

6. CLINICAL PRACTICE GUIDELINES AND PROTOCOLS

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6. CLINICAL PRACTICE GUIDELINES AND PROTOCOLS

6.1 Clinical Practice Guidelines in British Columbia

Clinicians in Canada and other countries increasingly use practice guidelines and protocols to improve patient care and health outcomes. Guidelines and protocols help health professionals offer the best possible care for their patients by recommending treatment based on scientific evidence and expert clinical opinion.

In British Columbia, guidelines and protocols are developed under the direction of the Guidelines and Protocols Advisory Committee (GPAC), jointly sponsored by the B.C. Medical Association and the Ministry of Health.

GPAC intends its guidelines to provide practical and easy-to-follow advice to general practitioners for effective patient care. The guidelines are based on scientific evidence, and are modified for circumstances in BC.

GPAC aims to:

- Encourage appropriate responses to common medical situations
- Recommend actions that are sufficient and efficient, neither excessive nor deficient`
- Permit exceptions when justified by clinical circumstances

NOTE:

Upon registration, nurse practitioners will be provided with a current set of clinical practice guidelines developed by the British Columbia Guidelines and Protocols Advisory Committee.

Clinical practice guidelines and protocols developed under the Guidelines and Protocols Advisory Committee of BC are available online at:

<http://www.healthservices.gov.bc.ca/msp/protoguides/index.html>

To request printed copies of guidelines, call (250) 952-1347 or email:

hlth.guidelines@gov.bc.ca

6.2 Guidelines and Protocols Advisory Committee

The Guidelines and Protocols Advisory Committee (GPAC) was established under Section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the Medical Services Commission (MSC). Joint responsibility for developing guidelines for medical services is mandated by negotiated agreements between the BCMA and the Ministry of Health.

GPAC is co-chaired by the BCMA and the Medical Services Plan (MSP), and most members are practicing physicians. To carry out its responsibilities, GPAC oversees three Subcommittees and about 20 Working Groups. Over 80 physicians and other experts serve on the various committees of GPAC.

GPAC chooses topics, approves draft guidelines for external review, and approves final guidelines for submission to the MSC for approval and adoption in B.C. It also coordinates strategies to implement and evaluate guidelines and protocols. As an MSC Advisory Committee, GPAC unites the efforts of the BCMA and the MSP to contribute to effective management of medical services.

6.3 Development of Guidelines and Protocols

Clinical practice guidelines and protocols are designed to apply to common conditions and to provide flexibility for clinical judgment in uncommon situations. They aim to improve patient care by developing recommendations for clinical practice in B.C.

Selection Criteria

- high volume or high cost
- high variability in practice patterns
- opportunity for improvement in practice
- support and interest of physicians

Development Process

GPAC's Subcommittees and Working Groups develop guidelines through an iterative process that involves:

- Topic choice (common condition, situation can be improved by a guideline, doctors interested) and scope definition
- Literature search (previous guidelines, critical literature reviews, randomized controlled trials)
- Consultation with experts
- Guideline drafts
- External review (random sample of general practitioners, random sample of relevant specialists, experts in the field, professional organizations)
- Consultation with experts
- Approvals (from B.C. Medical Association, Medical Services Commission)
- Two-year planned review (may occur earlier when prompted by new information)
- Guideline evaluation

Review of Guidelines

All guidelines and protocols are scheduled for review in the light of recent scientific literature two years after their initial distribution. They are reviewed sooner if warranted by new information.

6.4 CHRONIC DISEASE MANAGEMENT

Chronic Disease Management in BC

Chronic Disease Management (CDM) in B.C. is a government-supported initiative that involves the collaborative efforts of many medical and health care professionals, health authorities, researchers, and organizations across all sectors of the health care system. Rather than a specific program under the ownership or sponsorship of any one authority, it is a network of a number of individuals, groups, organizations and jurisdictions who share a common vision and collaborate on several initiatives to support health service delivery to patients living with long-term and life-threatening illnesses, and assist them with developing self-management strategies.

To date, guidelines developed by GPAC for the management of chronic diseases include:

- Diabetes Care
- Hypertension
- Asthma
- Heart Failure Care
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Hepatitis B and C
- Depression

Additional information about CDM in BC available online at:

<http://www.health.gov.bc.ca/cdm/index.html>

BC Initiatives in Chronic Disease Management

Several initiatives are underway in BC Elements of Chronic Disease Management to address systemic barriers and reduce the gap between current care and established evidence-based standards of care for specific diseases. These include strategies and elements for improving care in the health system, in communities, in organizations, in clinical practice and with patients.

- **Business cases** to identify economic and health outcome benefits based on evidence.
- **CDM structured collaboratives** to train and support medical practitioners in integrating chronic care best practices into clinical practice. Physician-led teams focus on comprehensive patient care including adoption of clinical practice guidelines; use of flow sheets and other tools to enable planned patient visits; and performance monitoring.
- **Patient registries** for diabetes, asthma, hypertension, depression and congestive heart failure initially.
- **Performance measures** for health outcomes, patient satisfaction, costs and utilization of health services.
- **Evidence-based clinical practice guidelines** for the management of asthma, diabetes, hypertension, congestive heart failure, depression, chronic kidney disease, Hepatitis B and C, and chronic obstructive pulmonary disease (COPD); .
- **Private/public partnerships** with the pharmaceutical industry to support the implementation of chronic disease management.
- **Professional Development** designed and delivered by B.C. physicians to enhance skills in self-evaluation, patient self-management coaching, and use of web-based and personal digital assistant (PDA) technology in clinical practice.
- **Web-based access** for patients and practitioners to information and tools to support them to manage chronic diseases. This includes a secure web site for practitioners providing information to help manage the care of their patients with chronic diseases.
- **Shared care models** – including support of general practitioners by specialists.
- **Self-management training** and supports for patients (e.g. BC HealthGuide, BC NurseLine), and patient input through surveys.
- **Two-year pilot project** testing impact of financial incentives on physicians' adoption of diabetes and congestive heart failure care consistent with clinical guideline recommendations.

6.5 Primary Care Prevention Support Program (PCPSP)

The Primary Care Prevention Support Program (PCPSP) was developed with the support of the Ministry of Health, Prevention and Wellness Planning Division, Medical Services Plan and the Primary Health Care Transition Fund (PHCTF).

Goal

To increase the application of evidence based prevention in primary care by implementing and evaluating a Primary Care Prevention Support Program in BC Health Authorities.

Objectives

1. To examine existing programs for putting prevention into practice to determine which is most suitable for BC.
2. To test prevention flow charts which will assist in effective implementation of prevention.
3. To implement selected category A/B level prevention recommendations from the Canadian Taskforce of Preventive Services Guide.
4. To identify deterrents to putting prevention into practice in primary care in BC.
5. To monitor and evaluate program implementation.

Context

Primary Health Care Transition Funds were allocated to support this initiative. The Primary Care Prevention Support Program (PSP) is managed by a Coordinator under the governance of a provincial steering committee. The PSP steering committee is composed of leads from each of the five Health Authorities, the medical consultant from the Prevention and Wellness planning division, and three family practice physicians (one of whom represents BCMA).

The timeline for program implementation once funding approval was achieved was approximately 18 months (October 04 to March 06.) Given the limited time frame and on the advice of the program steering committee, it was determined that the Prevention program should be rolled out as part of the Chronic Disease Management Strategy. The provincial CDM projects have had significant success and utilizing an already effective platform and community base provided a feasible means of achieving program objectives.

The second major “business decision” taken by the committee was to limit the cohort or number of patients included in the pilot. From a CDM perspective the 50-70 yr old cohort represents an important constituency. The evidence for prevention of chronic disease maneuvers clustered around this population.

An Expert Advisory Committee was struck to support the development of the Prevention Flowsheet and provide leadership on long-term Prevention strategies.

Current Status

Four of the five Health Authorities are directly engaged in the Prevention Support Program. A variety of service delivery models are working with the CDM toolkit and the Prevention Flow sheet. The steering committee has identified the 50-70 year cohort as the target for this phase of Prevention in Primary Health Care. Due to the very short time frame for accomplishing the project it was determined that utilizing existing and successful physician collaborative(s) would be a positive means of introducing prevention maneuvers into practice. The Chronic Disease Management Initiatives in the province provided an ideal starting place for this first foray into PHC. Prevention of Chronic Disease is after all the best way to “manage it”. Although the project started with a target of three Health Authorities and up to a dozen physicians, current registrants number nearly sixty.

The Prevention Flowsheet was developed in committee with significant feedback from the VIHA CDM collaborative. The final version of the flowsheet is live on the toolkit and just completed its first upgrade. The health authorities are currently responding to a provincial request for an update on expenditures to date.

Some clarification regarding the creation of a data extract for the evaluation and ongoing management of the collaborative is required. Apparently the PIA for the CDM toolkit may not address this matter. S. Turner is meeting with Ministry representatives to identify exactly what the barriers are to completing standard CDM management activities for the prevention portion of the toolkit.

Future Directions

- Broaden payment for proven effective clinical prevention.
- Link to public health and community prevention initiatives.
- Expand the Provincial Prevention Collaborative
- Establish Prevention guidelines for all age cohorts
- Link the CDM information management strategy with Provincial standards for Electronic Health Records