THE UNIVERSITY OF BRITISH COLUMBIA

college of Health Disciplines
#400 - 2194 Health Sciences Mall
Vancouver, B.C. Canada V6T 1Z3
Tel: 604.822.5571 | Fax: 604.822.2495
www.health-disciplines.ubc.ca

To: Select Standing Committee on Health
British Columbia
Health Care Sustainability: Call for Written Submissions

BC Pathfinder Plan for Primary and Rural Health Care: An Integrated Approach to Health Care Sustainability.

Executive Summary

This proposal to the BC Legislature's **Select Standing Committee on Health** outlines a systematic approach to simultaneously *act*, *gather, and evaluate evidence* for the best pathways forward that enable British Columbians' to be responsive to our diverse and changing health care needs, and to care for one another in ways that meet the goals of improved health in a sustainable and cost effective manner. Using a process of competition, evaluation, accountability and transparency, this initiative has the potential to create sustained improved health care delivery that is developed by communities for communities.

The 2014 report "Setting Priorities for the B.C Health System" has outlined the eight action priorities for the province and seven strategies for reaching these goals. It describes the current challenges for the system many of which involve primary care and rural communities. To achieve these ends, our proposed Pathfinder Plan is guided by the eight priorities and engages these seven strategies and the three-year timeframe to evaluate the most effective ways of transforming health care in the province.

A priority is the coordinated delivery of safe effective primary health care in rural, remote and urban settings of British Columbia. It is possible to undertake substantial reforms by flipping primary and rural health care from a top down model to a patient-centred community-based interdisciplinary team-care model; this would not affect the current health care infrastructure. This initiative builds on the evidence such as that seen in Alaska where the Nuka version of flipped care, building on community values, has had major success decreasing urgent and ER care by 50%.

Communities will be asked to compete to be part of the Pathfinder Plan Initiative. The initial application will consist of a one-page outline of the proposed plan, produced with input from at least four community stakeholder groups that include patients and at least two health professional groups. This will describe the local communities' problems, their team's strengths and their commitment to the plan. The ten successful first round teams

will then be supported in developing a complete proposal. Six teams will be selected to implement their plans.

The six successful teams comprised of health care professionals from several disciplines and local care recipients will adopt coproduction methodologies to embed patient and citizen perspectives from the start. The interdisciplinary teams will engage stakeholders in the selected communities, negotiating the formation of a three-year funding model for the implementation, evaluation and knowledge translation of the Pathfinder Plan. They will work with a designated representative from their health authority, and other regional structures such as Divisions of Family Practice to undertake the local Pathfinder Plan.

The evidence is clear that when a team approach is available the number of patients cared for and the quality of care is improved. Several provinces (e.g., Quebec, Ontario and Manitoba) have already formalized practice in interdisciplinary teams that match the mix of skills to community needs. Further, teaching of learners in interdisciplinary teams also has important advantages. The Pathfinder Plan proposal seeks to complement such other initiatives as the “GP for Me” program. When fully expressed, communities would move to the next step in improving health care that might be seen as "effective primary care for all”.

Building on the strengths of BC’s distributed health care teaching model, and established and developing interdisciplinary learning strategies, these six sites will be offered as learning centres for all health care disciplines at different stages of their training.

Over the period of three years, a joint oversight committee with representation from government, health authorities, universities and health user groups will assess the community health outcomes. An economic analysis will be built into the plans and continuous audit of the costs and outcomes will be publicly available for transparency. Introduction and use of advanced technologies and innovative care approaches such as using autonomous domiciliary teams will be evaluated in this process.

Triple Aim objectives will be addressed and sustainability and translation into a provincial wide change to primary and rural health care in second and third phases would be part of the overall expectations for this initiative.

The BC Pathfinder Plan for Primary and Rural Health Care

In response to the call for submissions to the Standing Committee on Health, a group of health professionals have been meeting over the last two months to develop ideas relevant to the intent of the Committee and the Ministry of Health. This group includes patients and health professionals from nursing, midwifery, dentistry, occupational therapy, physical therapy, social work, rural and remote health, family practice, undergraduate and postgraduate education, and pharmacy among others. This Pathfinder Plan addresses two pillars of the government's strategic priorities, namely rural and primary care. It will undertake and evaluate plans for primary health care delivery in underserved communities that lead to sustained change. The purpose is to understand the elements of successful implementation, the size of the health benefit, cost effectiveness, and create a process for wide scale deployment across the province. A timeline of three years for each Pathfinder Plan includes a community engagement phase, plan development supported by an oversight committee, change to existing funding contracts, initiation, establishment, and evaluation.

Overall Pathfinder Principles

a. Patient-Centred – Patients' and People's views first;
b. Interdisciplinary team-based care - A shift away from disease-centred and provider-focused care to a system that is responsive to health oriented and assessed needs;
c. Learning from successful community-based initiatives - building upon the many successful initiatives that exist and assessing their potential for dissemination and impact;
d. Creating effective working relationships between all groups; and
e. Sustained success through an ongoing approach of Appreciative Inquiry wherein the emphasis is on analyzing the reasons for successful initiatives.

Principles integral to each Plan:

a. Community-derived through broad engagement and community-based in execution
b. Focused on Continuity of Care (informational, management, and relational)
c. Interdisciplinary education and collaborative practice embedded into learning, teaching and service delivery models
d. Translation of information and lessons learned from rural pilot sites to other communities
e. Build on existing initiatives where possible through an Appreciative Inquiry approach
f. Effective and targeted resource allocation to sustain the initiatives

g. Safety evaluation, risk evaluation, and impact/outcome evaluation as part of every plan
h. Plan management and a clear governance structure employing the United Nations 8 principles

Announcement: The process will start with the announcement of the competition at a provincial strategic planning meeting on primary care and rural care held jointly by interested parties with an aim to identify current projects and share provincial success stories. The initial application will consist of one-page outline of the proposed plan, produced with input from at least four community stakeholder groups that include patients and at least two health professional groups. This will describe the local communities' problems, their team's strengths and their commitment to the plan.

First Round Evaluation of Applicants: The evaluation process will include stakeholders from across the spectrum involved in, or affected by, primary care health service delivery. Several universities from the province will support them. This evaluation committee will draw up a set of criteria by which the initial plans as well as the second phase plans are to be judged. Ten teams will be selected to develop proposals in the first round of this competition. Six will go through after the second phase of the engagement process.

Second Round Evaluation and Engagement Process: It is important that the Pathfinder Plans are set up to succeed. To this end, a two-day engagement workshop on health system change for primary care and rural care will be developed as part of this process for the ten successful teams through the first round. This two-day weekend workshop will be designed to help the teams to design a Pathfinder Plan likely to succeed. The ingredients of the workshop are still to be developed but will include segments on process, interdisciplinary team-based care, experience-based co-design and coproduction, hospital at home, telehealth, pharmacy-based monitoring, the Medical Home, funding models, lessons learnt from other countries and provinces, as well as impact and economic analysis. The workshop will be in the new Flipped Classroom style of significant pre-readings, videos, talks distributed to attendees in advance and highly interactive tele- and video-mediated sessions. The aim is that at the end of two days the ten teams will have developed the outline structure and identified all the processes required to achieve their Pathfinder Plan within three months. At the end of two months the teams will have an additional one-day session to workshop issues, and to share their work with the other teams. At the end of the three months they will submit their plan and have a 30-minute interview with a panel chosen from the Oversight Committee. Six of the ten applications will go through for implementation phase.

Pathfinder Plans

Interdisciplinary team-based care: Many countries and Canadian provinces have been using this model very successfully to deliver comprehensive high quality primary care. It makes use of all the health professional groups already involved such as pharmacy, nurse practitioners, and midwives to multiply several fold the effectiveness of the individual health professionals. The development of team-based care will vary within each setting based on local needs and examples already exist in several locations. Challenges and opportunities vary due to localized issues, in conjunction with some provincial challenges. By combining a community-based ground up approach with a Ministry of Health initiative

these challenges can be overcome and the success effectively evaluated and disseminated.

Identify Community Priority Outcomes: These may include aspects of care that focus on addressing various determinants of health such as health literacy, access to health care, unemployment, poverty, poor nutrition, poor oral health, lack of physical and social activity, inadequate housing, in addition to traditional health conditions. The ability to care for people in communities during their illness, rather than transferring them, is likely to become a priority for many.

The co-production Pathfinder process starts with asking patients and communities what they need and want to pursue wellness and achieve healthy living. It requires open conversations with multiple representatives of communities including political, educational, public health, council services, health care, cultural and others.

There are already several projects in British Columbia that are important to this initiative. They include Shared Care, an initiative from the Joint Standing Committee on underserved rural populations, e-health initiatives, Martha McLeod's CIHR/ Northern Health funded five northern BC communities project, "A GP for Me", and a number of initiatives of the *Rural Coordination Centre of BC*. It also includes initiatives from the First Nations Health Authority and the by Divisions of Family Practice. This indicates that the first deliverable should be a provincial strategic planning meeting involving a wide range of stakeholders.

The Medical Home: This is one of the core concepts for primary care in Canada with a robust framework that includes access and quality improvement. Elements of the Medical Home model should be addressed in each plan.

Education: Teaching and learning are important for sustainability and should be integral parts of these plans. This should include all levels of learners from students to practitioners from all disciplines and patient groups.

Environment: Physical components and layout of a community including roads, water, sewage, housing and transport require more than the traditional health care model to be incorporated onto these plans.

Examples of flipped health care: This idea has been tested in several countries. For example in the Netherlands teams of 12 nurses looked after neighborhoods of 10,000 people. These largely autonomous teams function because of the continuity of service. In Alaska the Nuka version of flipped care, building on community values, has had major success decreasing urgent and ER care by 50%.

Cost Drivers: Two of the major cost drivers in the health system are prescription drugs and care in the last six months of life. Our team suggests that there is a focus on these two areas in at least one of the projects and that the need for pharmacist involvement and hospital/health authority teams is a necessity. Other cost drivers to our health care system are due to the consequences of obesity and physical inactivity. These will be addressed and plans modeled on the experience gained from initiatives such as "Exercise is Medicine".

Evaluation: The evaluation of these projects could be coordinated through collaborations with multiple university departments in conjunction with engaged partners who determine

the nature and metrics of the process at the time of designing the program. This might include

1 Determine data of social and health statistics for the community (from BC stats – nothing new collected)

2 Define health priorities for the community (meetings with the community – school, council, regional communities)

3 Examine the practice(s) process (Primary Care Quality Initiative)

4 Examine the safety of the health care organizations

5 With patients and community organizations create areas for action (these might be traditionally medical or completely social or a mixture)

6 Set up measuring systems for the health and economic outcomes including safety

Team & Community Benefits in Participating:
The cost of the current funding for the health care of the communities will be made available to each team. A third of any demonstrated savings will be made available to the teams for further investment for health care in the community.

Process:

The six successful teams will be expected to engage with multiple stakeholders, to have created a financial model that addresses the community primary care/rural care issues, and to have a realistic timeline with milestones and a monitoring process. Using a process of competition, evaluation, accountability and transparency, this initiative has the potential to create sustained improved health care delivery that is developed by communities for communities.

Authors (Alphabetical)

Maureen Ashe, Granger Avery, Catherine Backman, Michelle Butler, Suzanne Campbell, Carolyn Canfield, Bill Cavers, Jim Christenson, Michael Coughtrie, Martin Dawes, Jayne Garland, Willa Henry, Dan Horvat, Maria Hubinette, Stefan Grzybowski, Jude Kornelsen, Isabella Losinger, Fairleth McCuaig, Rita McCracken, Margaret McGregor, Heather Anne McKay, Patricia Mirwaldt, Louise Nasmith, Christie Newton, Gina Ogilvie, John Pawlovich, Robin Roots, Charles Shuler, Joanie Sims-Gould, David Snadden, Robert Woollard, Peter Zed.

Electronic Signatures Available


Martin Dawes


Carolyn Canfield


Maria Hubinette

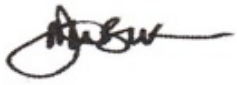

Catherine Backman

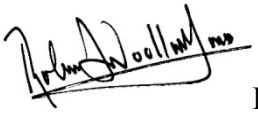

Maureen Ashe


Louise Nasmith

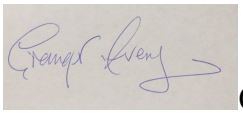

Christie Newton

Michelle Butler




Robert F Woollard


Suzanne H. Campbell


Granger Avery