Primary and Community Care in B.C.:
A Strategic Policy Framework
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 health system, delivering over thirty million health care services each year to B.C.’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, B.C. 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 strategic policy framework align with the strategic direction for the health system in Setting Priorities for the B.C. Health System (Priorities 1, 2, 3, 4, 5, 7 and 8) and the areas of focus set out in the B.C. 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 B.C. population will grow at an annual rate of 1.3 per cent per year to 5,229,463 by 2022. After which time population growth is projected to slow to just below one per cent towards the end of the projection period reaching 6,057,948 persons in 2036.

The Lower Mainland, home of more than 60 per cent 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 B.C. 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 per cent of the provincial population and accounts for nine per cent of health care expenditures.

The Getting Better population segment accounts for only three percent of the population and six per cent of expenditures. It includes those B.C. 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 per cent of the population and almost 50 per cent of all health system expenditures. This population group requires a significant, sustained, and co-ordinated 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 per cent of the provincial population, this group uses 35 per cent 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, the Provincial Health Services Authority 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.
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 B.C. correctional facilities and those that are on one form of community disposition order or another, monitored by community corrections.

Cancer care services are co-ordinated by the BC Cancer Agency (BCCA). The BCCA – an agency of the Provincial Health Services Authority – is responsible for nearly all cancer programs in B.C., 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 B.C. 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 co-ordination 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. B.C.’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 co-ordinated 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).

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 B.C. Health System and the areas of focus set out in the April 2014, the Ministry of Health published B.C. 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 B.C.* 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 (A 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 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 B.C. 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 B.C. 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 co-ordination; 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 B.C. 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 co-ordinated 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 health care 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 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 mental health and substance use. The intent will be to clarify roles and functions with respect to developing standardized treatment modalities for the major presenting mental health and substance use 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

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\(^1\) 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.
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 three 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 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.