: removing financial barriers to incorporating allied care providers within physician
offices; ensuring that expanded scopes of practice for allied health professionals are granted on the basis of sufficient training and demonstrated expertise; ensuring that where health professions take on new levels of care they assume responsibility and liability for that level of care; and, expanding successful General Practice Service Committee initiatives to other chronic disease management areas.

- Multidisciplinary care teams should have a written delineation of responsibility and accountability that is in accordance with legislated scopes of practice. Legislated scopes of practice need to correspond to levels of training in order to ensure patient safety. Removing barriers to multidisciplinary care implementation requires that regulatory bodies and professional associations be closely involved in any proposed changes to the scope of practice for allied health professionals who work with physicians.

- An individual pursuing optimum health can access their modality of choice from within a safe, efficient and kind system of provincially licensed practitioners.

- Create a Cardiology Centre that will result in significant cost savings ($25 million per year with additional long term savings), incorporate nurse practitioners in our rural and remote communities, develop an effective tele-video conferencing information highway to our most remote communities, incorporate a preventive care arm designed in rural British Columbia for the unique problems of that population, and create rural physician and nurse practitioner-based chronic disease programs to avoid the hospitalization costs of chronic cardiac problems such as congestive heart failure.

- A series of multidisciplinary pilots in health clinic settings, which incorporate chiropractic care, will demonstrate to provincial jurisdictions that chiropractic saves money and enhances care.

- Taking a leadership role in alternative medicine research will eventually attract talent to the province and perhaps we can develop sufficient expertise to start some centres of excellence that may eventually have revenue generating opportunities as well as cost reduction.

- Consider a multi-disciplinary approach to family health care where individuals and families are attached to a family health care team, and the team has a identified a group of people that they will provide to. Should the user decide to use care outside the team, a fee would be imposed. There would be funding incentives for good results which would be based on evidenced standards of professional practice. The health authorities would continue to run hospitals and residential care facilities and allied support.
Primary health care should be re-defined to be a multi-disciplinary, salaried cooperative with health care teams focused on the needs of each community.

Follow models, as in Sweden, where like pharmaceutical and dental services are all contained in medical system.

Provide funding and incorporate a more holistic approach to wellness and health care throughout the system.

Part of the whole shift is to enable teams to work creatively and innovate. Doing this effectively, however, required a distinct plan so that all of the communities are working together and talking to one another.

Look at European systems where integration has been successful.

Address a patient case through a holistic approach, including nutrition, day care issues, mental health, addictions, marriage issues, as well as primary medical needs.

To be effective in promoting good health for British Columbians, the government must regain control of the health care system, and include healers who work in the non-physical dimensions to heal the causes of illness, not just the symptoms.

We need a more holistic model where eastern and complementary modalities are recognized.

Networking could spread province-wide. In addition to having local collegial meetings, you would have a province-wide collaborative once a year. Obviously not everybody can attend, but you would go to one every two years or so. It would unify all of the primary care providers and make sure that we get efficient use of resources and desired outcomes, and that our patients do not slip through cracks anymore.

A location in which a group of health professionals work as a team to promote healthy living, and prevention and treatment of disease.

Partner with hospice to provide longer and proper convalescent care.

Family practice networks and collaborative multidisciplinary family practice clinics should be supported, including: proper chronic disease management, increased patient self management, collaborative care models and more non-facility community home supports. Family physicians and community supports will help to minimize unnecessary use of facility care.

Establish integrated health care clinics in British Columbia that would be lead by communities, health authorities, health providers groups, or not for profits. We would build these on the principles of inter-professional, collaborative, population based, population centric, innovation with multiple entry points and an outreach.
focus. The process would be to develop an expert panel that would include funders, community experts, educators and practitioners. That group would also develop the principles and the criteria. There would be community discussion to decide how these would go ahead and the communities themselves would lead that. We would hire an executive director, we would implement the clinic whenever possible and then we would do a lot of communication. Success would be when we had improved population health with provider satisfaction, improved accessibility, decreased pressure in the system and community satisfaction.

- A one size fits all approach will not work, so we need to tailor or fit the health care services to be provided to meet local needs. To help do that, we will collect health data. So if there is a predominance of certain diseases or issues in a local area, build the primary health care clinic to meet those needs.

- Another model of health care delivery that has shown to be extremely cost-effective, and leads to better health care is the creation and funding of community health centres. These centres employ salaried multi-disciplinary teams, including doctors, nurses, social workers, and home support workers, and incorporate community participation and community development in their planning of activities. A study in the Canadian Medical Association Journal shows that such centres are more likely to have organized approaches to care, including more counselling and education for its patients and other community residents who need such wide-ranging care.

- Implement integrated primary health care clinics that are accessible, comprehensive and efficacious. In order to get there we need a new model with a service framework, a governance structure, incentives, flexibility in business arrangements, and a comprehensive information technology structure tailored to the needs of the target population.

- British Columbia should support multidisciplinary care by removing existing barriers for incorporating allied health professionals within primary care physician offices while expanding the scope of chronic disease management activities.

- Both workers and the public would be more willing to go along for the ride in the policy making and governance process to develop ideas like multidisciplinary community based primary health care centres. Our health care system needs teams of professionals working together (on salary) serving their local communities. Such centres can provide total care to a given population and the team can focus on the task of providing continuing care without worrying about their personal incomes.
• Encourage and open more opportunities for registered massage therapists to work in an integrated health care system with other health care professionals, particularly in hospital settings.

• Ideas about change management:
  • We need to train the health professionals to work in a collaborative model.
  • You need financial incentives for multi-disciplinary models.
  • We do want a sustainable system, but that means doing things differently. We expect a level of responsibility from everyone. And we need to find a way of trying to work together in it. It may sound a bit too idealistic, but there are ways of breaking away and reframing the system. There needs to be the courage and the leadership to do that and take steps towards it, like not renewing contracts, unless we find something that is in the common interest.
  • To implement collaborative Teams you need to deal with the actual and perceived barriers or limits regarding scope of practice.
  • Increase the integration of non-profits with health care.
  • In order for the various health care providers to be effective, it means setting aside old conflicts and voluntarily working together with government in the restructuring process. It does not mean a refusal to change. Rather, it mandates that as part of our responsibility to deliver care to our patients, we must learn how to change and how to manage the change process.

• Ideas about impacts:
  • Redo how the health care system is structured and identify the parts that work well and those that are not integrated.
  • Restructure health care delivery to make team-work necessary.
  • Research shows that jurisdictions with multidisciplinary primary health care teams have healthier populations and lower costs. Professionals working with teams can also spell each other off and live more reasonable personal lives.
  • People have been recommending the whole community health centre concept. Those arguments are right; we are not going there in the near term or even the medium term. There are a whole lot of doctors out there who do not want to go there. There may in fact be more in the future who may want to go there, because there is a lot of material about the new cohorts of physicians who have very different references. But they are not in charge yet. It will take another 20 years as we get more and more physicians with a different philosophy of life who do not
want the hassles of running a practice, dealing with overhead, hiring, firing, and negotiating leases.

• This is not a new concept for by the way. We do have in our northern communities for example. They are called Diagnosis and Treatment centres (D and Ts), which actually to some extent serve as the health care hub for the community. Pretty much everything is housed out of them including senior's daycare programs.

• There is an Aboriginal healing framework strategy in Ontario for about twelve years. It is responsible for hundreds of millions of dollars of programs, costing about seventy million dollars a year. There are eight Aboriginal health access centres and there are programs for physical, mental, emotional and spiritual health. There is a focus on the continuity of care right from health promotion and prevention through to treatment and chronic care. The assumption is that this would work for any population not just Aboriginal.

• It is not like there is no groundswell of support for this. But we need to be very careful and strategic about making sure that we have the right processes and structures and that we do it in the right order, and that we start getting rid of stuff that gets in the way.

• In a team-based clinic environment, the patient population is analyzed within the clinical team to assess and develop group visit opportunities. The clinic engages representatives from all service domains to analyze results of care outcomes, patient input, efficiency measures, quality and safety measures and searches widely for examples of excellent practice with a view to constant improvement. Clinic staff evaluate themselves as an organization (team) on how well they (together) achieved key goals.

• There has to be some transitional funding.

• Rapid implementation of integrated clinics is the best way. We do not want this going around in circles and upper echelons for eons: we want rapid implementation so we can address the incoming surge of over sixty-five patient populations coming.

• **Ideas about administration and facilities:**

  • Move to a joint practice model where nurse practitioners, nutritionists, doctors, and so on work together.

  • Use decommissioned schools or public facilities for clinics.

  • Set up the core module or centres with defined amounts of space to do the core services with flexibility to add other services and do it in a highly leveraged way.
• Wellness prevention and holistic care should be in all facilities and community programs.

• Wellness clinics could detect conditions early and properly service the health needs of vulnerable groups alleviating backlogs in emergency.

• Integration of services needs to be scalable. There may be a gold standard where somebody might come in to an integrated service centre and have a really great ongoing relationship with a primary health care team, an income assistance worker, and a case manager, and would have connections with the cultural community and so on. That might be the gold standard, but not everyone is going to need that. So it is going to be scalable and more intensified as their needs increase.

• Address liability concerns for collaborative practice.

• Implement independent clinics run by Nurse Practitioners to look after a defined range of medical services including Midwifery. These clinics could be set up by government and rented to individuals or groups of nurse practitioners who would provide certain defined medical services for set fees paid for by Medical Services Plan and refer onto general practitioner doctors and in certain defined cases to medical specialists any problem beyond the range of their expertise. These clinics could relieve general practitioners and hospital emergency departments of some patient load and thus provides the required service at somewhat lower cost to the overall health care system.

• The literature is pretty clear that in terms of team building and collaboration, one of the most effective things is co-location. The virtual systems are not as effective in terms of building team and collaboration.

• Establish a structure around safety, confidentiality, efficiency, effectiveness, quality of care and accountability, but allow the teams to decide how they deliver the service.

• Geography is really important in terms of accessibility. It has to be servicing a small enough area that people feel comfortable going there. It really needs to be community based. I would almost go by postal codes.

• Bring in an inter-disciplinary team.

• Design a patient centered addiction and mental health primary care facility.

• Look at the Mid-Main and Reach Clinic models where they use nurse practitioners and dieticians to positive effect, the pharmacy is available for consultations, and doctors have more time for care and diagnosis and to just talk to patients.
• Establish pilot programs through the Northern Health Authority and the Lytton Health Centre to improve acute care and community health services utilizing an integrated approach to health and community programs as directed by the needs of First Nations.

• There should be a centralized space with multiple-practices, such as a community health centre.

• Have more multi-disciplinary health care centres focused on prevention and holistic care.

• A multi-disciplinary community care facility or one-stop shop with twenty-four hour access is needed in communities across British Columbia.

• Community health centres employ salaried multi-disciplinary teams, including doctors, nurses, social workers, and home support workers, and incorporate community participation and community development in their planning of activities. A study in the Canadian Medical Association Journal shows that such centres are more likely to have organized approaches to care, including more counseling and education for its patients and other community residents who need such wide-ranging care.

• When you are looking for financial sustainability you cannot come up with a concept like a collaborative, and just throw it open to grant applications. You need a standardized clinical model and a standardized administrative model. Otherwise it is just a dog’s breakfast.

• The services needed for your integrated centres will be different in Cranbrook than Victoria, and it depends on the demographics.

• In a clinic you need some diagnostics, nurses, nutritionists, kinesiologists, psychologists, a mental health team, para-natal support, and self-management support. Physicians need a really good risk assessment tool and then we need to have a way to move people to the appropriate place, whether it is a community centre or a supervised area like cardiac rehabilitation centre.

• There should be integrated health centres for the treatment of cancer victims, including homeopathy, nutrition, and counseling.

• We need more integrated health centres at the community level that are independent of a particular disease.

• Develop mobile clinics to service vulnerable populations, for example in isolated communities.
• To make the inter-disciplinary team work, we need appropriate information technology and information management infrastructure in the form of electronic health records, principally, but may also tele-health in rural communities.

• **Ideas about costs and funding models:**
  
  • Payment should be structured for the team. For example, everyone is salaried but there are contract milestones that they must meet in terms of how they provide care and who they provide care to and the outcomes they must achieve for the populations served. You cannot lose the team concept because that is key in terms of recognizing the value that each of the health providers, professionals brings to the team and valuing that contribution.
  
  • The provincial government should fund multidisciplinary care teams.
  
  • Remove patient caps from clinics.
  
  • It will take some financial commitment to put community health centres together but monies are available for this type of initiative via federal primary health initiatives.
  
  • Clinics should be funded through a pool of money, with designated leadership roles and flexible teams.
  
  • Create a governance structure and get community partners and build this thing up from the ground up. Then there will be resources there. That is what we are trying to do in the disability strategy is to build it one community at a time. No more pilots! In that way we will not be doing a pilot only to find that the funding will be pulled two years down the line. It is outcome focused. You have to add some new money because you have to create attractors. Money is a great attractor.

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**Collaborative and Multi-Disciplinary Care**

**Comments and Concerns**

**Models and Services**

**Administration and Funding**

**Human Resources**

**Facilities and Equipment**

• **Comments on models and services:**
  
  • There is a lack of multi-disciplinary team building for specific disease conditions.
• General practitioners are currently the gatekeepers to health care. This needs to stop.

• There currently are too many designated gatekeepers to the health care system.

• The challenge may lie in getting health care practitioners to collaborate with each other.

• The public might harbour preconceived notions about what primary health care teams will look like.

• Very few inter-disciplinary practice settings actually exist.

• Collaborative care has become a buzz word and needs to be given context.

• There is not much opportunity for inter-disciplinary collaboration in the workplace.

• There is no universally accepted model for a collaborative team. Professionals have their own expectation or concept of the team, and the reality is something completely different.

• The body is a complex machine. The doctor cannot be an expert in mental health and nutrition and exercise physiology as they do not possess the knowledge. There is no way one person can possess all the knowledge required to act as a psychologist, dietitian, kinesiologist, and to a certain extent, nurse. However that entire body of knowledge is necessary to actually deal with a patient.

• In New Zealand, the physicians and nurses are working with each other.

• A collaborative approach to health care will increase British Columbia’s general health outcomes.

• Pregnancy and birthing is a great example of how in the last three or four years we have moved from women being pregnant to families being pregnant. We have engaged the partners a lot more in bringing them into the delivery rooms and engaging in the process.

• Is the health care system actually structured in a way that would facilitate collaborative care on an ongoing basis?

• Physicians often have a certain position of power in a healthcare system. When a practitioner has that kind of power and autonomy, there must be a lot of incentive in order to share responsibilities health care delivery.

• Physicians see themselves as independent practitioners who provide service to the system but are not necessarily part of the system. It is so entrenched that in order to have a multi-disciplinary approach that is truly interdisciplinary, we have to be able to build in financial incentives.
Physicians are operating small businesses while the rest of the health care system is trying to be interdisciplinary.

Managerial staff are not properly integrating front line workers into a communicative implementation effort.

There is little coordination among the major players in health care; schools, policy makers, regions, and front line workers are all separate pages.

Teams of practitioners providing services based solely on the needs of the community would avoid over-crowding of emergency rooms and hospitals.

**Comments on administration and funding:**

There a risk that if team care is executed poorly, lacking basic administration and systems for coordination and communication, patients will fall through the cracks. There is a higher risk of this in a team-based model than in a single practitioner model.

At present the hospitals and care homes have many people working together but there is no clear chain of command. It is anarchy with each person following a job description without specific coordination or direction. Each shift needs a boss able to move their staff around to give additional help or to take on additional tasks. They need to be responsible to and for their team members and their individual and collective performance.

The current performance-based pay system will have to change.

The inherent difficulty in implementing a collaborating system changing individually funded care model.

In order for collaborative care to be successful, it must be proven that various administrations and staff are capable of working together.

In North Vancouver, a pharmacist educates doctors about drugs. This program has returned 150 percent of its costs.

The British Columbia Medical Association needs to change their standards as a fee for some hinders teamwork.

Fee for service system inhibits integrated care.

It is challenging in a situation where you have part-time workers or students who are present once or twice a week. It is a challenge to bring them into a team in an effective way.
• What is lacking is a policy framework for funding a real collaborative model.

• The stumbling block to the collaborative model is that if you have your Registered Nurse, neurosurgeon, medical doctor, naturopath, and your chiropractor, and the patient gets to choose, or is advised that among those five they are going to have to pay for two of them themselves? That limits their choices to the other three.

• Acute areas like emergency or a birthing unit or a critical care unit turn over so much that you might have a group of people who work together on a given day, yet they might not work together again for four months.

• Is collaborative care something that the Health Authority provides in the interim, or is it something that physicians will have to adopt on their own?

• Comments on human resources:
  
  • There are all kinds of health care professionals such as dieticians and respiratory therapists who are involved in chronic disease management but are not very well integrated. The issues lay with their scopes of practice and physical facilities.

  • Where does one go to see a team actually working? A student is kept in little isolated boxes for virtually of their educational and professional careers. There is no idea what the end vision is.

  • Social workers are often left out of articles and public announcements from the health authorities. They are suddenly the forgotten profession. Occupational therapists and physiotherapists seem to have made some inroads, but social workers are taking a back seat. It is very important in communication to use distinct professions such as child protection workers, hospital social workers, mental health, and psychiatric social workers.

  • Decrease the workloads of older professionals in order to allow them to deliver mentorship to new students.

  • There may be issues integrating older health professionals, who have little experience in team-based care, into a collaborative model of care.

  • Professional associations are more of a hindrance and they should not be considered the gatekeepers to health care.

  • If the team is made up of poor quality employees, the quality of care will lack.

  • Specialization and unionization will present a barrier to team-based care.

• Comments on facilities and equipment:

  • In Japan, many general practitioners’ offices have small surgical units with three to ten nurses on staff, with areas for administering vaccinations and nebulized
medicines. There is also laboratory equipment to enable simple blood tests to be done, such as hemoglobin and cholesterol with results delivered in 15 minutes. There is no need to make another doctor’s appointment for test results and treatment.

- The people of an Okanagan community are very happy with the health care centre and the nurse practitioner who has done a fabulous job, they work collaboratively. They have figured out where the value added was and who was doing what. They have also really reached out to the First Nations peoples.

**Ideas and Suggestions**

**Models and Services**

**Administration and Funding**

**Human Resources**

**Facilities and Equipment**

- **Ideas about models and services:**
  
  - These multi-disciplinary teams need to include community services.
  
  - Develop a holistic, prevention-focused, health care system utilizing all health care and social professionals. Resources and information should be shared among these professionals housed in a single location.

  - In a practice encompassing four or five doctors, the health authority should recruit a home-care and public health nurse to support the team. Involve them in the team and focus on the care of that patient. This would also allow the physician to do what is needed but also to be responsible for coordination with the nurse’s support.

  - Teams must cater to the needs of a changing population with higher rates of various chronic diseases and illnesses.

  - A health care team should be responsive to the patients needs. The team should be built of professionals selected for teach particular patients needs. The team would also be flexible enough to provide care that is regionally appropriate.

  - The co-operative idea could be uses a health human resource retention strategy. Absorb older health care providers such as the older physician, the older physiotherapist, or whomever wants to work fewer hours but still has an interest in practicing. They would be the mentors to the medical students, the nursing students, the physio students, who all have to go out and do their co-operatives for clinical practice.
There are a number of advantages of a co-operative model of multi-disciplinary care, especially in smaller communities. It provides one a very well organized place to take a measure of community health. It will also aide significantly in helping communities achieve social sustainability, because the co-operative has such a potent capacity for networking into both the education and social services. The co-operative as an entity in the community might as well be part of the Board of Trade, which allows you to bring in the private sector as part of the players, the cast of characters in creating community health.

Involve more than just lab technicians in dealing with patients who volunteer for clinical trials for cancer-treating pharmaceuticals.

Allow allied health providers not function independently, but connected to the whole. More than just medical doctors have the ability to diagnosis and treat patients. Re-assure faith in all other health care disciplines such as; registered nurses, nurse practitioners, physiotherapists, dieticians, occupational therapists and so on to allow them to function to their full scope of practice.

In the more urbanized areas, birthing clinics could be set up staffed by midwives and obstetricians acting together to provide care.

Promote and fund multi-disciplinary clinics that are staffed by physiotherapists and dieticians among other professions and that are triaged by a registered nurse or nurse practitioner.

A more highly developed team approach involving psychiatrists, nursing staff, social workers and family members to determine for those with mental illnesses:

a. Medication adjustments;

b. Counseling needs;

c. Potential housing after release; and,

d. Follow-up care in the targeted community of release.

Community care teams must be reorganized to work with clients in all housing types within their community. They are to provide planned care for every patient rather than working with individuals who have often been released too soon.

We need community health care teams that include all professions like care aides, assistants, nurses, counselors, doctors, chiropractors, naturopaths, massage therapists, physiotherapists, pharmacists, and nutritionists. Health dollars should go to support the integration of all modes of therapy with the patient empowered to manage his or her care for optimum health.

Encourage the team-nursing concept into hospitals. Couple registered nurses with aides or licensed practical nurses to increase support.
The future of primary care will depend not only on the family physician, but on strong collaborative relationships between specialists and other allied health professionals.

Professionals working in multi-disciplinary teams can contribute to inspiring healthy behaviors.

When the team of health care professionals is nurtured they have the strength to deliver quality care and will be reflected in public confidence. There needs to be a feedback mechanism to ensure the team continues to function.

Service should move from strictly medical doctors in solo or group practice to clinics which include dieticians, nurse practitioners, physical exercise specialists, naturopaths, chiropractors, and spiritual directors.

A registered nurse who is qualified to give psychological, nutritional and fitness advice could perhaps be engaged more in future health care teams.

Create a clinic staffed with a nurse and pharmacist to work with local physicians.

Community pharmacists should move from behind the counters, to working with physicians and patients on-location.

There is a need for collaborative and comprehensive care from a variety of health care professionals. This involves community health care teams that consist of a wide range of health care providers. These teams need to have mutual respect and appreciation for the expertise of all practitioners. Better integration and cooperation need to be part of the culture among health professionals. This can be achieved through team building, joint information sessions, and centralized professional services.

Allied health care professionals are specialized in their field of practice, yet are underutilized. A team approach would be more beneficial to patient care and compliance. Grouping patients and types of care to be delivered in a coordinated way would ensure continuity of care.

Have physicians collaborate more with pharmacists, drug companies should be able to contribute to but not conduct seminars.

Inter-disciplinary wellness care from birth to death - accessible to everyone supported by collaboration between all health care professionals.

The Kaiser Permanente Health Management Organization teams could be used as a model for multi-disciplinary care teams.

Create a multi-disciplinary team trained in the field of hospice and palliative care available by pager twenty-four hours a day, seven days a week for consult to end of life patients in their home or community facility setting. The team would
consist of a palliative physician, a registered nurse, a social worker, an occupational therapist or physiotherapist. The team would be accessed by community nursing, the general practitioner, a nurse practitioner, or physician who has been managing the care of the patient. The team would be dispatched to the patient’s setting to initiate and or titrate drugs, evaluate physical, environmental, mobility, placement needs, and making recommendation for course of action and facilitating resolution of the crisis. This team would work on a limited basis and address the crisis, not take the place of community services. This limited time intervention would be less stressful and provide more attention to the patient and caregivers than sitting in an emergency room. When admission is necessary, it could be done in a smoother fashion, and when unnecessary, it can be avoided. The team findings would be recorded with copies going to the patient’s family doctor and transferred on the patient’s person when transferred to a palliative care unit or into a new facility. If records were computerized, this information could be entered by a member of the team as evaluation takes place. Avoiding unnecessary use of emergency room and admissions would save health care dollars, decrease emergency room congestion, and free up bed availability. Calm in a crisis and facilitation solution at the end of a person’s life is the humane thing to do. Palliative care teams are greatly needed.

- The composition of primary health teams will vary by region in British Columbia. This must be researched and embraced so as to create effective delivery models based upon the needs of a specific community or region.
- Include the family and patient with in change decision, treatment, and discharge plans.
- Allow physicians to hire those with the specific skills needed to address smoking and help in cessation.
- Implement Short Term Assessment and Treatment teams (STAT).
- Success would consist of health practitioners maximizing the expertise of available health practitioners. Patients would experience fewer complications, greater choice of access points, greater percentage of health needs met, and comprehensive electronic health records.
- Share best practices in Aboriginal health programs between communities.
- When dealing with chronic disease and aging, family members must be included as essential members of these teams.
- Different chronic disease societies should collaborate with the medical community and the pharmaceutical companies to find solutions to treatments
such as Multiple Sclerosis. Streamline chronic care patients by making their need understood by everyone on staff.

- Put an emphasis on integrating some of the long established treatments like naturopathy, homeopathy, chiropractic, massage, acupuncture, reflexology, hydrotherapy, colonic therapy, traditional Chinese medicine and art therapy, with allopathic medicine. Encourage Medical Doctors to learn how to incorporate these treatments in their practice as they will always have plenty of patients. By developing integrative practices, they can treat more people rather than less and share some of the burden of difficult to treat patients.

- Policy change is necessary to support a new approach to health care, one that involves a team comprising a variety of health professionals collaborating to provide efficient, high quality, patient-centered care.

- Empirical data that proves multi-disciplinary care model to be more efficient than the current model of is needed.

- Engage the Health Authority directors in planning.

- Create demonstration projects in smaller, rural settings.

- **Ideas about administration and funding:**
  - There must be a reduction on the monopoly that Medical Doctors have on treatment decisions.
  
  - Use a multi-disciplinary primary health care model to expand access for patients beyond the emergency room. Instead of using three Medical Doctors in a nine-to-five clinic, employ one Medical Doctor for an eight hour shift, with three shifts per day.

  - Health team practitioners must be accountable for safety, confidentiality, efficiency, effectiveness, and to be as innovative as possible.

  - A team approach with team meetings and care including patients works very well.

  - Integrated teams do not meet just once a week or a month or even once a year. A well functioning team stops two, three, four times a day. They will stand up and the meeting will take two, three, four to five minutes maximum.

  - Each team should analyze the needs of those served and the skills of each member to jointly reassign work and maximize efficiency.

  - Nurse practitioners may lead these health care teams.
• One of the issues in relation to multi-disciplinary teams is liability insurance. There is a need to look at different models of liability insurance as they are provider specific. When one is working in a multi-disciplinary team, the accountability and responsibility becomes blurred. It is not always clear who has made what decision.

• Abolish contracted agencies providing home supports. Everything should be under the health authority and be part of one health care team.

• Health care teams held accountable for outcomes and paid as a unit.

• Funding of the multi-disciplinary model should be approached like a co-operative Integrated Health Network. As an incentive for sign-up, members would not be required to pay Medical Service Plan premiums. The Provincial share of those patients’ Medical Service Plan dollars would be moved into the Integrated Health Network Fund. There is double incentive to join such a network; the patient gets integrated care at little to no cost, and the Integrated Care Network receives a funding source and patients.

• Increase funding to collaborative care efforts to ensure that midwifery fits seamlessly into the range of maternity care options in each community, and that relations are clear, positive, and proactive.

• Facilitating the access of psychological services through primary care physicians would mean huge cost savings in the long term with no cost to the province.

• Move forward to ensure effective integrated team-based delivery through a capitated fee structure.

• Increase the levels of coordination of services between cross-disciplines such as mid-wifery, naturopathic, and pharmacy.

• Physicians may need to hold legal liability for those teams and the privacy laws that govern them.

• Building the team will require conflict resolution tools. People will imagine that the team is going to take the load off and then suddenly they have all these relationships to manage.

• A committee of multi-disciplinary practitioners, including practitioners from similar fields who are likely to understand the treatments, should review each of the therapies and treatments and recommend which to include under Medical Services.

• Address the liability concerns for collaborative practice.
• A team-based model should be take cues from oral health. Dentists operate under a fee-for-service structure, but harbour a much more team-based kind of environment. Canadian dentists work with a hygienist, an assistant, and sometimes a denturist. This model is possible because dentists are free to set it up. Insurers are more than willing to pay for the hygienist to clean teeth, rather than have a dentist who cleaning teeth.

• Ideas about human resources:
  • We need stability, not a constant change in teams.
  • Teams have to have time to get to know one another and should possess conflict resolution skills.
  • Provide training to organizations such as the Royal Canadian Mounted Police, social workers, and community service providers on how to compassionately handle those with mental health issues.
  • General practitioners should be encouraged to work openly with allied care providers.
  • There must a clear understanding by professionals regarding their responsibilities and their interlocking roles. The team is not handing over or giving away responsibility, it is about working together and using collective responsibility to provide patient care.
  • Create a patient care manager to access and build specific care models.
  • Doctors should be required to work closely with dieticians and nutritionists to avoid prescription mistakes.
  • Allow for more licensed practical nurses in community health service teams.
  • Increase the scope of practice for registered nurses, licensed practical nurses, registered care aides, and dental hygiene practitioners to facilitate a better team-based approach.
  • Provide support to General Practitioners to meet and discuss how to set up a primary health care team.
  • Managers and leadership must actively involve their staff in finding solutions to bridging the gaps between professions.
  • Educate the College of Physicians and surgeons on integrated care.
  • Create incentive to physicians who utilize allied health care providers.
  • Physicians must be able to volunteer into such a model of care. They must not be forced into them.
• Leadership from the Health Authorities is needed to begin the collaborative care model.

• Allow for autonomous practice within the collaborative system.

• Publicity is needed for the existing programs that are producing results.

• **Ideas about facilities and equipment:**
  
  • Physicians and other practitioners should be grouped together in clinics. The health authorities could start by setting up clinics, hiring staff and setting standards. These clinics must be public as the private systems are inefficient. Transition funds must come from the provincial government. Additionally, communication and patient flow must be administered and maintained.

  • Technology is needed to eliminate waste and to free up health care providers to provide comprehensive treatment in one facility.

  • There should be a centre in the Fraser Valley that assesses the needs of elderly patients as a whole, including gerontology, psychology, family medicine, physiotherapy and rehabilitation. These providers would be in contact with each other and agree on a resolution to the patient's problem together.

  • Collaborative, inter-professional care in group practice settings, well resourced with space and electronic medical records should provide the core of support.

  • Tools such as electronic health records can help in building interdisciplinary teams and provide better coordinated care.

  • Adequate systems and technical support are needed to make multi-disciplinary teams successful.