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Executive Summary

Strategic Context

This is the first time that the Ministry of Health has attempted to capture the significant and sometimes loosely connected initiatives and policy that make up efforts to improve primary care and home and community care, which in many respects have developed as two independent streams. Primary health care - as the foundation of Canada’s health care system - provides a critical entry point of contact to the health care system and serves as the vehicle for ensuring continuity of care across the system. Complementary with this, home and community care provides services designed to help people receive care at home, rather than in a hospital or long-term care facility, and to live as independently as possible in the community.

Primary and community care is a major component of the British Columbia (BC) health system, delivering over thirty million health care services each year to BC’s 4.5 million residents, with a total expenditure of approximately $5.4 billion. Nearly every British Columbian has contact with this part of the health care system each year.

In 2007, BC adopted a Primary Health Care Charter built collaboratively with nearly thirty stakeholder groups with the aim of creating a strong, effective, accessible and sustainable health care system for British Columbians. This policy paper aims to both focus and reenergize the commitment to achieve the 2017 vision of the Charter. It also builds on the work and learnings from the past twelve years, the work currently underway and the themes, and a fresh look at the systems current capacity against changing population and patient needs.

The goals and objectives of this policy paper align with the strategic direction for the health system in Setting Priorities for the BC Health System (Priorities 1, 2, 3, 4, 5, 7 and 8) and the areas of focus set out in the BC Health System Strategy Implementation: A Collaborative and Focused Approach published in April 2014 by the Ministry of Health.

The Case for Change

It is expected the BC population will grow at an annual rate of 1.3% per year to 5,229,463 by 2022. After which time population growth is projected to slow to just below one percent towards the end of the projection period reaching 6,057,948 persons in 2036.

The Lower Mainland, home of more than 60% of the province’s residents in 2013, is expected to see the highest population growth amongst all other areas of the province. Additionally, the Northeast region of the province will see the strongest and most consistent population growth amongst regions outside the Lower Mainland due to anticipated economic development. The population trends for the North Coast, Nechako, Kootenay and Vancouver Island are expected to remain relatively stable. The Aboriginal
population as well as the new immigrant population, especially from Asia will continue to grow at a faster pace.

The health care needs of the BC population are grouped into four areas: Staying Healthy, Getting Better, Living with Illness or Disability, and Coping with End of Life. The primary and community care system provides support to address these health care needs:

British Columbia has one of the healthiest populations in Canada. Currently, the *Staying Healthy* population segment accounts for 50% of the provincial population and accounts for nine percent of health care expenditures.

The *Getting Better* population segment accounts for only three percent of the population and six percent of expenditures. It includes those BC residents who experience minor episodic and major or significant time limited health needs due to sudden curable illnesses and/or accidents.

*Living with illness and/or disability* accounts for over 40% of the population and almost 50% of all health system expenditures. This population group requires a significant, sustained, and coordinated effort on the part of health service providers to achieve the best possible health outcomes. The Living with Illness or Disability dimension is subdivided as follows:

- Mental Health and Substance Use Needs (2% of population; 5% of expenditures);
- Low Complex Chronic Conditions (29% of population; 15% of expenditures);
- Medium Complex Chronic Conditions (9% of population; 12% of expenditures);
- High Complex Chronic Conditions (4% of population; 12% of expenditures); and
- Cancer (1% of population; 5% of expenditures).

For those with a life-limiting illness, *Coping with End of Life* focuses on comfort, quality of life, symptom management, respect for personal health care treatment decisions, support for the family, psychological and spiritual concerns. Age-related health concerns may either require residential care or substantial community based health care and support. While accounting for less than two percent of the provincial population, this group uses 35% of all services accounted for in the health system matrix ($3.7 billion):

- Frail in Community (<1% of population; 9% of expenditures);
- Frail in Residential Care (1% of population; 21% of expenditures); and
- Palliative Care – End of Life (<1% of population; 5% of expenditures).

Primary and community care services in British Columbia are delivered by a variety of health professionals in a number of different settings. These include: GP offices and health authority run primary care locations in the community; private providers; as well as aspects of hospital care and residential care. In practice, depending on the geographic location and the population base of a given area, how services are provided varies between small rural and remote communities those provided in large urban and metro areas.

The range of primary and community care services includes:
1. **Primary Care**
   1) GP Offices and Clinics
   2) Primary and Community Care Professionals
   3) Supportive Medical Specialist Services
2. Maternity Care Services
3. Developmental Disability Services
4. Mental Health and Substance Use Services
5. Cancer Care Services
6. Home and Community Care Services
7. Palliative Services

**Primary care services** are predominantly provided by approximately 3,500 GPs out of the 5,220 GPs across the province. GPs operate as autonomous medical professionals in either solo practices, or more commonly, small group, owner-operated practices. In addition, there are a range of other health professionals providing primary and community health care services including nurse practitioners, pharmacists, nurses, physiotherapists, chiropractors and massage therapists as well as a range of alternative health care providers providing naturopathy, traditional Chinese medicine and acupuncture.

There are also 37 categories of medical specialists who provide specialized diagnostic and medical care for a range of illnesses in the community, many of which are linked to chronic disease management.

**Maternity services** are provided along the continuum from family physicians providing full practice care to medical specialists, with dedicated practices only in obstetrics. However, women have various choices for their maternity care, including registered midwives. Currently the majority of births take place in hospitals, although a number of jurisdictions have alternate models and choices available to prospective parents that warrant consideration.

**Services to people with developmental disabilities** are provided by the Ministry of Social Development and Social Innovation, Community Living BC (CLBC) and the Ministry of Health. While CLBC is the service provider for people with developmental disabilities, the Ministry of Health, via regional health authorities, provides services to the population for health-related needs.

While the Ministry of Children and Family Development provides child and youth mental health and substance use services in B.C., the Ministry of Health provides **mental health and substance use services** overall responses in four population groups. Each group focuses on increasingly smaller numbers of people for whom the impacts of mental health problems and/or substance use are increasingly greater. Those services are provided to the populations in communities, at a sub-regional, regional and provincial level by the five regional and provincial health authorities, PHSA and the First Nations Health Authority.

*Mental health promotion strategies* aim to prevent mental health and substance use problems by improving knowledge of healthy lifestyles, managing stresses, life skills development at younger ages, and reducing stigma.
Targeted Prevention and Risk/Harm Reduction Strategies target those populations, who without adequate supports and early interventions may experience more significant mental health and/or substance use problems.

Therapeutic Interventions are categorized based on increasing levels of intensity:

1. People with Mild to Moderate Mental Health and/or Substance Use Problems: The mild to moderate population includes people with mild to moderate depression, anxiety, struggling with substances, but are otherwise not fully dependent.

2. People with Severe and Complex Mental Health and/or Substance Use Problems: People with mental illness and or substance use problems with high levels of severity include those individuals with:
   - psychotic disorders such as people with schizophrenia, delusional disorders;
   - bi-polar and major depression;
   - anxiety disorders;
   - personality disorders;
   - eating disorders; and
   - substance use disorders

Finally there is a range of mental health and/or substance use services to persons involved in the justice system. These include the delivery of mental health and substance use services provide to individuals incarcerated for less the two years in BC Correctional Facilities and those that are on one form of community disposition order or another, monitored by Community Corrections.

Cancer care services are coordinated by the BC Cancer Agency (BCCA). The BCCA - an agency of the Provincial Health Services Authority - is responsible for nearly all cancer programs in BC including: prevention; screening and early detection; research and education; and care and treatment (including treatment protocols), and delivers the services in partnership with general practitioners and regional health authorities. Cancer care services include:

- Case finding through screening, or symptom investigation, and diagnosis;
- Treatment via surgery, chemotherapy, radiation therapies or combinations; and
- Follow-up care and ongoing surveillance after treatment is completed.

Home and community care services provide a range of clinical and support services focused on individuals living in their own homes, or in home like settings. Services include professional care such as nursing, rehabilitation therapy and social work; services unique to the community setting such as home support and adult day programs; and a variety of health services provided in specialized accommodations such as assisted living and residential care facilities.

Home and community care services are generally designed to:

- Help individuals remain independent in their own homes for as long as possible;
- Provide short term care at home where possible to either avoid hospitalization or to minimize extended hospital stays;
• Provide alternate extended care options, like assisted living and residential care, when it is not possible to stay at home; and
• Support individuals at end of life.

Palliative care services include both home and hospice support. The BC Palliative Care Benefits Program supports home-based palliative care. It allows BC residents of any ages who have reached the end stage of a life-threatening illness and want to receive medically appropriate palliative care at home, rather than being admitted to hospital. The program gives palliative patients access to the same drug benefits they would receive in a hospital, and access to some medical supplies and equipment from their health authority. The program includes full coverage of approved medications and equipment and supplies (upon referral to, and assessment by the local health authority).

While comprehensive in scope, current primary and community care service delivery is still not optimally designed to address the needs of a number of key patient populations: an aging population with increased chronic disease and frailty and patients with moderate to severe mental illnesses. The fragmentation of the current primary and community care system for these populations continues to be neither ideal for patient care nor cost effective:

• There are gaps in effective care planning and coordination as services are provided through multiple health professionals operating independently of each other who are challenged to provide needed care.
• Current service configurations of primary and community care services are often unable to proactively respond to the changing needs of individual patients contributing to the need for hospitalizations
• Initiatives to reduce the length of time patients remain in hospital have resulted in community clinicians addressing higher post hospitalization patient volumes, with a growing complexity of needs.

For the past twelve years, British Columbia’s Health Care System has been engaged in collaboration to look for ways to improve primary and community care at a community level. Numerous practice and service delivery innovations and initiatives have been introduced at all levels - practice, health authorities, and provincial level - with the intent of meeting the expanding demand for services due to the population demographics. This policy paper highlights the most prominent practice and service delivery innovations and initiatives designed to improve the quality and accessibility of community based services and to minimize the costs associated with providing care.

In addition, time, resources and money have been committed to looking for emerging best practices to address individual patient and population demands, both in the present and for the future. BC’s experience and potential learnings are very consistent with those of other jurisdictions and the growing evidence on the ‘what’ but also the ‘how’ of successfully transforming primary and community care to meet the demands of a changing population while ensuring cost effective services are provided. The international best practices discussed in this policy paper point to the need for effective provision of coordinated primary, community and social care services close to home underpinned by the use of
comprehensive geriatric assessment at the right time. While acknowledging the challenge of change, it is clear that incremental, marginal change is no longer sufficient – change is needed at scale and pace.

The Next Steps - Focusing and Re-energizing the Commitment to Realize Patient Centred Integrated Primary and Community Care

The recommendations put forward in this paper push the boundaries of what we have been doing so far and emphasize a need for timely, short and longer term action. I want to emphasize that we are putting forward a range of proposed actions that we think will improve our health services in a number of important areas and better position our health system to meet increasing demand from key patient populations. The actions proposed would be undertaken opportunistically building on initiatives and innovative service delivery already underway across B.C., but also will require a systematic approach to change that builds a truly patient-centred system of care (The British Columbia Patient-Centered Care Framework – hyperlink).

You may have different views on the proposed action, how to improve the system or how to implement these recommendations and that is precisely what we are testing out by posting these papers. Your feedback will be part of a healthy and thoughtful discussion of these recommendations. Over the coming three months my aim is for us to achieve a good level of consensus across key partner and stakeholder groups of what the final set of specific actions should be; and then, for us to move forward collaboratively to figure out the detail, the how and the timing of implementation linked to better meeting current and emerging needs in a timely way. Patients as Partners will be an important part of this process.

I want to assure you the implementation of the final set of recommendations will allow enough flexibility for a diversity of implementation approaches across communities but that I also intend to push us to create a truly integrated system of health care that works for patients and not just for us. Your input, creativity and innovation in shaping and implementing the final set of recommendations at the local, organizational and provincial levels will bring new solutions and enrich our B.C. health system.

The proposed directions set out below align with the strategic direction for the health system in Setting Priorities for the BC Health System and the areas of focus set out in the April 2014, the Ministry of Health published BC Health System Strategy Implementation: A Collaborative and Focused Approach.

Going forward, there are a set of principles that will be used to drive decision making related to restructuring and shaping primary and community care:

1. **Patient-Centred:** Recognizing the need for health care to consider the whole person and not simply the presenting health issue, primary and community health services will be centered on the health needs of individuals, their families and communities; the objective will be to provide high-quality care, improve the overall patient experience, and improve patient outcomes.
2. **Integrated and Comprehensive**: Ensuring integrated and comprehensive patient-centred health care including health promotion and disease prevention drives all policy and system redesign. Primary and community services will be integrated around the patients and clients. Where services cannot be provided in the community, simple and clear pathways will be established to ease navigation and access to sub-regional, regional and provincially offered services.

3. **Quality and Value for Money**: Primary and community care will be built on the domains of quality (i.e., effectiveness, acceptability, appropriateness, accessibility, and safety), a desire to provide care outside of facility-based settings, achieving value for money and budget sustainability. There will be a focus on strengthening quality assurance (covering not only services but also health human resources, IM/IT, budget, and management) and routine reporting.

4. **Responsible Operational and Capital Investment**: Existing expenditures will be protected, appropriate reallocations from the acute to the community services sector must become part of go forward health authority planning and going forward a majority of net new funding must be assigned to developing primary and community services. Available primary and community care operational and capital funding will be used to improve community-based services in a manner that is reflective of the changing population health care needs and the principles of community based services, integration, quality and value for money.

These policy directions build on the work and learnings from the past twelve years, the work currently underway and the themes and findings of the systems current capacity against identified population and patient needs. These recommendations will be subject to consultation and refinement over winter but it is intended that the final recommendations will be implemented as part of a multi-year primary and community care transformational plan, starting April 2015.

The Leadership Council is currently working on developing a renewed governance structure, which will see the Leadership Council and its Standing Committees play a key role in the implementation policy directions, including the primary and community care action items.

**Reduce Complexity – the Need for a Coherent Policy Framework**

A key overall objective will be to reduce the complexity and fragmentation of the current service delivery system in a way that is both understandable and practical for patients and their families, providers and organizational stakeholders:

- **The Ministry of Health in collaboration with Health Authorities and the Doctors of BC, other relevant provincial Primary and Community Care stakeholder groups will undertake an immediate review of the numerous action plans, strategic initiatives and incentives set out above to reduce the complexity of service delivery policy and go-forward actions and initiatives.**

Currently there is a range of duplication, overlap and sheer volume. The Ministry of Health will collaboratively conduct a review of the major primary and community care policy, initiatives and incentives reviewed in this paper late spring of 2015 to ensure they are aligned with the
common set of principles set out above and streamlined into a coherent go forward policy framework. A single oversight and shared governance model will be developed for primary and community care that includes representation from key players involved in primary and community care. There will be a two day forum in late spring to discuss the outcome of the review and feedback on the proposed directions set out below.

In addition, the following specific policy directions are also proposed aimed at the practice, organizational, and provincial levels.

1. **Practice Level - Service Delivery**

These practice recommendations will be refined and adapted to the different contexts of metro, urban, rural, and remote areas (see the *Rural Health Services in BC* policy paper).

1.1 **Clarify The Role Of Walk In Clinics:**

Walk in clinics can provide a convenient health service to address minor episodic health needs of the staying healthy population but are inadequate to meet the need for continuity of care for major or significant time limited health needs and unsuitable for patients living with illness and chronic conditions or providing care towards end of life. The Ministry of Health will look at policy and regulatory options to appropriately frame the role of walk in clinics going forward and then ask the Medical Services Commission to complete a review of compensation levels and the fee for service requirements for this level of health service. This work will be completed by the end of 2015/16.

The Leadership Council will also look at policy and regulatory options to provide urgent care in Urgent Care Centres. The Urgent Care Centres will treat injuries or illnesses requiring immediate care (e.g., sprain, minor burn, stitches) but not life threatening or serious enough to require an emergency room visit. They will be open 24 hours a day, seven days a week, and 365 days a year. They could also provide diagnostic testing such as lab tests and x-rays. The Centres will be linked to hospital Emergency Departments by location or ambulance for rapid response to emergent higher level medical needs.

1.2 **Support the continued development of full-service family practices that support patients across their life spans but incrementally plan for and support the establishment of team-based family practices as full service sole practitioners retire.**

Working with Divisions of Family Practice, the Leadership Council will identify, provide information and list all full-service family practices (sole and group) by community (Local Health Area) in 2015/16. The Ministry of Health will continue to collaborate with the Doctors of BC and the standing GP Services Committee (GPSC) to support the development of full service family practice either solo practices, or more commonly, small group, owner-operated practices) but incrementally facilitate the replacement of solo or co-located practices with fully realized team-based family practices. A coherent policy framework for team-based family practice teams (that will include other primary health care providers) will be developed in collaboration with the GPSC with the objective that individuals/families will be incrementally attached to the team practice rather than an individual practitioner while supporting the practice of most responsible family physician for continuity of care to patients and their families. This
work will be used to better plan and support the development of full service family practices based on population and patient needs rather than simply relying on individual or groups of physicians randomly establishing practices.

As this initiative moves forward, team-based family practices will engage patients in service design, delivery, and evaluation.

It is critical, in line with what was an innovative approach to aligning compensation to providing guideline-based patient care, that there is continuous and vigorous evaluation of the effectiveness of full service family practice payments linked to evidence of improved patient-centred care and outcomes. There is the opportunity to continue to expand this approach away from traditional MSP fee setting as well as take steps to realize increased options for compensation models that include salaried, contractual, and population need-based approaches.

1.3 Assess and review Patient Attachment (the GP for Me) initiative
The initiative has highlighted how complex patient attachment is given population trends, migration and immigration movements, the supply of physicians within the province, and the changing needs of the sub-populations of patients. By June 30, 2015, the Ministry of Health working with the GPSC will complete an assessment of current progress and likely outcomes for the initiative’s targeted end date of 2015/16. In partnership with the Doctors of BC, the GPSC, Divisions of Family Practice, and the Ministry of Health will explore options to expand the definition of patient attachment in line with the approach set out above, while still adhering to the principle of primary, longitudinal care. This will include analyzing the level/type of attachment required by each sub-population and especially priority populations. It will also address the need for patient transition from one form of attachment to another, based on presenting health care needs.

1.4 Assess and review In-Patient Care
The Leadership Council, in consultation with the Ministry of Health, and the Doctors of BC will take a fresh look in metro and urban areas as to the practicality of physicians working in hospitals especially under the individual practice model that continues to dominate practice. The more integrated community-hospital practice approach of rural physicians provides a potential model, with modification for metro and urban communities, built around integrated clinics providing care into hospitals versus the current hospitalist model. This will also require a broader rethink and debate about the accountabilities of specialists for their patients and the potential expanded role of registered nurses (RNs) and Nurse Practitioners in caring for and discharging patients. This work will be completed by late fall 2015 with action undertaken starting in April 2016.

1.5 Assess and review Maternity Care
The PHSA/Women’s Hospital in consultation with obstetricians, gynaecologists, and midwives will review and make recommendations on the pros and cons of establishing birthing centres in BC as an option for women outside of hospital maternity units. The review and recommendations will be brought forward by late fall 2015.
1.6 Systematically and opportunistically establish Linked Community and Residential Care Service Practices for Older Adults with Moderate to Complex Chronic Conditions.

An emerging idea to better meet the needs of older adults with moderate to complex chronic conditions, linked to increasing frailty as they age into their seventies, eighties and nineties, is to provide continuity and flexibility of care linked to rapid mobilization of services through specialized community-based practices (see for example the idea of Multispecialty Community Providers envisaged in the NHS Five Year Forward View, October 2014). These are practical in urban and metro areas but might be adaptable to some rural areas.

In 2015, the Leadership Council, in collaboration with the Ministry of Health, health authorities and the Doctors of BC, other relevant provincial primary and community care stakeholder groups will develop a policy and budget framework to support the development of these practices across urban and metro centres of BC based on population and patient analysis and a five year roll out plan. What does this type of practice model look like?

First, a range of multidisciplinary practices will be developed across communities with the capacity to address longitudinal health care needs of older adults with chronic medical conditions, potentially requiring home support, cancer care, and/or palliative care; they will have the ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services.

This will require both flexibility and innovation in collaboration with patients, providers and local communities to design and structure these services. More than just a clinic, the vision would be to provide a community with 24/7 care (meeting the health, physical, emotional, social and spiritual needs of those served through compassionate care and creating a community of mutual support and care provided by the patients and their families). The practices will build around effective case finding; referral, intake and assessment processes; effective and proactive care planning and care coordination; and effective rapid mobilization of services. Where ever safe to do so, services will focus on the home including the provision of some services currently focused in hospital (the “virtual hospital service” provided by family physicians and/or nurses being currently developed in jurisdictions such as the UK NHS).

Critical to this approach is the combining of the right values, skill mix and numbers of health providers to meet the primary health care and social needs set out above on a 24/7 basis including Family Physicians, Nurse Practitioners, Medical Specialists, Gerontologists, Community Care Nurses, Community Paramedics, Pharmacists, Allied Health staff, Home Health Support staff, Social Workers. In practical terms, this has a number of implications: (1) a strong commitment from team members to the provision of compassionate care; (2) the need of team members committed to generalist health care provision while using their unique skills sets and expertise; that (3) have linkages to increased expertise at regional or provincial service centres; including access to (4) home and community care and (5) efficient patient-centred pathways to medical and surgical services; including (6) emergency services.
Physicians and health service providers and/or health authorities in collaboration with like-minded community family physicians would develop a number of these practices across communities based on an assessment of population need. The practices would be built both through marketing the services to older adults and their families and by referral from family practices and/or hospitals. Key features of the model include co-location (preferably in a recognizable branded location); coherent geography; and organizational leaders that promote collaboration and communication between staff. Models that provide these teams with the mandate and funding for providing broader range social services are also promising directions for this population.

Second, these practices will be linked to residential care services that include bed capacity designated for short term acute medical care needs including short-term stays for respite, end-stage palliative care or more short stay interventions than can be provided through home physician and nursing care. These beds would also provide step-down capacity for older patients who have been hospitalized in one of the level four or five acute hospitals. Referrals to these facilities will come primarily from the group of affiliated multidisciplinary practices. This will provide continuity of care, allow proactive care management and rapid mobilization in emergencies, and bypass the often-damaging process of going through a traditional Emergency Department. These beds will be supported by both the multidisciplinary practices and dedicated site-based nursing staff and allied health staff (OTs, physiotherapists, podiatrists, dieticians) with appropriate access to specialist consultations and services in both planned and emergent situations. These services must be connected to the clinics and affiliated with local hospital(s) site(s).

Third, these practices will be linked to assisted living and residential care services to provide proactive care planning, transitions, and continuity of care.

Where appropriate in rural and remote areas, visiting health professionals will augment the local full service family practice team and/or virtual Telehealth services will be provided, with consultations for both patients and providers using shared-care principles. Emerging technologies will be used as tools to promote and enhance the patient care in the context of the principles of patient/physician attachment and longitudinal care.

Additionally, where appropriate, these teams will be built in partnership with the First Nations Health Authority and incorporate traditional and holistic models of wellness in primary, maternity, mental health and substance use services.

The capacity provided through this initiative is linked to a clear objective to significantly reduce demand on level four and five hospital inpatient medical beds over the coming years. This approach will include protocols to admit being developed in collaboration with hospitals ensuring hospitals operate a ‘choose to admit’ policy so that only those frail older people who have evidence of underlying life-threatening illness or need for surgery are admitted as an emergency to an acute bed.
1.7 Systematically and opportunistically establish Community and Residential Care Services Practices for Patients with Moderate to Severe Mental Illnesses and/or Substance Use Issues

Similar to the above, a model to meet the needs of patients with moderate to severe mental illness and/or substance use will be explored to create a more coherent and comprehensive set of services building from the current frameworks but built as a community-based system of care in contrast to the current fragmented service continuum including health promotion and illness prevention activities. These are practical in urban and metro areas but might be adaptable to some rural areas.

In 2015, the Leadership Council, in collaboration with the Ministry of Health, health authorities and mental health and substance health providers will develop a policy and budget framework to support the development of these practices across urban and metro centres of BC based on population and patient analysis and a five year roll out plan. What does this type of practice model look like?

First, a range of multidisciplinary practices across communities with the capacity to address the longitudinal health care needs of patients, including children and adolescents, with moderate to severe mental illnesses and/or substance use issues. These practices would also provide outreach services for those requiring home support or street services; and the ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services. A specific practice would continue to be the provision of an eating disorder program with a broader provincial focus coordinated through the PHSA.

As above this will require both flexibility and innovation in collaboration with patients, providers and local communities to design and structure these services. More than just a clinic, the vision would be to provide a community of 24/7 care meeting the health, physical, emotional, social and spiritual needs of those served through compassionate care and creating a community of mutual support and care provided by the patients and their families. The practices will be built around effective referral, intake and assessment processes; effective and proactive care planning and care coordination; effective rapid mobilization of services. Where ever safe to do so, services will focus on the home.

Critical to this approach is the combining of the right values, skill mix and numbers of health providers to meet the primary health care and social needs set out above on a 24/7 basis including Family Physicians, Nurse Practitioners, Mental Health and Substance Use professionals and Psychiatrists, Community Care and Psychiatric Nurses, Allied Health staff, Home Health Support staff, Social Workers and Community Paramedics. In practical terms, this has a number of implications: (1) a strong commitment from team members to the provision of compassionate care; (2) the need of team members committed to generalist health care provision while using their unique skills sets and expertise; that (3) have linkages to increased expertise at regional or provincial service centres; including access to (4) home and community care and (5) efficient patient-centred pathways to higher level medical and surgical services that work for this patient population; including (6) emergency services.

Physicians and health service providers and/or health authorities in collaboration with like-minded community family physicians would develop a number of these practices across communities based
on an assessment of population need. The practices would be built both through marketing the services to the community, families and by referral from family practices and/or hospitals. Physicians and health service providers will facilitate their patients’ journey through the healthcare system and for the appropriate use of health and social services. To ensure access to a comprehensive range of appropriate services for the population they serve, they need to assist patients with healthcare decision-making and assist them to access other levels of the healthcare system, community resources and social services.

Second, these practices will be linked to residential/hospital mental health care and substance use services that include bed capacity designated for short term acute psychiatric care or substance use needs including short term stays for respite or more intensive work-ups than can be provided through community-based services. Referrals to these facilities will come primarily from the group of affiliated multidisciplinary practices. This will provide continuity of care, allow proactive care management and rapid mobilization in emergencies and bypass the often-damaging process of going through a traditional Emergency Department. These beds will be supported by both the multidisciplinary practices and dedicated site-based nursing staff and allied health staff with appropriate access to specialist consultations and services in both planned and emergent situations.

Third, these practices will be linked to assisted living, residential care, and psychiatric hospital services to provide proactive care planning, transitions, and continuity of care.

Where appropriate in rural and remote areas, visiting health professionals will augment the local full service family practice team and/or virtual Telehealth services will be provided, with consultations for both patients and providers using shared care principles. Emerging technologies will be used as tools to promote and enhance the patient care in the context of the principles of patient/physician attachment and longitudinal care.

Additionally, where appropriate, these teams will be built in partnership with the First Nations Health Authority and incorporate traditional and holistic models of wellness in primary, maternity and mental health services.

The capacity provided through this initiative is linked to a clear objective to significantly reduce demand on level four and five hospital inpatient medical beds\(^1\) over the coming twenty years. This approach will include protocols to admit being developed in collaboration with hospitals.

1.8 Support full service practice teams with appropriate medical specialist shared care and consultations and redesigned approaches to consultant services for older people, those with chronic conditions and patients with moderate to severe mental illnesses.

In the model outlined above, the role of specialists in chronic conditions becomes to provide direct support, education, clinical governance and specialist consultation to primary and community care teams via joint consultations and case review meetings (focused on the patients with the most complex

\(^1\) A Level 4 Hospital is a hospital with limited specialty services. A Level 5 hospital is a Regional Hospital with more specialty and complex services available. See the Rural Health In BC Policy Paper.
needs) or full team membership of the specialized population focused practices. In 2015, the Leadership Council, in collaboration with the Doctors of BC will identify and list all relevant medical specialist practices (sole and group) by community (Local Health Area) and develop policy and budget strategies to better align these services with the practices described above including facilitating full team membership.

1.9 Standardize mental health and substance use treatment and monitor and evaluate services. Beginning in 2015, the Ministry of Health will begin a dialogue with the PHSA regarding their respective roles and functions related to MHSU. The intent will be to clarify roles and functions with respect to developing standardized treatment modalities for the major presenting MHSU disorders; moving to a scalable and sustainable service delivery system; and, monitoring and evaluation of those services provided by the regional health authorities.

2. Organizational Level – Operationally Based Enabling Supports

2.1 Regional Health Authorities in collaboration with Divisions of Family Practice will create the enabling organizational structures and processes in support of the practice directions set out above. Starting 2015, Regional Health Authorities in collaboration with Divisions of Family Practice, and supported by the Ministry of Health and Doctors of B.C (including strategic leadership from the GPSC supported by the specialist and shared care committees, and from other stakeholders organizations, e.g., ARNBC) will implement an integrated, inter-professional primary and community care model of service delivery in each of their respective communities, based on the population demographics in support of the practice directions set out above. Key to this approach is to reduce the complexity of service delivery in a way that is understandable and practical for patients and their families. These models and specific action will be fully articulated in plans and communication materials for 2015/16 – 2017/18. Report on progress will be required and substantive action taken in the first two years to embed this approach.

2.2 Increase Practice Support Change Management
In 2015, Regional Health Authorities, in collaboration with other service partners, will establish regionally designated Practice Support leadership team(s) to enable the implementation of integrated, multidisciplinary/inter-professional primary and community care models of service delivery across their rural and remote communities. Leadership teams will work with local communities to establish partnership committees and then support the practice design and implementation phases of the work. This leadership team will also play a critical role in supporting the assignment and/or recruitment of health professionals to the inter-professional team as required.

2.3 Increase Appropriate Access to Specialist Consultation and Support
In 2016, building on the directions arising from the medical specialist shared care and consultations and redesign work set out above, Regional Health Authorities will establish a formal regional, and where appropriate, provincial network of specialized teams (the Provincial Health Services Authority can play a valuable role in supporting this) available by telephone, telepresence and/or visits with rapid access capacity to support primary and community care practices across rural and remote communities.
additional key area is the support for cancer care patients provided through the BC Cancer Agency needs to be effectively linked into this approach. These services will be provided as a supplement/augmentation to community based, integrated, co-located primary and community care teams providing longitudinal care.

2.4 Implement the Refreshed Dementia Action Plan

Over the next 3 years, implement the Refreshed Dementia Action Plan including the four priorities with their concrete actions: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care facilities and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care. Key priority actions include a strategy to keep people who are prone to wandering safe and to facilitate their safe return; and, focus in all care settings – from acute hospital admission to palliative and end of life care – on the specific needs of people with dementia and their caregivers with the development of a care pathway to ensure the needs of people with dementia are being respectfully met.

2.5 Palliative and End-of-Life Care

Continue the implementation the End-of-Life Care Action Plan and its key actions to improve the way health care providers meet the needs of people coping with end of life, including their families and caregivers.

The adoption of a palliative approach to care across the health care continuum needs to be supported throughout, and the palliative approach to care needs to begin at diagnosis of a life-limiting illness. Therefore, further pursue the population needs assessment currently underway to support the development of models of care and targets for hospices spaces and services based on demographics. Also, develop policy to support a standardized approach to hospice palliative care across the health care system to ensure the needs for palliative and end of life care are being addressed.

The Ministry of Health will work with partner organizations such as the BC Centre for Palliative Care, iPANEL and the BC Hospice Palliative Care Association on advancing the palliative approach to care and fostering collaborative transitions in care across the system.

3. Provincial Level – System Based Enabling Support

3.1 Governance and Strategic Leadership Review

In early 2015, the Leadership Council will oversee the conduct of a review of the appropriate governance and strategic structure for primary and community care at the regional/community level to ensure that an organizational body has both the accountability and the authority to drive and support change. This is designed to ensure that effective governance, administration, and managerial structures at the local/regional/provincial level are in place to improve system integration and to support the adoption of best practices.

The Ministry of Health will engage with Patients as Partners to ensure the voices of patients, families and caregivers are heard and appropriate mechanisms are put in place to ensure they participate in the design and planning of health services.
The GP Services Committee might evolve into a multidisciplinary primary and community care committee to take a strategic leadership role at a provincial level in moving the primary and community care strategy. The Ministry of Health will explore with the Doctors of BC refreshing the mandate of the committee and expanding its membership to include representatives of community health services. Activities will include:

A review of the Terms of Reference of the Physician Services Committee, General Practitioner Services Committee, Specialist Services Committee, Shared Care Committee and the Joint Standing Committee on Rural Issues to reduce duplication and/or streamline and focus activities aligned to the directions set out in this section.

A review of the operational obligations of the GPSC with respect to managing payments with a view to simplify and better support this activity.

In collaboration with the Doctors of BC and the Joint Clinical Committees, conduct a review of the existing work underway by the various Joint Clinical Committees with a view to aligning system-wide improvement and quality activities across all of the committees. This would include, but not be limited to, an evaluation of the incentive billings established by GPSC and the various strategic and operational quality improvement activities presently identified by each committee.

Strengthening and integrating Primary Care, Home Support and Residential Care services based on best evidence and practice will be a key focus in shaping services for priority populations. This will be undertaken in collaboration with experts and academics.

3.2 **Significantly Strengthen Human Resources Planning and Management for the Primary and Community Care Sector**

Working collaboratively with HEABC, health authorities, professional associations and unions, regulators, educators over 2015/16 a detailed primary and community care human resource policy and data set will be developed that aligns with and supports the direction set out in this section.

The policy paper and its enabling actions will identify priority improvements in a number of key functional areas:

- Workforce optimization and team development actions
- Recruitment and retention actions
- Changes to education, training and professional development to support quality improvement
- Utilization of compensation and practice incentive strategies
- Changes to professional regulation and oversight
- Ensuring integrated forecasting and planning and associated policies, to better address issues of supply, mix and distribution of primary and community health care professionals throughout the province.
3.3 Improve Data and Analytics to Support the Strategic Direction
The Ministry of Health in 2015 will complete work on developing a standardized data set to be used across primary and community care services (e.g., physician services, mental health and substance use, complex/chronic conditions and home and community care, drug prescribing and usage). Data fields and standards will be set at a practice/case management level so as to ensure accurate and timely business intelligence for understanding service demand trends and making resource allocation decisions.

3.4 Strengthen Information Technology
Starting in 2015, a range of specific actions will be incrementally taken through the Leadership Council’s Standing Committee on Information Management and Technology (IM/IT) in collaboration with the relevant physician and health provider associations and unions to support continued and improved use of IM/IT in primary and community care services across the province including supporting electronic medical record (EMR) utilization, Telehealth, the deployment of home health monitoring technologies and virtual office visits as service delivery policy is developed.

3.5 Complete Telemedicine Review
The Ministry of Health will develop telemedicine policy recommendations to ensure that emerging telehealth technologies are leveraged to support current strategies and objectives and deliver benefits to key populations.

Policy recommendations will include ensuring that telemedicine visits are aligned with longitudinal primary care. Telemedicine is safest and most effective for patients where a known treating relationship exists. As such, policies should align telemedicine visits as part of the suite of tools available to full service family practices (such as telephone visits). With longitudinal knowledge of the patient, practitioners are in a better position to determine the most effective and efficient means of providing a visit.

3.6 Complete Legislative, Regulatory, and Policy Review
In 2015, the Ministry of Health will conduct a review of the relevant statutes, regulations, policies, standards and guidelines to ensure they are positioned to support primary and community care transformation and bring forward any recommendations for change by late September 2015. Primary and community care is subject to multiple acts, regulations, policies, standards and guidelines. While developed to address specific issues, it is important to understand if they are aligned to support system change.

3.7 Mental Health and Substance Use Regulatory and Policy Review
The Ministry of Health will review its policy and regulatory options to create a more coherent provincial system of mental health and substance use services including health promotion and illness prevention to ensure the services are well-coordinated and integrated into a broader provincial system of health care. There is also a need to ensure mental health and substance use services have a common overall direction and practice framework supported by a technological infrastructure which assists with understanding the service demands and quality assurance measures across the province.
3.8  Improve Accountability and Implementation
The Ministry of Health, through the Health Service Policy and Quality Assurance Division, will establish primary and community care public reporting, monitoring and impact/outcome assessment mechanisms for deployment by the end of 2015.
Introduction

Primary and community care is a major component of the British Columbia (BC) health system, delivering over thirty million health care services each year to BC’s 4.5 million residents, with total expenditure of approximately $5.4 billion. Nearly every British Columbian has contact with this part of the health care system each year.

Primary health care - as the foundation of Canada’s health care system - provides a critical entry point of contact to the health care system and serves as the vehicle for ensuring continuity of care across the system. In practice, definitions of primary care differ in important ways depending on the jurisdiction, organization, and health care providers. The term primary care is also evolving in many jurisdictions to include additional elements.

The primary care term used in this paper is inclusive and designed to cover the spectrum of first-contact healthcare models from those whose focus is comprehensive, patient-centred care, sustained over time, to those that also incorporate health promotion and disease prevention. It also refers to inter-sectoral collaboration of the health sector with other parts or levels of government and with community groups.

In this context, primary care involves health professionals such as family physicians, nurses, nurse practitioners, specialists, pharmacists, dietitians, physiotherapists and social workers. It also includes telephone help lines which provide around-the-clock (24/7) access to health information and health care providers. The services provided are designed to improve access and quality of care. This type of care typically involves:

- Routine care
- Care for urgent but minor or common health problems
- Mental health care
- Maternity and child care
- Liaison with home care
- Support for health promotion and disease prevention
- End-of-life care

There is also no consensus on the definition of home and community care. For the purpose of this paper, home and community care services include those designed to help people receive care at home, rather than in a hospital or long-term care facility, and to live as independently as possible in the

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2 GPSC – Identified through GPSC initiatives.
4 ibid.
community. Home and community care is delivered by regulated health care professionals (e.g., nurses), non-regulated workers, volunteers, friends and family caregivers.  

In BC over ten years ago, a small group of Ministry of Health staff and physician leaders from what is now the Doctors of BC and the Society of General Practitioners undertook action to revitalize primary care in the face of an increasingly demoralized primary care physicians sector and changing population health needs. Like many jurisdictions, the BC health system was facing significant increasing demands to meet the needs of the population linked to an aging population with an increased prevalence of chronic diseases, disability and/or frailty. Their objective was to make primary and community care the centre of the health system and not a pre- or post- adjunct to the hospital system. Their efforts resulted in BC establishing a Primary Health Care Charter built collaboratively with nearly thirty stakeholder groups with the aim of creating a strong, effective, accessible and sustainable health care system starting with action in 2007/08. Indicators and milestones were to be established to effectively track progress. The transformation strategy was to be built around patients as partners with an emphasis on priority populations and focused on clinical transformation; practice and system transformation; and information and technology transformation. Looking forward to 2017 the Charter set out a range of long term goals:

- **Access to Primary Health Care** – ensure that all British Columbians have timely, local access to a primary health care provider or network to meet their health needs.
- **Access to Primary Maternity Care** – all British Columbians requiring maternity care will have timely, local access to a primary maternity provider or network.
- **Chronic Disease Prevention** – all British Columbians will have access to evidence-based clinical prevention in primary health care where there is sufficient evidence of effectiveness.
- **Chronic Disease Management** – that the majority of British Columbians who have a single chronic disease will receive guideline-directed care that minimizes or delays disease progression and development of complications.
- **Management of Co-Morbidities** – that all British Columbians who have multiple co-morbidities will have thoughtfully-crafted care plans created by an integrated proactive team with their input. The plan will mitigate against the combined impact of the co-morbidities and reduce unintended consequences, such as poly-pharmacy or communication delays during transitions that might result from uncoordinated care.
- **Frail Elderly** – that all British Columbians who are seniors-at-risk or frail will have thoughtfully crafted care plans, created by an integrated proactive team with patients’ and their caregivers’ input.
- **End-of-Life Care** – that all British Columbians when facing end-of-life will receive competent, compassionate and respectful care. Primary health care providers will work closely with other stakeholders to support death with dignity and comfort in the setting that best meets the needs of patients and family care givers.

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In response, over the past decade, BC has made a number of investments in primary care at the practice, regional and provincial levels of the health system. These investments helped improve the quality of services delivered to the public, improved provider morale, and contributed to varying levels of cost avoidance. The associated initiatives have allowed the BC health system to experiment in how to better meet the changing health care needs of the population.

Notwithstanding however, both significant effort and successes we are still short of achieving the 2017 vision. Home and community care has itself gone through significant changes in trying to meet the more complex needs of clients with the demand for services being gradually skewed away from earlier intervention to working with more clients’ post-hospital stay.

In sum, current service delivery approaches are still not optimally designed to address the needs of an aging population with increased chronic disease and frailty, which require increased time, planning and coordination of care across multiple health care providers:

- There are gaps in effective care planning and coordination as services are provided through multiple health professionals operating independently of each other who are challenged to provide needed care.
- Current service configurations of primary and community care services are often unable to proactively respond to the changing needs of individual patients contributing to the need for hospitalizations
- Initiatives to reduce the length of time patients remain in hospital have resulted in community clinicians addressing higher post hospitalization patient volumes, with a growing complexity of needs.

The fragmentation of the current primary and community care system continues to be neither ideal for patient care nor cost effective.

This policy paper aims to both focus and reenergize the commitment to achieve the 2017 vision. This paper expands on the focus of the earlier charter by emphasizing the need for an integrated primary and community system of health services. It includes cancer services as a primary and community care service and highlights mental illness as a significant chronic illness urgently requiring an integrated primary and community system of health services. It also firmly acknowledges and builds from the work of the past several years which provides an important infrastructure built on collaboration and experimentation as the starting point for a refreshed and sustained effort to realize a province wide system of primary and community care that will best meet challenges of the coming ten years.

This is the first time that the Ministry of Health has attempted to capture the significant and sometimes loosely connected initiatives that make up efforts to improve this sector that in many respects has developed as two independent streams of primary care and as home and community care. The importance of this sector to the future of health care, as well as its size and complexity, is a wakeup call to those who are focused on the acute hospital system. The range and complexity of initiatives
underway, the duplication and layering of initiatives, is also a wake-up call of the need to simplify and reduce the complexity of actions underway through more effective oversight, governance and discipline in shaping and then executing change management.

Various reviews have identified an emerging consensus that quality of health care can be improved by moving from a system focused mainly on acute hospital care to a proactive system of primary and community care built to address changing patient needs earlier and more effectively, especially the growing number of those with chronic conditions and the needs of an aging population.

This paper starts with an overview of the current BC provincial health system as a backdrop to understanding practice and system transformation of the primary and community care sector. It then sets out an updated analysis of the expected population and anticipated health care needs for the next 10 to 15 years. The paper summarizes current service delivery capacity and reviews the various initiatives undertaken within BC’s health system to attempt to improve care, before setting out a number of strategic policy and operational recommendations on how to move forward that will be the focus of a fulsome consultation over winter and refreshed action for 2015/16 – 2016/17.
Strategic Context

Understanding the Health System

In June 2014, the Ministry of Health introduced a framework (see Figure 1. Health System Performance Management Framework below) for the BC health system to drive a more structured and convergent discussion on health system delivery and performance. The premise being, that while the system is large and complex, there is an underlying structure and logic to service delivery and performance.

The framework proposes three contextual axes that must be continuously balanced and reconciled for the delivery of health services in BC: (1) ensuring quality; (2) ensuring effective and efficient budget allocation and cost management; and (3) ensuring effective distribution, delivery and management of services across metro, urban, rural and remote areas.

Within these axes the fundamental logic of the health system starts with achieving meaningful health outcomes for the population and individual patients. Outcomes are focused on what actual health outcomes are achieved and the quality of the health care experience:

- Effectiveness: Care that is known to achieve intended outcomes.
- Appropriateness: Care that is provided is evidence-based and specific to individual clinical needs.
- Accessibility: Ease with which health services are reached.
- Safety: Avoiding harm resulting from care.
- Acceptability: Care that is respectful to patient and family preferences, needs and values.

Two other dimensions of quality measure the performance of the system in which health care services are delivered:

- Equity: Distribution of health care and its benefits fairly according to population need
- Efficiency: Optimal use of resources to yield maximum benefits and results

Underpinning these dimensions of quality is a commitment to consistently strive to provide patient-centred care. Health care is about providing care to fellow human beings. Research demonstrates that a lack of human caring results in poorer health outcomes and higher health care costs. While many health organizations assert they put patients first, there is an overwhelming consensus that the health care system in many OECD jurisdictions is built around the needs of administrators and providers.
In any true patient-centred care delivery model, the primary driver of priorities is the delivery of quality care to the patient. Improving patient-centred care is about examining all aspects of the patient's experience and ensuring that the care provided is centered around their needs and preferences.
experience and considering them from the perspective of patients versus the convenience of providers. This requires a shift in the culture of health care organizations from being disease-centred, problem-based, and provider focused to being proactive in addressing patient needs from a person-centred approach. It requires translating high-level patient-centred care concepts linked to optimally and efficiently meeting patient health care needs into actionable, attainable and sustainable practices. It will require engaging medical, nursing and allied health care professionals in patient-centred care and challenging outdated concepts of professional autonomy and silo practice, while also empowering health professionals to work with patients to individualize the experience and using data to drive change.

As the system evolves, finding new ways of delivering care that are efficient and effective, without conceding the compassion patients expect and deserve, is both a challenge and a prerequisite of an effective system.

These outcome criteria must be applied to evaluate how well the health sector is meeting population and patient health needs across four broad groupings of the population: Staying healthy, getting better, living with illness or disability, coping with end of life. These groupings are further divided these four clusters into 13 subpopulations, against which the health system is able to assess current demand and project future needs through the use of health data.

In addition, the B.C. health sector, along with other heath sector jurisdictions, has framed its efforts to improve health care around three overarching goals (developed through the Institute of Health Improvement and known as the *Triple Aim*):

1. Improving the health of populations;
2. Improving the patient experience of care (including quality and satisfaction), to which B.C. has recognized the additional requirement of improving the experience of delivering care for providers and support staff as critical to patient-centred care built on efforts of those who deliver and support health services; and
3. Reducing the per capita cost of health by focusing on quality (especially effectiveness and appropriateness) and the efficiency of health care delivery.

In B.C., we propose to achieve these goals by and opportunistically improving the health of our population through effective health promotion and disease prevention strategies, while also increasing value for patient populations by providing patient-centred, quality services (accessibility, acceptability, appropriateness and safety) that are known to achieve health outcomes that matter to patients and their families (effectiveness). This value will be achieved by efficiently and effectively using the fiscal resources provided through government from tax payers to deliver a financially sustainable health system.

Aligning the right human resource skill sets enables service delivery to best meet the needs of the population. The overall system is then supported by clinical and analytical information, health technology and work place infrastructure.
These system elements are provided through a provincial health authority and five regional health authorities (divided into health service delivery areas or HSDAs and further divided into local service delivery areas) and physician service providers. These organizational structures are underpinned by the need for effective governance and management which includes effective health authority board governance, competent executive management, aligned operational plans and line accountability and engagement structures, along with change management skills in support of delivering an effective and efficient system. Most recently a provincial First Nations Health Authority has been added to this structure through a tripartite agreement between First Nations, the Federal and Provincial Governments.

To be successful, the entire health care enterprise must be driven by a coherent set of aligned policy objectives and system wide coordinated strategy with effective monitoring, reporting and accountability processes.

This framework provides a robust tool for driving analysis and understanding of both strategy and operations of primary and community care linked to other parts of the health systems to deliver a high quality health system for its citizens. The starting point is an understanding of population and patient health care needs.
Understanding Population Health and Patient Health Care Needs

To be able to deliver quality, patient centred health care services that are cost effective and meet the demands of BC residents it is imperative to understand the present and anticipated trends within the general population and across multiple key subpopulations that place significant demands on the BC health care system. Understanding the populations will allow for better short and long term planning of health care service delivery, across the province.

BC Demographics

British Columbia’s population was estimated at 4,631,302 (50.3% women and 49.7% men) as of July 1, 2014. This is a 1.1% increase over the past year. The increase was largely due to international migration.\(^6\)

It is expected the BC population will grow at an annual rate of 1.3% per year to 5,229,463 by 2022. After which time population growth is projected to slow to just below 1% towards the end of the projection period reaching 6,057,948 persons in 2036.

A third of BC’s population is 50 years or older and approximately 25% of the population is under 25 years of age. Except for those in the age group of 20 -25, BC’s population in all other ages are expected to be larger in 2036 than today, with the very young and very old populations expected to grow the fastest.\(^7\) Within the next 15 years it is anticipated there will be fewer school age children than people over 65. By 2022, it is expected one in five British Columbians will be over 65 years old.

The Lower Mainland, home of more than 60 % of the province’s residents in 2013, is expected to see the highest population growth amongst all other areas of the province. Additionally, the Northeast region of the province will see the strongest and most consistent population growth amongst regions outside the Lower Mainland due to anticipated economic development. The population trends for the North Coast, Nechako, Kootenay and Vancouver Island are expected to remain relatively stable.

Within the overall population, there are two sub-populations that warrant special mention because of their somewhat unique health needs profile.

Aboriginal Peoples in BC: Key Demographic Trends

Based on 2011 Census data there were 232,290 Aboriginal people in BC, of which 67% were First Nations, 30% were Métis, and less than one percent was Inuk (Inuit). The rest of the Aboriginal people identified themselves as having mixed Aboriginal ancestry.\(^8\) The Aboriginal population is growing almost

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\(^6\) BC Stats (July 1, 2014). *Quarterly Population Highlights*. ISSUE #14-02.


twice as fast as the rest of the population of BC. This trend is expected to continue over the next two decades with a growth of 29% over the period 2001 – 2026.\(^9\)

Nearly 78% of the Aboriginal population lived off-reserve, regardless of age and gender. The majority lived in Vancouver (23%); however, they comprised only 2.3% of the total population of the city. The largest concentration of Aboriginal people was found in Prince Rupert (38.3% of the total population), followed by Terrace (21%) and Williams Lake (20.6%).

Of the 232,290 Aboriginal persons living in BC at the time of the 2011 Census, 52% were registered under the \textit{Indian Act} of Canada.\(^{10}\) Registered Aboriginals are more likely than the broader Aboriginal population to live on-reserve, with men and older individuals more likely to be residents. The percentage of BC’s Aboriginal population that lives on the province’s reserves has decreased over the past decade.\(^{11}\)

In BC, the Aboriginal population is generally much younger than the non-Aboriginal population. Based on 2011 Census data, the median age for the Aboriginal population in BC was 29 years of age compared to 42 years of age for the non-Aboriginal population. The same figures for Canada were 28 and 41 years of age respectively.

Nearly 45% of the Aboriginal population in BC is under 25 years of age compared to nearly 28% of non-Aboriginal population. In contrast, only 16% of the Aboriginal population is over 55 years of age compared to 30% of the non-Aboriginal population.

\textbf{Ethnic Minorities in BC: Key Demographic Trends}

In BC just over 80% of the population gain between 2006 and 2011 was due to migration. International migration accounted for most of the gain (66%), while interprovincial migration represented 15%. The rest (19%) was due to natural increase.

Over the previous 10 years BC has received on average 40,000 immigrants per year (roughly 4% are refugees). The majority of immigrants to BC came from Asian countries (70%);\(^{12}\) the top three countries in 2013 were China, India and the Philippines (see Table 1).\(^{13}\) Their destination, more often than not, is the Vancouver Census Metropolitan Area (CMA), with 85% of all immigrants settling there from 2002 to 2012. In contrast, the non-immigrant BC population is spread more evenly across the province with 53% located in the Vancouver CMA. This inflow of immigrants to the Vancouver CMA has contributed significantly to Vancouver’s growth while many other smaller communities, except for “boom towns” such as Dawson Creek and Fort St. John, are shrinking. In 2012/13 compared to 2011/12, Vancouver CMA increased by 1.4%, Dawson Creek Census Amalgamation (CA) by 1.6% and Fort St. John CA by 2.4%
whereas Penticton CA decreased by 1.2%; Prince Rupert CA decreased by 2.5% - the greatest decrease of all CMAs or CAs.

The Vancouver CMA was home to one million visible minorities, or 16.4% of all visible minorities in Canada. They accounted for 45.2% of the population in Vancouver. Within the Vancouver CMA, the municipalities of Richmond (70.4%), Greater Vancouver (62.2%), Burnaby (59.5%), Surrey (52.6%) and the city of Vancouver (51.8%) had higher proportions of visible minorities than the average for the whole Vancouver metropolitan area.\textsuperscript{14}

Fraser Health Authority has a large Asian, Indo-Canadian, Korean, and Filipino populations. The region is home to the majority of BC’s South Asian population, with South Asians comprising 15% of Fraser Health’s entire population (compared to 3% for the rest of BC). Countries of origin include: Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. The South Asian community is also growing rapidly, contributing close to half of the region’s population growth between 2001 and 2011.\textsuperscript{15}

\begin{table}
\centering
\begin{tabular}{|l|l|}
\hline
\textbf{Top 10 Reported Single Ethnic Origins for B.C. - 2011} & \textbf{\% of Single Origin} \\
\hline
Chinese & 17.5 \\
Canadian & 13.9 \\
East Indian & 10.3 \\
English & 10.2 \\
German & 4.5 \\
Filipino & 4.4 \\
Scottish & 3.7 \\
Dutch & 2.4 \\
Korean & 2.3 \\
Irish & 2.1 \\
\hline
\end{tabular}
\caption{Top 10 Reported Single Ethnic Origins for B.C. - 2011.}
\end{table}

Additionally, in 2012, BC saw roughly 50,000 temporary residents, up 141% from 20,505 in 2002. This growth rate is linked to the economy and dramatically outpaces yearly inflows of permanent residents. A portion of this growing population, those with immigration permits of six or more months become eligible for MSP once they are resident in BC for six month. It is likely that continued growth in this population will impact health care demand in certain parts of the province.


\textsuperscript{15} Fraser Health Authority (June, 2014). \textit{Fraser Health Authority Strategic and Operational Plan 2014/15 – 2016/17}.
**General Overview of BC’s Population’s Health**

BC generally has the healthiest population in Canada, experiencing among the highest life expectancy rates in the country and across the world (BC, 82 years; Canada, 81 years; World, 70 years). BC continues to see decreasing premature mortality rates. However, there are still room for significant improvement with over 550,000 British Columbians who smoke and over one million who are overweight or obese. However, the decrease in premature mortality is not consistent across the province. In particular, there is a gap between the Northern health region and other health authorities across the province. There also continues to be significant differences in health outcomes between Aboriginal and non-Aboriginal people in the province, notably in terms of health indicators such as life expectancy and mortality. These elements point to the importance of the social determinants of population health in addition to the role the health care system plays.\(^{16}\)

**Health Status Trends Among Aboriginal Peoples**

Life expectancy of Status Indians has improved over the past decade, increasing from a baseline of 73.8 years (2001–2005) to 74.7 years (2006–2010). This increase of 0.9 years was larger than the increase for other BC residents (0.5 years) in the same period.\(^{17}\) While the trend suggests life expectancy for Status Indians to increase to 75.3 years by 2015, a considerable gap is still projected between the life expectancy for Status Indians and other BC residents.

Age-standardized mortality rate (ASMR) measures the number of deaths due to all causes, expressed as a rate per 10,000 people. This measure allows for comparison in death rates between Status Indians and other BC residents by adjusting for differences in population age distribution. ASMR for Status Indians has decreased in recent years. However, the rates for other BC residents, has also decreased contributing to a continued gap between Status Indians and other BC residents. If the current trend continues, the projected ASMR in 2015 will have decreased by 3.1 down to 64.5 per 10,000.

First Nations experience higher rates of chronic disease and sustain more injuries than other British Columbians. The unique root causes for the health challenges faced by First Nations and Aboriginal peoples needs to be considered when recommending programs and services to improve health outcomes. Through a tripartite agreement between First Nations, the Federal and Provincial governments, the First Nations Health Authority was established in October 2013 to improve the health of communities by advancing the quality of health care, health promotion and disease prevention programs delivered to BC First Nations and Aboriginal people. The Ministry of Health and regional health authorities are working together with the First Nations Health Authority to ensure the Healthy Families BC Policy Framework is aligned with the First Nations Perspective of Wellness and can be adapted where necessary, to fit the unique needs of First Nations and Aboriginal people in BC.

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\(^{16}\) BC Ministry of Health (February, 2014). *Setting Priorities for the BC Health System.*

Health Status Trends Among Ethnic Populations

As noted above, British Columbia is home to a number of ethnic minority populations, which are mostly concentrated in the lower mainland area of the province. These sub-populations have been observed to develop various chronic diseases at increased rates compared to other ethnic groups.

Over the past decade, the province has seen a marked increase in immigration from South Asian countries. People from South Asia face particular health challenges, including a diabetes prevalence rate estimated to be twice as high as that of the general population, earlier onset of diabetes, higher rates of hypertension and cardiovascular disease, and a dialysis rate over one and a half times that of the general population.

Besides the increase rates of chronic diseases, there are a number of socio-demographic, cultural and religious, economic and structural barriers for ethnic minority populations to access health care services. Barriers include but are not limited to: literacy and health literacy in their own language; difficulty accessing transportation and translation; less knowledge regarding disease, risk factors and self-management; and some reluctance to change dietary habits due to custom and/or religious values.

The interventions and services required by the multi-cultural ethnic populations need to be appropriately considered in health systems planning.

Patient Health Care Needs

Overview of Patient Health Care Needs and Health Care Utilization

The Ministry of Health uses a framework that groups BC residents according to their major health care needs in any particular year. It then collates the non-identifying health data to track emerging trends in utilization at an aggregate level.

The framework divides the population into thirteen dominant health care needs segments, assigned to the four categories identified earlier: staying healthy, getting better, living with illness or disability, coping with end of life. Currently it tracks utilization in the following areas: physician billings, PharmaCare, most acute and home support services; but does not yet include salaried physicians, a portion of emergency department and hospital outpatient care, some home and community services, community mental health and substance use services, and funding for health promotion and disease prevention.

Notwithstanding, the framework incorporates approximately two-thirds of all yearly expenditures, providing a good representation of provincial health care use to inform analysis and decision making both with respect to current demand, and using multiple years of data, future need. The matrix shows service distribution utilization for each of the segments expressed as average dollars per person spent data (Table 2) or total expenditures (Table 3).

While age is an important factor affecting health care utilization, health status is more important in understanding this utilization.
Table 2: Residents of BC by Health Status Group and Use of Selected Health Care Services ($ per person)

<table>
<thead>
<tr>
<th>Residents of BC by Health Status Group and their Use of Selected Health Care Services, 2012/13</th>
<th>$ PER PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Non-User</td>
<td>681.6</td>
</tr>
<tr>
<td>Healthy / Minor Episodic Health Needs</td>
<td>1,017.5</td>
</tr>
<tr>
<td>Maternal and Healthy Newborns</td>
<td>109.6</td>
</tr>
<tr>
<td>Major or Significant time limited health needs: &lt;18 yrs</td>
<td>43.0</td>
</tr>
<tr>
<td>Major or Significant time limited health needs: Adults</td>
<td>113.8</td>
</tr>
<tr>
<td>Mental Health &amp; Substance use needs</td>
<td>71.4</td>
</tr>
<tr>
<td>Population with Cancer</td>
<td>55.2</td>
</tr>
<tr>
<td>Low Complex Chronic Conditions</td>
<td>1,389.7</td>
</tr>
<tr>
<td>Medium Complex Chronic Conditions</td>
<td>404.5</td>
</tr>
<tr>
<td>High Complex Chronic Conditions without Frail ADL supports</td>
<td>198.4</td>
</tr>
<tr>
<td>Frail Population, Living in the Community</td>
<td>16.2</td>
</tr>
<tr>
<td>Frail in Community with High Complex Chronic Conditions</td>
<td>21.9</td>
</tr>
<tr>
<td>Living in the Community with Palliative Needs</td>
<td>16.2</td>
</tr>
<tr>
<td>Frail Population, Living in Residential Care</td>
<td>37.7</td>
</tr>
<tr>
<td>All Population Segments</td>
<td>8,780.9</td>
</tr>
</tbody>
</table>

Summary from Health System Matrix 5.6, 2013/13
Table 4 shows average services used increased dramatically by population segment, with much less variation between the age groups within each population segment.

Table 4: Per Capita Use of Health Care by Population Segments and Age Groups – 2012/13

The above aggregate data identifies emerging trends in health service utilization. These trends are examined in more detail below.
Staying Healthy

Ideally as many British Columbians as possible would stay healthy throughout their lives. Currently, the staying healthy population segment accounts for 50% of the provincial population and accounts for 9% of health care expenditures in the areas of:

- Healthy Non-User (14% of population; 0% of expenditures);
- Healthy with Minor Episodic Health Needs (34% of population; 5% of expenditures); and
- Maternity and Healthy Newborns (2% of population; 4% of expenditures).

While there are many contributors to overall health, there are number of major protective and modifiable risk factors for chronic disease and some mental health and substance use disorders that negatively impact on staying healthy: unhealthy weight (overweight/obesity), physical inactivity, unhealthy eating, tobacco use and harmful alcohol use. Up to 80% of heart disease, stroke and type 2 diabetes, and over 30% of cancers, can be prevented by eliminating tobacco, unhealthy diet, physical inactivity and the harmful use of alcohol. However, these behavioural risk factors are embedded in, and often determined by, a number of socio-environmental factors (e.g., cultural, environmental, economic, etc.), which makes addressing the issue of chronic disease complex.

*Physical Activity* is an important risk mitigation factor for heart disease, stroke, hypertension, type 2 diabetes, colon cancer, breast cancer, osteoporosis, obesity, depression, anxiety and stress. It helps promote healthy weights and is critical to healthy development in children and adolescents while preserving mobility and independence in older adults. BC is known for being a leader in physical activity with a consistent reporting of the highest provincial physical activity levels. However, there are currently over 1.5 million British Columbians who are classed as physically inactive. The proportion of the population who are moderately active or active with respect to leisure-time physical activity ranges from a high of 70% in Kootenay-Boundary to a low of 53% in Richmond. Average rates are particularly low among low-income persons and immigrants. It is estimated that physical inactivity costs the British Columbia health care system $335 million a year in direct costs (hospital, physician, drug, institutional and other costs).

*Obesity and Overweight* is one of the most common, yet modifiable, risk factors that contributes to the development of chronic diseases such as heart disease, diabetes, hypertension, osteoarthritis and certain types of cancer. Overweight and obesity are major risk factors for a number of chronic diseases, including diabetes, cardiovascular diseases and cancer, and it is the second highest preventable, contributing cause of death in BC after tobacco use. Although BC enjoys the lowest rate of persons with excess weight among the provinces, this provincial average largely reflects the lower rates in the most populated areas of the province: the south western mainland and southern Vancouver Island. There is substantial variation among Health Service Delivery Areas (HSDA): from a low of 33% in Vancouver to a high of 61% in the Northeast HSDA. There is also substantial variation among population groups. For example, males have a substantially higher rate than females and higher income males have a substantially higher rate than lower income males.

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18 Canadian Community Health Survey, 2011/12.
It should be noted that the majority of patients in the staying health category will have minor episodic health concerns and live relatively healthy lives. The key focus for health service delivery to this group is to provide timely access to quality, community care to avoid unnecessary use of emergency departments and/or other hospital services.

A second important service delivery area in this grouping is maternity care, which is currently provided mainly through hospitals. Within BC, the live birth rate has been declining since 1960 but has stabilized since 2002\(^{19}\). In 2012/13, there were 43,897 babies born to British Columbian women, with the average age at delivery for the mother being 30 years and almost half of the births being to first time mothers (46.5\%)\(^{20}\).

An interesting trend within BC is the number of caesarean sections vs. natural births. As indicated below, BC report 31.3\% of deliveries were by caesarean section, ranking it highest for caesarean sections above all other provinces and Canada (see Figure 2). This is an issue that warrants further attention at the policy level. It is a key consideration in recommending assessing whether to establish birthing centres in BC as an option for women outside of hospital maternity units.

**Figure 2: Number of Deliveries by Caesarean Section by Province in Canada, 2013\(^{21}\)**

Survey data suggests that:

- Pregnant women want to be involved in their care and more specifically in making decisions about their care based upon clinical evidence and the patient’s preferences and values.\(^{22}\)
- Women want the use of mobile devices to provide access to health information and services, including the use of self-tracking and other interactive tools that enable pregnant women to receive information (education) individualized to their stage of pregnancy and personalized to their needs.
- Women want care that is collaborative, woman- and family-centered, and culturally sensitive.


\(^{20}\) ibid.

\(^{21}\) CIHI Health Indicators Report 2013.

Women who live in rural and remote areas want high-quality maternity care as close to home as possible.\(^{23}\)

Clearly, the optimal outcome for the health system is to ensure that as many British Columbians as possible reside in this group, free from major health concerns.

### Getting Better

*Getting Better* accounts for only three percent of the population and six percent of expenditures. It includes those BC residents who experience minor episodic and major or significant time limited health needs due to sudden curable illnesses and/or accidents.

The key focus for health service delivery in this group is to provide timely access to quality, major and/or significant time-limited care that includes access to diagnostics, medical and surgical services as required. While immediate attention may require facility based services, the goal is to provide high quality health care services in the community to support patients convalescing in their home environment.

Responding to individuals with mild mental health and/or substance use problems is an important subset of this population. The majority of those with mild to moderate mental health and/or substance use problems can be effectively supported or treated by intervening early through primary care services, or through other low-intensity community-based approaches services.

Responding to injuries is also an important subset of this population segment. The leading causes of hospitalization from unintentional injuries in BC in 2010 were falls and transport-related incidents. Preventing injuries means assessing the risk, addressing the causes and/or minimizing the impact through the design and implementation of protective mechanisms.

Approximately 1,200 people in British Columbia are unintentionally injured daily, of these, five die and 26 are permanently disabled as a result of preventable injuries. Injuries are the leading cause of death for British Columbians aged one to 44 years and the fifth leading cause across all age groups. Young people, aged 15 to 24 years old, experience the highest burden of unintentional, injury-related, death. These account for 85% of all childhood (<25 years) unintentional injury deaths. Injury-related hospitalization rates by age groups over the five-year period between 2006/07 and 2010/11 show a marked increase during the adolescent period and a significant increase after the age of 65. In 2004 (the last year for which data is currently available), injuries cost British Columbians $2.8 billion and 1,721 lives.

### Living With Illness or Disability

Living with illness and/or disability accounts for over 40% of the population and almost 50% of all health system expenditures, accounted for in the health system matrix ($5.4 billion). From a health service

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delivery perspective, the focus for this group is three-fold: to help manage health conditions and enhance their quality of life throughout the course of their illness; to help prevent conditions from becoming more severe or complicated by additional health issues; and, if possible, to returning patients to full health.

This population group requires a significant, sustained, and coordinated effort on the part of health service providers to achieve the best possible health outcomes. The Living with Illness or Disability dimension is subdivided as follows:

- Mental Health and Substance Use Needs (2% of population; 5% of expenditures);
- Low Complex Chronic Conditions (29% of population; 15% of expenditures);
- Medium Complex Chronic Conditions (9% of population; 12% of expenditures);
- High Complex Chronic Conditions (4% of population; 12% of expenditures); and
- Cancer (1% of population; 5% of expenditures).

Mental Health and/or Substance Use Needs

**Adult Mental Health**: This represents a high burden of disease in the population (from both its impact on quality of life and health care costs) due to the early age of onset for severe mental illness and the need for ongoing treatment through the patient’s life span. Hard data in this area is generally weak and often based on estimates of prevalence. There is also significant debate over the incremental classification of human behaviour as within the purview of ‘mentally ill’ and the inclusion of more and more categories within the Diagnostic and Statistical Manual of Mental Disorders (DSM).24

There is also the issue of degree with some mental health conditions being episodic and circumstantial, and on a scale of mild to severe in terms of their impact on daily functioning and a person’s sense of well-being. A small proportion of people experience severe and complex mental health and/or substance use problems that require more intensive service approaches.

According to available evidence, over any 12-month period, about one in five individuals in Canada will experience significant mental health and/or substance use problems leading to personal suffering and interference with life goals25. Concurrent disorders are common across diagnostic groups, yet prevalence estimations are difficult to determine. Of persons with a mental illness, approximately 20 - 25% also have a co-occurring substance use problem26.

The impact of mental health and substance use problems in BC is significant (see Table 5). Based on available evidence, an estimation of between 27 19.6 and 26.228 percent of adults in BC will experience a

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24 See for example Butcher et al. (2004). Are We All Becoming Mentally Ill? The Expanding Horizons of Mental Disorder. *Abnormal Psychology*.
27 This range is due to the fact that a proportion of individuals will have more than one, or co-occurring disorders. As concurrent disorders are common across diagnostic groups, the estimated prevalence of any mental disorders is lower than the sum of all disorders.
mental disorder each year, among whom approximately 4 – 9.8% will experience a substance use disorder. It is also important to note that many more British Columbians will experience sub-clinical or symptoms of mental illness, which when left untreated may develop into more serious disorders.

Severe mental illness makes up a large portion of the burden of disease in BC including impacts on quality of life, financial cost, and morbidity and mortality. BC and epidemiological studies indicate that approximately 130,000 adults in British Columbia meet the criteria for Severe Addiction and/or Mental Illness\textsuperscript{29}. Individuals with concurrent mental health and substance use problems in addition to significant complex social difficulties such as homelessness or involvement with the justice system make up roughly 2200 individuals in British Columbia.

**Table 5: Prevalence of Mental Disorders in Adults in BC\textsuperscript{30}**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Estimated prevalence (%)</th>
<th>Estimated BC population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Mental Disorder\textsuperscript{31}</td>
<td>19.9 - 26.2</td>
<td>776,993 - 1,022,976</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>12.2 - 15.6</td>
<td>476,348 - 609,100</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>14.8</td>
<td>577,864</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder (PTSD)</td>
<td>2.1 - 3.5</td>
<td>81,994 - 136,657</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder (OCD)</td>
<td>2.0 - 4.9</td>
<td>78,085 - 190,006</td>
</tr>
<tr>
<td>Alcohol Use Disorder</td>
<td>3.5 - 8.6</td>
<td>136,659 - 335,788</td>
</tr>
<tr>
<td>Cannabis/Other Substance Use Disorder</td>
<td>2 - 2.2</td>
<td>78,300 – 86,130</td>
</tr>
<tr>
<td>Any Substance Use Disorder (Alcohol, Cannabis or Other)</td>
<td>4 - 9.8</td>
<td>157,044– 382,416</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>4.6 - 9.6</td>
<td>179,606 - 374,831</td>
</tr>
<tr>
<td>Bipolar Disorders</td>
<td>1.4 - 1.8</td>
<td>54,663 - 70,281</td>
</tr>
<tr>
<td>Eating Disorders (based on point prevalence)</td>
<td>2.0</td>
<td>76,866</td>
</tr>
<tr>
<td>Psychotic Disorders*</td>
<td>0.34 - 0.45</td>
<td>13,275 - 17,570</td>
</tr>
<tr>
<td>Severe Complex Co-Occurring Disorders***</td>
<td>0.0006</td>
<td>2,202</td>
</tr>
</tbody>
</table>

*Schizophrenia and schizophreniform disorders only
**At least two mental disorders, substance use disorders, and court convictions and $5,000 in shelter payments.

Note: See Appendix A for detailed references for this table.

**Utilization Data & Trends**


\textsuperscript{29} The CARMHA publication “Housing and Support for Adults with severe Addiction and or mental illness in BC”, commissioned by MoH in 2008: see: http://www.sfu.ca/content/dam/sfu/carmha/resources/hsami/Housing-SAMI-BC-FINAL-FD.pdf


\textsuperscript{31} This number is smaller than the sum of prevalence of specific disorder group because one individual may have more than one disorder.
Ministry of Health data indicates that roughly 774,261 unique individuals (aged 15 and up) in British Columbia were receiving mental health services available through health authorities in 2010/2011. This number is up from the previous report of 711,869 in 2005/2006.

Table 6: Number and Rate per 10,000 Population of Unique Clients Receiving Any MH and/or SU Service by HA

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interior</td>
<td>127,146</td>
<td>142,374</td>
<td>1,867</td>
<td>1,938</td>
<td>203,286</td>
</tr>
<tr>
<td>Fraser</td>
<td>233,497</td>
<td>259,382</td>
<td>1,591</td>
<td>1,612</td>
<td>362,922</td>
</tr>
<tr>
<td>Vancouver Coastal</td>
<td>161,616</td>
<td>174,183</td>
<td>1,536</td>
<td>1,527</td>
<td>224,451</td>
</tr>
<tr>
<td>Vancouver Island</td>
<td>134,501</td>
<td>142,474</td>
<td>1,888</td>
<td>1,880</td>
<td>174,366</td>
</tr>
<tr>
<td>Northern</td>
<td>45,881</td>
<td>46,560</td>
<td>1,619</td>
<td>1,613</td>
<td>49,276</td>
</tr>
<tr>
<td>Unknown</td>
<td>9,228</td>
<td>9,288</td>
<td></td>
<td></td>
<td>9,526</td>
</tr>
<tr>
<td>BC</td>
<td>711,869</td>
<td>774,261</td>
<td>1,696</td>
<td>1,709</td>
<td>1,023,827</td>
</tr>
</tbody>
</table>

Limitations: May exclude some individuals who received services at privately run and contracted addictions treatment centres. Clients with invalid Personal Health Numbers (PHN) have been excluded. Data include persons hospitalised with an ICD-10 mental disorder.

In 2013 – 2014, the Province spent over $1.38 billion on services that directly addressed mental health and substance use. The indirect costs of mental illness and/or substance use are also significant. A recent Canadian study has suggested that mental illness costs the Canadian economy $51 billion annually in lost productivity\(^{32}\) – B.C.’s proportional share of this burden would be more than $6.6 billion each year. Indirect costs of lost productivity related to alcohol use alone are estimated at $1.1 billion\(^{33}\).

Persons with mental health and/or substance use treatment needs are significant users of hospital services, with 29% of emergency visits resulting in admission to an inpatient bed. This sub-set suffers from chronic and disabling substance use; and frequently severe psychosis, bipolar, neuro-developmental disorders, and/or cognitive impairment. Many of these individuals either do not or cannot access existing therapeutic supports. As a result, they use emergency services more than most other groups and are frequently involved with the justice system. This cohort is also at high risk for homelessness.

**Children and Youth Mental Health:** It is estimated that about one in eight children and youth in British Columbia may be experiencing mental health problems serious enough to interfere with their ability to be successful and productive in their relationships (family and peer) and in school and the community. According to available evidence, an estimated 12.6% of children and youth aged 4-17 years may be

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experiencing mental disorders at any given time, suggesting that as many as 84,000 children and youth in BC may be affected$^{34}$.

Of the estimated 84,000 children and youth experiencing mental disorders in BC, 3.8% or 25,300 are estimated to have an anxiety disorder, 2.5% or 16,600 to have attention deficit hyperactivity disorder and 2.4% or 8,400 to have a substance use disorder (including problems with alcohol – see Tables 7 and 8). Some of the other mental disorders affecting children and youth are less common, for example, depression, autism spectrum disorder, bipolar disorder, eating disorders and schizophrenia$^{35}$.

$^{34}$ Waddell et al. (2014). *Child and Youth Mental Disorders: Prevalence and Evidence-Based Interventions*. A Research Report for the British Columbia Ministry of Children and Family Development. Children's Health Policy Centre, Simon Fraser University.

$^{35}$ CYMH Select Standing Committee report Z:\HSD General\Programs\MHSU\Mental Health & Substance Use\Community Paper\Literature_Reports\Select Standing Committee on Children and Youth - Written Submission MAS.docx.
### Table 7: Estimated Prevalence of Mental Disorders in young People in BC and Canada

**Prevalence of Mental Disorders in Young People**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence (%)</th>
<th>Age (y)</th>
<th>Population Affected (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>3.8</td>
<td>4-17</td>
<td>25,300</td>
</tr>
<tr>
<td>ADHD</td>
<td>2.5</td>
<td>4-17</td>
<td>16,600</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>2.4</td>
<td>11-17</td>
<td>8,400</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>2.1</td>
<td>4-17</td>
<td>14,000</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>1.6</td>
<td>4-17</td>
<td>10,600</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>0.6</td>
<td>4-17</td>
<td>4,000</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>0.6</td>
<td>11-17</td>
<td>2,100</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>0.2</td>
<td>11-17</td>
<td>700</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0.1</td>
<td>11-17</td>
<td>300</td>
</tr>
<tr>
<td><strong>Any Disorder</strong></td>
<td><strong>12.6</strong></td>
<td><strong>4-17</strong></td>
<td><strong>83,700</strong></td>
</tr>
</tbody>
</table>

*These estimates represent the expected rather than the actual number of children and youth affected by mental disorders in BC and Canada, based on our meta-analysis of disorder prevalence in other countries.

**The prevalence estimate for schizophrenia is drawn from a previous review.

***The overall estimate for children and youth with at least one disorder is less than the sum of estimates for specific disorders, since many children and youth have two or more disorders concurrently.

### Table 8: Estimated Children and Youth Affected by Mental Disorders in Each Region of BC

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Estimated Prevalence (%)</th>
<th>Age</th>
<th>Estimated Population Affected*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Anxiety Disorder</td>
<td>3.8</td>
<td>4-17</td>
<td>BC: 1,900</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>0.7</td>
<td>4-17</td>
<td>BC: 400</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder</td>
<td>0.5</td>
<td>4-17</td>
<td>BC: 300</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>0.4</td>
<td>4-17</td>
<td>BC: 200</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder</td>
<td>2.5</td>
<td>4-17</td>
<td>BC: 1,300</td>
</tr>
<tr>
<td>Any Substance Use Disorder</td>
<td>2.4</td>
<td>11-17</td>
<td>BC: 600</td>
</tr>
<tr>
<td>Alcohol Abuse or Dependence</td>
<td>1.4</td>
<td>11-17</td>
<td>BC: 400</td>
</tr>
<tr>
<td>Marijuana Abuse or Dependence</td>
<td>1.2</td>
<td>11-17</td>
<td>BC: 300</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>2.1</td>
<td>4-17</td>
<td>BC: 1,100</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>1.6</td>
<td>4-17</td>
<td>BC: 800</td>
</tr>
<tr>
<td>Any Autism Spectrum Disorder</td>
<td>0.6</td>
<td>4-17</td>
<td>BC: 300</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>0.6</td>
<td>11-17</td>
<td>BC: 200</td>
</tr>
<tr>
<td>Any Eating Disorder</td>
<td>0.2</td>
<td>11-17</td>
<td>BC: &lt;100</td>
</tr>
<tr>
<td>Schizophrenia**</td>
<td>0.1</td>
<td>11-17</td>
<td>BC: &lt;100</td>
</tr>
<tr>
<td>Any Disorder***</td>
<td>12.6</td>
<td>4-17</td>
<td>BC: 6,400</td>
</tr>
<tr>
<td>Unmet Need for Intervention</td>
<td></td>
<td></td>
<td>BC: 4,400</td>
</tr>
</tbody>
</table>

*These estimates represent the expected rather than the actual number of children and youth affected by mental disorders in each BC MCDFD region or Health Authority across BC, based on our meta-analysis of disorder prevalence in other countries. Caution is warranted when interpreting estimates for less common disorders in smaller regional populations.


37 ibid.
The prevalence estimate for schizophrenia is drawn from a previous review, since schizophrenia was not assessed in the surveys included in this review.

The overall estimate for children and youth with at least one disorder is less than the sum of estimates for specific disorders, since many children and youth have two or more disorders concurrently.

The number of children and youth identified based on diagnostic groupings across the province are: 12,994 for Severe Mental Illness, 2,586 for Schizophrenia, 7,811 for Bipolar, 29,538 for Depression, 26,671 for Anxiety, 7,881 for Substance Use, and 72,119 for all other diagnoses. These numbers are mutually exclusive and individuals could be captured in more than one category.

**Substance Use Disorders:** Based on recent research, an estimated 173,690 individuals (4.7% of adult British Columbians) meet the criteria for any substance use disorder per year, with one in four experiencing a substance use disorder at some time in their lives. However, these estimated rates are dramatically higher among the homeless population, with 8,673 people (82.6% of the homeless population) estimated to have a substance use disorder of some kind, with illegal drug use problems being more prevalent than alcohol use problems. The total combined estimate of British Columbians with a substance use disorder is 182,363. This number does not include Aboriginal people living on reserve.

The CADUMS (2012) reports that every year 14.9% of adult British Columbians use drugs other than alcohol. Based on the CCHS, 1.2% of adult British Columbians (i.e., an estimated 45,847 individuals), meet the criteria for cannabis use disorder and 28,293 (0.8%) meet the criteria for substance use disorders involving drugs other than alcohol or cannabis. The Homeless Survey Report suggests that the rates of drug addiction among the homeless are at 70.1% at a given point in time (7,361 individuals).

Using a needs-based planning methodology, a recent analysis for substance use services in BC, suggested that while approximately 84,000 people require specialized substance use services (withdrawal management, community outpatient services, residential services), only 54,000 people were served – a potential gap of approximately 30,000 individuals. In each of the three services types the gaps are approximately 12,500 for community outpatient services, 7,500 for withdrawal management, and 9,000 for residential services.

**Alcohol Use:** After tobacco, the greatest harms (and costs) from substance use are from alcohol, including chronic diseases such as cirrhosis of the liver and cancers, injuries and public safety issues.

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38 BC Ministry of Health Data (September 2014).
While 78% of adults in BC report using alcohol in any one year\(^43\), an estimated number of 127,592 individuals (3.4%) have problems with alcohol use in any one year, and one in five have such problems at least once during their lives. These rates are higher for the homeless population, where an estimated 3,906 individuals (37.2%) meet the criteria for alcohol use disorder.

Hospitalizations related to alcohol are on the rise and are expected to exceed tobacco-related hospitalizations in the next few years (see Figure 3).

![Figure 3 – BC Hospitalization Rates Caused by Alcohol vs. Tobacco Use, 2013 – 2017](image)

Furthermore, fetal alcohol spectrum disorder (FASD) is the leading preventable cause of developmental disability among Canadian children.

**Chronic Conditions (Low, Medium, High Complexity)**

In BC, people with chronic conditions of medium or high complexity represent 13% of the provincial population and use 26% of health services. Those with highly complex chronic conditions use the most hospital, PharmaCare, and home and community care services. They are also are high users of general practitioner and specialist services. Both high and medium complex chronic conditions are expected to increase by over 70% when projected to 2036 (see Figure 4)

![Figure 4: Projected Growth in Population by Health Status Groups in BC](image)

The aging population is a key driver of this projected growth, as the prevalence of chronic conditions increases with age (Figure 5); 91% of seniors have at least one or more chronic conditions and three-quarters have two or more.

Figure 5: Number of Chronic Conditions by Age in Canada

In Canada, seniors with more than two chronic conditions have nearly three times the number of health care visits than seniors with no reported chronic conditions. However, it is important to note that the

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44 CIHI (2011).
same rise in health care visits increases with the number of chronic conditions in all age cohorts (Figure 6).\textsuperscript{45} This underscores that the issue is not only a service pressure for the older population.

**Figure 6: Average Number of Health Care Visits by Age and Disease in Canada**

![Average Number of Health Care Visits by Age and Disease in Canada](image)

Multiple chronic conditions are difficult for health service providers to treat. In one study, only 55% of Canadian physicians reported feeling well prepared to treat people with multiple chronic conditions\textsuperscript{46}. A wide range of chronic illnesses (e.g., arthritis, asthma, lung disease, chronic pain, congestive heart failure, diabetes, high blood pressure, and stroke) requires sustained and co-ordinated medical and non-medical management.

Evidence shows that people newly diagnosed with one or more chronic conditions have hospital and specialist costs that are much higher than for people who have been diagnosed previously. This can be explained by the significant medical intervention needed in the initial acute onset of the illness, as opposed to the disease management stage that follows. From both a quality of life and health service spending point of view, benefits can accrue from helping patients better manage and then avoid or delay the progression of chronic disease through proactive, informed care.

Patients with chronic conditions require more health professional time, care planning, and care co-ordination. This becomes even more important as they age into their 70’s and 80’s, with increasing frailty for a subset of the population. When people have access to palliative care services integrated with their other care, they report fewer symptoms, better quality of life, and greater satisfaction with their care. Inadequate or ineffective community care results in an increased demand for acute care services, which is both sub-optimal for patient care and wellbeing and more expensive for the system.

**Polypharmacy** is the use of multiple medications by a patient. As they age, many seniors develop a progressively more complex mix of health conditions which often require multiple prescription

\textsuperscript{45} CIHI (2014).
\textsuperscript{46} Schoen et al. (2006).
medications to help manage these conditions and control symptoms. A patient taking more than 10 drugs was once an anomaly. Now, around 20 per cent of people over 70 are taking at least five medications and 16 per cent are taking 10 or more.\textsuperscript{47} In BC, four percent of British Columbians are age 85 or older and 31\% take at least five drugs (see Figure 7).\textsuperscript{48}

**Figure 7: Polypharmacy in BC Outpatients**

Increased prescribing driven by population aging, aggressive marketing and application of chronic disease management guidelines that do not account for the complexities of multi-morbidity, presents an increasing challenge for patients, their families and care providers. It also highlights the need for medication management systems focusing on this population.

A range of surveys point to what patients would like to see in their care:

- Patients value the ability to develop individualized treatment plans according to the importance they place on health outcomes and choosing the care they need. For example, some prioritize maintenance of functional independence over intense medical management while others are willing to tolerate the inconvenience and risk of adverse effects associated with complex multiple medication regimens if this is linked to longer survival, even if at the expense of quality of life.\textsuperscript{49}


• These patients appreciate education activities designed to teach self-care and self-management, but they also look for professional support to self-manage their chronic conditions and avoid adverse events associated with care.  

• While many British Columbians with chronic conditions live “normal” lives, they want support from the broader socio-economic system (housing, transportation, etc.). This system support needs to be flexible and adjust for changes in the chronic condition that suddenly requires acute treatment.

• Finally, patients want support and assistance for caregivers. The caregivers’ wellbeing impacts the patients’ ability to manage their own health. Currently, there are insufficient support programs exclusively designed for caregivers. Also, most attention is paid to helping caregivers deal with the emotional aspects of living with and caring for a person in need of intensive care. The caregivers want programs designed specifically to help partners and other family members provide positive self-management support to the patient.

The current Shared Care Polypharmacy Risk Reduction initiative through the Shared Care Committee is improving the management of patients on multiple medications that may impact quality of life and patient safety. This initiative supports family and specialist physicians to improve the management of elderly patients on multiple medications that may impact their safety and quality of life, especially the frail elderly. It also aims to improve their quality of life and decrease hospital admissions through quality improvement measures such as, de-prescribing unnecessary medications and preventing adverse drug reactions. Prototyping was completed in eight residential care facilities, and prototyping within acute care is currently underway.

There is evidence that multidisciplinary teamwork and interventions that address polypharmacy decrease inappropriate prescribing and medication-related problems in patients so a key recommendation of this paper is to build multidisciplinary teams – including pharmacists - for people with complex needs, including social care, mental health, substance use and other services.

Cancer

People with cancer account for one percent of the population and five percent of all health system expenditures accounted for in the matrix. Those receiving treatment for cancer are often significant users of health resources during the two year period following diagnosis, when they are receiving treatment.


British Columbia has some of the best patient outcomes in the world. The province has the lowest incidence and mortality rates (see Figure 8) for cancer in Canada.

**Figure 8: Cancer Mortality per 100,000 in Provinces in Canada**

![Figure 8: Cancer Mortality per 100,000 in Provinces in Canada](image)

In 2011, 23,655 adults and 174 children and adolescents in British Columbia were diagnosed with cancer. About 65 adults are diagnosed with cancer in BC every day; a child or adolescent is diagnosed with cancer in the province approximately every two days.

The annual number of new cases of cancer in British Columbia is growing steadily (see Table 9). In recent years, the number of new cases has grown by more than 500 cases each year. The growth and aging of the BC population will result in a significant increase in the number of new cancer diagnoses in the province over the coming 15 years.

**Table 9: Actual and Projected Numbers of New Cancer Cases for 2011 and 2027 Cancer**

<table>
<thead>
<tr>
<th></th>
<th>Actual 2011</th>
<th>Projected 2027</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cancers (total)</td>
<td>23,829</td>
<td>34,666</td>
<td>+45 %</td>
</tr>
<tr>
<td>Males (total)</td>
<td>12,526</td>
<td>18,411</td>
<td>+47 %</td>
</tr>
<tr>
<td>Females (total)</td>
<td>11,303</td>
<td>16,255</td>
<td>+44 %</td>
</tr>
<tr>
<td><strong>Selected Sites</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast (female)</td>
<td>-</td>
<td>3,453</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4,659</td>
<td>+35 %</td>
</tr>
<tr>
<td>Colorectal</td>
<td>1,636</td>
<td>1,310</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2,299</td>
<td>+36 %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,695</td>
<td></td>
</tr>
</tbody>
</table>

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54 Canadian Cancer Society (2013).
The overall increase in new cancer cases is expected to be roughly equal between men (+47%) and women (+43%), however the projected increase for some specific cancers does vary by gender.

In 2011, breast cancer was the most common cancer diagnosed both in females and overall with 3,453 new cases. Breast cancer is expected to remain the most commonly diagnosed cancer in females with 4,659 projected new cases for 2027.

Prostate cancer is the only cancer projected to eclipse breast cancer by 2027 with 4,939 expected new cases; this represents a 45% increase from the 3,397 cases diagnosed in 2011. Prostate cancer has however proven difficult to predict in past years and some caution should be exercised in interpreting these projections.

New cases of melanoma are expected to increase quite dramatically over the next 15 years to more than 2,100 cases in 2027. This is driven by both the projected population changes and by increases in incidence rates in both men and women in BC. Melanoma is one of the few cancers where incidence rates have been increasing recently in both males and females.

Lung cancer was among the most commonly diagnosed cancers in 2011 (2,842 total new cases) and is expected to continue to represent a significant portion of the cancer burden in 2027 with 3,664 new cases. By 2027, the projected number of female lung cancer cases is expected to be about 350 cases higher than the number in men. Historically in BC, the number of lung cancers diagnosed in men has always been higher than the number diagnosed in women. This has been attributed to differences in trends in rates between men and women associated with past smoking patterns.

Not all cancer types will see the same percentage increase in the number of new cases over this period. Recent patterns in cancer incidence rates and the ages at which different cancers tend to arise in individuals both influence the expected percentage growth in individual cancer types (see Figure 9).

Figure 9: Actual and Projected Total New Cancer Diagnoses by Health Authority, 2011-2027
Fraser Health Authority will see the most significant increase in the number of cancer cases due to the strong population growth in that region. Projections suggest that in 2027 one in three new cancers diagnosed within the province will be diagnosed within the Fraser Health Authority (FHA). The number of new cases expected within FHA in 2027 is about 50% greater than the number expected for the next largest Health Authority (Vancouver Coastal Health).

The total number of deaths from cancer is also expected to grow (see Table 10). Lung cancer is expected to continue to account for the greatest number of deaths; with breast, prostate, and pancreatic cancers expected to continue to be significant sources of cancer mortality.
Table 10: Actual and Projected Numbers of Cancer Deaths, 2011 and 2027

<table>
<thead>
<tr>
<th></th>
<th>Actual 2011</th>
<th>Projected 2027</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cancers (total)</td>
<td>8,767</td>
<td>10,784</td>
<td>+23 %</td>
</tr>
<tr>
<td>Males (total)</td>
<td>4,677</td>
<td>5,892</td>
<td>+26 %</td>
</tr>
<tr>
<td>Females (total)</td>
<td>4,090</td>
<td>4,892</td>
<td>+20 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Selected Sites</th>
<th>Males 2011</th>
<th>Males 2027</th>
<th>Females 2011</th>
<th>Females 2027</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast (female)</td>
<td>-</td>
<td>576</td>
<td>-</td>
<td>509</td>
<td>-12 %</td>
</tr>
<tr>
<td>Colorectal</td>
<td>583</td>
<td>486</td>
<td>700</td>
<td>621</td>
<td>+24 %</td>
</tr>
<tr>
<td>Lung</td>
<td>1,167</td>
<td>1,052</td>
<td>1,179</td>
<td>1,519</td>
<td>+22 %</td>
</tr>
<tr>
<td>Lymphoma/Leukemia</td>
<td>366</td>
<td>271</td>
<td>474</td>
<td>352</td>
<td>+30 %</td>
</tr>
<tr>
<td>Pancreas</td>
<td>289</td>
<td>239</td>
<td>454</td>
<td>224</td>
<td>+28 %</td>
</tr>
<tr>
<td>Prostate</td>
<td>510</td>
<td>-</td>
<td>595</td>
<td>-</td>
<td>+17 %</td>
</tr>
</tbody>
</table>

A range of surveys point to what patients would like to see in their care:

- Coordination and integration of care: Patients want a seamless transfer of information between those with responsibility for their medical care and those providing social support services in the community.
- Communication skills: Patients with cancer want effective communication enabling them to better understand and recall of information without causing psychological harm.
- Pain and symptom management: Unrelieved pain has a serious effect on the quality of life, interfering with sleep, daily activity, enjoyment of life and social interaction.\(^{55}\)
- Support: Patients want effective psychological interventions and appropriate spiritual needs as part of palliative care services.
- Services for caregivers and families: Patients, families and caregivers want a range of services including home care, respite and “sitting” services, activities within social networks, support groups and individual psychotherapy or education.
- Bereavement support: Assessing the need for bereavement support and counselling should be regarded as an important part of palliative care.

Frail or Coping with End of Life

For those with a life-limiting illness, coping with end of life focuses on comfort, quality of life, symptom management, respect for personal health care treatment decisions, support for the family, psychological and spiritual concerns. Age-related health concerns may either require residential care or substantial community based health care and support. While accounting for less than two percent of the provincial population, this group uses 35% of all services accounted for in the health system matrix ($3.7 billion):

- Frail in Community (<1% of population; 9% of expenditures);

- Frail in Residential Care (1% of population; 21% of expenditures); and
- Palliative Care – End of Life (<1% of population; 5% of expenditures).

The focus with this population is on aiding with the management of conditions in a way that produces the best possible health outcomes and quality of life in a cost-effective manner.

**Frailty**

Frailty (complex care needs necessitating assistance with activities of daily living) increases with age, especially after a patient reaches the age of 75. It is also compounded often by an increased prevalence of dementia and other forms of cognitive decline. However as Figure 9 shows, a wider population than just older seniors experiences the condition of frailty.

As the data in Figure 10 illustrates, attention must be paid through primary and community care to the health needs of the younger population experiencing frailty both in the community and through residential care.

With respect to older adults, while the majority of seniors are comparatively healthy and have few serious health concerns, others within this age cohort are not as fortunate and a significant minority experience frailty. Clearly most seniors prefer to remain in their homes and communities rather than move to a care facility. When community care provides a viable alternative, patient experience is enhanced. When seniors are admitted to acute care, they can experience prolonged periods of inactivity during which time their level of functional ability is reduced and may never recover.

**Figure 10: Frailty in the BC Population**

<table>
<thead>
<tr>
<th>Type of Frailty</th>
<th>Percentage of Population Living with Frailty</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail Population, Living in the Community</td>
<td>17% 16% 13% 10% 17% 26%</td>
<td>16,200</td>
</tr>
<tr>
<td>Frail in Community with High Complex Chronic Conditions</td>
<td>6% 13% 33% 47%</td>
<td>21,900</td>
</tr>
<tr>
<td>Living in the Community with Palliative Needs</td>
<td>19% 22% 27% 27%</td>
<td>16,200</td>
</tr>
<tr>
<td>Frail Population, Living in Residential Care</td>
<td>6% 9% 26% 56%</td>
<td>37,700</td>
</tr>
<tr>
<td>Total Population</td>
<td>18% 43% 22% 9% 5%</td>
<td>4,726,900</td>
</tr>
</tbody>
</table>

Analysis shows that health care costs, especially hospitalization expenditures, rise in the year before a patient enters residential care; often due to a health concern that precipitates need for this type of care. This same analysis points to the need for community-based, coordinated care that: (a) defers, where possible, the need for residential care; or (b) when residential care is required, facilitates access in a planned manner rather than through a health crisis requiring an emergency visit and inpatient stay in the hospital. The per-person cost of caring for a frail senior through home health care services and/or
assisted living services is less than half the cost of caring for them in residential care (e.g., residential care: $59,210; community: $20,290; community with high chronic condition: $29,690). This is true even though frail seniors in the community have a higher number of emergency department visits than those who live in residential care\(^{56}\) (i.e., 18 % for frail seniors living in the community versus 7.1 % for those living in residential care).

British Columbia’s 303 residential care facilities are home to approximately 42,000\(^{57}\) residents, with an average age of 85 years (see Table 11 below). Many of these residents have one of more chronic conditions at varying levels of severity\(^{58}\). For example, 61.4 % have dementia and 20.2 % have diabetes. In addition, 6.7 % have cancer while almost one-third have severe cognitive impairment. Although frail seniors in residential care represent only 1% of the population, they use 21% of all health system expenditures included in the matrix. A large driver of this cost is the provision of 24/7 residential care.

<table>
<thead>
<tr>
<th>Residential Care in British Columbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Residents</td>
</tr>
<tr>
<td>Average Age</td>
</tr>
<tr>
<td>Younger Than 65 (%)</td>
</tr>
<tr>
<td>85 and Older (%)</td>
</tr>
<tr>
<td>Female (%)</td>
</tr>
<tr>
<td>Diagnosis of Dementia (%)</td>
</tr>
<tr>
<td>Diagnosis of Hypertension (%)</td>
</tr>
<tr>
<td>Diagnosis of Cancer (%)</td>
</tr>
<tr>
<td>Diagnosis of Diabetes (%)</td>
</tr>
<tr>
<td>Severe Cognitive Impairment (%)</td>
</tr>
<tr>
<td>Signs of Depression (%)</td>
</tr>
<tr>
<td>Daily Pain (%)</td>
</tr>
<tr>
<td>Some Aggressive Behaviour (%)</td>
</tr>
<tr>
<td>1+ Emergency Room Visits (%)</td>
</tr>
<tr>
<td>1+ Admissions to Hospital (%)</td>
</tr>
</tbody>
</table>

Improving geriatric care across the continuum of health service delivery is a key factor in ensuring appropriate care designed to promote the best outcomes and quality of life.

A range of surveys point to what patients would like to see in their care:

- Frail seniors living in the community greatly value continuity of care, with health professionals and carers who are familiar with their needs and who can help them to navigate multiple services.
- Frail seniors want to remain at home and enjoy clean and warm accommodation.
- They want to feel safe and to maintain independence, control, personal appearance and dignity.

\(^{56}\) CIHI, 2013-2014b.

\(^{57}\) Figure based on bed utilization flow.

\(^{58}\) CIHI, 2013-2014a.
• Frail seniors don’t want to be a burden on their families, therefore they want their needs assessed in partnership with their families to ensure the family members can continue their role as caregivers.\(^{59}\)

**Palliative Care**

According to the Canadian Hospice Palliative Care Association, by 2025 only 20% of Canadians will die with an illness that has a recognizable terminal phase.\(^{60}\) In 2012/13 in BC, 16,200 people (<1% of the population) were in the category “Living in the community with Palliative needs” (see Table 2). Determining which patients may benefit from the palliative approach involves an understanding of their likely illness trajectory and assisting individuals and their caregivers to negotiate transitions in the goals of care. This lack of predictability means that palliative care may not be provided until very late in a patient’s illness. In addition, chronic disease management exists in isolation of palliative care; as a result, patients and their families sometimes lack the necessary support through the transition from advancing illness to death.\(^{61}\) An integrated palliative approach would close the care gap\(^{62}\).

The availability of, and access to, palliative care has become increasingly important as British Columbia’s population grows and ages. As with other health care requirements, palliative care needs to be provided in a patient centred manner based on the domains of quality. The focus needs to be on meeting the anticipated demand for service in a manner that is consistent with providing services in patient’s home and/or communities. Key components will need to include:

- Community based 24/7 access to specialized hospice palliative care services;
- Palliative and end-of-life services in residential care settings;
- Consideration of special sub-populations, including Aboriginal persons, those with mental health and addiction issues, people with dementia, and for children with life-limiting illnesses; and
- Across all transitions between and among care providers that are faced by individuals with a life-limiting illness and their families.

End of life is a natural part of life for individuals and their families. It should be supported in a compassionate and caring manner. Health care services need to be flexible and focused on maintaining the quality of life so wherever and whenever possible people can spend the final stage of life in their home/community, surrounded by their loved ones with dignity and respect. A range of surveys point to what patients would like to see in their care:


\(^{61}\) iPanel (2014). *Dying to Care: How can we provide sustainable quality care to persons living with advanced life limiting illness in British Columbia*.

• Communication and patient-centred care: Patients value being involved in decision-making; receiving accurate information, education, coordination of care, respect for preferences, emotional support, physical comfort, involvement of family and friends, and continuity and transitions in care.\textsuperscript{63}

• Pain and symptom management: Unrelieved pain has a serious effect on the quality of life, interfering with sleep, daily activity, enjoyment of life and social interaction.

• Understanding and managing the complex drug regimens: Patients often have difficulty understanding and managing the complex drug regimens required and have less formal knowledge of their diagnosis and prognosis.

• Improved Coordination of Care: Patients and families experience poor coordination of care and difficulty forming a relationship with any single professional because of multiple-admissions during crises.

• Relief for family members: The physical and emotional burden on family members is well documented, as is their grief at slowly losing the loved one.

• Preferences for place of care and place of death: People receiving care for a serious illness say they would prefer home care at the end of life.

Conclusion

Living with illness and/or disability will be a reality for a significant number of BC residents at some point during their lives. By ensuring timely and appropriate care the severity of a person’s illness and/or disabilities can be mitigated and/or onset delayed. By better understanding the health needs of this population group, the BC primary and community care system will be positioned to meet the needs of the population, consistent with the domains of quality, in a cost effective manner.

BC’s Current Primary and Community Care Services and Initiatives

British Columbia’s primary and community care services are delivered throughout the province in metro, urban, rural and remote communities. Annually, physicians, nurse practitioners, pharmacists, nurses, community health workers, mental health, substance use, and other clinical professionals provide over 30 million health care services in the community. There are also 21 million prescriptions dispensed by community pharmacies via the BC PharmaCare program. Community based services are governed, managed and provided by a complex matrix of Acts, Regulations, Policies, Standards and Guidelines as well as a number of regulatory bodies and professional associations. To be able to assess primary and community based services, it is important to understand the primary components of the community health system.

Primary and Community Care Services

Primary and community care services in British Columbia are delivered by a variety of health professionals in a number of different settings. These include: general practitioner (GP) offices and health authority run primary care locations in the community; private providers; as well as aspects of hospital care and residential care. Most patients have a relationship with a GP who either provides many of the primary care services needed by patients or is uniquely situated to assist patients in accessing services in the community. It is the access to and effective coordination of services for chronic conditions, services for the elderly, complex conditions, pregnancy and childbirth and mental health and substance use across multiple providers that prove most challenging for the system. Further, as independent businesses, physicians determine the type(s) and amount of services they wish to deliver, which may or may not be aligned with the health needs of the population.

In practice, there are multiple, but often uncoordinated, primary care resources in the community. Patients attached to a full service family physician enjoy more coordinated access to these services, but those unattached patients that receive episodic services through a walk-in clinic or ER may not be well connected to the additional primary care services that would improve their health status. Further, depending on the geographic location and the population base of a given area, how services are provided varies dramatically from services being provided in small rural and remote communities by full practice family physicians and a small handful of allied health professionals, to exceedingly specific care being delivered by highly trained and specialized physicians and other health care service providers in large urban and metro areas. There is generally an inverse relationship between the comprehensiveness of primary and community care services available directly out of the GP office and the size of the community.

A range of complementary primary and community care services are generally provided through health authorities (See Table 12).

Table 12 – Range of Primary and Community Services by Density of Population

64 BC Ministry of Health (October 27, 2014). Rural Health in BC: A Policy Framework.
<table>
<thead>
<tr>
<th>Community Category</th>
<th>Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Pop. Density</td>
<td>Highly specialized care, with subspecialties, to meet tertiary care needs of surrounding community and health authority-wide referrals. Residential care and assisted living generally available in all communities generally available in all communities.</td>
</tr>
<tr>
<td>Urban/Small Urban</td>
<td>Specialty medical, surgical and intensive care to meet regional care needs of broad referrals from across a large health area.</td>
</tr>
<tr>
<td>Rural</td>
<td>General inpatient care and some specialized services (such as general surgery, critical care and inpatient psychiatry), diagnostics, mental health team available. Residential care and assisted living generally available in all communities generally available in all communities.</td>
</tr>
<tr>
<td>Small Rural</td>
<td>Some specialized acute services (such as perinatal and day surgery), residential care and assisted living generally available in all communities generally available in all communities.</td>
</tr>
<tr>
<td>Remote</td>
<td>Limited general inpatient care to meet basic acute care needs of local population, health promotion and disease prevention, mental health and substance use services available in community, residential care and assisted living services available in some communities.</td>
</tr>
<tr>
<td>High Community Isolation</td>
<td>Primary and community care that meets most health needs of the population, with potential for urgent and basic emergency care in some locations. Emergency transportation mechanisms are crucial. Visiting child, youth and family and mental health and addictions outreach services.</td>
</tr>
<tr>
<td>Remote</td>
<td>First aid and physician or nurse-led care to meet immediate needs of remote population. May include facilities for itinerant primary and community care that meets basic health needs.</td>
</tr>
</tbody>
</table>

The BC primary and community care services are therefore best understood linked to these geographies:

**Metro Communities**

Metro communities, found only in the Lower Mainland and Southern Vancouver Island have more than 190,000 occupants and are where the most fragmentation of primary and community care services occurs. Services are often designed to meet specific patient needs but exhibit poor coordination that impacts patient outcome. There are no incentives designed for the Metro areas and typically they are not deficient in GPs, but the wide variety of settings in which they practice and a fee for service business model that permits a range of practices to emerge (walk in clinics, 65 Facilities that are within an hour of a higher level of care, in most cases, would have fewer services than typically expected in a community of comparable size due to their proximity to a larger centre. 66 Each category typically includes everything in the categories below it.
maternity care, full service without maternity care) inhibits the ability or capacity to provide longitudinal care to all residents who need it.

Walk-in clinics are prevalent, offering services for patients unattached to a GP or those that are experiencing difficulty accessing their regular provider. Hospitalists, GPs specializing in providing primary care to inpatients, have supplanted community GPs in the province’s largest 16 hospitals providing a dedicated service through the health authorities while also depleting the number of family physicians providing full family practice services in the community and also making the transitions in and out of acute care less coordinated with the community than in those locations where there is a common provider in both locations. The full continuum of Home and Community Care and Mental Health and Substance Use services are available, however, demand often is much greater than the capacity of the current service configuration and delivery system. This unmet demand increases the request for hospital services.

**Urban Communities**

In Urban communities, up to 190,000 residents, primary care is still dominated by GPs generally delivering comprehensive primary care, but the population characteristics and fee for service business model the GPs work under permit a range of practices to emerge (walk in clinics, maternity care, and full service without maternity care). Health authority employed professionals (GPs, registered nurses, nurse practitioners) are identified to fill care gaps that emerge in the local setting. Rural incentives may still be at play in some communities but diminish as the community size increases.

Something that resembles a free market force takes over to meet patient demand though it is heavily influenced by the relative value of services as reflected in the fee schedules for GPs and the initiatives of the General Practice Services Committee. Home and Community Care and Mental Health and Substance Use services are typically present with the same caveats as in metro communities.

**Rural Communities**

With populations exceeding 10,000 but fewer than 40,000 inhabitants, these communities are better positioned to sustain physician services but attracting candidates can be challenging. A suite of rural incentives have been designed not only to recruit physicians to these locations but to retain them in the community through both fee premiums and payments that support residency and key services such as maintaining a 24/7 emergency response. Like remote communities, general practitioners (GPs) that serve these communities generally provide the full range of primary care services as the ability of the community to support a wide array of providers focussed on particular aspects of primary care service such as maternity care is limited. Limited Home and Community Care and Mental Health and Substance Use services are available. Patients requiring specialized assessment and/or treatment often have to travel to Urban or Metro areas.

The Rural Services Cross-Sector Policy Discussion Paper articulates the action framework that will be used to enable a consistent approach to addressing health service priorities through a rural lens.
This framework will be used by the regional health authorities to work in collaboration with its key partners and stakeholders to improve the design and delivery of rural health services in the province. It includes changes to the regulatory framework and expanded roles for paramedics to enable effective use of Advance Care Paramedics in rural and small urban communities. BC Emergency Health Services will work in collaboration with the Ministry to implement the regulatory changes as well as introducing a minimum of 80 new FTEs in community paramedicine at the Primary Care Paramedic or Advanced Care Paramedic level over the period April 1, 2015 to March 31, 2018.

Remote Communities
For communities with fewer than 10,000 residents, the influence of the Health Authority is often greatest as the predominant physician compensation model of fee-for-service and incentives may not effectively attract a physician to the community. The community’s location may also lower the propensity of a physician to build a business sustained by fees. Physician services are more often provided on an alternatively paid basis, typically contracted through the health authority, and likely augmented through other health care providers also in the employ of the health authority. These communities exist in the Northern and Interior Health Authorities. These very remote communities may only have the services of nurses or nurse practitioners with some physician service provided on a part time basis or accessed by patients through provincial travel programs. While some home health care services may be available, sometimes there may be residential services available.

Additionally there often is not full-time, permanent mental health and substance use services in the community. If available, they are either part-time or more often provided by visiting professionals from larger communities. Given the challenges with providing services in remote communities it is anticipated technologies such as tele-health will begin to have a growing role in the provision of health care services.

The range of primary and community care services includes:

1) GP Offices and Clinics
2) Primary and Community Care Professionals
3) Medical Specialist Services
4) Maternity Care Services
5) Developmental Disability Services
6) Mental Health and Substance Use Services
7) Cancer Care Services
8) Home and Community Care Services
9) Palliative Services
10) Community based diagnostic and pharmacy services.

1) GP Offices and Clinics
Primary care is provided by approximately 3,500 GPs out of the 5,220 GPs across the province. GPs operate as autonomous medical professionals in either solo practices, or more commonly, small
group, owner-operated practices. They are the most common point of contact for patients, providing diagnosis and treatment of acute illness, ailments, and injuries including scheduling and interpreting diagnostic tests, prescribing treatment, referring to medical specialists and other health providers, coordinating medical and surgical procedures and overseeing recovery. The majority of chronic disease and mild to moderate mental health and substance use issues are managed by GP.

In 2008/09, the province spent $853.6 million on family physician services. Consistently, four out every five British Columbians receive a service through their GP each year.

Walk-in clinics became part of the primary care landscape approximately 30 years ago. Walk-in clinics provide a convenient health service in a non-urgent situation to address minor episodic health needs of the staying healthy population. They allow patients to attend the clinic at their convenience without an appointment, and often provide office hours extending into the evenings and on weekends. In addition to offering easy and convenient access to a physician, walk-in clinics are also a means of seeking care for individuals without a family physician.

Walk-in clinics most often operate in a fee-for-service model. There is a general perception that walk-in clinics primarily see patients with low acuity, low complexity conditions. However given challenges in accessing family physicians it is likely that walk-in clinics also see a wide range of patient conditions, some of which require one or more follow up visits. This may create additional challenges if the walk-in clinic is not well structured to provide ongoing care.

Also, walk-in clinics are inadequate in meeting the need for continuity of care for major or significant time limited health needs, and they are unsuitable for patients living with illness and chronic conditions or requiring care towards end of life. The Ministry’s primary care strategy aims to provide attached, longitudinal care to patients. In addition, a number of other initiatives such as advanced access and the introduction of multi-disciplinary care teams aim to provide better access and convenience to patients. With wider access and a more patient-centred approach to scheduling, many of the features that made walk-in clinics attractive to patients may soon be routinely offered by full service family practitioners. As this shift occurs, the role and value of walk-in clinics will need to be further contemplated.

2) Primary and Community Care Professionals

There are a range of other health professionals providing primary and community health care services including nurse practitioners, pharmacists, nurses, physiotherapists, chiropractors and massage therapists as well as a range of alternative health care providers providing naturopathy, traditional Chinese medicine and acupuncture. Some of these services are coordinated with a patient’s GP and the patient privately seeks others. There may or may not be a formal link back to the GP in relation to these services. The link depends on whether the referral came through the GP office or the patient was responsible for accessing that care. Further, these health professionals may be employees of the local health authority or be in private business generally supported by fees charged to patients who may or may not be part of extended health plans.

3) Medical Specialist Services
Medical specialists provide specialized diagnostic and medical care for a range of illnesses following a referral from the GP to their community-based practices. There are 37 categories of medical specialists, many of which are linked to chronic disease management. In 2008/09 the province spent $435 million on medical specialist services in the community. Medical specialists are typically based in urban and metro areas of the province, where the population base is sufficient to support their practices. Access to the specialist from rural and remote communities often results in patients and their families having to travel great distances for very short and/or specific appointments.

4) Maternity Care Services

Maternity care for BC residents is provided for under the BC Medical Services Plan. Women have various choices for their maternity care including: some family physicians, registered midwives, and/or obstetricians.

Family physicians work largely in community-based practices, typically offering maternity care as one component of their medical services. When complications develop, such as the need for cesarean birth, family doctors consult with obstetricians, pediatricians and other specialists. Not all family physicians in BC provide maternity care. If a family physician does not provide the service s/he refers patients to a colleague, a midwife or an obstetrician for pre-natal care and delivery. Registered midwives in BC offer primary and community care to healthy pregnant women and their newborn babies from early pregnancy, through labor and birth, and up to six weeks postpartum. Midwives are regulated and registered through a professional college and have hospital privileges. They also provide the option of home birth to low-risk mothers. When complications develop registered midwives work with obstetricians, pediatricians and other specialists to minimize the risk to the mother and her unborn child.

Obstetricians are physicians with specialized education and training in pregnancy, labour and birth. They are qualified to manage complex pregnancies and have surgical training for performing cesarean births. Obstetricians can serve as a patient’s primary physician, or may act as a consultant during a women’s pregnancy.

Maternity services are provided along the continuum from family physicians providing full practice care to medical specialists, with dedicated practices only in obstetrics. Like primary care, how and where services are configured and provided is influenced by geography, population and individual service providers preferred business model for providing care.

5) Developmental Disability Services

Services to people with Developmental Disabilities are provided by the Ministry of Social Development and Social Innovation (MSDSI), Community Living BC (CLBC) and the Ministry of

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68 ibid.
69 ibid.
Health. While CLBC is the service provider for people with developmental disabilities, the Ministry of Health, via regional health authorities, provides services to the population for health-related needs.

The *Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities* (GCSD) were developed to provide a framework for integrated collaborative planning for the Ministry of Health, health authorities, CLBC and MSDSI. They outline the roles and responsibilities of each organization in the provision of services for adults with developmental disabilities, including setting out a framework for collaborative service delivery since individuals with complex functional and medical issues require a collaborative approach to successfully support them. Health services that are necessary to augment an individual’s high intensity care plans are the responsibility of the health authorities. This augmentation may be a combination of consultation support, specialty resources, care plan development, education and training for service clients and family members’ providers and funding.

6) **Mental Health and Substance Use Services**

As noted earlier, the mental health and substance use care needs of British Columbians varies depending on a number of factors, including the type and severity of problems/illnesses being experienced, and the extent to which an individual is being impacted by mental health problems and/or substance use issues.

In BC, the mental health and substance use system provides overall responses in four population groups. Each group focuses on increasingly smaller numbers of people for whom the impacts of mental health problems and/or substance use are increasingly greater (see Figure 11).

**Figure 11: Intervention Approaches Across Specific Population Groups**

![Figure 11: Intervention Approaches Across Specific Population Groups](image)

Services are provided to the populations in communities, at a sub-regional, regional and provincial level by the five regional and provincial health authorities, PHSA and the First Nations Health Authority. The health authorities use a blended model of employment with some services provided directly by health authorities while others are contracted to community based and regional service providers.
Mental health promotion strategies aim to prevent mental health and substance use problems by improving knowledge of healthy lifestyles, managing stresses, life skills development at younger ages, and reducing stigma. Most health authorities deliver health promotion and prevention services; often, these are delivered in partnership with school districts, Ministry of Children and Family Development and other partners. The Provincial Health Services Authority also provides a provincial mental health literacy function, which includes the development and dissemination of evidence-based child, youth and family mental health promotion resources including online and paper-based toolkits, apps, interactive tools and mobile websites.

Targeted Prevention and Risk/Harm Reduction Strategies target those populations, who without adequate supports and early interventions, may experience more significant mental health and/or substance use problems. Targeted interventions attempt to reduce risk and enhance protective factors, within the overall population during times when people are more vulnerable to developing mental health and/or substance use problems. Examples include:

- Community based home visitation programs for young and/or low-income families; and
- Parenting programs that aim to improve psychosocial health of parents to help reduce depression, anxiety or stress, and improve self-esteem and relationships.

Therapeutic Interventions are categorized based on increasing levels of intensity:

1. People with Mild to Moderate Mental Health and/or Substance Use Problems: The mild to moderate population includes people with mild to moderate depression, anxiety, struggling with substances, but are otherwise not fully dependent. The majority of children, youth and adults with mild to moderate mental health and/or substance use problems can be effectively supported or treated through moderate or low-intensity community-based services, such as:

   - Primary Care Physicians;
   - Telephone based programs like Bounce Back, which is an evidence-based program designed to help adults experiencing symptoms of mild to moderate depression, low mood, or stress, with or without anxiety;
   - Tele-mental Health;
   - Outpatient services, such as individual counselling, group programs, and community based residential services; and
   - Outreach services like street youth peer-based programs and outreach workers.

2. People with Severe and Complex Mental Health and/or Substance Use Problems: People with mental illness and or substance use problems with high levels of severity include those individuals with:

   - psychotic disorders such as people with schizophrenia, delusional disorders;
   - bi-polar and major depression;
   - anxiety disorders;
   - personality disorders;
• eating disorders; and
• substance use disorders

Addressing the health care needs of a diverse population of people with severe mental illness and/or substance use disorders involves a continuum of services that allows individuals to access a range of treatments and interventions, from health promotion and disease prevention, and supportive treatment through to acute and long-term treatment and rehabilitation. Within such a continuum, the fundamental components of service delivery include integrated community-based and hospital services, continuity of providers and treatments, family support services and culturally sensitive services:

Primary Care/Shared Care

Among different types of collaborative primary and community care models, shared care and reversed care have evidence to support their effectiveness with individuals with moderate mental health and, in some cases, problematic substance use. Shared care services are generally provided at primary care site, and the care manager provides follow-up care by monitoring individual’s responses and adherence to treatment. The patient’s treatment plan is a component of primary care and includes MHSU as a component. Reversed shared care services for moderate to severe and persistent cases are provided at the MHSU site in a shared space where the general/nurse practitioner works in a psychiatric/MHSU setting such as a local Mental Health Centre. The patient’s treatment plan is primarily a MHSU component of care and includes primary care assessment and treatment information.

• Urgent/Emergent/Crisis response services are generally available 24/7 and may take many forms:
  o Mobile Crisis Response teams where first responders and clinicians provide outreach to individuals at risk to themselves or others
  o Crisis Response Emergency Short Stay Treatment facilities providing crisis response and stabilization in a short-term residential setting.
  o Sobering Centers provide short-term accommodation to allow inebriated persons to “sleep off” intoxication in a safe place, thus avoiding unnecessary visits to jail or hospital.
  o Community and Outpatient Services such as assessments and referrals, individual and group therapy, Early Psychosis Intervention (EPI), Assertive Community Treatment (ACT) teams, and other forms of Intensive Case Management. Included are specialized services such as eating disorder programs, perinatal mental health services, developmental disabilities and mental illness treatment programs, community forensic services.
  o Day and Home Treatment that includes intensive child and youth mental health, adult/geri-psychiatry and specialized services for people with eating disorders, perinatal depression and reproductive psychiatry services. In addition community-based alternatives to inpatient treatment, such as acute home based treatment, day hospital services, and Intensive Day Evening Weekend mental health treatment programs.
Psychosocial Rehabilitation includes a variety of supported employment and supported education services, including clubhouses, leisure, basic living skills and wellness supports.

Residential Care and Supported Housing includes a range of safe, secure and affordable housing options.

Acute Care and Tertiary Services are designed to serve those clients whose needs are complex, refractory and cannot be met within primary and community mental health care.

A sub-population of people with severe mental illness and substance use also exhibit complex behavioural issues. This client population is frequently presenting aggression and/or antisocial behaviours, and often is difficult to engage and maintain in usual community-based mental health and substance use treatment settings. In addition to the services outlined above (for people with severe mental illness and substance use disorders), this client population requires a strong and integrated proactive mental health and substance use system that addresses complex behaviours. The common service components for this client population include:

- Comprehensive Diagnostic Assessments for Treatment and Care Planning;
- Range of intensive and assertive Case Management and Community-based Treatment Approaches, such as Assertive Community Treatment and Intensive Community Treatment teams;
- Use of Specialized Treatment Modalities to manage problem and anti-social behaviors;
- Appropriate Pharmacological Treatment;
- Community Supports including Housing, Supported Employment, Social Skills training;
- Access to Primary Care;
- Access to Forensic Treatment System;
- Community-based Crisis Stabilization; and
- Inpatient Crisis Stabilization and Secure Inpatient Treatment.

In British Columbia, the treatment of substance use disorders is based on recognition that instances and patterns of substance use occur on a spectrum from problematic to chronic dependent. Many people occasionally or routinely use psychoactive substances without problems, and do not require substance use services. Others use psychoactive substances in ways that could cause harm to themselves, their families, or to society, but do not necessarily constitute an addiction; this is considered problematic substance use. Finally, a small minority of people who use alcohol, medications, and other drugs such as marijuana, cocaine, methamphetamine and heroin become addicted to these substances. The type and intensity of substance use treatment will be determined by where an individual falls along the spectrum, in addition to individual characteristics and circumstances.

Substance use disorders are part of a larger group of substance-related and addictive disorders, which include intoxication, withdrawal and substance-induced mental disorders, including substance induced psychosis. Appropriate medical intervention is required for treating many of these disorders and

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70 American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders DSM-5* (Fifth Edition),
stabilization is often needed before embarking on therapy to treat substance use disorders. Detoxification alone is inadequate to resolve a substance use disorder, and leads to increased risks for some clients.

Across the province, health authorities use the 5 Tiered Model from A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy to provide appropriate residential services, as well as outreach, health promotion and prevention programming:

**Tier 5 – Complex/Concurrent Services - Specialist, Inpatient, Residential:** Services and supports include services that link people with highly complex concurrent substance use and mental health problems of the full range of needed assessment, treatment and support services and residential, tertiary or hospital-based services.

**Tier 4 – Intensive Outpatient Counselling, Day Treatment, Supportive Residential:** Services and supports include intensive day programming for early recovery (BC e.g., daytox), structured residential services, active outreach services (BC e.g., Intensive Case Management Teams).

**Tier 3 – Outpatient/Community Based Services - Outreach Services, Methadone Maintenance Treatment, Home-Based Withdrawal management:** Services and supports include outpatient counselling, home-based withdrawal management, supervised injection sites and methadone and buprenorphine maintenance treatment (e.g., provided by primary care and pharmacists).

**Tier 2 – Early Intervention - Primary care, Health Promotion and Disease Prevention, Employment Programs:** Services and supports provide the important functions of early identification and intervention and may include screening, brief intervention and referral. Systems well positioned to provide such services include primary care, social services, emergency care, health promotion and disease prevention, and employment programs. (BC e.g., brief intervention in primary care – however this is not fully implemented or consistent across the province.)

**Tier 1 – Health Promotion and Disease Prevention - Self-Care, Family Support, School-Based Prevention:** Services and supports include health promotion and disease prevention initiatives targeted to the general population and those targeted to at-risk populations. Other resources and supports in tier 1 are open to all, through which people with problems of varying severity may choose to participate (BC e.g., Alcoholics Anonymous). This tier also provides aftercare or continuing care for people who have previously accessed services and supports in higher tiers (e.g., various types of support groups).

Finally there is a range of mental health and/or substance use services to persons involved in the justice system. These include the delivery of mental health and substance use services provide to individuals incarcerated for less the two years in BC Correctional Facilities and those that are on one form of community disposition order or another, monitored by Community Corrections.

Washington, DC.
Operated by the Provincial Health Services Authority, British Columbia’s Forensic Psychiatric Services Commission (FPSC) is a multi-site health organization providing specialized hospital and community-based assessment, treatment and clinical case management services for adults with mental health disorders who are in conflict with the law. This provincial service ensures that forensic psychiatric patients throughout the province have access to high quality care and services; and that the BC Review Board and court authorities across the province are supported by the expert advice and opinions provided by specialized, interdisciplinary teams of health professionals. Specialized assessment, treatment and case management services are provided at the Forensic Psychiatric Hospital and six regional community clinics located in Vancouver, Victoria, Surrey, Nanaimo, Kamloops and Prince George. Core services provided include:

- Court-ordered assessments;
- Inpatient and community-based services to persons found Not Criminally Responsible on Account of Mental Disorder or Unfit to Stand Trial;
- Psychiatric / Psychological Pre-sentence Assessment Reports;
- Hospital treatment of adults with mental health disorders who are in conflict with the law and in provincial correctional centres, admitted on temporary absence to the Forensic Psychiatric Hospital; and
- Court-ordered assessment and treatment of individuals on bail, probation and conditional sentences.

The FPSC supports a team approach to patient care and service delivery. Teams are comprised of psychiatrists, psychologists, nurses, social workers and rehabilitation specialists.

In addition to the services provided by Forensics, there are a number of provincial and regional based initiatives targeted to the population including:

- Downtown Eastside (DTES) Initiatives: Vancouver Intensive Supervision Unit, Drug Court, Downtown Community Court addresses the complex needs of MHSU clients within the DTES.
- Integrated Offender Management/Homeless Intervention Project (IOM/HIP): The program has partnered with the HIP in a pilot project that links IOM clients to housing, income assistance, substance use treatment, mental health and primary health services for successful transition from custody to the community services.
- Primary Care and Mental Health and Substance Use Services in Correctional Facilities: Health services, usually short term to stabilize clients, are provided to adults in BC Correctional Centres by a single private provider, Sentry Correctional Health Services Incorporated, under a 5-year contract to the Ministry of Justice.

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71 Partners in IOM/HIP: MoH, MoJ, Ministry of Social Development, BC Housing, Health Authorities, Community Living BC
72 Offenders with a minimum sentence of 135 days for male / 90 days for female offenders; minimum 6 months community supervision following custodial sentence; previous admission; high needs; high Corrections Risk Needs Assessment rating.
While there is both a coherent service framework philosophy and a wide range of services available to address each of the population groupings they are not provided as a coherent functioning system that coordinates short term or longitudinal care sufficient to meet the current demands for service. Neither are these services well-coordinated and integrated into the broader a provincial system of health care. They are lacking a common overall direction and at a practice and program level are missing standardized definitions of services and treatment modalities as well as an integrated technological infrastructure to understand services demands across the province, the deployment of resources to meet them and allow practitioners to share information. There is not an even distribution of services based on population needs and no coherent framework that addresses the geographical challenges of providing access to quality services across metro, urban, rural and remote areas of the province.

7) Cancer Care Services

British Columbia’s cancer care system is broad service delivery network at the community, sub-regional, regional and provincial level. It provides a number of services including:

- Case finding through screening, or symptom investigation, and diagnosis;
- Treatment via surgery, chemotherapy, radiation therapies or combinations; and
- Follow-up care and ongoing surveillance for survivors.

Cancers are initially recognized through proactive screening of asymptomatic patients or appearance of symptoms. Tests conducted/referred by community based GPs and other medical workers are followed up by further diagnostic investigation, if required. Once a diagnosis is made, most patients are referred to the BC Cancer Agency (BCCA) for disease staging, treatment planning and treatment; those referred first for surgery may not have it done. Treatment may take place in a BCCA cancer centre or in/near a patient’s home community. Surgery may be part of the treatment plan. Specialists and oncologists in the health authority determine the plan to perform the surgery or not.

The BCCA is an agency of the Provincial Health Services Authority (PHSA). It is responsible for all cancer programs in BC including: health promotion and disease prevention; screening and early detection; research and education; and care and treatment (including treatment protocols), and delivers the services in partnership with regional health authorities. The services provided by BCCA include: patient assessment; diagnostic and therapy planning; radiation therapy; chemotherapy services; nursing care; patient and family counseling; pharmacy services; pain and symptom control services; and teaching and applied research activities.

There are currently four provinical screening programs for breast cancer, cervical cancer, colorectal cancer, and hereditary cancer. The BCCA currently operates six comprehensive regional cancer centres:

- Vancouver Centre;
- Fraser Valley Centre in Surrey;
- Abbotsford Centre;
- Sindi Ahluwalia Hawkins Centre for the Southern Interior in Kelowna;
- Vancouver Island Centre in Victoria; and
• Centre for the North.

While Vancouver Centre has approximately 26 inpatient beds, the other sites are each adjacent to a major hospital with a number of dedicated inpatient cancer beds. Most services are provided on an outpatient basis. The BCCA centres provide a full range of treatments including oncology consultations, chemotherapy and radiotherapy treatments. They also provide a full range of services including prevention, treatment, screening, genetic counseling and supportive care.

Regional health authorities support the delivery of provincial cancer care via the Communities Oncology Network by housing regional cancer services linked to, but outside the main BCCA centres, primarily chemotherapy treatments, and on an outpatient basis. Network sites are categorized into four tiers of service. Cancer services are very specialized services. Community based GP-oncologists are certified through a BCCA training program; care plans overseen by BCCA oncologists.

As noted earlier, the annual number of new cases of cancer in British Columbia is growing steadily. In recent years, the number of new cases has grown by more than 500 cases each year putting pressure on current service level capacity. The introduction of additional screening tools will further increase demand on services and requires careful planning for managing the increased demand for upstream services as recently demonstrated though the introduction of the FIT test. Overall it is anticipated, that the growth and aging of the BC population will result in a dramatic increase in the number of new cancer diagnoses in the province over the coming 15 years.

Evidence based updates of screening policies can also lead to changes in demand for services. As part of the Provincial Breast Health Strategy, an updated Breast Screening Policy was developed and implemented in 2014. It was based on a comprehensive review of scientific data and other evidence-based screening mammography materials. It provides clarity to women on when to get screened and helps women to make informed decisions about screening. It includes screening every 2 years for average risk women, and screening annually for higher risk women (who have a first degree relative with breast cancer).

Recent data shows that since the policy update there has been a corresponding 8% increase in the number of 50-69 year old women attending for screening, due in part to higher risk women now being recalled annually. Also, during this first year of policy transition, 40 – 49 year old average risk women were provided information about the updated policy at their expected recall interval. A 41% drop in attendance for this group compared to the same period in the previous year, suggests women are considering the recommendation to shift to screening every two years.

Policy transition and adoption is complicated. Data suggests the 2014 information and promotion campaigns which included physician notification, education rounds, broad public communications and direct information to patients are working.

In addition, the integration of the cancer agency services with primary and surgical care warrants attention. From a patient perspective screening programs are not closely linked to the surgery component of the treatment plan should surgery be required. Reviewing patient pathways from presentation to family physician, diagnosis, to treatment (including surgical oncology) and post
treatment care and monitoring require review and refresh. The recommendations presented following
the current review of the BCCA services will be evaluated for potential implications on the delivery of
primary and community care as well as diagnostic and surgical services.

8) Home and Community Care Services
The home and community care services sector provides a range of clinical and support services focused
on individuals living in their own homes, or in home like settings. Services include professional care such
as nursing, rehabilitation therapy and social work; services unique to the community setting such as
home support and adult day programs; and a variety of health services provided in specialized
accommodations such as assisted living and residential care facilities.

People receiving home and community care services may have a short term need, due to an episode of
illness, surgery or specialized treatment, or a long term need as a result of a chronic condition or life
limiting illness. Although home and community care services are provided to adults of all ages, the
majority of clients are seniors.

Because home and community care services are provided to those living in the community, the factors
influencing the plan of care are much broader than in a controlled hospital setting. Health services in
the community are provided to supplement the efforts of the client and their family to manage their
own condition, which means understanding not just clinical needs, but also functional and psycho-social
needs, cultural influences and a recognition that what defines quality of life is unique to the individual.

Home and community care has been described as “a complex terrain”\(^{73}\). Not contained by the physical
structures of the hospital, and including care facilities but ranging beyond them and throughout the
community, home and community care services may be combined into bundles or delivered individually
to address specific needs. Clinical and service supports are linked to the medical assessment and
treatment plan but often require a different focus to address functional abilities, activities of daily living,
availability of informal support and the personal goals of the individual.

Home and community care services are generally designed to:

- Help individuals remain independent in their own homes for as long as possible;
- Provide short term care at home where possible to either avoid hospitalization or to minimize
  extended hospital stays;
- Provide alternate extended care options, like assisted living and residential care, when it is not
  possible to stay at home; and
- Support individuals at end of life.

Achieving these goals presents many challenges. The development of a successful plan must include a
wide variety of factors, many of them outside the usual health terrain of symptom management and
treatment protocols. Managing changes in health status and the impact on personal abilities and social

\(^{73}\) Williams, A. Paul (November, ?). Canadian Research Network for Care in the Community, Building for Change,
Integrated Services for Seniors. Keynote Presentation to North West LHIN, Thunder Bay.
supports through the course of a long-term condition is a very personal journey, which requires coordinated care planning and access to a flexible range of services to meet individual needs. As a result, it can be difficult to clearly map a condition-specific care continuum, or outline the specific mix of services that may be provided to clients with common diagnoses or similar clinical characteristics.

There is a broad mix of services provided to a variety of client populations. With such a mix of client needs and service considerations, home and community care services are currently provided by professional and support staff with a generalist focus, with limited access to specialist support for complex circumstances.

A growing number of hospital admissions are through the emergency department, and increased numbers of ‘alternate level of care’ patients in acute beds suggest strongly that there is a need for more capacity in the community – for proactive care management to prevent or reduce the need for hospital admission and for responsive options to provide the appropriate care for convalescence and long-term care.

**Home and Community Care Clients:** In 2012/13, home and community care services were provided to 127,786 individual clients across the province, with 80,734 receiving professional services; 38,810 receiving home support services; 6,147 receiving adult day programs; 6,028 receiving assisted living services and 38,527 receiving residential care services.74

Of the 127,786 individuals receiving home and community care services in 2012/13; 98,250 or 77% were 65 or older. However, for those receiving residential care or assisted living services, 40,490 of 43,443 or 93% were 65 and older.75 Publicly subsidized residential care services are provided to approximately 5% of the total senior’s population (65 and older).

Over the past decade, growing numbers of clients with urgent needs, and the need to reduce pressure on the acute care system has drawn community care disproportionately towards urgent and acute response, and residential care settings now manage clients with more complex care needs, as well as post-acute convalescence and palliative care. Clients discharged from hospital now have very high medical and/or rehabilitative care needs, and are much less stable than was the case when many of the current service models were designed.

The information provided below provides some indication of the complexity of care needs being addressed by home and community care services. While this data is from a 2007 extract of all initial assessments of HCC clients with the interRAI Home Care assessment instrument, the profile, if anything, has only become more complex76:

- 79% were aged 75 or older, with 18% aged 90 or older.

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76 HCC Client Profiles RAI HC Analyses, 2008
• 64% were widowed, divorced or single
• 45% had a primary caregiver living with them, 13% had a secondary caregiver living with them
• 61% were female, 39% male
• 48% of clients were alone for long periods of time

Caregivers
• More than 50% of primary caregivers indicated they could not increase the amount of emotional supports, or supports with Instrumental Activities of Daily Living, or Personal Activities of Daily Living
• 13% of caregivers indicated they were unable to continue providing care
• 20% expressed distress, anger or depression

Functional Abilities
• 63% of clients were assessed as in danger of falling due to an unsteady gait, and 37% limited outdoor activities due to a fear of falling
• 33% have pain that disrupts daily activity
• 52% of all clients had a decline in their “Activities of Daily Living” abilities in the prior 90 days
• 55% have great difficulty preparing meals
• 76% do not think they can increase their functional ability

Medical Challenges
• 37% were taking nine or more medications in the previous seven days
• 58% had some impairment in making everyday decisions
• 30% had dementia (Alzheimer’s and non-Alzheimer’s)
• 40% had arthritis
• 47% had hypertension

Choices
• 63% of clients and caregivers indicated that they do not feel the client would be better off in a different location
• 13% have advanced health care directives in place

Another way to portray home and community care clients is from a population lens. The “Home and Community Care Complexity of Needs Triangle” was developed based upon the “Kaiser Permanente Population Health Model” and the National Health Service and Social Care Model, “Supporting People

with Long Term Conditions as part of work on developing a care management strategy for home and community care (see Figure 12). The BC triangle is a generic model which can be applied to all client populations. The model recognizes that clients will have episodes of interaction with acute care services and provides a mechanism to ensure integration with both acute care and primary health care.

This version of the triangle shows a proposed change in focus for providing clinical and care management support to Level 3 and Level 4 populations, and is supported by additional documentation on a proposed care management service delivery model for home and community care services.

**Figure 12: Home and Community Care Complexity of Needs Triangle**

**Range of Current HCC Services and Service Delivery:** In BC, home and community care services are available from both private-pay and publicly subsidized providers:

Private pay services: are accessed by clients directly from a service provider. Individuals can explore various options for services that best meet their needs and preferences. The individual and the service provider agree to all aspects of the service provision. Government does not provide any financial assistance to individuals or service providers for the service.

Publicly subsidized home and community care services are accessed through the health authorities, based on provincially set eligibility criteria. Services are subsidized by the Ministry of Health and administered and delivered by the health authorities and contracted providers. While individual preference for service is considered, the individual’s need as determined by a formal assessment is the primary consideration in determining the type and mix of services that are provided. Health authorities may provide these services directly or through contracts with not-for-profit and for-profit service providers.

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As of March 31, 2014, 34% of subsidized residential care beds and 37% of subsidized assisted living units were privately owned and operated; 33% of all subsidized residential care beds are owned and operated by health authorities directly, but only 4% of subsidized assisted living units are owned and operated by health authorities. Almost 60% of all publicly subsidized assisted living units are owned and operated by not-for-profit enterprises (see Figures 13 and 14).

**Figure 13: Breakdown of Residential Care Ownership Type in BC as of March 31, 2014**

Health authorities have contracts with service providers that establish deliverables based on compliance with policies and standards as well as reporting requirements. Each health authority has a mix of ownership types used to provide subsidized services, but there are notably a higher percentage of not-for-profit enterprises in the Vancouver Coastal Health Authority (52.8%), and less contracted (of either for profit or not-for-profit) service providers in Northern Health Authority where 76% of residential care and assisted living services are owned and operated by the health authority.

**Figure 14: Ownership types of Assisted Living and Residential Care Services by Health Authority**
Publicly Subsidized Home and Community Care Services are provided to people who are able to continue to live in their own homes and to people who require care in a supportive housing environment including family care homes, assisted living and residential care facilities (see Table 13).

**Table 13: Publicly Subsidized Home and Community Care Services**

<table>
<thead>
<tr>
<th>Home Setting</th>
<th>Housing and Health Services</th>
<th>Residential Care Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes Supportive Housing</td>
<td>Includes Group Homes, Family Care Homes and Assisted Living</td>
<td></td>
</tr>
<tr>
<td>○ Home Support Services</td>
<td>○ Personal Care Services</td>
<td>○ 24/7 Professional Supervision</td>
</tr>
<tr>
<td>○ Adult Day Services</td>
<td>○ 24/7 Emergency Response</td>
<td>○ Nursing Care</td>
</tr>
<tr>
<td>○ Health Services for Community Living (HSCL)</td>
<td>○ Meals and Housekeeping Support</td>
<td>○ Medical Coordination</td>
</tr>
<tr>
<td>○ Choice in Supports for Independent Living (CSIL)</td>
<td></td>
<td>○ Personal Care Services</td>
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<tr>
<td></td>
<td></td>
<td>○ Rehabilitation</td>
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<td></td>
<td></td>
<td>○ Activities Programs</td>
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<td></td>
<td></td>
<td>○ Social Work</td>
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<td></td>
<td></td>
<td>○ Dietician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Meals and Housekeeping</td>
</tr>
</tbody>
</table>

**Services Across Community Settings**

○ Community Nursing
○ Community Rehabilitation
○ Social Work
○ Pharmacy
○ Quick Response Teams
○ Home Oxygen
○ Facility Access and Transition
○ Dietician Services

**Services Across All Settings**

Hospice Palliative Care, Case Management, Respite Care

Services provided include:

*Community Nursing Services*: are provided by a licensed nursing professional to clients in the community who require acute, chronic, palliative or rehabilitative support. Services include assessment and nursing interventions such as education, wound care, medication management, chronic-disease management, care management, post-surgical care and palliative care. Generally, community-nursing services will be provided on a short-term basis and community nurses assist clients and their families to be confident in taking over care at home. Community nursing services may be provided in a variety of settings such as clinics, the client’s home, assisted living residences, family care homes, group homes, or other community settings.

*Community Rehabilitation Services*: are provided by a licensed physical therapist or occupational therapist to clients who require acute, chronic, palliative or rehabilitative support. The main goals of rehabilitation therapy are to help improve or maintain physical and functional abilities and to provide assessment and treatment to ensure a client’s home is suitably arranged for their needs and safety. Generally, community rehabilitation services will be provided on a short term basis and
Community rehabilitation therapists assist clients and their families to be confident in taking over care at home. Community rehabilitation services may be provided in a variety of settings such as clinics, the client’s home, assisted living residences, family care homes, group homes, or other community settings.

**Adult Day Services**: include an organized program of personal care, health care and therapeutic social and recreational activities in a group setting that meet client health care needs and/or caregiver needs for respite. In some cases transportation is provided, while in others clients are responsible for their own transportation to and from the program. Many adult day service programs are connected with residential care facilities, while others operate independently.

**Home Support Services**: are designed to help clients remain independent and in their own home as long as possible. Home support services are provided by community health workers to clients who require personal assistance with activities of daily living, such as mobilization, nutrition, lifts and transfers, bathing, cueing, grooming and toileting, and may include safety maintenance activities as a supplement to personal assistance when appropriate, as well as specific nursing and rehabilitation tasks delegated by health care professionals.

**Choice in Supports for Independent Living (CSIL)**: provides eligible home support clients (clients living with physical disabilities and who have high-intensity care needs) more flexibility in managing their home support services. CSIL clients, or a designated representative or a client support group, receive funds directly for the purchase of home support services and assume full responsibility for arranging services, including recruiting, hiring, training, scheduling, supervising, and paying home support worker(s).

**Palliative and End-of-Life Care Services**: Palliative care improves the quality of life for people and their families facing the problems associated with serious illness, through the prevention and relief of suffering. It is appropriate at any age and at any stage in a serious illness and can be provided together with any beneficial treatment. End-of-life care generally refers to formal and informal care provided during the final year of life and is associated with advanced, life-limiting illnesses. It focuses on comfort, quality of life, respect for personal health care treatment decisions, and support for the family, psychological, and spiritual concerns. It is provided whatever the age or wherever the client is living, whether in their home, in hospice, an assisted living residence or a residential care facility.

**Caregiver Respite/Relief Services**: Many people receiving home and community care services are assisted by informal caregivers, often a friend or family member. Respite care can give the caregiver temporary relief from the emotional and physical demands of caring for a friend or family member.

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79 Palliative care may be offered to children and teenagers with cancer. If a young person requires palliative care, it is specialized to focus on enhancing quality of life by addressing their unique physical, social, spiritual and emotional needs.
Respite may take the form of a service that is provided in an individual’s home or a residential care facility, hospice or other community care setting such as an adult day centre.

**Family Care Home Services:** are provided in a single-family residence that accommodates clients with specialized care needs that cannot be optimally met in a residential care facility. Family care homes provide a home-like atmosphere, nutritious meals, laundry and housekeeping services and supervision, along with any required assistance with daily living activities, such as bathing, grooming and dressing. As they are unlicensed they cannot house more than two clients.

**Assisted Living Services:** provide housing, hospitality services and personal care services for adults who can live independently and make decisions on their own behalf but require a supportive environment due to physical and functional health challenges.

**Short-Term Residential Care Services:** are provided on a short-term basis (usually less than three months) and include convalescent care, residential hospice palliative care and respite care. Respite care provides a client’s main caregiver a period of relief; it can also provide a client with a period of supported care to increase their independence. Convalescent care is provided to clients with defined and stable care needs who require a supervised environment for reactivation or recuperation prior to discharge home, most commonly following an acute episode of care. Residential hospice care is provided to clients who require support with comfort, dignity and quality of life in the final days or weeks of their lives, and is distinct from palliative care provided to residential care clients.

**Long-Term Residential Care Services:** are provided in facilities that provide 24-hour professional care and supervision in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence.

**Home and Community Care Funding:** The Ministry of Health provides global funding to health authorities across British Columbia for the delivery of publicly subsidized home and community care services. Provision of home and community care services has changed significantly over the past few decades. Since the late 1980’s, what began as ‘homemaking’ support and follow-up hospital care has expanded enormously. As British Columbia’s population has changed and the demand for health care services has continued to grow, home and community care services have absorbed larger volumes of clients with increasingly complex health care needs. This impacts existing services structures, and creates significant challenges for the capacity of the system in all community settings.

Clients co-pay for publicly subsidized home and community care services, specifically residential care, assisted living, and home support services and a fixed rate of $10 or less is charged for receiving adult day services:

**Income-Based Client Rates – Home Support:** Clients receiving long-term home support services pay a daily rate based on their income (and the income of their spouse, if applicable) which is calculated by multiplying “remaining annual income” by 0.00138889. Clients in receipt of an income benefit
pay no fee, and if a client or their spouse has earned income, they pay no more than $300 per month for home support services.

**Income-Based Client Rates – Assisted living:** Clients receiving assisted living or family care home services pay up to 70% of their after-tax income towards the cost of their accommodation and hospitality services, subject to a minimum and maximum client rate. The maximum rate is based on a combination of the market rent for housing and other actual costs.

**Income-Based Client Rates – Long-term residential care/ Family Care homes:** Clients receiving long-term residential care or family care home services pay up to 80% of their after-tax income towards the cost of their accommodation and hospitality services, subject to a minimum and maximum client rate per month. The maximum client rate is adjusted annually based on changes to the Consumer Price Index (CPI).

**Minimum Residual Income:** Client rates are calculated so that most clients receiving residential care services retain a minimum income amount to cover personal expenses, such as personal toiletry items or over-the-counter medications. On February 1, 2012, the Government of British Columbia increased the minimum residual income amount from $275 per month to $325 per month. When implemented, this was the highest minimum residual income amount in Canada.

**Fixed Daily Client Rates:** Clients receiving short-term residential care services for respite care, convalescent care, or hospice/end-of-life care, pay a fixed daily rate based on the minimum monthly client rate for residential care services.

**Clients Receiving Income Benefits from MSD:** There are unique arrangements for clients receiving income benefits from the Ministry of Social Development and Social Innovation (MSDSI). MSDSI fully subsidizes the cost of residential care services, Medical Service Plan (MSP) premiums and additional expenses such as optical, dental, and medical supplies and equipment for these clients. The Ministry of Health works with MSD to align the policies and processes for these clients.

**Temporary Reduction of Client Rates:** If payment of the assessed client rate would cause the client or their spouse/dependents serious financial hardship, the client can apply to their local health authority for a temporary reduction of their client rate. In 2013, the temporary rate reduction process was revised based on a standardized approach to ensure consistency across the province and to make the process more fair and transparent for clients, their family members and caregivers, and the public.

Information for Care and Planning is provided through InterRAI, developed though a collaborative network of researchers in over 30 countries who developed and maintain evidence-based clinical

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80 The increase in the minimum residual income amount reflects the changes made to the OAS/GIS benefits on July 1, 2011 under which seniors may be eligible for additional benefits of up to $50 per month for a single senior. The increase in the minimum residual income amount ensures that the additional OAS/GIS benefits are not counted as income when assessing client rates.
assessment tools tailored to people with chronic conditions, including frail seniors. British Columbia has implemented the InterRAI standardized assessment tools for both home care and residential care settings, giving the capacity to access reliable, validated assessment protocols, outcome measures, case-mix algorithms and quality indicators.

InterRAI data is an important component of the national Home Care and Continuing Care Reporting Systems, providing relevant information on which to compare client outcomes across national and international jurisdictions. This information, along with the data collected through the Minimum Reporting Requirements for home and community care services, provides a robust information source to aid understanding of needs, outcomes being achieved for clients, to inform research and performance accountability for overall health system improvement, and target planning to the needs of populations.

Analysis

Comprehensive Assessment

BC has mandated the use of two interRAI assessment tools for clients receiving long term services (home support, assisted living, adult day services, group homes, family care homes and residential care services). However, in most health authorities, there is no standardized assessment tool being used for many clients receiving short term acute care, short term rehabilitative care or palliative care. This represents a significant gap in the home health sector, and could be addressed through the introduction of other interRAI instruments, such as the Contact Assessment, which is being used in Vancouver Island Health Authority and Ontario, or the Community Health Assessment, also used in Ontario, to ensure standardized comprehensive assessments are carried out on all home health clients.

Service Models and System Coordination

Despite many changes over the past 20 years, home and community care services remain organized in large part around eligibility criteria and service guidelines that limit who may receive services and in what format. Clinical services such as community pharmacy, social work and dietician services are available in some communities, but not others. Other ministries or community agencies may share responsibility for services in some cases. As a result, home and community care services can be complex and restrictive in their coordination and delivery. This creates frustration for clients trying to navigate the health care system, for caregivers and for family physicians and other health providers needing to link with community based care.

Funding

Related to the above challenges is the way that home and community care services are currently funded, with a co-payment model with user fees charged to clients based on their income for home support, assisted living and residential care services. With redesign of services and the transition to new innovative care models focussed on interdisciplinary teams, new options for subsidizing clients who may not be able to afford the cost of necessary services need to be explored. This will include exploring how
other jurisdictions fund home support, assisted living and residential care services and include a dialogue with health authorities and major stakeholders on how to provide the services.

1) Palliative Care Services
A range of Palliative Care Services are provided across the province by regional health authorities that include:

**Acute/Tertiary Palliative Care Unit Beds** are always located in an acute care setting or campus. As of March 2014, there were 88 adult acute/tertiary palliative care beds across the Province in nine distinct locations: Nanaimo RGH, Victoria Hospice, St. Paul’s hospital, Vancouver General, Lion’s Gate Hospital, Richmond General, Burnaby Hospital, Surrey Memorial Hospital and Abbotsford Regional Hospital and Cancer Centre.

Patients in acute palliative care unit beds may be clinically unstable with complex needs requiring increased nursing staff, direct daily involvement by palliative physician specialists and other palliative team members (social work, spiritual care providers as well as volunteers). Care requirements involve complex decision-making and medical interventions. Access to acute care services with lab, diagnostics and procedures (such as chest tubes and intra-thecal administration of medications) is required, as is support for complex psychosocial interventions.

**Community Hospice Beds** (currently defined as short-term residential end of life beds) are designated adult short-term residential end of life beds located in a variety of settings. The number of short-term residential care beds was 247 with 24 flexible beds as of March 31, 2014. Patients in community hospice beds have a No CPR order, are in the last months of life and have chosen comfort care goals. Admissions may also be for pain and symptom management needs, support through to death, and/or respite due to caregiver exhaustion.

**Home-Based Palliative Care Services** are primarily delivered in the patient’s home by their primary care physician/team and home health teams with access to specialized palliative team members (for example palliative care physicians, Advanced Practice Nurses, pharmacist; social workers/counsellors, volunteers) as needed.

The BC Palliative Care Benefits Program supports home-based palliative care. It allows BC residents of any ages who have reached the end stage of a life-threatening illness and want to receive medically appropriate palliative care at home, rather than being admitted to hospital. The program gives palliative patients access to the same drug benefits they would receive in a hospital, and access to some medical supplies and equipment from their health authority. The program includes full coverage of approved medications and equipment and supplies (upon referral to, and assessment by the local health authority).

2) Community-Based Diagnostic Services and Pharmacies

**Community-based diagnostic services:** Community-based diagnostic services (such as laboratory
services and diagnostic imaging services) are delivered by both health authorities and contracted or fee for service providers. There are five regional health authorities, plus a Provincial Health Services Authority (PHSA) that provides province-wide diagnostic services, such as screening mammography through the British Columbia Cancer Agency.

In British Columbia, outpatient services are those services provided in community facilities and outpatient areas of hospital facilities. Outpatient diagnostic services are insured through the Medicare Protection Act and administered through the Medical Services Commission (MSC), which has a mandate to facilitate reasonable access throughout BC to quality medically necessary outpatient diagnostic services for beneficiaries. Services are paid through the Medical Services Plan (MSP) on a fee for service basis.

To bill MSP, all outpatient diagnostic facilities (both private and public) must apply to, and be approved by, the Advisory Committee on Diagnostic Facilities (ACDF), a committee of the MSC. The ACDF reviews and makes decisions on applications related to the following diagnostic services:

- diagnostic radiology (including, computerized axial tomography—CT/CAT);
- diagnostic ultrasound;
- nuclear medicine scanning;
- pulmonary function;
- polysomnography;
- electromyography;
- electroencephalography;
- laboratory medicine; and
- laboratory specimen collections stations.

Of note, all publicly funded Medical Resonance Imaging (MRI) scans are funded through hospital budgets. Private pay scans are not reimbursed.

All laboratory and diagnostic imaging facilities in BC must be accredited by the provincial Diagnostic Accreditation Program, a program of the College of Physicians and Surgeons of BC, prior to rendering services to a patient. While access to community laboratory services is generally excellent (especially in urban and metro areas) diagnostic imaging experiences challenges both in terms of accessing certain types of imaging services (especially MRI) and geographical access due to both access to equipment and appropriate health care providers.

Laboratory medicine is advancing rapidly and requires a framework to strengthen and standardize B.C.’s clinical laboratory system. Over the next three years, the Ministry plans to consult with stakeholders as it implements the new Laboratory Services legislation, which enables government to strengthen patient services and ensure that resources are deployed efficiently and where they’re most needed. It also provides authority for the Province to better co-ordinate in-patient and out-patient clinical laboratory
systems province-wide and enables British Columbia to enter into agreements with service providers to provide greater certainty regarding costs.

**Pharmacies:** Community pharmacists working in approximately 950 pharmacies throughout the Province provide pharmaceutical care to patients, including dispensing prescription drugs, adapting and renewing prescriptions, solving drug related problems, counselling and education concerning optimal use of drugs, vaccinations and medication management. The BC PharmaCare program helps eligible BC residents with the expense of eligible prescription drugs and designated medical supplies. BC Pharmacare provides reasonable access to drug therapy in the community through seven drug plans including the income based Fair PharmaCare program and spent over $1 billion in 2008/09.

**Health Human Resources**

Undertaking this review has demonstrated the woeful inadequacy of primary and community care health human resource data and policy for the purposes of understanding the scope, skills, and current practice of the existing workforce or for the purpose of adequately planning for future needs. Most of the data is at a group level of raw supply of different professionals, age distribution, and community distribution (see the Data Booklet that accompanies the Health Human Resource Strategic Policy Paper). A key issue at this macro level is that of retirements. As the population of British Columbia ages, so does the pool of qualified workers. More than 20% of clinicians, technicians and support workers who currently provide home and community care in British Columbia will become eligible for retirement over the next five years.\(^81\)

An important component of building an effective, integrated primary and community care system is a clear understanding of roles and responsibilities between team members. Little work has been undertaken on this to date.

Finding solutions to better understand, develop, and maintain the necessary skills and experience, with the right mix of staff to meet the needs of the population, will be a major human resources challenge for this area going forward.

**Information Management and Technology**

Health care organizations strive to implement clinical information systems that enable them deliver high quality and error free 21\(^{st}\) century medical services. Creating a single health record for each patient will promote high quality care and improve health outcomes by ensuring clinicians have a greater level of accurate and consistent patient information. A single electronic health record per patient across the continuum of care (acute, ambulatory, and residential integrated with lab, medical imaging, health information, and pharmacy) will streamline the care process, improve the safety and efficiency of patient care, and provide clinicians with a longitudinal view of a patient’s medical history for better care decisions.

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\(^81\) Estimates provided by Northern Health Authority, Interior Health Authority, Fraser Health Authority, Vancouver Coastal Health Authority, and Vancouver Island Health Authority.
The BC health authorities have started working on a couple of projects to establish a common standardized, integrated, end-to-end clinical information system and environment which are using the Cerner software, including the Clinical and Systems Transformation project – initiated by the Provincial Health Services Authority, Vancouver Coastal Health Authority and Providence Health Care – and the iHealth project of the Vancouver Island Health Authority. They will enable the standardization of administration functions, such as referrals, scheduling, and registration. They will also enable the health organizations to better manage and measure wait times as well as provide comparable and timely data for efficient resource management.

These projects aim to deliver real-time health information to clinicians and researchers in a way the current heterogeneous systems do not. In time these and similar projects will be expanded to allow British Columbia to better manage future health care costs while improving the quality of patient care.

The advancement of technology for communications and information sharing has vastly improved in recent years resulting in more timely access to information by primary and community care providers, regardless of the historical challenges created by the province’s geography and dispersed health care system. The goal being pursued by the BC health system is to provide technology that allows physicians and health staff to bring increased services to patients than presently possible, in a safe and effective manner and increase the amount of relevant information available to practitioners and managers to both provide and plan for quality services.

**Telehealth** is an overarching term used to describe information and communication technologies used to connect health care providers, patients and educators over distance, to enable:

- clinical consultation; health care management;
- general health promotion and disease prevention; and
- continuing professional education.

Presently there are three broad categories of Telehealth technologies: store-and-forward, remote monitoring, and (real-time) interactive services, including the use of video conferencing technologies.

Telehealth services in British Columbia began with a principle of enabling care from a distance with services provided in health authority facilities. Developing services in this manner allowed for controlled growth, provision of support by multidisciplinary teams, and the capacity to fulfill privacy and security requirements by operating within the health authority technical infrastructure. That noted there are six Telehealth programs operated by each of the health authorities with no common, provincially endorsed standardized approach to Telehealth to support inter-health authority Telehealth. Its evolution to date might therefore be best characterized as ‘pilot project driven’ across a range of clinical areas (e.g., TeleMental Health; TeleThoracic; TeleOncology; TeleStroke; First Nations Telehealth; and, Home Health Monitoring).
Recently, there has been growth in internet-based Telehealth options for physicians to provide Medical Services Plan Insured Telehealth services from anywhere, to patients located anywhere in the province. The largest changes have been related to the frequency of use of billing codes for general practitioner Telehealth services. The number of consults has increased from 140 delivered in 2011 to 3,999 in 2013 and 5,636 in the first 3.5 months of 2014.

**Telemedicine** provides interactive healthcare utilizing modern technology and telecommunications. Health care services are provided from private vendor telehealth platforms and enabling patients to visit with physicians live over video for immediate care.

Telemedicine has demonstrated effective outcomes in rural communities. Using a blended model where the physician has a part time physical presence in the community, supplemented by telemedicine visits may be an effective way of increasing access to care by rural and remote residents including First Nations. Appropriate service delivery models which include a “tele-presenter” to facilitate capturing patient biometrics through the use of peripherals such as electronic stethoscopes should be further developed and evaluated along with appropriate reimbursement mechanisms.

Evidence suggests that as many as 40% of patients seeking help for mental health problems are seen only by family physicians. Telemedicine is well suited for addressing mental health issues by family physicians and Ministry policy should support the use of telemedicine visits, where appropriate to patients that are attached to a family physician or primary health care team.

Following an announcement by the Minister in June 2014, the Health Services Policy and Quality Assurance division is developing a set of policy recommendations on emergent telemedicine technologies including private vendor telemedicine providers. A fragmented, unmanaged approach to the expansion of telemedicine has led to increased Medical Services Plan costs, e.g., private vendor telehealth in BC resulted in both in and out-of-office general practice paid telemedicine services to rise 966 per cent as of March 31, 2014, compared to the prior year.

The current situation creates a risk of creating a number of “virtual walk-in clinics” delivering fragmented episodic care. The development of Ministry telemedicine policy recommendations is to ensure that emerging telehealth technologies are leveraged to support current strategies and objectives and deliver benefits to key populations.

**Electronic Medical Records** is a critical tool currently used by physicians to track, understand and deliver quality primary and community care to patients and across the health system. The meaningful use of

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84 Ministry of Health WorkForce Analysis Branch (Feb. 2014). Telehealth fee codes GP.
electronic medical record enables physicians to understand the needs of their patients and to monitor and evaluate how they are doing in providing quality primary care to improve the quality of care provided to patients and ultimately improve patient outcomes.

Additionally, knowing the characteristics of the patient population at a community aggregate level enables primary and community care service providers to work with community leaders and other partners to address population health needs and to mobilize health promotion and disease prevention action.

The key direction going forward needs to be founded on a system wide approach to information management and technology. Strategic direction and operational implementation must address key issues of system standardization and interoperability, while also ensuring patient privacy and security is maintained.

The use of technology to improve communication between health providers, to expand access to important information for managing specific health conditions, and to supplement direct care provision with health monitoring and care management tools represents an important opportunity for both clients and health care providers.

**Governance and Management**

Good governance and management is central to enhancing performance in primary and community care delivery. It is essential for the governance and management models to support a patient-centred model of care, remove barriers, give permission, set directions, better allocate resources, and enable change.

The Ministry has overall responsibility and stewardship for ensuring that quality, appropriate, cost effective and timely health services are available for all British Columbians. The Ministry currently directly manages a number of provincial programs and services. These programs include the Medical Services Plan, which covers most physician services; PharmaCare, which provides prescription drug insurance for British Columbians; and the BC Vital Statistics Agency, which registers and reports on vital events such as a birth, death or marriage.

The health authorities are the organizations primarily responsible for health service delivery. Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination and accessibility of services and province-wide health programs. These include the specialized programs and services that are provided through the following agencies: BC Cancer Agency; BC Centre for Disease Control; BC Renal Agency; BC Transplant; Cardiac Services BC; BC Emergency Health Services, which provides ambulance services across the province; BC Mental Health and Substance Use Services; and Perinatal Services BC. The Provincial Health Services Authority is also responsible for the BC Children’s Hospital and Sunny Hill Health Centre for Children and the BC Women’s Hospital and Health Centre.
The Ministry also now works in partnership with the First Nations Health Authority and Health Canada to improve the health outcomes for First Nations in British Columbia and build a better, more responsive and more integrated health system that will narrow the health gaps for First Nations. The First Nations Health Authority is Canada’s first provincial First Nations Health Authority and its creation is a key achievement of the Tripartite First Nations Health Plan signed in 2007.

**Primary Care Governance Mechanisms**

The BC government is revitalizing its primary care sector through operational rather than structural reform enabling gradual but systemic change from within. This approach involves providing incentives and bonuses for full-service family doctors, training programs to enhance clinical skills and promote practice redesign, recruitment incentives, and other efforts.

**General Practice Services Committee (GPSC):** since 2002, it has been the organization responsible for leading primary care reform. Its mandate is to find solutions to support and sustain full service family practice. Following a comprehensive consultation with BC’s family physicians in 2005, the GPSC developed and implemented a number of initiatives to improve patient access to quality primary health care, family physician job satisfaction, and facilitate system-wide improvements in the delivery of primary health care.

**Divisions of Family Practice:** were created in 2008 to participate in joint health-service decision making with their regional health authority, the GPSC, and the Ministry of Health to identify the gaps patient care in their community and develop solutions.

There are currently 34 Divisions of Family Practice located across the province. They serve as the mechanism for family physicians’ voice in local health care delivery decision making, family physicians engagement with their local health authority to enhance their ability to deliver care, improving professional support for family physicians, and helping family physicians work together to improve their clinical practices for comprehensive patient services.

The majority of BC family physicians are now members of their local division, and have identified improved collegiality, enhanced relationships with other health care practitioners, streamlined processes and better patient support across the spectrum of the health care system as a result of joining a Division of Family Practice.

A case study of one Division of Family Practice showed the following results:

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86 Ontario, Quebec, and Alberta embraced structural change. This includes encouraging physicians to leave private solo or small-group practices and changing compensation models from fee-for-service to salary, under capitation, or blended payment model with allied health teams or in community health clinics.

• Greater interaction among family physicians
• More ownership and accountability by family physicians for the implementation of projects
• Increased engagement by physicians in decisions about service delivery
• Greater implementation of initiatives to address community issues.

**Specialists Services Committee (SSC):** facilitates the collaboration between the Government, the Doctors of BC and the Health Authorities on the delivery of Specialist Physicians services. The SSC’s mandate is to improve access to needed, evidence-based, quality services to meet patients’ medical needs for optimum health outcomes. The approach is built on understanding population health needs, linking the optimized mix of service delivery options, technology options and health human resource options.

The SSC’s Health Authorities System Redesign initiative helps to ensure the long-term success of BC’s health care system by having Specialists play an important role in influencing, developing and implementing redesign plans. SSC funding is allocated to compensate specialists asked to participate in health system redesign initiatives led by the health authorities. The SSC supports Specialist’s leadership training available to promote or further work being undertaken within each health authority.

**Shared Care Committee:** is a subcommittee of the GPSC and SSC and was established under the 2006 Government/Doctors of BC Physician Master Agreement.

The relationship between family physicians and specialists physicians is fundamental to the delivery of effective health care, especially for the most complex patient populations. Shared Care Committee initiatives help strengthen this relationship, fostering mutual trust, respect and knowledge of each physician’s expertise and responsibilities, all of which are integral to effective collaboration and collegiality.

The mandate of the Shared Care Committee is to provide funding and project support to family physicians and specialist physicians to develop and test models of care that will improve the flow of patient care from primary to specialist services. Since 2006, the Shared Care Committee has helped more than 2,500 family physicians and 240 specialist physicians to work together on over 240 prototype projects across BC.

**Home and Community Care Governance Mechanisms**

The BC government has adopted legislation, regulations and policies mandating the licencing, delivery and funding of services of home and community care services. Services are authorized in the following ways:

• Overall, services and fees are prescribed under the *Continuing Care Act*, Continuing Care Fees Regulation and Continuing Care Programs Regulation;
• *The Community Care and Assisted Living Act* and the Residential Care Regulation and Assisted Living Regulation guide most residential care and assisted living services; and
• Services provided by licensed private hospitals or extended care hospitals are designated under the *Hospital Act*, Hospital Act Regulation, and *Hospital Insurance Act* and Regulation.

**Professional Regulation**

The regulated health professions in British Columbia are governed by 22 regulatory colleges under the *Health Professions Act* - including nurses, pharmacists, nurses, physiotherapists, chiropractors, midwives and massage therapists as well as a range of alternative health care providers providing naturopathy, traditional Chinese medicine and acupuncture - while emergency medical assisting is regulated by a government-appointed licensing board under the *Emergency and Health Services Act*.

The colleges have the authority to govern the practice of their members in the public interest. Their mandate is to serve and protect the public.

The primary function of the colleges is to ensure their members are qualified, competent and following clearly defined standards of practice and ethics. All colleges administer processes for responding to complaints from patients and the public and for taking action when it appears one of their members is practicing in a manner that is incompetent, unethical, illegal or impaired by alcohol, drugs or illness.

There are also social workers that practice within the health system. Social workers are a self-regulating profession governed by a regulatory college under the *Social Workers Act*.

Finally, a large percentage of non-regulated workers, volunteers, friends and family caregivers deliver home and community care services.

**Primary and Community Care Service Innovations and Initiatives in BC**

Since the early 2000s and more specifically through the signing off of the Primary Health Care Charter, the Ministry of Health, Health Authorities and the Doctors of BC have introduced numerous practice and service delivery innovations and initiatives with the intent of meeting the expanding demand for services due to the population demographics. The focus has been on identifying ways to improve the quality and accessibility of community based services and to minimize the costs associated with providing care, particular those, which are hospital and facility, based. These initiatives have been focused in all areas of primary and community care at the practice, organizational and provincial levels of primary and community care, including physician services, those services provided by regional and provincial health authorities and ministry/government wide strategic initiatives aimed at addressing the key sub-populations.

**Practice Level Incentives:**

A number of incentives have been introduced through the *GP Service Committee* (GPSC) to support the provision of quality care for priority services or support the restructuring of service delivery to better meet patient needs:
The Family Practice (FP) Incentive Program that supports and compensates GP delivery of guideline-based patient care. Incentive fees include:

- **Chronic Disease Management (CDM)** provides funding for GPs to not only identify chronic illnesses such as diabetes, hypertension, chronic obstructive pulmonary disease, and congestive heart failure but also to develop a care plan and work with flow sheets and registries to manage patient care;
- **The Conferencing Fee Initiative** for palliative care planning helps GPs provide compassionate, collaborative, and holistic care to palliative patients. The acute care discharge planning conference fee may be billed for patients who need support from a multi-disciplinary team or who need to transition from an acute care facility to the community or another facility;
- **The Complex Care Initiative** compensates FPs for the time and skill needed to work with patients with two or more of the qualifying chronic diseases (e.g., diabetes and ischemic heart disease), to develop a care plan, and liaise with the patient;
- **The Maternity Network Initiative** helps family physicians form “shared care networks” to share the responsibilities of providing continuous obstetrical coverage and full-scope maternity care through links with midwives, specialists, and other GPs;
- **The Mental Health Initiative** supports and compensates FPs for the time and skill it takes to work with patients with mental health illnesses. Physicians develop care plans in collaboration with the patient and his or her support network and, where needed, become an active member of a broader care team in order to help those patients remain safely in their community;
- **The Palliative Care Incentive** supports family physicians in planning and coordination of end-of-life care for patients, ensuring the best possible quality of life for dying patients and their families; and
- **Maternity Care for BC (MC4BC)** supports GPs who have dropped their obstetrical privileges to refresh and regain obstetrical skills and also supports additional training for graduating FP residents who want to incorporate obstetrics into their practice.

It is critical, in line with what was an innovative approach to aligning compensation with providing guideline-based patient care, that there is continuous and vigorous evaluation of the effectiveness of these payments linked to evidence of improved patient centred care and outcomes. There is the opportunity to continue to expand this approach away from traditional MSP fee setting as well as take steps to realize increased options for compensation models that include salaried, contractual and population need-based approaches.

**Practice Support Program (PSP)** that provides training and support for physicians and their medical office assistants that are designed to improve clinical and practice management and to support enhanced delivery of patient care. Initiatives include:

- **PSP Technology Group** supports BC physicians and clinic staff preparing for, adopting, and optimizing Electronic Medical Records.
• Learning Modules are physician-led group training sessions offered in communities throughout BC. These group sessions are followed by action periods during which PSP participants try out what they have learned in their own practice.

• Practice Coaching is ongoing support provided by PSP regional coordinators to help physicians (including those who have not participated in a PSP learning module) implement practice changes and sustain improvements.

• Practice Self Assessments provides GPs with a simple method for examining the needs of their clinical practice and identifying key areas for change or improvement. GPs and their staff can explore new ways of working to enhance the efficiency of your practice and your effectiveness as care providers.

• Orientation includes materials to assist in PSP module delivery.

Going forward, there is the opportunity and need to expand practice support in line with exploring alternative compensation models. With both an aging physician demographic and a changing work ethos for younger physicians joining the health system new practice models are required. With a number of retiring physicians not being able to find younger physicians to take on their practice resulting in multiple patients becoming unattached (an especially critical issue for older patients) there is a need to actively pursue new practice models including multi-professional owned- health authority/MSP contracted clinics as well as health authority owned and operated clinics to better meet patient needs. This requires practical tools and help to physicians transitioning their services at the end of their careers or for younger physicians entering the health system.

In-Patient Care Program which is designed to better support existing care provided by GPs for patients in hospitals. The GPSC’s In-Patient Care Program recognizes the importance of a continuous doctor-patient relationship. An important component of which is the coordination of patient transitions between community family physicians and hospitals. The In-Patient Care program is designed to better support existing care provided by FPs for patients in hospitals. Funding totaling $31.9 million has been identified to provide incentives aimed at better supporting and compensating FPs who provides this important aspect of care. They include:

• Assigned In-patient Care Network Incentive;
• Unassigned In-patient Care Network Incentive;
• Unassigned In-patient Care Fee; and
• Enhanced clinical fees for select In-patient MRP services.

Going forward this area requires renewed debate and fresh thinking, especially in metro and urban areas as to the practicality of physicians working in hospitals especially under the individual practice model that continues to dominate practice. The more integrated community-hospital practice approach of rural physicians provides a potential model, albeit needing modification in metro and urban communities, built around integrated clinics providing care into hospitals versus the current hospitalist model. This will also require a broader rethink and debate about the accountabilities of specialists for their patients and the potential expanded role of RNs and Nurse Practitioners in caring for and discharging patients.
A GP for Me/Attachment Initiative recognizes the importance of continuous doctor-patient relationships. It is aimed at improving quality health care in community and improving the health outcome of BC residents. Announced in February, 2013, the GP for Me initiative runs until the end of fiscal year 2015/16 and strives to:

- Confirm and strengthen the relationship between family physicians and patients;
- Better support the needs of vulnerable patients;
- Increase capacity within the system; and
- Enable patients who want a family doctor to find one.

The aim of the approach is to ensure that all BC citizens who want a family doctor are able to access one by the end of the initiative. The program includes $60.5 million for two years for new family physician fees including: Zero Sum Attachment Participation Code; Telephone Management (Visit) Fee; Expanded Complex Care; Management Fee; Patient Conference Fee; and, Unattached Complex/High Needs Patient Attachment Referral Fee. It also includes $40 million to Divisions of Family Practice over three years to:

- Conduct research to evaluate the number of people looking for doctors in their community, the needs of the local family physicians, and the strengths and gaps in local primary care resources
- Develop a community plan for improving local primary care capacity, including a mechanism for finding doctors for patients who are looking for one.

A range of additional initiatives and supports have been introduced through both the Specialist Services Committee and the Shared Care Committee:

- **Partners in Care**: Working through Divisions of Family Practice this initiative enables physician teams to develop, test, and implement new processes, systems, and models of care. A model of care that has received national attention is the RaceLine, a telephone advice hotline providing family physicians in Vancouver, Northern BC and the Central Okanagan with access to non-urgent, specialist advice (calls returned within two hours, on average);
- **Transitions in Care**: Providing seamless patient care varies from one BC community to another as a result of hospital and community size, local culture, and history surrounding the creation of treatment pathways. This initiative works with local Divisions of Family Practice and other groups in acute care and community settings throughout BC in order to create or support sustainable processes to alleviate tension or congestion at patient transition points in the local health care system;
- **The Polypharmacy Risk Reduction initiative** supports family and specialist physicians to improve the management of elderly patients on multiple medications that may impact their safety and quality of life. The initiative aims to improve patients quality of life and decrease hospital admissions through quality improvement measures such as, de-prescribing unnecessary medications and preventing adverse drug reactions;
- **The Teledermatology initiative** supports the use of digital technology and the Internet to improve access to dermatological consults for family physicians in urban, remote, and isolated
communities in BC. More than 400 BC physicians are using a process known as "store and forward" to eliminate the prolonged wait times for dermatologists that patients in rural, remote, and even urban areas of the province usually endure;

- **The Rapid Access to Psychiatry initiative** is increasing capacity and using existing resources for psychiatric patient care in BC through an alternate model of care that includes group medical visits and/or physician-patient e-mail communication for treatment of patients with depression and anxiety;

- **The Children and Youth Mental Health and Substance Use Collaborative** is a provincial wide initiative aimed at improving system integration, addressing systemic barriers to timely and effective care and increasing timely access to support and services for child and youth mental health and substance use services in BC. Three\(^8\) of the Health Authorities actively involved in this collaborative which involves an unprecedented number of stakeholders youth, parents, family doctors, specialists, three government ministries, RCMP, school counsellors, and First Nations groups; and

- **System Redesign**: In partnership with the General Practice Services Committee and the Specialist Services Committee, this initiative supports physician participation in system redesign initiatives led by the BC health authorities by providing funds to compensate physicians for their time spent participating to improve the delivery of both primary and specialist care services. This partnership also offers scholarships for physicians for successful completion of leadership training approved by a health authority.

Taken together, the GPSC, Shared Care and Specialist Services Committees’ initiatives have represented a significant investment either directly in primary care or to support the interface between primary and acute/facility based care. They have served to stabilize, support and enhance full family practice and longitudinal care for patients in their communities. They provide an infrastructure to further improve services but also a challenge in how to incorporate this collaborative, consensus based approach into realizing effective change in a timely manner.

Over the coming year there is a need to reconcile these two objectives through creative thinking and recognizing the need to mature these structures into an integral part of the health system with attention being paid to assessing results achieved to investment made, role clarity, efficient and effective decision making and collaboration, strong professional relationships between physicians, health authorities and the Ministry of Health. Going forward there is the opportunity to take a leadership role in bringing forward and facilitating new practice models for specialists including virtual or collocated multi-professional owned fee for service or health authority/MSP contracted clinics as well as health authority owned and operated clinics to better meet patient specialist needs in terms of referrals, consults and treatments.

\(^8\) Interior Health Authority, Fraser Health Authority, and Vancouver Island Health Authority.
Health Authority-Based Initiatives

At the organizational level of the health system, regional and provincial health authorities, there have been a number of investments by the BC Government to encourage system level integration and to target identified high risk/need sub-population groups. Three waves of activities have occurred to date in the form of experimenting with Integrated Health Networks; Bi-Lateral Agreements between Ministry of Health and Health Authorities; and through the reorientation and redesign of existing health authority community services:

**Integrated Health Networks (2008-2010):** In 2007 the Primary and Community Care Charter identified the need to focus on a small number of high impact system wide ‘infrastructure’ initiatives for priority populations. Between 2008 to 2010 regional health authorities established approximately 2599 Integrated Health Network (IHN) ‘teams’ - focused on patients with multiple chronic health conditions, as well as those with moderate to severe mental health and substance use challenges, and/or the frail elderly - in each of the regional Health Authorities90.

IHNs incorporated evidence that more value could be gained by focusing dedicated multidisciplinary resources as a team to meet the defined medical (and psychosocial) needs of sub segments of the population over a defined geography91. Each network or integrated team of providers would provide functions such as patient self-management training and support, education; life coaching and solutions focused counselling, group medical visits, and effective linkages to home and community care, medical specialists and local hospital to home transition teams. The goal was to shift the patient experience away from multiple fractured services to support continuous patient centred care across the continuum of health status and needs, with patients having a central role in staying healthy and managing their own conditions.

The following five outcome objectives were identified for the program:

- Improved health outcomes and quality of life for chronic disease patients;
- Decreased average annual cost per patient for chronic disease patients;
- Improved patient access to primary and community care;
- Improved patient experience with primary and community care; and
- Improved provider experience with primary and community care.

At the end of the formal IHN funding period (March 2010) 26,178 patients had received services (most for less than one year), and 423 family physicians across the province had been engaged92. 13,008 consented patients out of a total of 26,178 IHN patients, who were receiving services, participated in the evaluation (out of 36,157 targeted). Delays in patient enrollment due to challenges with putting in place

privacy and information sharing agreements meant a shortened window for evaluating the impacts of receiving services prior to the agreements concluding.

Evaluation findings of the initiative included:

- Hospitalization rates of Ambulatory Care Sensitive Conditions (ACSCs) and re-hospitalization rates increased for most IHN patients during their short enrollment, but were lower when compared to the non-IHN control group patients for the same period.
- Cost savings were achieved in some IHNs but not all; two IHNs did achieve cost neutrality while others showed a positive trend toward decreasing costs in acute care.
- IHN patients reported a high level of satisfaction in accessing primary and community care services; all IHNs met the target set out for improving patient access to primary and community care.

Outcomes and lessons learned from the experience of putting in place Integrated Health Networks set the stage for the next phase of integration efforts in BC in the form of bilateral agreements.

**Bilateral Agreements:** The 2010 – 2015 bilateral agreement between the Ministry and Health Authorities, defined clinical and service integration principles and parameters to enable a broader systems approach to meeting community health needs along the Triple Aim of improved health of the population, improved per capita costs and improved patient and provider experience. The vision was to implement an integrated system of community based health care (IPCC), where all services are coordinated and delivered in the community by a family physician and an integrated health care team. By focusing on planned proactive integrated primary and community care, patients that have chronic, co-morbid and/or complex medical care needs can be cared for more effectively and appropriately within the community and reduce avoidable utilization of acute and residential services.

Established principles of successful health system integration adapted to BC as part of these agreements included\(^93\): comprehensive services across the continuum of care, patient focus (population based needs, role and experience); geographic coverage (system takes responsibility for an identified population in a geographic area); standardized care delivery through inter-professional teams; performance management; integrated electronic information systems for shared clinical care and data management; organizational culture and leadership at practice, organizational, and provincial levels; physician engagement and integration; governance structures that promote coordination, responsiveness and accountability; and integrated financial management (versus differentiated funding across service sectors).

Using these principles, a fundamental shift during this time was realigning existing Integrated Health Networks and reorienting services (cross sector) for priority populations with newly forming Divisions of Family Practice. To establish physician engagement in collaborative decision making and priority setting

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around a shared vision of community health needs and services, locally responsive structures were developed called a Collaborative Services Committee (CSC).

In October 2013, an interim IPCC evaluation report called ‘Making Strides in Integration’, prepared by the Michael Smith Foundation for Health Research as part of an embedded evaluation approach concluded that overall, with respect to the ten externally derived principles associated with successful integration, IPCC had made significant strides with respect to the majority of them but perhaps most significant was the establishment of a joint governance structures (Collaborative Services Committees, Interdivisional Strategy Councils) and a common vision.

The report identifies the ongoing establishment of Divisions of Family Practice as critical with respect to the fundamental principle of physician engagement and integration and that “with hindsight, there is now recognition that for both these processes, considerable amounts of time had to be invested in overcoming historical differences and building trust”. However, these investments resulted in an essential foundation for moving forward on integration and team-based care. The report concluded ‘there is much more work to be done, including building an information system that will support transformation and developing a provincial strategy for patient reported measures so that the patient focus is truly incorporated. At this juncture, overall, we find that significant strides have been made in laying the foundation for successful integration’.

Island Health in partnership with the Ministry conducted further outcome analyses in 2012 of its IHNs, which have continued to provide services to patients in the identified target populations (mainly chronic co morbid and frail elderly) as part of the next phase of integrated primary and community care activities across the province. Impacts on the target populations over the four-year timeframe demonstrated:\(^\text{94}\):

- Reductions in lower acuity emergency department visits for IHN patients (Canadian Triage Acuity Scale 4 and 5) by between 10 and 20%;
- An estimated $1.2M hospital cost savings measured within a three year attachment period;
- Improved clinical outcomes for IHN patients including: improved hemoglobin A1C test scores, improved blood pressure, smoking cessation (participation in classes and clients remaining smoke-free);
- Improved patient confidence to manage their own care (78% of clients currently participating in goal setting in shared-care plans);
- Increased Group Medical Visits (GMV) approach with over a third of the physicians involved with IHNs having held a GMV: a new way of delivering integrated services with an associated outcome of increasing capacity;
- Increased physician participation with a low withdrawal rate indicating IHN teams have been successful in establishing reliable working relationships with local physicians; and
- Improved provider satisfaction / job satisfaction and benefits for IHN team members when working in multidisciplinary teams.

The report concludes with the following recommendation:

‘Overwhelmingly, from both the data and the patient and clinician’s perspectives, the interdisciplinary team approach has shown positive results in caring for complex, co-morbid patients. Given the measured reduction in hospital care costs – coupled with the reduction in ER visits for less urgent situations – the Integrated Health Network [team] model needs to be incorporated into VIHA’s planning for increased integrated primary and community care.’

Additionally, in 2014 Interior Health (IH) conducted an analysis of its re-aligned IHNs which continued beyond the initial bilateral agreements but were transitioned to align with newly formed Divisions of Family Practice95. This process also allowed IH to collaboratively re-establish the local priority populations and associated functional needs jointly with the Divisions (through local CSCs), along with co-decide types of allied health services to be oriented around the family practice. Currently there are 352 physicians involved and 28 FTEs of IH bilateral funded allied health services including: Registered Nurses, Social Workers, Registered Dieticians, Integrated Care Coordinators (one palliative focused) with links to home health team, Respiratory Therapists, PTs and OTs. Services are offered through multiple points of access but mainly by physician referral to services outside of the physician’s offices rather than through co-location of services.

Selected key findings from the IH (baseline) report include:

- While numerous multidisciplinary team activities are occurring, and care planning process occurs with patient engagement and one or more clinician, the team approach is more visible in the models that provide care primarily from the physician offices (co-located);
- Over 3,550 patients from the target populations were served between April 2013 and April 2014 and while 71% have care plans created, there is a need to agree on a standardized shared care plan template to facilitate better integration and information sharing;
- Current information systems do not facilitate communication, linking of patient information and shared care activities between physicians and linked health authority allied health services; this area is a barrier to team-based care and requires enhancement; and
- Assigning allied health teams around a geographical group of physicians has been identified as an enabler toward integrated care; potential to increase physician capacity for complex patients with additional team-based supports as part of the continuum of care rather than a stand-alone referred enhanced service.

Reorientation and Redesign of Existing HA Services: Between 2010-2014, health authorities have selectively redesigned and streamlined existing community-based allied health services and processes to develop a more streamlined and efficient community-based system, including improved linkages and

95 Interior Health Authority (July, 2014). Describing the Service Delivery Models of Integrated Primary Care in CIHS, Internal Report.
coordination to family physicians, integrated processes and new models of service delivery for priority populations (chronic co-morbid, frail elderly, mental health and substance). Examples include:

- Case managers and/or home health staff reoriented around individual family doctors (or groups of family doctors) to provide coordinated, comprehensive continuous care for shared patients, rather than geographic caseloads that are not aligned to physician practices96;
- Re-orientation of patient education, self-management training and peer support groups (i.e. group patient visits / Group Medical Visits);
- A patient-held collaborative care plan and involvement of patients and families/caregivers in care planning and goals setting based on individual needs;
- Integrated provider training, multidisciplinary practice support and inter-professional education;
- Enhanced shared care between medical specialists and family physicians in the areas of regional intensive complex patient care planning and collaborative care models;
- Formal and informal memoranda of understanding and service agreements outlining information sharing, roles and responsibilities, and scopes of practices; and
- Enhanced clinical decision support through access to office-based information technology hardware, connectivity and electronic medical records, such as EMRs, myHealth Plan, Smart Phone App and e-Shared Care Framework.

The IHNs and subsequently Integrated Primary Care Teams (IPCC Teams), along with the health authority service re-orientation of existing services and processes, represent significant policy initiatives undertaken to shift the system toward the establishment of inter-professional teams and a system of primary and community based care. Notably, these policies were implemented in the context of existing payment systems: Fee-For-Service payment model for physicians, targeted incentive payments for chronic and complex care planning, management and conferencing with other providers (GPSC Full Service Family Practice incentives), and global payments to regional HAs for community based allied health services). While progress has been made, consistent barriers and challenges to the spread of team-based care in BC following IPCC policy implementation have been identified including:

- Services have been added as net new service and at additional system cost (earmarked funding), rather than full redesign of community-based system of HA services to integrate with GP practices and patient panels. Non-standardized care plans, definitions and processes.
- Multiple systems of electronic documentation and communication that are not integrated. Information sharing between providers to support shared care and multidisciplinary charting for common patients is limited by lack of interoperability across electronic medical records and HA systems.
- The current policy implementation has created ‘haves and have-nots’ - there is not equity in terms of accesses to and distribution of enhanced allied health services for specified patients and providers. Space limitations for co-location of providers and distance between GP offices and allied health staff create further barriers.

96 Health Authority Quarterly IPCC Monitoring Reports (2011 to 2014).
• There is limited change management /coaching supports and applied multidisciplinary training and education available to support putting in place appropriate team members based on functional needs assessments and service gaps at the practice and community level. Change management to build trust and create a culture and expectation of team-based care based on clarity around scopes of practice, and documentation of roles and responsibilities of team members needs to be better coordinated at all levels and resourced appropriately. A culture of hierarchy among professionals is deeply embedded. Access to timely and appropriate data for planning (baseline), implementation monitoring and action learning (quality improvement cycles) is needed, as is linkage to provincial databases in order understand whether or not population needs are being addressed effectively and efficiently.

• Clarity as to operational and managerial oversight of the teams locally, and how that is established in context of CSCs and Interdivisional Strategy Councils.

Recently, the Conference Board of Canada produced a four part series aimed at improving primary and community care through collaboration and the establishment of inter-professional teams. Findings with respect to barriers that impede successful inter-professional teams mirror the experience and learnings in BC. The report identifies barriers to collaboration that inhibit the optimization of inter professional primary care teams:

• At the individual-level barriers include lack of role clarity and trust, and hierarchical roles and relationships;
• At the practice-level barriers include lack of strong governance and leadership; difficulties in establishing appropriate skill mix and team size; and inadequate tools for communication; and
• Finally, at the system-level barriers include inadequate inter professional education and training, suboptimal funding models, and lack of appropriate monitoring and evaluation.

Additionally, in June 2014 the three western provinces held a roundtable to discuss policy options to support team-based primary care. Four policy imperatives were identified:

1. Align health system goals, policies, workforce and structures (Ministry of Health, regional health authorities and independent practices) to optimize team-based primary and community care;
2. Develop appropriate and sustainable compensation models to support team-based primary and community care;
3. Invest adequate resources to support system change and a team-based primary and community care model; and
4. Integrate collaborative practice metrics in primary and community care monitoring and evaluation.

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97 [http://www.conferenceboard.ca/temp/860f82ca-ef06-4240-9866-bb0f05db1e5d/13-146_primaryhealthcare-briefing-2.pdf](http://www.conferenceboard.ca/temp/860f82ca-ef06-4240-9866-bb0f05db1e5d/13-146_primaryhealthcare-briefing-2.pdf).

98 Alberta Health Services Workforce Research and Evaluation Roundtable on Policy Options for Team Based Primary and Community Care (June 2014). *Finding the Right Policy Levers for Interprofessional Team Work in Primary and community care.*
In addition to these three waves of activity focused on strengthening team-based-care, there have also been a number of population-based initiatives:

**Accelerated Integrated Primary and Community Care**: Since 2012, each health authority has received up to $10 million annually to accelerate the implementation of integrated primary and community care. Access to quality evidence-based community care services to better support patients and their families. The integrated primary and community care acceleration initiatives (aIPCC) were developed to tailor services and focus on enhancing supports to frail seniors in the community, those with severe mental health and substance use (MHSU) issues and patients with low, medium or high complex chronic conditions. The initiatives are part of the long-term plan to shift the focus from the acute sector to the community, which coincides with the service delivery strategy that includes home and community supports and effective and efficient service delivery.

Reported aIPCC initiative outcomes to date include a reduction in emergency department visits, acute care admissions, average hospitalization rate and length of stay. Initiatives include:

- **Frail Seniors in the Community: Home is Best** – Comprised of a suite of aIPCC initiatives and strategy underway in all five regional health authorities to better support patients, their families and caregivers, the Home is Best program’s goal is to support high-needs clients to live in their homes while waiting for residential care, to avoid residential care if possible, to avoid acute care use if not appropriate and for end of life clients to allow for a supported home death if possible.

- **Severe Mental Health & Substance Use (MHSU)**: Four health authorities (Fraser, Interior, Island and Vancouver Coastal) have aIPCC MHSU initiatives including: Psychosis Treatment Optimization Program (PTOP), Integrated Community MHSU with Primary Care, Assertive Community Treatment (ACT) and Acute Home Based Treatment (AHBT). The MHSU aIPCC initiatives focus on expanding treatment in the community.

- **Chronic Conditions (Low, Medium, High Complexity)** - The HAs which have aIPCC complex chronic conditions initiatives include FHA, IHA, Island Health and VCH: Initiatives include: BreathWell, Community REDi, Early Support Discharge (ESD), Frail Senior/Chronic Disease Community Transitions and Intensive Integrated Care Management Approach. The complex chronic disease aIPCC initiatives are improving assessment of seniors at risk from multiple chronic conditions and building care teams to support an early discharge from acute care.

**Provincial Initiatives**

The Ministry of Health has or is taking a number of steps to shape provincial policy and action in support of primary and community care through several initiatives:

- **Innovation and Change Agenda** - In 2010 the Ministry of Health implemented the Innovation and Change Agenda, which included as a priority “meeting the majority of health needs with high quality primary care and community based care and support services.”
In 2013, the Ministry initiated a project aimed at evaluating the impact that the Innovation and Change Agenda has had at the system, health sector service delivery system, and strategic planning levels. This project is a collaboration between the Ivey International Centre for Health Innovation (ICHI), the Institute for Health System Transformation and Sustainability (IHSTS) and BC Ministry of Health.

The project aims to assess the strengths and effectiveness of the Innovation and Change Agenda, identify key learnings and promising or best practices and ultimately provide recommendations on ways to catalyze provincial innovation at the health system level. When finalized, the project could be used to inform implementation and successful execution of the Ministry’s strategic agenda.

Implementing a Quality Assurance Framework - Achieving Meaningful Outcomes and Quality Dimensions – Currently, BC, like many other jurisdictions, has limited capacity to routinely report out on many of the quality dimensions associated with the primary and community care services it provides to BC citizens. A number of steps are underway to address this deficit – first by incrementally implementing a health services quality framework to shape the collection and analysis of information and second, strengthening the IM/IT infrastructure to provide information (see below in the section on IM/IT). The Health Services Quality Framework (the Framework) is under development to support the BC’s health system’s commitment to improving continuously improving quality (see BC Health System Strategy Implementation, April 2014) by describing important enablers of quality improvement and a consistent approach to quality assurance activities. The Framework is intended to describe a high-level approach to quality that ties together the wide variety of existing quality activities while also guiding the development of new programs and initiatives in a consistent, quality-focused manner.

It is proposed that the Framework will have three sections (see Figure 15):

1) The Quality Foundations section will set out the core concepts that are used to approach all other aspects of the Framework: patient-centeredness and the seven dimensions of quality described in the BC Health Quality Matrix.

2) The Quality Assurance Enablers section will describe the key system functions that are required to drive improvement in quality of care.

3) The Quality Assurance Functions will set out how the health system can approach enhanced ways of measuring, reporting, understanding, and improving health service outcomes.
The Framework will be applicable to all health care organizations in BC across all areas of care, including primary and community care and will be used collaboratively to drive improvements to primary and community care services. As noted in Setting Priorities for the BC Health System (February 2014), while improvements have been achieved in many areas there are ‘several service areas linked to primary and community care that remain challenging form a quality of care perspective in spite of significant effort (see below on service innovations in BC): access to family physicians and primary care services in many areas of the province; access to mental health and addiction services; proactively responding to the needs of patients with moderate and high complexity chronic illnesses and/or frailty to avoid hospitalization wither through effective and appropriate primary and community care services or access to medical specialists services; proactive planning for residential care rather than through hospitalization. These areas provide a challenge to improve the quality of the primary and community care services in the coming decade. Existing policies and programs need to be reviewed against the domains of quality and a patient centered lens to ascertain where additional or different actions are needed to enhance care.

Patients as Partners: Patients as Partners was developed in 2007 based on the recognition that the health care system is typically designed around the healthcare needs of health professionals leaving patients without sufficient information and supports to make informed decisions and implement changes (see Figure 16). Patients were provided with appropriate self-management support[99] and an

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[99] Adams, Greiner & Corrigan (2004). Self-management support is defined as the systematic provision of education and supportive interventions by health care staff to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.
opportunity to self-manage and undertake tasks to live well with one or more chronic conditions. In addition, families, friends and caregivers have a unique perspective on the health care system that is different from that of the provider, health care worker or administrator.

The Patients as Partners philosophy can lead to key improvements at each level of the health system (practice, organizational, and provincial levels).

Figure 16: Patients as Partners Charters

Key benefits of the Patients as Partners approach include:

- Patient voice adds value in both understanding challenges in the health care system and creating solutions;
- Patients who are more engaged in their own health care have better health outcomes, are safer, and have an improved experience of care;
- Providers report an improved experience in care-delivery when they work with patients at the centre of care, and the system itself saves money when people are healthier and safer; and
- Providers and frontline health care staff also experience a positive impact, including: improved attitude towards engagement and health care users; acceptance of patients as full partners in care; and enriched teamwork and morale.”

The Patients as Partners perspective and approach will continue to directly inform the Ministry’s strategic directions for the health system including the development of an integrated system of primary and community care.

Closing the Health Status Gap for Aboriginal Peoples: In the summer of 2014, the Ministry of Health and the First Nations Health Authority signed a mutual letter of accountability outlining the roles, functions, and emotional management.

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Adams, Greiner & Corrigan (2004). Self-management refers to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management, and emotional management.
commitments and accountabilities of each party, with respect to the planning, administration, delivery and monitoring of health services in support of the FNHA’s responsibility to design, manage, and deliver health promotion and disease prevention services to BC First Nations. Additionally, the parties are working to improve the services accessed by First Nations across the broader provincial health system as set out in the BC Tripartite Framework Agreement on First Nation Health Governance (2011, Section 4.2(2)) 101.

In 2014, the FNHA leveraged a $15 million dollar multi-year commitment from BC through an agreement in lieu of MSP premiums. As per the Agreement, the Joint Project Board has a three-year multi-million dollar fund available to initiate primary care projects across the province that will be sustained in future years. Projects funded through this envelope will result in health service improvements and may include such investments as: additional health care providers to previously underserved locations, and the introduction of new, innovative models of health service delivery102.

Regional Partnership Accord tables will be the forum for identifying projects and recommending to Joint Project Board which projects to fund in their region. Joint Project Board investments in Primary Care projects – for regional decision-making will total $5.55 million for 2014-2015. In addition to the regional planning targets, $4 million will be invested directly by the Joint Project Board to support flagship innovation projects in each region103.

Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia: The Government of BC released Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia (Healthy Minds, Healthy People) in 2010. It highlighted the importance of addressing mental health and substance use as key factors in the overall health of British Columbians. Jointly developed by the Ministry of Health and the Ministry of Children and Family Development, Healthy Minds, Healthy People emphasizes the determinants of good mental health and well-being by building strengths and resilience in children, youth and families. It outlines strategies to prevent and delay the onset of problems in people of all ages, and to improve treatment and support when problems occur. This “whole-systems approach” required partnership and action across sectors, involving individuals and their families, promoting evidence-informed policy and practice, and ensuring accountability for results.

The overall goals of Healthy Minds, Healthy People are to:

- Improve mental health and wellbeing of the population;
- Improve the quality and accessibility of services for people with mental health and substance use problems; and
- Reduce the economic cost to the public and private sectors resulting from mental health and substance use issues.

101 Ministry of Health/First Nations Health Authority 2014/15 Letter of Mutual Accountability.
102 First Nations Health Authority: 2014-15 Year ahead, pg. 11.
103 Ibid.
Key areas of focus in the community for the next three years are under development with four areas under consideration:

1. Expanding services for people with mild to moderate mental health and/or substance use problems.
2. Expanding the reach and range of harm reduction initiatives. The Ministry of Health is working with health authorities to create 500 additional substance use spaces that will include a significant role for the non-profit sector in the delivery of these new spaces, by 2017. The locations and type of additional substance use spaces being developed will be based on a needs-based planning exercise that will consider the gap between current services available and unmet need for service.
3. Strengthening cross-system collaboration and coordination for a comprehensive and integrated system of care.
4. Improving Reach, Access and Responsiveness of Services and Interventions for People and Families with Complex Needs.

Cross Ministry Initiatives on Adults with Developmental Disabilities: In December 2011, a committee of Deputy Ministers considered concerns expressed by individuals with developmental disabilities and their families and reviewed the operations of Community Living BC (CLBC) and related linkages to relevant government ministries. A cross-ministry team that included representatives from Social Development and Social Innovation, Children and Family Development, Education, Health and CLBC, was tasked with developing an action plan for delivering on 12 recommendations provided by the Deputy Ministers. The goal of this team was to develop an integrated service delivery system that would provide a long-term sustainable care system for individuals with developmental disabilities and their families.

The Ministry of Health and Health Authority leads have been active participants in the working groups established by the Services to Adults with Development Disabilities (STADD) initiative during the past two years. In the first year of the project (2012/13), the business processes, including a common assessment platform and performance measures, were developed for the early implementation sites launched in late 2013 and early 2014. The Ministry, in collaboration with CLBC, developed a three-year aging action plan for adults with developmental disabilities in 2013/14, which includes three major priorities/goals:

1. Provide access to early information and early planning;
2. Assess and redesign health services and supports as individuals move through the transitions associated with aging; and
3. Forecast future demand for services and supports for aging adults.

The action plan deliverables for year one (2013/14) have been completed. There are two deliverables for completion in year two (2014/15): building awareness and understanding of the needs of aging adults with developmental disabilities to the health care community and exploring the creation of customized technologies and services for use by CLBC eligible individuals and their families. The remaining deliverables will be completed in year three (2015/16).
Improving Care for BC Seniors: An Action Plan: In February of 2012, the government of BC released Improving Care for BC Seniors: An Action Plan (Seniors Action Plan) to address concerns expressed by seniors, their families, and care providers about seniors care in British Columbia. The Seniors Action Plan was informed by the findings and recommendations of the BC Ombudsperson in the report The Best of Care: Getting it Right for Seniors in British Columbia (Part 2), which was released at the same time. It committed to making improvements to seniors’ care through twenty-six key actions organized into six themes, corresponding to the Ombudsperson’s report.

They included:

- **Concerns & Complaints:** To provide appropriate avenues to have complaints heard and dealt with in a fair manner;
- **Information:** To improve the scope, quality and access to the information seniors and their families need to understand and access services in a timely and informed way;
- **Standards & Quality Management:** To ensure more consistent delivery of care across services.
- **Protection:** To improve the protection of seniors from abuse and neglect;
- **Flexible Services:** To provide flexible services to meet care needs; and
- **Modernization:** To modernize the home and community care system to provide sustainable and lasting improvements that will better serve seniors across the province.

Most of the actions in the plan were completed in the first year. Some actions were completed in the second year of the plan, while others focusing on the modernization of BC’s home and community care system were intended to take longer and will continue as part of government’s refreshed health system strategy for British Columbia. In 2013 the Ministry of Health committed to revisit the details of the Ombudsperson’s report with a commitment to greater specificity of action and reporting on the recommendations going forward. This work is now underway and will remain a focus over the coming two years.

**Dementia Action Plan:** Due to the present and anticipated increase in the number of people living with dementia in BC, the Ministry of Health released The Provincial Dementia Action Plan for British Columbia in 2012 to support improved health outcomes for people in BC with dementia and their families. The plan was developed in collaboration with health authorities, health care providers, clinical experts and key partners, such as the Alzheimer Society of British Columbia. The plan committed to specific priorities designed to improve the health and quality of care for people with dementia from early diagnosis through to end of life, including: supporting prevention and early intervention; ensuring quality person-centred dementia care; and strengthening system capacity and accountability.

Built around a system of integrated primary and community care, the plan aims to increase individual, family, community and health services capacity to provide early, safe and appropriate person-centred care. It supports people living with dementia in BC to stay at home and in their communities to the greatest extent possible reducing or delaying transition to a residential care facility and the important

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role of family caregivers. The initiative also supports increasing awareness of brain health strategies and providing early access to support and information to manage the physical, behavioural and psychological symptoms of dementia.

To reach these goals the Ministry of Health set out a number of actions. Notable achievements to date include:

- Expansion of the Alzheimer Society of BC’s First Link® Program which provides connections to learning, services and support to individuals diagnosed with dementia and their families;
- Health care providers in residential care are being trained with the P.I.E.C.E.S.\(^{105}\) program which provides a systematic framework for detection, assessment and care planning using a person-centred approach; and
- The 48/6 Model of Care for hospitalized seniors is being used in our hospitals and all acute inpatient care settings. The 48/6 model focuses on screening and assessment in six (6) key care areas – including dementia - and the development of a personalized care plan in 48 hours.

The 2012 Dementia Action Plan was conceived as a two-year plan. Its achievements were mapped against best practices, gaps and areas for improvement were identified, and recommended actions to address these gaps were developed. A newly drafted/Refreshed Dementia Action Plan for the next three years (2015/16 - 2017/18) incorporates dementia related priorities from Setting Priorities for the BC Health System, expands the work identified in the first action plan and provides a comprehensive approach to the patient’s journey from diagnosis to end of life.

Dementia impacts roughly 70,000-75,000 British Columbians. The number of people suffering from dementia is expected to rise to 105,000-110,000 by 2025.\(^{106}\) This increase marks dementia as one of the biggest health challenges for the province and indeed for elsewhere in Canada and around the world. To meet this challenge, the draft dementia action plan aims to improve the lives of people at risk for dementia, people living with dementia, their families and caregivers.

The Refreshed Dementia Action Plan has four priorities: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care facilities and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care. It is structured around the journey travelled by people with dementia, their families and caregivers. It was designed to address the health care needs of the BC population into the four areas of focus: staying healthy, getting better, living with illness and disability, and coping with end of life.\(^{107}\) Finally, the four priorities touch on the transitions along the way. Transitions include: receipt of a diagnosis of dementia; changes in the living environment (e.g., need for family and/or caregiver support to allow independent living); and decisions about residential and end-

\(^{105}\) P is for Physical health; I for intellectual capacity and behaviour; E for emotional health, spiritual; C for capacity (function); E for environment; and S for social, cultural, life story.

\(^{106}\) Workforce Analysis, Health Sector Workforce Division, Ministry of Health, Dementia (age 45+ years) March 24, 2014, project 2014_010 PHC.


of-life care. These transitions often increase the need for additional support from health care or other support services.

A skilled, informed, collaborative and respectful health care workforce\textsuperscript{108} is needed to implement the Refreshed Dementia Action Plan. This includes actions aimed at strengthening the workforce’s ability to provide quality dementia care, especially the requirement for health care providers to engage in open and respectful communication with those living with dementia, their families and caregivers and to provide care that is person centred and dementia specific.

\textbf{End-of-Life Care Action Plan:} Research increasingly suggests that Canadians prefer to die at home or in their home communities instead of in hospital settings.\textsuperscript{109} In BC in 2014, for cancer deaths, 15.4\% have occurred in the home setting, 10.2\% in the residential care setting, 34.5\% in the hospice setting and 38.2\% in the hospital setting. While the percentage of deaths in hospitals has decreased slightly in the last 3 years, and the percentage of deaths in hospices has increased slightly, the percentage of deaths in home and residential care settings has remained relatively unchanged.\textsuperscript{110}

While the need for hospice palliative care was identified in the priorities and actions within the End-of-Life Care Action Plan (March 2013), government has further committed to creating a plan for hospice expansion and beginning the process of doubling the number of hospice spaces in British Columbia by 2020.\textsuperscript{111} Through the Minister of Health’s mandate letter in June 2013, and reinforced in June 2014, work has begun to lay the foundation for determining the palliative population needs.

Through a needs-based assessment, demographic and resource information about palliative populations of interest, their service utilization, location (metro, urban, rural and remote) and other elements are being gathered. The needs-based assessment will inform the development of models of care to improve access to a range of quality palliative and end of life care services. Once collected, this information will be used to forecast future demand, set expectations related to models of care – including number and location of additional acute/tertiary and community hospice beds – and service levels, and also establish outcome and performance metrics.

The Ministry of Health is leading a provincial End-of-Life Working Group comprised of Ministry representatives as well as palliative care physicians and health authority leads for palliative and end-of-life care. The End-of-Life Working Group identified as one of top three priorities identified the need for a population needs assessment. This assessment – which is currently underway - aims to support the development of models of care and targets for hospices spaces and services based on demographics.

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\textsuperscript{108} Workforce refers to all people (e.g., volunteers, housekeeping, health care providers, etc.) involved in the provision of assistance, care, information or support services to people with dementia, their caregivers or families at home and in all health care settings.


\textsuperscript{110} Ministry of Health (September 12, 2014). \textit{Number and Percentage of Cancer Deaths in Each Setting}, QUARTERLY REPORT: Q2-2014, Year-to-date. CeRTS No. 2014-1164. BC Ministry of Health Measurement Site: Hospice Reports. Please note, as some cancer deaths occur outside of these setting, figures do not add to 100\%.

The provincial End-of-Life Working Group also identified the need for improvements to the BC Palliative Care Benefits Program (BC PCBP) and improvements in palliative and end-of-life care in residential care. The Ministry is working in collaboration with the BC Centre for Palliative Care to standardize the approach to Medical Orders for Scope of Treatment (MOST) and to incorporate advance care planning in goals of care.

Moving forward, other partner organizations such as the BC Centre for Palliative Care, iPANEL112 and the BC Hospice Palliative Care Association will play a vital role in working with the Ministry of Health on advancing the palliative approach to care and fostering collaborative transitions in care across the system.

**The Case for Change: Learning from Experience and Building on What Has Been Achieved**

For the past twelve years, British Columbia’s Health Care System has been engaged in collaboration to look for ways to improve primary and community care at a community level. Time, resources and money have been committed to looking for emerging best practices to address individual patient and population demands, both in the present and for the future. Multiple initiatives aimed at the practice, organizational/regional, and provincial levels provide a platform, learnings and opportunities to improve patient quality care and direction for needed system wide improvements.

This paper is the first time that the Ministry has pulled together into one document the multiple primary and community care initiatives that have emerged over the last several years. The sheer volume, the sometimes loose connection between and the iteration and layering of initiatives over several years is somewhat overwhelming and challenging, warranting serious review and simplification. However, the range of initiatives, innovation and experimentation is also a credit to a wide range of individuals and teams who have brought this agenda forward to the centre of health care change in the province and been willing to risk change to better meet patient needs. The scope brings to the forefront the issue of results achieved, value for money, change management and the issue of successful execution, the dynamics associated with change in a large complex sector such as is health services. There is both coherence and disjointedness in overall efforts to date; both discipline and consistency mixed with lack of discipline and inconsistency in moving forward initiatives to achieve system wide (versus local and partial) change; there is evidence of efforts to coordinate and at the same time evidence of under management of the required change process.

BC’s experience and potential learnings are very consistent with those of other jurisdictions and the growing evidence on the ‘what’ but also the ‘how’ of successfully transforming primary and community care to meet the demands of a changing population while ensuring cost effective services are provided.

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112 Initiative for a Palliative Approach in Nursing: Evidence and Leadership (iPANEL)
A consensus is emerging in the literature about the critical impact that community-based health care can have on improving patient and population health outcomes. Edwards (2014), provides an overview of key strategic directions in this sector in a recent article for the King’s Fund, a UK health care think tank. He argues that the most effective community approaches require “locally-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services.” This very much supports the direction BC is striving to take. The paper argues that when all components are present, the approach is expected to lead to transformative system change with reductions in hospital admissions in the following range:

- Reductions in admissions: 5–20 % for medicine, less for surgery;
- Reductions in extended stays: 14–40 %, including bed days avoided by reducing admissions;
- A range of direct and semi-variable costs can be released but the full cost per bed day may not be available in the short to medium term; and
- 50 % of elective patients staying more than six days could be cared for in alternative settings (excluding respite admissions).

These are very much in line with what would need to be achieved in BC. There are a number of observations and directions set out in the paper that both affirm efforts under way in BC and point to next steps:

1. **Reduce Complexity of Services:** The current community health care system is comprised of a complex and fragmented array of services delivered by multiple, poorly coordinated providers. This has led to a disjointed system that is difficult to navigate and understand, even for health care professionals. This means “patients receive multiple visits from different professionals, incurring high costs of co-ordination, and leading to frustration for the referring clinicians, their patients and carers. Not only is this not necessarily cheaper, but it may also mean that important opportunities to notice changes in the patient’s condition are missed.” Edwards warns that interventions to reduce complexity without more fundamental change can often just add another service layer without reducing complexity (e.g. care co-ordinators and navigators, single points of access). Therefore, services should be simplified by creating larger community teams with a single, shared assessment process that can be undertaken by any team member. The team will include specialists (e.g., respiratory problems, Parkinson’s, palliative care etc.) but in a role that is more focused on education, support, and providing expertise in difficult cases.

2. **Wrap Services Around Primary Care:** Care teams should include generic and specialist staff including GPs, nurses, support workers, therapists, and social workers. Then tasks are delegated to the most appropriate level; for example, advanced nurse practitioners can support patients with complex conditions, while supervising and training other clinicians. This model strengthens

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114 Ibid.

115 Ibid.
connections between primary care, community services and hospital services without the
downfalls that come with a centralized workforce model. Edwards argues that the latter model
can reduce the effectiveness of the entire care system by disrupting relationships and care
planning. Integrated care co-ordinators within the team should play a critical role in supporting
patients with chronic conditions. The team will also need generic mental health skills, as
members will likely undertake a significant amount of work currently done by mental health
specialists. This approach responds to the growing number of patients with dementia and the
high prevalence of anxiety among individuals with chronic conditions.

Key features of the model include: co-location where possible (preferably in a recognizable
location); coherent geography; and organizational leaders that promote collaboration and
communication between staff. Models that provide these teams with the mandate and funding
for providing broader range social services are also promising directions.

In terms of geography, Edwards proposes that this model is appropriate for populations of
30,000 and above or 50,000-120,000 in regions with larger populations.

(3) Build Multidisciplinary Teams for People with Complex Needs, Including Social Care, Mental
Health, Substance Use and Other Services: Co-ordinated, multidisciplinary teams that involve
patients and their families in health care planning in a meaningful way can improve outcomes
and quality of life for individuals with chronic conditions and reduce the demand for hospital
care. This approach is particularly important for patient segments with high levels of service
utilization; these individuals can be identified and targeted by combining predictive software
and professional judgement. Co-ordination programmes are most effective when operated at
the neighbourhood level.

Key components of effective case management components include:

- Case finding;
- Assessment;
- Care planning; and
- Care co-ordination, usually by a case manager within a multidisciplinary team, can
  include, but is not limited to: medication management; self-care support; advocacy and
  negotiation; and monitoring and review.

Edwards highlights that clear responsibility for patient oversight is needed as they move through
the system. Therefore, new models should not remove responsibility for patient oversight from
GP practices but instead provide support, case management and other complementary services.
Nursing home and residential care residents may warrant particular attention; for example,
some health care organisations in the United States have experienced strong results by using
specialist teams and geriatricians to provide tailored, high-intensity services. The inclusion of
housing, criminal justice and other key services in the care plans of key populations can also improve outcomes and reduce unnecessary system use.

(4) Support These Teams With Specialist Medical Input and Redesigned Approaches to Consultant Services – Particularly For Older People and Those With Chronic Conditions: In the model outlined above, the role of specialists in chronic conditions becomes to provide direct support, education, clinical governance and specialist consultation to primary and community care teams via joint consultations and case review meetings (focused on the patients with the most complex needs). Community providers such as specialist nurses then support these changes by developing specialist disease management services.

(5) Create Services That Offer an Alternative to Hospital Stay: Estimates from the literature indicate that 20% to 30% of emergency admissions could be avoided through alternative forms of care or better condition management prior to admission. Preventing and reducing hospital stays requires high-quality expert decision making as early as possible in the process and rapid access to alternative services and diagnostics. Community-based ambulatory medical units are one promising approach to delivering acute assessment and rehabilitation of frail patients.

In addition, UK studies have found that between 50 to 60% of medical inpatient-beds are occupied by patients who could be cared for in alternative settings. The top seven services required are home with services, intermediate care, home, nursing home, community rehab, sub-acute care, and rehab alternative. However, reducing lengths of stay requires the following conditions to be in place: staff knowledge of and willingness to use such services; sufficient capacity in those services and seven-day availability; and the removal of funding and assessment delays.

Edwards outlines the following set of service design changes that would be required:

- Ensuring hospitals operate a ‘choose to admit’ policy so that only those frail older people who have evidence of underlying life-threatening illness or need for surgery are admitted as an emergency to an acute bed;
- Providing early access to an old age acute care specialist, ideally within the first 24 hours, to set up the right management plan;
- Assess to discharge as soon as the acute episode is complete, in order to plan post-acute care in the person’s own home or at least a more appropriate setting than an acute hospital;
- Providing comprehensive assessment and re-ablement during post-acute care to determine and reduce long-term care needs;
- Operating response times that meet the needs of patients and other parts of the system, not the internal time clock of community services;
- Creating in-reach services in emergency departments and to support discharge planning
Developing a single point of access for health and social care professionals to provide signposting and to mobilise services (that is, not multiple single points);

Ensuring that packages of care can be kept open for short periods where patients have short stays in hospital; and

Providing access to short-term beds in nursing or residential homes (or extra care housing for patients where home care is not the best option)

(6) **Build an Infrastructure to Support the Model Based on These Components Including Much Better Ways to Measure and Pay For Services:** The model outlined above requires a number of system-wide changes including:

- Creating systems for shared access to up-to-date patient records for all carers;
- Developing registers for specific groups of patients including those with particularly complex needs and at the end of life where co-ordination seems to be particularly effective;
- Simplifying and standardising assessment processes;
- Using self-care initiatives, including patient education and self-management, exercise and rehabilitation, which can be effective when used with carefully targeted payment mechanisms (Purdy, 2010);
- Controlling admission processes to mitigate against the risk that reductions in length of stay allow the admission threshold to fall;
- Eliminating obstacles in contractual and payment arrangements – e.g., block contracts, poor specification, and replicating historic commissioning patterns;
- Developing new payment methods for specialists that encourage multidisciplinary working and promote the new models;
- Understanding that these models may require a new type of workforce with greater ability to provide whole person care and support rather than systems that provide large numbers of different inputs from many professionals.

(7) **Develop the Capability to Harness the Power of the Wider Community:** Edwards argues that current methods of care and case management are unable to reach a sufficient number of people to make a significant difference and often come too late in the process. To substantially improve outcomes, community and primary care services will need to develop very different approaches that are focused on earlier action and health promotion and disease prevention, target particular communities, mobilise the wider community.

Linked to practice and system transformation is also the issue of clinical transformation, especially for the priority populations identified in the Setting Priorities (2014) paper. A recent King’s Fund paper by Oliver et al\(^\text{116}\) provides perspective on the rigour required to focus on evidence-informed practice in service design and delivery. The paper identified a number of key components and what is known about what can work:

\[^{116}\text{Oliver, D., Foor, C. and Humphries, R. (2014). Making Our Health Systems Fit for an Aging Population. The King’s Fund.}\]
- Healthy, active aging and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex co-morbidities, dementia and frailty
- Rapid support close to home in times of crisis
- Good acute hospital care when needed
- Good discharge planning and post-discharge support
- Good rehabilitation and re-ablement after acute illness or injury
- High quality nursing and residential care for those who need it
- Choice, control and support towards end of life
- Integration to provide person-centred co-ordinated care

In line with the earlier paper, the author’s point to the need for effective provision of co-ordinated primary, community and social care services close to home underpinned by the use of comprehensive geriatric assessment at the right time. A similar comprehensive and adequately coordinated evidence based approach is required to address the needs of patients with mental illness and/or substance use issues building on the framework set out earlier in this paper.

Both papers while acknowledging the challenge of change, also argue that incremental, marginal change is no longer sufficient – change is needed at scale and pace.
The Next Steps: Focusing and Reenergizing the Commitment to Realize Patient Centred Integrated Primary and Community Care

The recommendations put forward in this paper push the boundaries of what we have been doing so far and emphasize a need for timely, short and longer term action. I want to emphasize that we are putting forward a range of proposed actions that we think will improve our health services in a number of important areas and better position our health system to meet increasing demand from key patient populations. The actions proposed would be undertaken opportunistically building on initiatives and innovative service delivery already underway across B.C., but also will require a systematic approach to change that builds a truly patient-centred system of care (*The British Columbia Patient-Centered Care Framework* – hyperlink).

You may have different views on the proposed action, how to improve the system or how to implement these recommendations and that is precisely what we are testing out by posting these papers. Your feedback will be part of a healthy and thoughtful discussion of these recommendations. Over the coming three months my aim is for us to achieve a good level of consensus across key partner and stakeholder groups of what the final set of specific actions should be; and then, for us to move forward collaboratively to figure out the detail, the how and the timing of implementation linked to better meeting current and emerging needs in a timely way. Patients as Partners will be an important part of this process.

I want to assure you the implementation of the final set of recommendations will allow enough flexibility for a diversity of implementation approaches across communities but that I also intend to push us to create a truly integrated system of health care that works for patients and not just for us. Your input, creativity and innovation in shaping and implementing the final set of recommendations at the local, organizational and provincial levels will bring new solutions and enrich our B.C. health system. The proposed directions set out below align with the strategic direction for the health system in *Setting Priorities for the BC Health System* and the areas of focus set out in the April 2014, the Ministry of Health published *BC Health System Strategy Implementation: A Collaborative and Focused Approach*.

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Going forward, there are a set of principles that will be used to drive decision making related to restructuring and shaping primary and community care:

1. **Patient-Centred**: Recognizing the need for health care to consider the whole person and not simply the presenting health issue, primary and community health services will be centered on the health needs of individuals, their families and communities; the objective will be to provide high-quality care, improve the overall patient experience, and improve patient outcomes.
2. **Integrated and Comprehensive**: Ensuring integrated and comprehensive patient-centred health care including health promotion and disease prevention drives all policy and system redesign. Primary and community services will be integrated around the patients and clients. Where services cannot be provided in the community, simple and clear pathways will be established to ease navigation and access to sub-regional, regional and provincially offered services.

3. **Quality and Value for Money**: Primary and community care will be built on the domains of quality (i.e., effectiveness, acceptability, appropriateness, accessibility, and safety), a desire to provide care outside of facility-based settings, achieving value for money and budget sustainability. There will be a focus on strengthening quality assurance (covering not only services but also health human resources, IM/IT, budget, and management) and routine reporting.

4. **Responsible Operational and Capital Investment**: Existing expenditures will be protected, appropriate reallocations from the acute to the community services sector must become part of go forward health authority planning and going forward a majority of net new funding must be assigned to developing primary and community services. Available primary and community care operational and capital funding will be used to improve community-based services in a manner that is reflective of the changing population health care needs and the principles of community based services, integration, quality and value for money.

These policy directions build on the work and learnings from the past twelve years, the work currently underway and the themes and findings of the systems current capacity against identified population and patient needs. These recommendations will be subject to consultation and refinement over winter but it is intended that the final recommendations will be implemented as part of a multi-year primary and community care transformational plan, starting April 2015.

The Leadership Council is currently working on developing a renewed governance structure, which will see the Leadership Council and its Standing Committees play a key role in the implementation policy directions, including the primary and community care action items.

**Reduce Complexity – the Need for a Coherent Policy Framework**

A key overall objective will be to reduce the complexity and fragmentation of the current service delivery system in a way that is both understandable and practical for patients and their families, providers and organizational stakeholders:

- The Ministry of Health in collaboration with Health Authorities and the Doctors of BC, other relevant provincial Primary and Community Care stakeholder groups will undertake an immediate review of the numerous action plans, strategic initiatives and incentives set out above to reduce the complexity of service delivery policy and go-forward actions and initiatives.

Currently there is a range of duplication, overlap and sheer volume. The Ministry of Health will collaboratively conduct a review of the major primary and community care policy, initiatives and
incentives reviewed in this paper late spring of 2015 to ensure they are aligned with the common set of principles set out above and streamlined into a coherent go forward policy framework. A single oversight and shared governance model will be developed for primary and community care that includes representation from key players involved in primary and community care. There will be a two day forum in late spring to discuss the outcome of the review and feedback on the proposed directions set out below.

In addition, the following specific policy directions are also proposed aimed at the practice, organizational, and provincial levels.

1. **Practice Level - Service Delivery**

These practice recommendations will be refined and adapted to the different contexts of metro, urban, rural, and remote areas (see the *Rural Health Services in BC* policy paper).

1.1 **Clarify The Role Of Walk In Clinics:**

Walk in clinics can provide a convenient health service to address minor episodic health needs of the staying healthy population but are inadequate to meet the need for continuity of care for major or significant time limited health needs and unsuitable for patients living with illness and chronic conditions or providing care towards end of life. The Ministry of Health will look at policy and regulatory options to appropriately frame the role of walk in clinics going forward and then ask the Medical Services Commission to complete a review of compensation levels and the fee for service requirements for this level of health service. This work will be completed by the end of 2015/16.

The Leadership Council will also look at policy and regulatory options to provide urgent care in Urgent Care Centres. The Urgent Care Centres will treat injuries or illnesses requiring immediate care (e.g., sprain, minor burn, stitches) but not life threatening or serious enough to require an emergency room visit. They will be open 24 hours a day, seven days a week, and 365 days a year. They could also provide diagnostic testing such as lab tests and x-rays. The Centres will be linked to hospital Emergency Departments by location or ambulance for rapid response to emergent higher level medical needs.

1.2 **Support the continued development of full-service family practices that support patients across their life spans but incrementally plan for and support the establishment of team-based family practices as full service sole practitioners retire.**

Working with Divisions of Family Practice, the Leadership Council will identify, certify and list all full-service family practices (sole and group) by community (Local Health Area) in 2015/16. The Ministry of Health will continue to collaborate with the Doctors of BC and the standing GP Services Committee (GPSC) to support the development of full service family practice either solo practices, or more commonly, small group, owner-operated practices) but incrementally facilitate the replacement of solo or co-located practices with fully realized team-based family practices. A coherent policy framework for team-based family practice teams (that will include other primary health care providers) will be developed in collaboration with the GPSC with the objective that individuals/families will be incrementally attached to the team practice rather than an individual practitioner while supporting the
practice of most responsible family physician for continuity of care to patients and their families. This work will be used to better plan and support the development of full service family practices based on population and patient needs rather than simply relying on individual or groups of physicians randomly establishing practices.

As this initiative moves forward, team-based family practices will engage patients in service design, delivery, and evaluation.

It is critical, in line with what was an innovative approach to aligning compensation to providing guideline-based patient care, that there is continuous and vigorous evaluation of the effectiveness of full service family practice payments linked to evidence of improved patient-centred care and outcomes. There is the opportunity to continue to expand this approach away from traditional MSP fee setting as well as take steps to realize increased options for compensation models that include salaried, contractual, and population need-based approaches.

1.3 Assess and review Patient Attachment (the GP for Me) initiative
The initiative has highlighted how complex patient attachment is given population trends, migration and immigration movements, the supply of physicians within the province, and the changing needs of the sub-populations of patients. By June 30, 2015, the Ministry of Health working with the GPSC will complete an assessment of current progress and likely outcomes for the initiative’s targeted end date of 2015/16. In partnership with the Doctors of BC, the GPSC, Divisions of Family Practice, and the Ministry of Health will explore options to expand the definition of patient attachment in line with the approach set out above, while still adhering to the principle of primary, longitudinal care. This will include analyzing the level/type of attachment required by each sub-population and especially priority populations. It will also address the need for patient transition from one form of attachment to another, based on presenting health care needs.

1.4 Assess and review In-Patient Care
The Leadership Council, in consultation with the Ministry of Health, and the Doctors of BC will take a fresh look in metro and urban areas as to the practicality of physicians working in hospitals especially under the individual practice model that continues to dominate practice. The more integrated community-hospital practice approach of rural physicians provides a potential model, with modification for metro and urban communities, built around integrated clinics providing care into hospitals versus the current hospitalist model. This will also require a broader rethink and debate about the accountabilities of specialists for their patients and the potential expanded role of registered nurses (RNs) and Nurse Practitioners in caring for and discharging patients. This work will be completed by late fall 2015 with action undertaken starting in April 2016.

1.5 Assess and review Maternity Care
The PHSA/Women’s Hospital in consultation with obstetricians, gynaecologists, and midwives will review and make recommendations on the pros and cons of establishing birthing centres in BC as an option for women outside of hospital maternity units. The review and recommendations will be brought forward by late fall 2015.
1.6 Systematically and opportunistically establish Linked Community and Residential Care Service Practices for Older Adults with Moderate to Complex Chronic Conditions.

An emerging idea to better meet the needs of older adults with moderate to complex chronic conditions, linked to increasing frailty as they age into their seventies, eighties and nineties, is to provide continuity and flexibility of care linked to rapid mobilization of services through specialized community-based practices (see for example the idea of Multispecialty Community Providers envisaged in the NHS Five Year Forward View, October 2014). These are practical in urban and metro areas but might be adaptable to some rural areas.

In 2015, the Leadership Council, in collaboration with the Ministry of Health, health authorities and the Doctors of BC, other relevant provincial primary and community care stakeholder groups will develop a policy and budget framework to support the development of these practices across urban and metro centres of BC based on population and patient analysis and a five year roll out plan. What does this type of practice model look like?

First, a range of multidisciplinary practices will be developed across communities with the capacity to address longitudinal health care needs of older adults with chronic medical conditions, potentially requiring home support, cancer care, and/or palliative care; they will have the ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services.

This will require both flexibility and innovation in collaboration with patients, providers and local communities to design and structure these services. More than just a clinic, the vision would be to provide a community with 24/7 care (meeting the health, physical, emotional, social and spiritual needs of those served through compassionate care and creating a community of mutual support and care provided by the patients and their families). The practices will build around effective case finding; referral, intake and assessment processes; effective and proactive care planning and care coordination; and effective rapid mobilization of services. Where ever safe to do so, services will focus on the home including the provision of some services currently focused in hospital (the “virtual hospital service” provided by family physicians and/or nurses being currently developed in jurisdictions such as the UK NHS).

Critical to this approach is the combining of the right values, skill mix and numbers of health providers to meet the primary health care and social needs set out above on a 24/7 basis including Family Physicians, Nurse Practitioners, Medical Specialists, Gerontologists, Community Care Nurses, Community Paramedics, Pharmacists, Allied Health staff, Home Health Support staff, Social Workers. In practical terms, this has a number of implications: (1) a strong commitment from team members to the provision of compassionate care; (2) the need of team members committed to generalist health care provision while using their unique skills sets and expertise; that (3) have linkages to increased expertise at regional or provincial service centres; including access to (4) home and community care and (5) efficient patient-centred pathways to medical and surgical services; including (6) emergency services.
Physicians and health service providers and/or health authorities in collaboration with like-minded community family physicians would develop a number of these practices across communities based on an assessment of population need. The practices would be built both through marketing the services to older adults and their families and by referral from family practices and/or hospitals. Key features of the model include co-location (preferably in a recognizable branded location); coherent geography; and organizational leaders that promote collaboration and communication between staff. Models that provide these teams with the mandate and funding for providing broader range social services are also promising directions for this population.

**Second**, these practices will be linked to **residential care services** that include bed capacity designated for short term acute medical care needs including short-term stays for respite, end-stage palliative care or more short stay interventions than can be provided through home physician and nursing care. These beds would also provide step-down capacity for older patients who have been hospitalized in one of the level four or five acute hospitals. Referrals to these facilities will come primarily from the group of affiliated multidisciplinary practices. This will provide continuity of care, allow proactive care management and rapid mobilization in emergencies, and bypass the often-damaging process of going through a traditional Emergency Department. These beds will be supported by both the multidisciplinary practices and dedicated site-based nursing staff and allied health staff (OTs, physiotherapists, podiatrists, dieticians) with appropriate access to specialist consultations and services in both planned and emergent situations. These services must be connected to the clinics and affiliated with local hospital(s) site(s).

**Third**, these practices will be linked to **assisted living and residential care services** to provide proactive care planning, transitions, and continuity of care.

Where appropriate in rural and remote areas, visiting health professionals will augment the local full service family practice team and/or virtual Telehealth services will be provided, with consultations for both patients and providers using shared-care principles. Emerging technologies will be used as tools to promote and enhance the patient care in the context of the principles of patient/physician attachment and longitudinal care.

Additionally, where appropriate, these teams will be built in partnership with the First Nations Health Authority and incorporate traditional and holistic models of wellness in primary, maternity, mental health and substance use services.

The capacity provided through this initiative is linked to a clear objective to significantly reduce demand on level four and five hospital inpatient medical beds over the coming years. This approach will include protocols to admit being developed in collaboration with hospitals ensuring hospitals operate a ‘choose to admit’ policy so that only those frail older people who have evidence of underlying life-threatening illness or need for surgery are admitted as an emergency to an acute bed.
1.7 Systematically and opportunistically establish Community and Residential Care Services Practices for Patients with Moderate to Severe Mental Illnesses and/or Substance Use Issues

Similar to the above, a model to meet the needs of patients with moderate to severe mental illness and/or substance use will be explored to create a more coherent and comprehensive set of services building from the current frameworks but built as a community-based system of care in contrast to the current fragmented service continuum including health promotion and illness prevention activities. These are practical in urban and metro areas but might be adaptable to some rural areas.

In 2015, the Leadership Council, in collaboration with the Ministry of Health, health authorities and mental health and substance health providers will develop a policy and budget framework to support the development of these practices across urban and metro centres of BC based on population and patient analysis and a five year roll out plan. What does this type of practice model look like?

First, a range of multidisciplinary practices across communities with the capacity to address the longitudinal health care needs of patients, including children and adolescents, with moderate to severe mental illnesses and/or substance use issues. These practices would also provide outreach services for those requiring home support or street services; and the ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services. A specific practice would continue to be the provision of an eating disorder program with a broader provincial focus coordinated through the PHSA.

As above this will require both flexibility and innovation in collaboration with patients, providers and local communities to design and structure these services. More than just a clinic, the vision would be to provide a community of 24/7 care meeting the health, physical, emotional, social and spiritual needs of those served through compassionate care and creating a community of mutual support and care provided by the patients and their families. The practices will be built around effective referral, intake and assessment processes; effective and proactive care planning and care coordination; effective rapid mobilization of services. Where ever safe to do so, services will focus on the home.

Critical to this approach is the combining of the right values, skill mix and numbers of health providers to meet the primary health care and social needs set out above on a 24/7 basis including Family Physicians, Nurse Practitioners, Mental Health and Substance Use professionals and Psychiatrists, Community Care and Psychiatric Nurses, Allied Health staff, Home Health Support staff, Social Workers and Community Paramedics. In practical terms, this has a number of implications: (1) a strong commitment from team members to the provision of compassionate care; (2) the need of team members committed to generalist health care provision while using their unique skills sets and expertise; that (3) have linkages to increased expertise at regional or provincial service centres; including access to (4) home and community care and (5) efficient patient-centred pathways to higher level medical and surgical services that work for this patient population; including (6) emergency services.
Physicians and health service providers and/or health authorities in collaboration with like-minded community family physicians would develop a number of these practices across communities based on an assessment of population need. The practices would be built both through marketing the services to the community, families and by referral from family practices and/or hospitals. Physicians and health service providers will facilitate their patients’ journey through the healthcare system and for the appropriate use of health and social services. To ensure access to a comprehensive range of appropriate services for the population they serve, they need to assist patients with healthcare decision-making and assist them to access other levels of the healthcare system, community resources and social services.

Second, these practices will be linked to residential/hospital mental health care and substance use services that include bed capacity designated for short term acute psychiatric care or substance use needs including short term stays for respite or more intensive work-ups than can be provided through community-based services. Referrals to these facilities will come primarily from the group of affiliated multidisciplinary practices. This will provide continuity of care, allow proactive care management and rapid mobilization in emergencies and bypass the often-damaging process of going through a traditional Emergency Department. These beds will be supported by both the multidisciplinary practices and dedicated site-based nursing staff and allied health staff with appropriate access to specialist consultations and services in both planned and emergent situations.

Third, these practices will be linked to assisted living, residential care, and psychiatric hospital services to provide proactive care planning, transitions, and continuity of care.

Where appropriate in rural and remote areas, visiting health professionals will augment the local full service family practice team and/or virtual Telehealth services will be provided, with consultations for both patients and providers using shared care principles. Emerging technologies will be used as tools to promote and enhance the patient care in the context of the principles of patient/physician attachment and longitudinal care.

Additionally, where appropriate, these teams will be built in partnership with the First Nations Health Authority and incorporate traditional and holistic models of wellness in primary, maternity and mental health services.

The capacity provided through this initiative is linked to a clear objective to significantly reduce demand on level four and five hospital inpatient medical beds over the coming twenty years. This approach will include protocols to admit being developed in collaboration with hospitals.

1.8 Support full service practice teams with appropriate medical specialist shared care and consultations and redesigned approaches to consultant services for older people, those with chronic conditions and patients with moderate to severe mental illnesses.

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117 A Level 4 Hospital is a hospital with limited specialty services. A Level 5 hospital is a Regional Hospital with more specialty and complex services available. See the Rural Health In BC Policy Paper.
In the model outlined above, the role of specialists in chronic conditions becomes to provide direct support, education, clinical governance and specialist consultation to primary and community care teams via joint consultations and case review meetings (focused on the patients with the most complex needs) or full team membership of the specialized population focused practices. In 2015, the Leadership Council, in collaboration with the Doctors of BC will identify and list all relevant medical specialist practices (sole and group) by community (Local Health Area) and develop policy and budget strategies to better align these services with the practices described above including facilitating full team membership.

1.9 Standardize mental health and substance use treatment and monitor and evaluate services.
Beginning in 2015, the Ministry of Health will begin a dialogue with the PHSA regarding their respective roles and functions related to MHSU. The intent will be to clarify roles and functions with respect to developing standardized treatment modalities for the major presenting MHSU disorders; moving to a scalable and sustainable service delivery system; and, monitoring and evaluation of those services provided by the regional health authorities.

2. Organizational Level – Operationally Based Enabling Supports

2.1 Regional Health Authorities in collaboration with Divisions of Family Practice will create the enabling organizational structures and processes in support of the practice directions set out above.
Starting 2015, Regional Health Authorities in collaboration with Divisions of Family Practice, and supported by the Ministry of Health and Doctors of B.C (including strategic leadership from the GPSC supported by the specialist and shared care committees, and from other stakeholders organizations, e.g., ARNBC) will implement an integrated, inter-professional primary and community care model of service delivery in each of their respective communities, based on the population demographics in support of the practice directions set out above. Key to this approach is to reduce the complexity of service delivery in a way that is understandable and practical for patients and their families. These models and specific action will be fully articulated in plans and communication materials for 2015/16 – 2017/18. Report on progress will be required and substantive action taken in the first two years to embed this approach.

2.2 Increase Practice Support Change Management
In 2015, Regional Health Authorities, in collaboration with other service partners, will establish regionally designated Practice Support leadership team(s) to enable the implementation of integrated, multidisciplinary/inter-professional primary and community care models of service delivery across their rural and remote communities. Leadership teams will work with local communities to establish partnership committees and then support the practice design and implementation phases of the work. This leadership team will also play a critical role in supporting the assignment and/or recruitment of health professionals to the inter-professional team as required.

2.3 Increase Appropriate Access to Specialist Consultation and Support
In 2016, building on the directions arising from the medical specialist shared care and consultations and redesign work set out above, Regional Health Authorities will establish a formal regional, and where
appropriate, provincial network of specialized teams (the Provincial Health Services Authority can play a valuable role in supporting this) available by telephone, telepresence and/or visits with rapid access capacity to support primary and community care practices across rural and remote communities. An additional key area is the support for cancer care patients provided through the BC Cancer Agency needs to be effectively linked into this approach. These services will be provided as a supplement/augmentation to community based, integrated, co-located primary and community care teams providing longitudinal care.

2.4 Implement the Refreshed Dementia Action Plan
Over the next 3 years, implement the Refreshed Dementia Action Plan including the four priorities with their concrete actions: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care facilities and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care. Key priority actions include a strategy to keep people who are prone to wandering safe and to facilitate their safe return; and, focus in all care settings – from acute hospital admission to palliative and end of life care – on the specific needs of people with dementia and their caregivers with the development of a care pathway to ensure the needs of people with dementia are being respectfully met.

2.5 Palliative and End-of-Life Care
Continue the implementation the End-of-Life Care Action Plan and its key actions to improve the way health care providers meet the needs of people coping with end of life, including their families and caregivers.

The adoption of a palliative approach to care across the health care continuum needs to be supported throughout, and the palliative approach to care needs to begin at diagnosis of a life-limiting illness. Therefore, further pursue the population needs assessment currently underway to support the development of models of care and targets for hospices spaces and services based on demographics. Also, develop policy to support a standardized approach to hospice palliative care across the health care system to ensure the needs for palliative and end of life care are being addressed.

The Ministry of Health will work with partner organizations such as the BC Centre for Palliative Care, iPANEL and the BC Hospice Palliative Care Association on advancing the palliative approach to care and fostering collaborative transitions in care across the system.

3. Provincial Level – System Based Enabling Support

3.1 Governance and Strategic Leadership Review
In early 2015, the Leadership Council will oversee the conduct of a review of the appropriate governance and strategic structure for primary and community care at the regional/community level to ensure that an organizational body has both the accountability and the authority to drive and support change. This is designed to ensure that effective governance, administration, and managerial structures at the local/regional/provincial level are in place to improve system integration and to support the adoption of best practices.
The Ministry of Health will engage with Patients as Partners to ensure the voices of patients, families and caregivers are heard and appropriate mechanisms are put in place to ensure they participate in the design and planning of health services.

The GP Services Committee might evolve into a multidisciplinary primary and community care committee to take a strategic leadership role at a provincial level in moving the primary and community care strategy. The Ministry of Health will explore with the Doctors of BC refreshing the mandate of the committee and expanding its membership to include representatives of community health services. Activities will include:

A review of the Terms of Reference of the Physician Services Committee, General Practitioner Services Committee, Specialist Services Committee, Shared Care Committee and the Joint Standing Committee on Rural Issues to reduce duplication and/or streamline and focus activities aligned to the directions set out in this section.

A review of the operational obligations of the GPSC with respect to managing payments with a view to simplify and better support this activity.

In collaboration with the Doctors of BC and the Joint Clinical Committees, conduct a review of the existing work underway by the various Joint Clinical Committees with a view to aligning system-wide improvement and quality activities across all of the committees. This would include, but not be limited to, an evaluation of the incentive billings established by GPSC and the various strategic and operational quality improvement activities presently identified by each committee.

Strengthening and integrating Primary Care, Home Support and Residential Care services based on best evidence and practice will be a key focus in shaping services for priority populations. This will be undertaken in collaboration with experts and academics.

3.2 Significantly Strengthen Human Resources Planning and Management for the Primary and Community Care Sector

Working collaboratively with HEABC, health authorities, professional associations and unions, regulators, educators over 2015/16 a detailed primary and community care human resource policy and data set will be developed that aligns with and supports the direction set out in this section.

The policy paper and its enabling actions will identify priority improvements in a number of key functional areas:

- Workforce optimization and team development actions
- Recruitment and retention actions
- Changes to education, training and professional development to support quality improvement
- Utilization of compensation and practice incentive strategies
- Changes to professional regulation and oversight
• Ensuring integrated forecasting and planning and associated policies, to better address issues of supply, mix and distribution of primary and community health care professionals throughout the province.

3.3 Improve Data and Analytics to Support the Strategic Direction
The Ministry of Health in 2015 will complete work on developing a standardized data set to be used across primary and community care services (e.g., physician services, mental health and substance use, complex/chronic conditions and home and community care, drug prescribing and usage). Data fields and standards will be set at a practice/case management level so as to ensure accurate and timely business intelligence for understanding service demand trends and making resource allocation decisions.

3.4 Strengthen Information Technology
Starting in 2015, a range of specific actions will be incrementally taken through the Leadership Council’s Standing Committee on Information Management and Technology (IM/IT ) in collaboration with the relevant physician and health provider associations and unions to support continued and improved use of IM/IT in primary and community care services across the province including supporting electronic medical record (EMR) utilization, Telehealth, the deployment of home health monitoring technologies and virtual office visits as service delivery policy is developed.

3.5 Complete Telemedicine Review
The Ministry of Health will develop telemedicine policy recommendations to ensure that emerging telehealth technologies are leveraged to support current strategies and objectives and deliver benefits to key populations.

Policy recommendations will include ensuring that telemedicine visits are aligned with longitudinal primary care. Telemedicine is safest and most effective for patients where a known treating relationship exists. As such, policies should align telemedicine visits as part of the suite of tools available to full service family practices (such as telephone visits). With longitudinal knowledge of the patient, practitioners are in a better position to determine the most effective and efficient means of providing a visit.

3.6 Complete Legislative, Regulatory, and Policy Review
In 2015, the Ministry of Health will conduct a review of the relevant statutes, regulations, policies, standards and guidelines to ensure they are positioned to support primary and community care transformation and bring forward any recommendations for change by late September 2015. Primary and community care is subject to multiple acts, regulations, policies, standards and guidelines. While developed to address specific issues, it is important to understand if they are aligned to support system change.

3.7 Mental Health and Substance Use Regulatory and Policy Review
The Ministry of Health will review its policy and regulatory options to create a more coherent provincial system of mental health and substance use services including health promotion and illness prevention.
to ensure the services are well-coordinated and integrated into a broader provincial system of health care. There is also a need to ensure mental health and substance use services have a common overall direction and practice framework supported by a technological infrastructure which assists with understanding the service demands and quality assurance measures across the province.

3.8 Improve Accountability and Implementation
The Ministry of Health, through the Health Service Policy and Quality Assurance Division, will establish primary and community care public reporting, monitoring and impact/outcome assessment mechanisms for deployment by the end of 2015.
Appendix A. Detailed References for Table 5. Prevalence of Mental Disorders in Adults in BC


