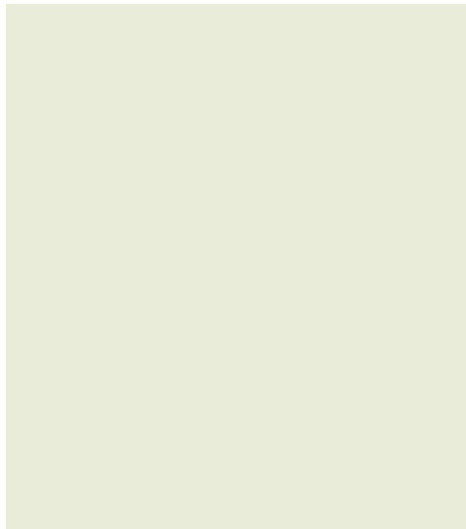


Innovations in Community Care

FROM PILOT PROJECT TO SYSTEM CHANGE

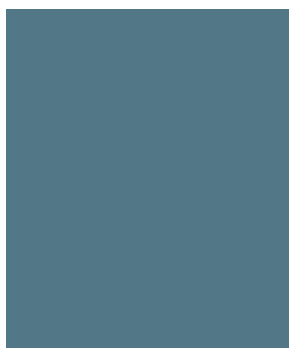


by Marcy Cohen
Nancy Hall
Janice Murphy
and Alicia Priest

April 2009



CCPA
CANADIAN CENTRE
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By Marcy Cohen, Nancy Hall, Janice Murphy and Alicia Priest

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Summary

THIS PAPER HIGHLIGHTS POSITIVE EXAMPLES of what is working well in home and community care in British Columbia. BC can boast of a number of local, small-scale initiatives that support people with significant health challenges who continue to live in their homes or in residential care. Many of these people are individuals with low income, frail seniors, and/or people living with a mental or physical disability. By helping them function in the community, these innovations take pressure off in-patient hospital and emergency services. And while they often cost more at the start, over the long term these innovations can reduce costs and improve the health status of those using these services.

While these innovations hold much promise, they remain at the margins — isolated pockets of excellence in the midst of a home and community care system that is largely in decline. This paper identifies changes needed at the provincial and regional levels to rebuild home and community care and make these positive models part of the mainstream of service delivery.

Through interviews and reviews of journal articles and government reports, this paper builds on the literature and experience of health providers in BC and elsewhere. Included are case studies of projects in single communities or health authorities, as well as studies of higher-level strategic initiatives that support broader implementation and systemic change. Based on this research and analysis, we identified the following key findings:

- The provincial government has devoted 10 years of increasingly generous funding for primary care reform. Most of that support has focused on financial incentives to change the way physicians practice—specifically, to improve their management of people with one or two chronic conditions.
- There has been much less support from the provincial government for innovation in home and community care and community mental health. In fact, there is little connection between services delivered in physicians' offices and services delivered by the home and community care system. For the most part, these two streams operate as two solitudes even though they often share the same patients.

BC can boast of a number of local, small-scale initiatives that support people with significant health challenges who continue to live in their homes or in residential care. These innovations take pressure off in-patient hospital and emergency services.

Individuals with complex conditions use a higher proportion of health services, in particular hospital and physician services, and therefore should be a priority for community health innovation.

- This is particularly problematic for people who suffer from complex, multiple, chronic conditions who require access to co-ordinated community services if they are to reduce their use of emergency and acute care services.
- Decades of research tells us that people from impoverished social and economic circumstances are much more likely than other Canadians to suffer from complex, multiple, chronic conditions. And in a very recent study, researchers found that those in the lowest socioeconomic group were more than twice as likely to be hospitalized for chronic conditions that could be treated in the community.
- Recently, the provincial government has provided some funding for Integrated Health Networks (IHNs). IHNs combine the two solitudes by linking physicians with community agencies and health authority services to create a more integrated and community-based approach to health care. However, the funding for IHNs is short term and limited to specific communities while the funding for physician incentives is far greater, province-wide and longer term.
- While there are some very positive initiatives in BC, only one includes community health workers—even though these providers have the greatest contact with home and community care clients.

Based on the case studies reviewed, the following six key change elements to boost community care were identified:

- **FOCUS ON PEOPLE WITH COMPLEX NEEDS.** Individuals with complex conditions use a higher proportion of health services, in particular hospital and physician services, and therefore should be a priority for community health innovation.
- **ACKNOWLEDGE THE LINK BETWEEN INCOME AND HEALTH STATUS.** Supporting good health outcomes for those with complex means that access to affordable housing, social support, and assistance with the tasks of daily living must be included as part of the mix.
- **TAKE A MULTI-FACETED APPROACH TO PREVENTION.** Effective prevention interventions vary with population needs. Successful programs such as Fraser Health's Early Psychosis Intervention for young people need to expand province-wide as do prevention programs for the frail elderly.
- **REALIGN PRIMARY CARE AND HOME AND COMMUNITY CARE.** Aligning case managers with physicians' offices is a positive step (as is happening in Northern Health and in Vancouver Island Health Authority), but needs to be replicated province-wide and broadened to include community health workers and community mental health.

PRIMARY CARE is usually understood to be care provided in family physicians' offices.

HOME AND COMMUNITY CARE services support people in the community who require post-acute care, have multiple chronic conditions, are frail elderly, or are living with a mental or physical disability. Providers are usually not physicians, but rather nurses, long-term and home health care workers, nurse practitioners, and psychologists.

- **EMPHASIZE WAYS TO INTEGRATE CARE.** People with complex conditions who remain in the community need a fully-integrated, interdisciplinary team available 24/7.
- **FOSTER NEW ROLES FOR PROVIDERS, PATIENTS, FAMILIES AND CAREGIVERS.** A shift to interdisciplinary teams means all members must learn new ways to work together, and learn to support patients making decisions about how their care and about how services are delivered.

As important as these six elements are, they are not enough. BC has no province-wide structure that would allow these innovations to expand. Provincial and regional strategies are needed to ensure that successful local initiatives go province-wide.

This point is highlighted by Northern Health Authority's transformation of primary health care services. Northern Health (NH) has established a region-wide integrated approach that includes a strategy for managing people with more complex needs. It has established 10 formal IHNs in seven communities serving more than half of the region's population aged 65 and over. That compares to a provincial average of seniors served by IHNs of 8 per cent. NH also has twice the proportion of family physicians participating in the Chronic Care Management initiative as the provincial average and 50 per cent more involved in the Practice Support Program.

What's makes Northern Health different? We argue that NH has three essential ingredients for success: unequivocal support from the HA board and CEO, dedicated funding, and a supportive region-wide framework. Without these elements at the provincial level, innovations can not be implemented province-wide.

The recommendations at the end of this report include the six key change elements described above, plus the following three higher-level strategies:

- **BUILD LEADERSHIP AT ALL LEVELS.** The importance of having support, not only from local champions, but also senior management, cannot be overstated.
- **PROVIDE CONSISTENT DIRECTION AND TARGETED FUNDING.** Dedicated funding is critical for ensuring sustained change over time. There is solid evidence that innovations such as preventative home health services and early intervention programs for young people living with psychosis reduce costs over the long term.
- **ESTABLISH PROVINCIAL LEVEL STRUCTURES.** Provincial level structures that set the parameter and foster innovation are critical to success. BC would do well to look to the governance structure in Saskatchewan, where science—not politics—rules, and where collaboration with health authorities and local providers is built into the process.

If BC truly wants to shift health services away from acute care, focus on prevention and community treatment, and reduce pressures on acute care, it must integrate primary care with community and home care. Treating home and community care as the focal point of reform is critical. To ignore this sector is folly not only for the financial state of BC's health care system, but for some of the most vulnerable citizens of our province.

If BC truly wants to shift health services away from acute care, focus on prevention and community treatment, and reduce pressures on acute care, it must integrate primary care with community and home care.

Introduction

In the early days, medicare could be summarized in two words: doctors and hospitals. That was fine for the time, but it is not sufficient for the 21st century.

— Roy Romanow, Commission on the Future of Health Care in Canada, 2002

Despite the increased emphasis on providing community services closer to home, serious concerns about the adequacy of these services continue.

THE CONTENT, COST AND DELIVERY of Canadian health care services have changed tremendously over the past 50 years, as has the demographic character of Canadian society. Perhaps the greatest change in the past 15 years has been the pivotal role community-based services have come to play in the system's goal of restoring and sustaining Canadians' health.

In British Columbia today, as elsewhere, an increased reliance on a broad range of community health services aims to ensure that people with significant health challenges remain in their own homes and/or community facilities for as long as possible. Community health services provide support for people who require post-acute care, have multiple chronic conditions, are frail elderly, or are living with a mental or physical disability. Many of these services—home care and home support, residential services, community mental health, community rehabilitation services—depend primarily on non-physician care providers.

However, despite the increased emphasis on providing community services closer to home, serious concerns about the adequacy of these services continue.¹ In 2000, the CCPA published a report on the changes introduced in this sector during the 1990s,² and between 2004 and 2006 the CCPA released three studies analyzing the BC government's restructuring of the home and community care sector (previously called the continuing care sector) since 2001.³ These studies found that:

- Because of increased demand and insufficient funding, the focus of home and community care services has shifted to people with more significant health issues, and away from people with more limited needs.
- The emphasis on prevention and early intervention—once the strength of the home and community care health system—has diminished.

- Instead of intervening early and thereby reducing the likelihood of more intensive and expensive interventions down the road, services are increasingly delivered in response to a crisis such as an emergency room visit or hospital admission.
- More and more, individuals and families must rely on their own resources to provide the basic services they need.

The authors of these studies conclude that while these changes have had a disproportionately negative impact on BC's most vulnerable citizens—individuals with low income, frail seniors, and/or people living with a mental or physical disability—they affect all British Columbians. That's because inappropriate utilization of expensive emergency and in-patient hospital beds unnecessarily increases costs to the system and wait times for those who genuinely require these services.

The purpose of this paper is to investigate how best to shift the restructuring of community health reform toward reducing rather than increasing pressures on acute care. To this end, the paper focuses on the key role nurses and other non-physician, front-line caregivers play in implementing prevention and early intervention strategies and in supporting people with more significant health needs to remain in their own homes and communities. These improvements depend, in part, on increased funding to improve access to home and community care services—a discussion that is thoroughly explored in the companion report, *An Uncertain Future for Seniors*. But, they also depend on innovations that improve the effectiveness of the existing community health system. This not only requires strategies for improving the home and community care and community mental health sectors, but strategies for increasing co-ordination with physician services and with a broader system of social supports.

The paper includes case studies, primarily from BC, of successful innovations in single communities or health authorities where providers found a better way of working with clients to improve care and reduce reliance on emergency and in-patient hospital beds. These examples are used to highlight the key components of a more effective community health system. The challenge, as always, is how to ensure that small-scale innovations or pilot projects, once evaluated as successful, become the standard way of providing care. In addressing this issue, this paper relies on three additional case studies to identify the higher-level strategic initiatives required to support broader implementation and systemic change.

The paper builds on the literature and experience of health providers working in innovative community health programs in BC and elsewhere. The research includes interviews with 56 individuals (see list of interviewees in Appendix A), and reviews of 35 peer-reviewed journal articles, 14 institutional/association reports, and 14 government reports. The case studies were identified through key informant interviews, and are representative of the different populations accessing community health services across the province. The articles referenced in this report were selected from a review of the literature from Canada, the United States and Britain on effectiveness of community health reform strategies in palliative care, chronic care, assertive case management (for people living with a mental illness), integrated care delivery (for the frail elderly), shared and team based care, home support, and early psychosis intervention. The paper also includes a history of primary care reform initiatives in BC, since this is the one area of community health where BC has introduced some significant systemic changes over the last 10 years.

This paper focuses on the key role nurses and other non-physician, front-line caregivers play in implementing prevention and early intervention strategies and in supporting people with more significant health needs to remain in their own homes and communities.

SETTING THE CONTEXT FOR CHANGE

The increasing reliance on community health services is about more than changing the location of health service delivery (e.g. the shift away from institutional care for the frail elderly and people living with a mental illness). It is also a response to changing health needs. In the 1950s and 1960s when medicare was first established, the goal was to reduce the burden of acute illness and disease (e.g. a broken limb, appendicitis, infections) on individual families. Today, the majority of health services and health expenditures are directed at people with chronic conditions. It is estimated that two thirds of medical admissions via emergency departments are due to the exacerbation of a chronic disease, and 80 per cent of primary care physician visits are related to chronic conditions.⁴

Examples of chronic conditions include diabetes, chronic obstructive pulmonary disease, asthma, mental illness, arthritis, epilepsy, heart disease and increasingly—with high survival rates—for cancer. Chronic care differs from acute care in that chronic conditions are ongoing rather than episodic and treatment most often focuses on minimizing symptoms, disability and health crises rather than on finding a cure.

People with multiple chronic conditions require ongoing support, and yet the current organization of the community health sector is often inadequate and ill-suited to their needs.

Because people with chronic conditions, particularly those with multiple chronic conditions, require ongoing support, the co-ordination and integration of care at the community level is paramount. Government policy aims to maintain these people in their own communities for as long as possible, and yet the current organization of the community health sector is often inadequate and ill-suited to their needs. In many respects, the community health system is not a system at all. It grew over time as a disparate array of programs and services coordinated by no one. An individual with multiple chronic conditions may receive home care from a home support worker, mental health care from a psychiatrist, and general health care from a family physician, with none of these providers ever being in contact with each other.⁵ All too often, miscommunication or non-communication leads to an undetected deterioration of the client's health. The end result is often a prolonged hospitalization and/or admission to residential care.

COMMUNITY HEALTH CARE REFORM INITIATIVES IN BC AND CANADA

In Canada, efforts to support the better management of care for people with chronic conditions in the community have focused almost exclusively on primary care reform. It is the one area where governments have dedicated funding for more than 10 years—first by the federal government and then by the provincial government—with the explicit goal of “buying” change in how primary care services are delivered.

Primary care is often regarded as the foundation of the health system—“where people first enter the health system and where all health services are mobilized and co-ordinated.”⁶ It can be narrowly focused on family physicians and medical office assistants working in family physician offices or be more broadly defined to include nurses, long term and home health care providers, nurse practitioners and psychologists (i.e. home and community care services).⁷ The narrower definition is often referred to as primary care, while the broader definition is referred to as primary *health* care.

The World Health Organization and many reports from Health Canada, including the 2002 Romanow Commission, point to the benefits of this broader, more inclusive definition, as it supports a greater focus on prevention, increased co-ordination, improved quality and a more effective use of resources.⁸ In the Romanow report, primary health care includes the following:⁹

- The combination of high quality comprehensive medical, nursing and other health services with disease prevention and health education programming;
- The provision of services, not only to individuals, but to whole communities;
- The organization of services in ways that address the characteristics of the populations serviced;
- The expectation of teamwork and interdisciplinary collaboration;
- The availability of services 24 hours a day, seven days a week; and
- The decentralization of decisions to ensure community relevance and buy-in.

By this definition, primary health care includes both primary physician care and the non-physician, home and community care services that are the subject of the previously mentioned CCPA studies. However, in reality and as noted above, there is little connection between the primary health care services delivered in physicians' offices and the home and community care system. Because of the different ways these services evolved, they have tended to operate as two solitudes with distinct funding mechanisms and criteria for access and no established process for communication between them. Finding ways to connect these two halves of the community health system is one of the most significant challenges to effective health reform.

In BC, as in other provinces, funding for primary care reform initiatives has focused first and foremost on the family physician. This paper begins by looking at how and to what extent these initiatives have moved beyond the family physician to include a broader range of practitioners within their own offices and to connect with home and community care. To this end, the paper reviews the four successive waves of primary care reform within BC—beginning in 1997 and purposed to continue to 2011. Because primary care is the one area of health care that has received more than 10 years of dedicated federal and provincial funding, it is a good place to take stock of BC's progress in community health care innovation, both in terms of the systemic barriers to change and opportunities for "scaling up" innovation.

Following the discussion of primary care reform in BC, this paper turns to home and community care and identifies six key components of an effective community health system, including case studies of how to better align primary physician and home and community care services. The final section focuses on what is required to take successful innovations and implement them broadly across the system.

Because primary care is the one area of health care that has received more than 10 years of dedicated funding, it is a good place to take stock of BC's progress in community health care innovation, both in terms of the systemic barriers to change and opportunities for "scaling up" innovation.

Primary Care Reform

Primary care reform funding has increased dramatically—from \$9.6 million during 1997–2001 to more than \$500 million during 2008–2011.

PRIMARY CARE REFORM has had four waves of innovation in BC, each with a different focus and direction. While funding has increased dramatically—from \$9.6 million during 1997–2001 to more than \$500 million during 2008–2011—the reform’s priorities have constantly shifted (see summary on page 13). This has made it difficult for initiatives to build on the knowledge and achievements of each other. One aspect of reform, however, has been consistent: innovations have focused on physicians as the central player.

FIRST WAVE

The federally funded Health Transition Fund was the first wave of primary care reform. Created in 1997 and based on the findings of the 1997 report *Canada Health Action: Building on the Legacy*, the goal was to encourage and support evidence-based decision making in health care reform. This reform wave was time-limited and driven by policy makers who hoped it would generate relevant policy findings. This national effort included 140 innovative projects in four priority areas: primary care, home care, Pharmacare, and integrated services delivery.

BC policy makers, researchers and health care providers initiated a wide range of small scale experiments and many produced significant improvements in health outcomes and service utilization. For example, in the area of home care a series of BC studies demonstrated that home care for the elderly is a cost-effective alternative to various levels of care in residential facilities.¹⁵ Another project demonstrated the effectiveness of home based care for psychosis (see case study page 32).¹⁶ But the most richly funded projects were the seven primary care project sites that provided 24-hour/7-day-a-week access to medical care and to a full range of services such as illness and injury prevention and health promotion.

BC was seen as being fairly successful in implementing an integrated model with all of the elements deemed essential at that time.¹⁷ But the BC Medical Association (BCMA) was

Summary of BC Primary Health Care Innovation Funding 1997–2008

FIRST WAVE: HEALTH TRANSITION FUND, 1997–2001

FUNDING: \$9.6 million from the federal Health Transition Fund and \$3 million diverted from MSP fee-for-service fund. (*Nationally \$150 million: \$120 million to provinces and \$30 million to national projects.*)

KEY FEATURES: Projects were in four areas: home care, primary care, Pharmacare, and integrated services. In BC there were 28 projects, of which seven were primary care. Features included: capitation, not fee-for-service funding; 24 hour coverage; information systems; patient rostering; and multi-disciplinary.

RESULTS: These early projects had some positive outcomes, but the BC Medical Association was not supportive of the requirement that the funding model eliminate the existing fee-for-service reimbursement for doctors.¹⁰

SECOND WAVE: PRIMARY CARE HEALTH TRANSITION FUND, 2000–2006

FUNDING: BC's share was \$74 million—70 per cent to health authorities (HAs) and 30 per cent to the Ministry of Health. (*Nationally \$800 million, 68 projects in five funding envelopes: provincial, multi-jurisdictional, national, Aboriginal, and official languages.*)

KEY FEATURES: HAs implemented chronic care initiatives in two areas: congestive heart failure (CHF) and diabetes based on a “collaborative learning model” and using a variety of service delivery models. The ministry had some money for projects, e.g. a nurse 1-800 line, developed a chronic care toolkit to support the CHF and diabetes collaboratives, and funded the University of Victoria to develop a province-wide Chronic Disease Self-Management Program based on a successful model from the US.¹¹

RESULTS: In 2006, just under 20 per cent of BC's primary care providers enrolled in collaboratives.¹² The ministry reports fewer visits and hospital stays for diabetes-related health problems, and a drop in provincial costs for diabetes care from \$4,400 per patient in 2001/02 to \$3,966 in 2004.¹³ Evaluations of self-management programs showed that participants experienced improved health status and improved ability to manage their disease and its symptoms.¹⁴

THIRD WAVE: PRIMARY HEALTH CARE CHARTER AND BCMA PRACTICE SUPPORT PROGRAM, 2007–2011

FUNDING: \$454 million over four years in incentives to family physicians under BCMA's fee-for-service agreement. Approximately \$10 million to non-government groups to develop patient support programs.

KEY FEATURES: Annual incentive payments to physicians paid on a fee-for-service basis for each of their patients with diabetes and CHF, for preventative cardiovascular assessments, and for each complex patient (i.e. those with more than two chronic conditions). Funding to support provincial practice support program implemented through Impact BC, with 1,600 family physicians currently involved. Funding to community groups for patient education to help close gaps in care on issues ranging from strokes to dementia to depression. Ministry to develop electronic patient record.

FOURTH WAVE: BC HEALTH PRIMARY CARE INNOVATION FUND PROJECT and INTEGRATED HEALTH NETWORKS

FUNDING: Approximately one third of the \$100 million Innovation Fund. For Integrated Health Networks (IHNs), \$31.2 million over one year for primary health care projects in 2007/08, plus \$12 million per year for 2008/09 and 2009/10; these funds matched by health authorities.

KEY FEATURES: 10 Primary Health Network projects funded for one year. 25 IHNs in operation or “under development.” 100 IHNs targeted, but no timeline or funding committed as yet.

not supportive of this initiative because it replaced the existing fee-for-service payment model with a population needs based, or capitation model.¹⁸ Capitation is a reimbursement method based on the number of patients who receive care and the complexity of their needs, rather than on the number of specific interventions by physicians as is the case with fee-for-services. Because it is tied to patients and not providers, capitation funding facilitates the inclusion of other practitioners (e.g. nurses, nutritionists, community mental health and outreach workers) within the primary care team.¹⁹

SECOND WAVE

In 2000, at a federal-provincial meeting where provincial premiers demanded increased federal funding for health care, primary care reform was the only area where the premiers agreed to support dedicated funding. In response, the federal government created an \$800 million Primary Health Care Transition Fund (PHCTF). In BC, most of this funding went to health authorities (HA) to initiate projects for managing specific chronic conditions using provincially-developed tools and programs. There was no requirement to move away from the fee-for-services payment system. Health authorities adopted variations of the Chronic Care Model (CCM),²⁰ an internationally recognized approach for changing systems based on evidence of what works best for patients with chronic illnesses (see box below).

BC's Primary Health Care Transition Fund projects focused on two major conditions: congestive heart failure and diabetes. The initiative was supported by the Ministry of Health through the development of a "tool kit" that included information on how to set up patient registries, prescribing guidelines and patient education materials.

BC's Primary Health Care Transition Fund (PHCTF) projects focused on two major conditions: congestive heart failure (CHF) and diabetes. The Healthy Heart Society facilitated the CHF collaboratives and reported some positive initial results.²¹ The initiative was supported by the Ministry of Health through the development of a policy framework: an expanded CCM and a "tool kit" that included information on how to set up patient registries, prescribing guidelines and patient education materials.²²

The province-wide diabetes collaborative followed a similar format. Forty-five different clinical teams participated in partnership with health authority staff around the province. Some teams joined forces with hospital-based diabetes education centres while others were supported by nutritionists from public health. The ministry reported lower costs and fewer visits for diabetes related care after 2001.²³

BC also funded researchers at the University of Victoria to implement a Chronic Disease Self Management Program modelled on the work of Kate Lorig and colleagues at Stanford University.

When federal funding ended in March 2006, the provincial government continued to fund the chronic disease management initiative for physicians under the Primary Care Charter

BC's collaborative Chronic Care Model is based on the Institute for Healthcare Improvement's "Breakthrough Series" for helping organizations close the gap between "what is known and what is done." Breakthrough collaborations involve an orientation session followed by a series of learning workshops. Between the workshops, participants engage in action periods, where, for three to four months, they test best practice ideas in their local settings.

(third wave below). There was, however, no provincial funding for projects that included other practitioners (e.g. nurses, nutritionists, etc).

THIRD WAVE

Primary care innovation continued with a third wave of reform in May 2007. This time there was no role for health authorities. Called the Primary Health Care Charter,²⁴ the focus was exclusively on physicians. With support from the non-profit agency Impact BC, the BCMA rolled out a four-year, province-wide Practice Support Program backed up with training resources and individual incentives for physicians to the tune of \$454 million. This was the most significant step in BC primary care reform to date, and so far about 1,600 or 44 per cent of BC family physicians have become involved in some aspect of the program.²⁵ However, only about 22 per cent of BC family physicians are participating in the chronic disease management section of Practice Support.²⁶

Physicians in this part of the program are provided with: education about advanced access (leaving appointment calendars open for some same-day access); patient registries so that those with chronic diseases can be seen regularly; planned recall (a system that facilitates various types of care, such as lab tests and referrals to specialists); electronic medical tools; patient self-management (patients learn how to adopt healthy behaviours) and group visits. Their work is based on a fee incentive structure whereby the government pays an extra annual fee of \$125 per patient in a chronic disease registry maintained by a family doctor, plus a one time start-up fee of \$10,000 for a primary care practice involved in chronic disease prevention.²⁷

Also part of this third wave was approximately \$10 million to non-governmental organizations to develop patient education packages for issues ranging from stroke to dementia to depression. The ministry is also working on design and implementation of an electronic medical record, a key element for proactive management of chronic illness.

With the Primary Health Care Charter, which focused exclusively on physicians, the BCMA rolled out a four-year, province-wide Practice Support Program backed up with training resources and individual incentives for physicians to the tune of \$454 million.

FOURTH WAVE

In May 2007, the BC Ministry of Health Services also released a discussion paper on Integrated Health Networks (IHNs). Backed by the primary health care charter, the ministry emphasized linking physicians with community agencies and health authority services to create a more integrated and community-based approach to providing care for people with significant health needs. The IHNs share much in common with primary health care as defined in the Romanow report. They have a similar focus on effective utilization of resources through improved teamwork, better community linkages and the combination of comprehensive medical care with preventive services, health education, and population-based approaches.

In 2007–08 the province announced a \$100 million Innovation Fund of which \$31 million was allocated to primary care, some of which was used to initiate IHNs. This was followed by two one-year funding allotments of \$12 million each for the piloting of 25 IHNs across the province (see Appendix C). Health authorities are required to match this funding dollar for dollar. The ministry aims to establish 100 IHNs, but has not said when it expects to achieve that number, nor committed to funding IHNs beyond 2010. Much of the decision to further expand IHNs rests on the results of an evaluation, currently underway and expected to be

completed by March 2010. The evaluation is examining a wide range of outcomes, including acute care utilization rates, visits to emergency departments, recommended care, provider satisfaction across the health care team, patients' experiences, and all other components of the expanded chronic care model to ensure that IHNs are taking a holistic approach for the system, patients and providers.²⁸

The amount allocated for individual incentives for physicians is much greater than that dedicated for province-wide establishment of IHNs. This is, in our view, very problematic. Incentives for physicians buy change in how physicians practice as individuals while funding for IHNs buys changes in how the entire system operates.

Clearly there is some recognition of the need for a more integrated approach. However, the amount allocated for individual incentives for physicians—more than \$100 million each year for four years—is much greater than that dedicated for province-wide establishment of IHNs—\$24 million over two years. This is, in our view, very problematic. Incentives for physicians buy change in how physicians practice as individuals while funding for IHNs buys changes in how the entire system operates. Despite overwhelming evidence that interdisciplinary practice is the key to successful management of care for people with chronic conditions, BC persists on focusing most provincial resources on changing family physician practice rather than changing the overall community care system.²⁹ The consequence, we argue, is that changes that would benefit patients with the most complex conditions—those who use and cost the system the most—are often left to languish.

This report argues that focusing on people with complex needs is essential if our health system is to be both effective and sustainable. While we applaud the work being done to reform primary physicians' care in BC, we also want to shine a light on home and community care and community mental health. This area, which is so vital for people with complex needs, has been largely neglected.

Six Key Change Elements in Home and Community Care

CHANGE IN HEALTH CARE is hugely challenging. As noted at the beginning of this report, the changes that resulted in reduced access to home and community care (HCC) services since 2001 have had significant negative consequences. Even physicians—those who most benefit from current primary care reforms—recognize that more needs to be done in community care. A recent BCMA report on HCC pointed to “a system in decline largely because of deteriorating access to (home and community care) services.”³⁰ When asked for their views, three quarters of physician respondents reported having HCC patients who needed “a higher level of care than was currently offered.”

There is no question that access to these services must be increased. But in addition, it is important to understand how best to build the system of care in the community. BC has no province-wide process for supporting innovation in community care that would reduce emergency room visits and hospital admission and re-admission rates. While primary care reform initiatives for primary care physicians have been systematic and supported at the provincial level, home and community care reform has not. What few reforms there are exist primarily because of the passion of individual providers working to create services they know work better for their clients. Some promising innovations in home and community care are now being supported through the IHNs, yet they remain as isolated pockets or general small-scale experiments, either in a single health authority or a single community.

A number of these innovations are described in this report. They include examples primarily from BC, but also from other parts of Canada and elsewhere. Based on this analysis, we identify the following six key change elements that would result in a more effective community health delivery system and move community care to the next level of reform.

BC has no province-wide process for supporting innovation in community care that would reduce emergency room visits and hospital admission and re-admission rates. While primary care reform initiatives for primary care physicians have been systematic and supported at the provincial level, home and community care reform has not.

1. Focus on People with Complex Needs

Most of the chronic care management work in BC has focused on physician-based care for individuals with one or two chronic conditions. While it is easier to begin reform with less complex individuals, addressing the needs of those with complex needs is critical. In fact, because individuals with complex conditions use a disproportionately higher proportion of health services, some researchers argue that they should be the first priority of health system integration.³¹

BC data highlights the need to target this small but complex group made up of extremely high users of health care. Of the nearly three million adults registered in BC's Medical Services Plan during 1996/97, approximately 126,000 individuals (about 5 per cent) accounted for almost 30 per cent of the total MSP payments made to physicians. These "high users" saw, on average, more than three times as many different physicians, had more than five times as many encounters with different physicians, and had encounters that were more costly. Overall, they were responsible for 17 per cent of all visits to general and family practitioners, 30 per cent of visits to specialists, 36 per cent of hospitalizations, and a staggering 64 per cent of all hospital days.³² These individuals had multiple chronic conditions and most have a psychological co-morbidity. Eighty per cent of the high user group had at least six different types of illnesses and almost half of the group were aged 60 or over.³³

Similar findings were identified in more recent research on Medicare recipients in the US (i.e. people on limited income). Researchers found that people with a chronic illness were at higher risk of developing additional chronic conditions and "over half of the adults were being managed for five or more chronic conditions." This accounted "for 76 per cent of total health care spending and virtually all growth in spending from 1998 to 2002."³⁴

Appropriate home and community care is crucial to reducing wait times and emergency room congestion, especially for people with complex, chronic health needs. The more this care is lacking, the more likely people are to show up in hospital emergency rooms. For example, in 2003 in Canada, 30 per cent of hospital days involved dealing with a patient with a primary or secondary diagnosis of mental illness and, of those admitted into and then discharged from hospital in 2003, 37 per cent with a mental illness were re-admitted within the year.³⁵ The next sections target some specific strategies for reducing hospital and emergency admissions and re-admissions for people with complex conditions, including those living with a primary or secondary mental illness diagnosis.

BC data highlights the need to target this small but complex group made up of extremely high users of health care. About 5 per cent of individuals were responsible for 17 per cent of all visits to general and family practitioners, 30 per cent of visits to specialists, 36 per cent of hospitalizations, and a staggering 64 per cent of all hospital days.

2. Acknowledge the Link Between Income and Health Status

When practitioners deal with someone with multiple chronic conditions, they must shift away from disease management to an understanding of the individual and his or her social circumstances. Those circumstances include a range of challenging factors such as:

- Poverty, poor housing, poor environments or rural isolation;
- Age-specific care and support issues for the very young and very old;
- Emotional and physical needs due to abuse and violence—primarily women, people leaving correctional institutions, and refugees;
- Culturally and circumstantially disadvantaged or excluded individuals—minority ethnic groups, homeless people, Aboriginal people;
- Disabilities, including profound, severe or long term impairment or disabilities; and
- Marginal, high risk and hard to reach populations involved in substance misuse, mental illness, antisocial behaviour and those being at risk of exclusion.³⁶

Anyone who works in health care or studies health care policy knows that social circumstances have a huge impact on the chance that a person will acquire a chronic disease. That's because the social determinants of health—that is, the economic and social conditions under which people live—determine, to a large degree, their health status. In fact, a wealth of evidence from around the world supports the idea that socioeconomic circumstances play an equal if not greater role in health status than medical care and personal health behaviours, such as smoking and diet.³⁷ Most recently, research by the Wellesley Institute and the Community Social Planning Council of Toronto confirmed—once again—that poverty makes hundreds of thousands of Canadians sick and costs the health care system millions of dollars. This research dramatically illustrates the strong link between low income and poor health.³⁸

As people age, the consequences of living in impoverished social and economic circumstances accumulate so that by late middle age and onward they are more likely to be disabled and living with one or more chronic conditions than their more privileged counterparts.³⁹ This is precisely when people with chronic conditions need good community care, including non-medical support, in order to remain relatively independent and out of the acute care system.

Recent research from the Canadian Institute for Health Information (CIHI) focused on the link between an individual's socioeconomic status and hospital utilization. The researchers compared 21 health-related indicators between high, average and low socioeconomic status groups across 15 of Canada's largest urban areas. The study concluded that Canadians in the lowest socioeconomic group were more than twice as likely to be hospitalized for chronic conditions that could potentially be treated in the community. For example, people in this group were almost two and a half times more likely to be hospitalized for diabetes and almost three times more likely to be hospitalized for chronic obstructive pulmonary (i.e. lung) disease.⁴⁰ People in the lowest socioeconomic group have less access to community care and are less able to afford supports such as house cleaning and shopping. They are also the most likely to *not* have safe and affordable housing.

A recent study from the Canadian Institute for Health Information concluded that Canadians in the lowest socioeconomic group were more than twice as likely to be hospitalized for chronic conditions that could potentially be treated in the community.

HOUSING AND HEALTH

A good home goes a long way to creating good health. The importance of housing as a health issue is highlighted in a recent report by Simon Fraser University researchers showing there are approximately 11,500 people across BC who are absolutely homeless and have an untreated mental illness and or addiction.⁴¹

The average homeless, street-living adult with mental illness and/or an addiction in BC is estimated to cost the public system in excess of \$55,000 per year. Provision of adequate housing and supports are estimated to cut this cost to \$37,000 per year.

Society's neglect of this population is costly. The average homeless, street-living adult with mental illness and/or an addiction in BC is estimated to cost the public system in excess of \$55,000 per year. Provision of adequate housing and supports are estimated to cut this cost to \$37,000 per year. This would result in an overall cost avoidance of about \$211 million per year, if politicians were willing to invest in best practice mental health care and supported housing.⁴²

Housing First is a social service model developed in the US as a response to the growing numbers of mentally ill and/or addicted people who were becoming homeless as they failed to meet the requirements of the regular office-based treatment system. The distinguishing feature of this approach is a commitment to offer permanent housing *first* to hard-to-serve homeless persons, rather than requiring them to achieve a period of stabilization, sobriety, or commitment to treatment in order to demonstrate housing readiness. The housing is accompanied by 24/7 intensive supports and team-based treatment. One of the most successful examples of integrated services to people with serious mental illness is the Pathways to Housing project in New York (see case study on page 21).

3. Take a Multi-faceted Approach to Prevention

Prevention aims to reduce the likelihood of a disease or disorder. Primary prevention reduces the chances of developing a disease or disorder; secondary prevention prevents or minimizes the progress of a disease or disorder that is at an early stage; and tertiary prevention focuses on halting the progression of damage already done.⁴⁶ Although prevention is usually thought of in terms of individual behaviour and its relationship to disease, studies show that loneliness and social isolation are risks for illness and can be addressed through preventive outreach.

Everyone wants to see more prevention of illness and chronic disease. After all, “an ounce of prevention is worth a pound of cure.”⁴⁷ In recognition of this consensus, the Select Standing Committee on Health challenged BC to double its public health investment from 3 per cent of the total health budget to 6 per cent.⁴⁸ The BC government responded by providing primary prevention—promoting lifestyle changes in the general population—and by providing secondary prevention by focussing on people with one or two chronic conditions.

Effective prevention is, however, multi-faceted and interventions vary with population needs. At the same time as the government increased its support for prevention programs for people with one or two chronic conditions, prevention activities appropriate for people with complex needs have been in decline. This discrepancy reflects the difference in the government approach to primary care reform as compared to their approach to restructuring home and community care services over the last eight years. This section reviews these two quite different approaches to prevention.

Pathways to Housing (New York)

Pathways to Housing provides people who are homeless and mentally ill with immediate independent and permanent housing along with client-driven treatment and support services.⁴³ In before-and-after studies of this integrated program, clients were followed over a three year period and averaged 327 inpatient days before housing, contrasted with an average of 27 days after.⁴⁴ That is a reduction of 92 per cent. A recent randomized trial of homeless people demonstrated a significantly improved housing stability rate for Pathways clients compared to those in usual care.⁴⁵

This “housing first” model combines street outreach, assertive community treatment and housing in a client-driven and non-bureaucratic service in order to reach those most at risk. Typically, these services rely on the work of trained community mental health outreach workers who engage people to come in from the cold. Medical services follow when the individual is ready to seek care.

Practitioners in BC are just beginning to appreciate the power of the Pathways to Housing model and are trying to address local housing needs in a similar manner. The Expert Panel Group of the Victoria Mayor’s Task Force on Homelessness identified “housing first” as the service model required to address the Capital Region’s chronic homeless population and the newly established Community Coalition to End Homelessness is working to implement this integrated housing and health care approach.

Clearly, supporting good health outcomes for those with complex needs is about more than traditional medical care. To a large extent, it is also about access to housing and supports for daily living (e.g. meal preparation, housekeeping and transportation), emotional/psychological care, and public funding strategies that meet combined housing, social care and health care needs. For homeless people with mental health issues, housing is obviously the most basic need of all. But once people are housed, preventative services and basic health services provided by home support allow them to remain in their own homes and not be institutionalized.

Over the last several years there has been a move away from residential care for both the frail elderly and people living with a mental illness. However, the de-institutionalization of these people has not been accompanied by a corresponding boost in community support services, most importantly housing. And reductions in residential care have not resulted in an increase in access to 24/7 home-based services.

Pathways’ “housing first” model combines street outreach, assertive community treatment and housing in a client-driven and non-bureaucratic service in order to reach those most at risk.

Possibly BC's most successful prevention initiative is the Chronic Disease Self Management Program (CDSMP) designed for relatively mobile and independent people with one or two chronic conditions. Developed at Stanford University in California, it was introduced in the province as part of the second wave of primary care reform (see page 14).⁴⁹ There is ample evidence showing that this low-cost program improves participants' health status (e.g. fatigue, pain, health distress) and reduces health care costs because of fewer hospitalizations⁵⁰ and visits to physicians and emergency departments.⁵¹

At the same time as the government increased its support for prevention programs for people with one or two chronic conditions, prevention activities appropriate for people with complex needs have been in decline.

CDSMP is a peer-support model where people meet in small groups to support one another. Trained volunteers, who have chronic conditions themselves, or in some cases health professionals, lead sessions that teach skills such as developing a suitable exercise program, cognitive symptom management, and strategies for dealing with anger and depression. In 2003, the BC Ministry of Health Services used \$1 million of federal health transition money to provide three years of funding for province-wide implementation of CDSM programs. In 2006, the University of Victoria's Centre on Aging received another \$1 million in provincial funds to continue the program at the same level for the next three years. CDMS programs are now offered in over 36 communities throughout the province's five health authorities.

Approximately 1,000 British Columbians participated in a program evaluation. After six months of being in the program, participants reported having improved their health status (less disability, fatigue, distress, and pain and depressive symptoms) and their ability to manage their disease and its symptoms, (e.g. through increased aerobic exercise and use of coping strategies).⁵² However, despite repeated requests for funding to conduct an evaluation of the impact on health care utilization, funding has not been forthcoming.⁵³

The case study of the Garrett Wellness Centre (see case study on page 23) is a leading example of an enhanced self-management prevention program linking services provided by physicians, the community health authority, and the municipality. At this point it is one of a kind and not part of a broader provincial plan for improving the coordination of prevention services at the community level.

PREVENTION FOR PEOPLE WITH COMPLEX NEEDS

Garratt Wellness Centre clients are relatively well, having one or perhaps two chronic illnesses. For the most part, they manage their lives independently with the Wellness Centre providing an opportunity to learn about self care and link with others. However, primary, secondary and tertiary prevention for people with complex conditions are, if anything, in decline. For instance, while there is now funding for nutrition education in schools, there is no support for people living in their own homes who are unable to shop for groceries or cook a meal themselves. Similarly while there is now funding for exercise programs in schools, there is less funding in long-term care for activity programs for frail seniors.

In a related vein, many studies document the benefits of good nutrition in maintaining health and preventing disease, particularly for frail seniors. Whereas well-nourished seniors have "fewer medical complications and diseases, faster wound healing, and fewer infections," malnourished seniors experience "decreased quality of life, decreased independence, and deterioration in overall health status, increased use of health-care resources, and increased morbidity and mortality."⁶²

CASE STUDY

Garratt Wellness Centre

The Garratt Wellness Centre is a Richmond-based community health care partnership where family physicians, the local community, and the CDSMP combine to offer a “one-stop shop” for people living with chronic conditions like heart disease and diabetes. The program is based on BC’s Expanded Chronic Disease Management Model and the ICIC (Improving Chronic Illness Care) processes in diabetes management and care.⁵⁴

The impetus for the Wellness Centre came from community health providers who saw the benefits of having diabetes and cardiac rehabilitation and community education services accessible to clients on a daily basis.⁵⁵ Family physicians, the city, community participants and Richmond Health Services identified what was available in the community for chronic disease management, what gaps existed and what the community vision was. Around the same time, the Vancouver Coastal Health Authority received funding for primary care reform initiatives and an empty school became available that the city leased at a minimal price.⁵⁶ The centre opened in September 2004.

Community partners such as neighbourhood residents, the University of Victoria’s Center on Aging, the Canadian Diabetes Association and S.U.C.C.E.S.S.⁵⁷ provided input and feedback on programs.⁵⁸ The Garratt Wellness Centre now operates six days a week and serves about 45 participants a day. Programs are offered both by community and health partners, reducing the cost to the health care system and adding to the sustainability of the project.⁵⁹

In addition, Garratt supports 11 family physicians in a collaborative model designed to improve the health of more than 900 patients with diabetes. The physicians reported that more weight management programs were needed. In response, Garratt and partners set up new services that reduced the diabetes education waitlist from 15 weeks to two. In 2007, physicians began targeting chronic kidney disease, with Garratt responding by increasing nutrition therapy, education, and cooking skills development.

A client self-assessment evaluation revealed several significant positive results.⁶⁰ Yet a big challenge for the program is continuing funding. Garratt coordinator Barb Leslie explains: “I’m trying to expand the program with the same operating dollars. If I can keep bringing community partners in, I can keep bringing in new programs.”⁶¹

The impetus for the Wellness Centre came from community health providers who saw the benefits of having diabetes and cardiac rehabilitation and community education services accessible to clients on a daily basis.

However, instead of expanding home support to meet this growing demand, the preventative and maintenance functions of home support have shrunk, making fewer and fewer daily living supports—meal preparation, housekeeping, transportation and social support—available. A recent BCMA report on home and community care underscores this fact, noting that: “The impact of reductions in home support services on the health care system is potentially significant, as home support is a form of preventive health care that can delay the need for institutional care.”⁶³

Prevention for people with more complex needs is in decline, and yet these individuals are most at risk for hospitalization. BC-based research shows that the elimination of supports for daily living (i.e. meal preparation, shopping, housekeeping and social contact) from home support resulted in higher overall health expenditure and greater utilization of long term and acute care services.⁶⁴ In other words, for frail seniors, supports for daily living are a critical preventive service. In Denmark, a country most often seen as having exemplary care for seniors, all citizens aged 75 and over are offered support services twice a year because proactive support and early intervention have proven to be more cost-effective than restricting those services only to those most in need.⁶⁵

In Denmark, a country most often seen as having exemplary care for seniors, all citizens aged 75 and over are offered support services twice a year because proactive support and early intervention have proven to be more cost-effective than restricting those services only to those most in need.

Similarly, early and appropriate treatment can prevent many of the most devastating outcomes suffered by people with a psychosis. The Prevention and Early Intervention Program for Psychoses (PEPP) in London, Ontario reported that 82 per cent of those entering the program with less than six months duration of untreated psychosis (DUP) were in remission at one year, compared to 58 per cent of those with a DUP greater than six months. By increasing public awareness and case detection initiatives in the London area, the duration of untreated psychosis has been decreasing significantly.⁶⁶

In 1999/2000, the BC Ministry of Health undertook an Early Psychosis Intervention (EPI) Initiative designed to reduce reliance on acute care. The initiative received a one-time funding of \$1.15 million. The goal was to establish a process for ongoing regional inter-ministry prevention and intervention for young persons aged 13 to 30. Because of its population prevention approach, the EPI initiative cast BC as a national leader in preventative care to youth entering the mental health system for the first time.

A second initiative received \$300,000 for five sites to implement psychiatric best practices (South Fraser, Central Vancouver Island, Vancouver/Richmond, North West, and Okanagan/Similkameen). The government also set up an inter-ministry co-ordinating group and developed a document outlining goals and procedures for establishing a best practices program.⁶⁷ However, with a change in government, implementation was left to individual health authorities. The remaining funding was allocated to Fraser Health, which continued to build a more extensive EPI program.⁶⁸ Today, only in Fraser Health can a young person in the grips of his or her first psychotic episode be assured access to a health authority-wide program that offers best practices in clinical care, psycho-education and peer support.

In 2003/2004, the BC Schizophrenia Society surveyed hospitals and community-based mental health services as to their ongoing early psychosis practice.⁶⁹ While the report noted some improvements for young people coming into the acute care system, the presence of evidence-based treatment strategies varied widely. Almost half of hospitals reported no specific training for staff regarding first episode psychosis, despite the fact that most first-episode patients enter the mental health system via inpatient facilities.⁷⁰ Researchers from Melbourne, Australia comparing early intervention with usual treatment regimes for people

with psychosis estimate savings of \$39,934 (discounted to current Australian dollars) per person over the five years of the critical period: \$15,487 were financial savings and \$24,447 were savings in reduced pain and suffering for the individual.⁷¹

This is an example of a secondary prevention activity that should be mandated province-wide in BC, but is currently left up to individual health authorities to implement and fund.

4. Realign Primary Care and Home and Community Care

Providing care for people with complex needs requires combining primary care and home and community care services. Yet because of how these services evolved, they generally operate separately. Access to primary care health services is based on medical need, and the gate keeper, normally a family physician, is paid on a fee-for-service basis. Access to publicly-funded home and community care services, on the other hand, is based on functional status as determined by a nurse or social worker employed by a health authority (HA). And while individuals are free to choose their family physician regardless of where they live, home and community care services are most often assigned based on geographic proximity to an individual's place of residence or, in the case of residential care, on the "next available bed policy." As a result, even though home and community services providers and physicians have the same clients, they rarely communicate or work together.

Because provincial support for primary care reform has focused almost exclusively on introducing the CCM into physicians' practices, realigning primary care and home and community services is in its infancy. But some communities and health authorities are beginning to move in this direction, particularly with the added support from the provincial Integrated Health Network initiative. The area where the most progress is being made is in the aligning of home and community care case managers with primary care physicians. The Vancouver Island Health Authority (VIHA)'s Primary Health/Home and Community Care Partnership Program was first initiated in Sooke and Victoria and is now in place in Burnside/Tillicum, Nanaimo and Ladysmith. As of Fall 2008, there were 76 separate partnerships operating throughout Vancouver Island.⁷²

The area where the most progress is being made is in the aligning of home and community care case managers with primary care physicians.

INTEGRATING INTERDISCIPLINARY PRIMARY CARE INTO RESIDENTIAL CARE

Residential care could also benefit from better integration with primary care. Compared to nursing home residents of the 1980s, today's residents are often sicker, more likely to have dementia, and often have numerous chronic diseases treated with multiple medications.⁷⁵ Yet, staffing and services have not increased to meet the more complex needs of residents.⁷⁶ According to Dr. R.J. (Dick) Raymond of the Family Practice Residency Program in Prince George, "residents' physical and psychosocial care needs have become so complex that residential care facilities are like "mini-hospitals."⁷⁷

VIHA's Primary Health/Home and Community Care Partnership Program

Traditionally, there was little connection between home care case managers and family physician. The home care case manager looked after all clients in a defined geographic area, while primary physicians often have patients scattered across the city, each with a different case manager. In this partnership in the Vancouver Island Health Authority, a home care case manager is assigned as the primary liaison for a group of physicians. The case manager's caseload consists of only clients of these physicians—regardless of where they live. The case manager develops care plans with clients and their caregivers, coordinates and links clients with appropriate community resources, and keeps the physicians informed of their patients' care plans and progress. He or she also acts as the liaison with physicians for the rest of the HCC team (e.g. physiotherapists and social workers).

Feedback from the physicians involved has been very positive. In the past, physicians in the Victoria area could have contact with 40 different HCC case managers. Now, they are linked with a single case manager who has seen their patients in their home environments. Clients in turn report feeling reassured knowing that their case manager is in regular contact with their physician.

Another benefit from this partnership is that case managers are beginning to practice a more preventive role as they see clients at an earlier stage than they did in the past. While some clients don't meet the eligibility criteria for HCC services, the case manager is still involved in their care, making sure they are accessing appropriate services such as diabetes education or social programs at a seniors' centre. Case managers also find that because they meet regularly with physicians, more clients are being identified in need of home care services. Jo Dunderdale, Program Leader for Home and Community Care at VIHA, noted that "anecdotally we are getting a lot of stories that by having referrals earlier, we've really made a difference in clients' health outcomes."⁷³ An evaluation of the program, however, to determine whether these "early interventions" prevent avoidable visits to emergency departments has not progressed due to lack of resources.

The partnership faces challenges: seeing individuals in a geographically dispersed region, coping with heavy workloads, and dealing with the inefficiencies of paper-based medical records (electronic paper records are under development).⁷⁴

While VIHA's initiative shows promise, it is important to note that home support services are not incorporated into this new partnership and that there is no formal evaluation process for the initiative.

Another role that is helping to realign primary care with home and community care is that of nurse practitioners. Carrie Murphy is a nurse practitioner with the Integrated Health

In VIHA's program, case managers are beginning to practice a more preventive role as they see clients at an earlier stage than they did in the past.

VIHA's Primary Health/Home and Community Care Partnership Program, continued

Network (IHN) for the Older Adults' Clinic in Abbotsford. The clinic focuses on seniors with multiple chronic conditions. These clients tend not to be well served by the traditional medical model where the GPs acts as the "gatekeeper" to other medical services and Home and Community Care works as a separate system. Integrated Health Networks function on a shared care model: agreements to co-manage clients with a range of health care professionals such as geriatricians, mental health workers, pharmacists and social workers.

Murphy, who has been in her position since October 2007, is working on the details of the collaborative arrangement. While the family physician and nurse practitioner are the two key players, they rely on a network of people and services aimed at managing the care of complex seniors. For instance, Murphy does physical and mental assessments, prescribes a wide range of medications, orders lab tests, X-rays and other diagnostic tests, makes referrals to specialists and helps decide when a client needs to see the family physician. She also makes referrals to and works with the region's geriatric mental health team. As well, she does home visits to seniors who are house-bound.

The GP manages other medical conditions. The nurse practitioner role is well suited for this particular population, says Murphy, because "with seniors the goal of care is about function and quality of life. Also, elderly people need more time and nurse practitioners can spend more time with them than can a GP. And from a nursing point of view, we're able to address some of those functional issues probably better than a physician can."

Reforming residential care practice is cost effective as demonstrated by research from Ontario where on-site treatment for pneumonia successfully reduced emergency transfers to acute care, hospital admissions, lengths of stay and overall cost of care.⁷⁸ The leading work in this area is from the Netherlands. Dutch nursing homes (similar to our residential care facilities) report far lower hospitalization rates of residents, which, researchers argue, can be attributed to enhanced staffing and the presence of a specialist physician working with a multi-disciplinary health care team.⁷⁹ "Diseases such as pneumonia, heart failure, dehydration, and mismanaged diabetes that would require hospitalization in other countries [are] treated by nursing home physicians within the homes."⁸⁰

In the Netherlands, nursing homes have a rehabilitation function, offer palliative care, and include day and night centres all covered by government funding.⁸¹ Nursing homes are staffed with one physician with special training for every 100 residents; one physiotherapist, occupational and speech therapist for every 35 residents; as well as dieticians, psychologists, social and recreational workers. Improved communication results from the continuous presence of the nursing home physician, which contributes to better decisions and care planning.

In BC, staffing levels in residential care homes not attached to a hospital are among the lowest in the country.⁸² Moreover, residential care physicians in these facilities rarely have easy access to examination rooms, laboratory, x-ray and other diagnostic services that enable treatment of residents in a facility. Interestingly, recently published BC research found that

Dutch nursing homes (similar to our residential care facilities) report far lower hospitalization rates of residents, which, researchers argue, can be attributed to enhanced staffing and the presence of a specialist physician working with a multi-disciplinary health care team.

Northern Health's Residential Care Physician Project

Prince George was seeing more long-term care residents going to the hospital for treatments that could have been better provided in the residential care facilities if staff and resources were available. The Long-term care Physician Project was implemented in three facilities in February 2007 with the aim of attracting more physicians to residential care, thereby enhancing residents' care and reducing transfers to acute care.⁸⁴ The leadership of Dr. Raymond and Dr. Garry Knoll, local physicians long interested in improving the quality of residential care, was instrumental in getting the project off the ground. Funding from the Emergency Room Decongestion Initiative also provided impetus for the project.

Similar to the Dutch house physician model, a larger number of residents (e.g. 10 to 20) were consolidated under the care of one physician. Ten physicians agreed to take on additional residential care patients (in consultation with residents and their families) with 40 physicians turning over their patients to the 10 doctors.

The 10 project physicians take turns being on-call (a week at a time) responding to emergencies that arise for any of the residents. Similarly, if a project physician is on-site and another physician's resident needs immediate attention, the doctors cover for each other, resulting in quicker medical attention for the resident and more effective use of the physicians' time. Because of the on-call service and comprehensive coverage, many residents who would otherwise go to an emergency department are seen and treated in the facility, thus decreasing emergency admissions.⁸⁵

Leadership, administration and financial support have been instrumental to the implementation and success of this project.⁸⁶ In addition to the new MSP billing schedule that allows physicians to bill for attendance at case conferences, physicians have been provided with additional "sessional" funding (from the Northern Health Authority) to conduct comprehensive assessments and evaluations of their new patients. As a result, physicians' visits to residential care facilities are more regular, which improves communications and relations with residential care staff. To date, nursing staff and residential care managers are very positive about the project.

To enable physicians to treat, when possible, their residents in the facility, equipment has been ordered for examination rooms in each facility.⁸⁷ However, the residential care facilities are still trying to find space for examination rooms, so the equipment is not yet set up for use. The NHA would like to extend the Long-term care Physician Project to other residential care facilities in the area, but continued financial support for funding physicians is needed.⁸⁸

Prince George was seeing more long-term care residents going to the hospital for treatments that could have been better provided in the residential care facilities if staff and resources were available.

residential care facilities attached to a hospital had significantly lower hospitalization rates for pneumonia, urinary tract infections, falls, and anaemia and pressure ulcers than other residential care facilities.⁸³ While the precise reason for the lower hospitalization rates were not identified, higher staff levels and access to hospital resources—both more specialized staff and diagnostic services—may be significant.

To date, there are few places in BC where primary care (i.e. either a nurse practitioner or primary care physician) has been more fully integrated into delivery of residential care services. Two examples of where this has occurred are five residential care facilities at Providence Health Care in Vancouver and two Northern Health residential care facilities in Prince George. These initiatives are quite similar, and, as the case study on page 28 indicates, show promising results.

5. Emphasize Ways to Integrate Care

Integration of community services is a widely desired goal. However, the term is used loosely and means different things to different people. In health care, integration is often described as being on a continuum with three distinct levels: linkage, coordination, and full integration.⁸⁹ At the *linkage* level, attempts are made to improve referral and collaboration between health services, but organizations continue to function independently with regard to their own policies and operational rules. At the *coordination* level, although each organization keeps its own structure, each participates in an “umbrella” system⁹⁰ and develops shared policies and processes (e.g. shared clinical information, a single point-of-entry for patients, case management). In the *full integration* model, the integrated organization is responsible for all services, either under one structure or by contracting some services with other programs; these programs are usually built around day centres and function in parallel with health organizations already in place.

In Canada, health service programs are integrated only at the linkage level, if at all. Much of what is suggested by the Ministry of Health’s current Integrated Health Networks (IHN) operates at the coordination level (see previous case study from the Vancouver Island Health Authority on page 26) and although these initiatives are promising, they are few due to limited funding.

Furthermore, while coordinated care works well for many people with multiple chronic conditions whose health is relatively predictable, for the small number of people with the greatest need—those with complex, persistent and multiple health problems who are the highest users of health services—fully integrated care is needed to avoid repeated hospitalizations and/or institutionalization. The people most in needs of full integrated care are frail elderly with multiple chronic conditions and people living with a serious and persistent mental illness. Currently, in BC there is little in place in the community for either of these groups despite the evidence that fully integrated programs could significantly reduce their acute care utilization and improve their health status.

For the small number of people with the greatest need—those with complex, persistent and multiple health problems who are the highest users of health services—fully integrated care is needed to avoid repeated hospitalizations and/or institutionalization.

Chilliwack's NetCARE: Fully Integrated Care for Seniors with Complex Needs

In 2000, a local review of Chilliwack area services⁹⁴ identified a rise in acute care use by seniors and the desire of seniors to remain in their homes rather than move to residential care. This review encouraged a small but visionary group of service providers to adapt a PACE-type program for their community.⁹⁵ NetCARE (Network of Comprehensive Response and Evaluation) is a single-site program with an outreach component.

It provides comprehensive health, rehabilitation and social services to older adults with multiple chronic conditions or complex needs who are experiencing declining functional ability, cannot be managed by home health staff, and are frequent users of hospital services. While modeled after Alberta's CHOICE program, it does not provide short-term care beds or 24-hour emergency response. The program components include a day program, a rehabilitation clinic, a health clinic, and a "watch" program (see below). Since the service began in 2003, 914 clients have been referred to the program; there are currently 196 NetCARE clients (in all components).

NetCARE is more than an enhanced day program. It includes a comprehensive range of health services provided by a multi-disciplinary team. A primary benefit of the program is its on-site delivery.

The day program provides respite, monitoring of chronic health conditions and functional abilities, social support and therapeutic programming for about 25 clients each day. Therapeutic programming (e.g. woodworking, fitness and music programs), is delivered by a team of recreation workers. Day program clients also have access to the rehab clinic, with a fully equipped gym that is used to provide exercise programs and treatments. In the health clinic, a NetCARE physician specializing in geriatric care teams up with clients' family physicians, geriatricians, a neuro-psychologist, RNs, LPNs, social workers, dieticians and rehabilitation staff.

There are approximately 30 clients enrolled in the watch program, an ongoing surveillance service for NetCARE clients no longer needing programs or interventions. Watch program clients have been referred to NetCARE, assessed and stabilized, but may be tenuously coping and/or at risk of a health crisis that could interfere with their ability to remain in the community.⁹⁶ Watch program clients are also flagged as NetCARE clients in the "home health care system" so that home support staff can notify NetCARE if issues arise.⁹⁷

The NetCARE program benefits from its physical layout, which includes a secure garden and greenhouse, as well as easy access to the neighbouring acute care hospital. An evaluation after one year of the program found that clients had decreased lengths of stay in hospital and fewer visits to hospital emergency departments. A formal research partnership now exists with the University College of the Fraser Valley with the aim of evaluating the program and improving services.

Chilliwack's program provides comprehensive health, rehabilitation and social services to older adults with multiple chronic conditions or complex needs who are frequent users of hospital services.

FULLY INTEGRATED CARE FOR SENIORS

The concept of a fully integrated program that helps the frail elderly remain in their homes began with the California On-Lok project, which in turn led to the PACE (Program for All-Inclusive Care for the Elderly) programs in the US.⁹¹ Seniors, who are frequent users of acute care and who would otherwise be in residential care, attend a community day program several times a week and also receive rehabilitative care, medical monitoring, foot care, bathing, social activities, transportation and nutritious meals. A nurse and physician are on-call 24/7, and on-site treatment/respite beds are used to prevent hospital admissions, to enable early discharge from hospital and/or to provide caregivers with much needed respite. Participants in PACE have fewer hospitalizations and shorter stays if they are admitted. They are also less likely to be admitted to residential care, use fewer drugs and have somewhat lower overall service costs.⁹²

Three PACE-like programs in Alberta, known as CHOICE (Comprehensive Home Option of Integrated Care for the Elderly) are realizing similar benefits: improved client satisfaction, reduced ambulance utilization and emergency department visits, and reduced acute inpatient days.⁹³ In BC there is only one fully integrated program for frail seniors—NetCARE in Chilliwack—and while other health authorities have shown an interest in this program, no other programs have been funded to date.

FULLY INTEGRATED CARE FOR PEOPLE WITH MENTAL ILLNESS

Outside of BC there has been considerable progress in developing fully integrated care models for people with mental illness. Beginning in Wisconsin in the 1970s with the closure of long-stay psychiatric institutions in that state, two researchers introduced the first community-based, fully-integrated teams for people with mental illness. Their initial research demonstrated the effectiveness of community teams compared to institutional care.⁹⁸ Since that time, the Program in Assertive Community Treatment (PACT) has spread throughout the US and now more than 1,000 assertive community treatment teams are in operation.⁹⁹

Over time, the program name changed from PACT to Assertive Community Treatment (ACT). ACT teams are multidisciplinary, treat individuals in their own communities, and have services available 24/7. Teams are usually composed of a psychiatrist, a nurse, a social worker, a supported employment worker, a peer support worker, and an outreach worker. The staff client ratio of one staff person per 10 to 12 people is very low compared to the usual case management ratio of one worker to 50 or 60 individuals.

Since the 1970s, there has been extensive research on ACT involving over 2,647 patients who were enrolled in randomized controlled trials of ACT and usual care.¹⁰⁰ The length of hospital stay of ACT patients was reduced on average 50 per cent compared to control clients.¹⁰¹ A meta analysis of ACT studies and their economic impacts found that ACT teams are cost effective if the patient spends more than 50 days per year as an inpatient.¹⁰² Current wisdom recognizes that a program of assertive community treatment is part of the continuum of health and social services.¹⁰³

Ontario has had over 80 ACT teams in operation since 1998, while BC is just beginning to establish a handful of teams in Victoria and Vancouver, a curious fact given the history of

VIHA's Shared Care in Home-Based Mental Health Treatment

Vancouver Island Health Authority's Acute Home Treatment Program (AHTP) began as a 2000 Health Transition Fund pilot project. It was the brainchild of clinical nurse specialist (in psychiatry) Liz Howey. The aim was to provide acute psychiatric home nursing care to patients who would otherwise require hospitalization for acute psychosis.

The project used a shared care model, with training for experienced inpatient psychiatric nurses to deliver care to acutely psychotic patients in their homes. The AHTP team consisted of a coordinator, five RNs and referring psychiatrists who saw patients once a week. Care plans were collaborative and there was a sharing of expertise between psychiatrists and team members.

At that time, Victoria had 83 acute psychiatric beds serving a population of approximately 350,000 people operating at virtually 104 per cent occupancy. Acutely ill mental health clients experienced "holding" for many hours, often exceeding 24 hours, in the emergency room. The team provided management of acute symptoms and/or a new medication regime and education and support for clients and families dealing with an acute episode. The project was modeled on a successful home-based program for acute psychosis in Toronto.¹⁰⁶ However, Victoria was the first nurse-driven acute home psychiatric treatment program and the first such program not connected with an academic setting.

The pilot was a huge success. It showed that acute episodes of serious mental illness could be safely, effectively and cost-efficiently cared for outside of acute hospitals. Mental health professionals from around the world—New Zealand, Australia, Europe, and Japan—expressed interest in the program. The project demonstrated a 68 per cent reduction in home care costs per acute treatment episode of care, a very low recidivism rate of 8 to 10 per cent of home treated patients ending up in hospital, good patient outcomes, and high satisfaction from patients and families.

"The whole purpose is empowerment of the patient," says Denis Rodrique, former coordinator of AHTP. The program is now a permanent feature of mental health services in the Capital Regional District. Recommendations were made that it should expand to other regions. However, with the exception of Fraser Health Authority, which has recently completed a pilot of the program, it has not been replicated elsewhere in BC. Howey and Rodrique identify two major barriers to expansion: the remuneration of psychiatrists who earn more money treating patients in hospital than in the community, and a nursing shortage that results in a smaller pool of experienced mental health workers.

Key to the program's success was the 10 days of training AHTP RNs received before they began working in a new and challenging environment. When the project began, RNs had to have three years of acute psych experience to enter training. That was reduced to one year. The training period then shrunk from 10 to seven to three days. One of the latest members of the team was an RN who was given a half day of orientation.

"The level of competence of the team [when we had Health Transition Fund funding] gave us credibility with the doctors," Rodrique says. "The quality of care was exceptional and that was recognized. Now it has eroded."

Rodrique says he could remove 60 per cent of patients from the acute psychiatric ward right now if he had the former levels of training and support.

deinstitutionalization of the psychiatric institution Riverview. Although past attempts were made to establish ACT teams in BC, they did not survive in a resource-starved mental health service environment. For example, in the 1980s two Victoria teams that went to Wisconsin to study with ACT co-founder Mary Anne Test were dismantled a few years later.¹⁰⁴

However, last year, in response to the Victoria Mayor's Task Force, VIHA committed \$7.6 million toward services for the homeless and those struggling with mental health and addiction issues. Part of that initiative included the creation of four outreach teams, two of which are strictly based on ACT principles. The first ACT team started up in May 2008 and the second in December 2008. The teams are directed by psychiatrist Ian Musgrave, a pioneer of Canada's first ACT team in Ontario.¹⁰⁵

In May 2008, \$10 million in federal funding over five years was committed for new treatment services for residents of Vancouver's downtown eastside as part of the National Anti-Drug Strategy's Treatment Action Plan. The treatment services include an ACT team made up of approximately 12 members representing the fields of psychiatry, medicine, nursing, therapy, and rehabilitation. This team will have 24/7 service capacity for 70 to 75 clients with the most severe functional impairments who do not access traditional mental health and addictions services.

There is, however, one relatively long-lasting and very successful made-in-BC model for home treatment of acute psychosis, which although similar to the ACT program, focuses on younger people at an earlier stage in the disease. This program was initiated in 2000 under the first wave of Health Transition funding. Although it has been recognized internationally for its effectiveness in treating early onset acute psychosis, it has not been replicated province-wide. In fact, reduced funding over the last several years has resulted in an erosion of key program components.

Ontario has had over 80 ACT teams in operation since 1998, while BC is just beginning to establish a handful of teams in Victoria and Vancouver.

6. Foster New Roles for Providers, Patients, Families and Caregivers

New models of care demand new roles for everyone—for providers who must work differently both with each other and with patients, and for citizens who must take on new roles both as individuals and as health care system advocates. Seeing patients as partners instead of as passive receivers of care is a difficult cultural transition for many health care professionals, but it is essential if patients are to become active in managing their chronic conditions.

TEAMWORK

Implicit in the act of assuming new roles is the idea that care is delegated and/or shared between a specialist and a primary care physician or between a primary care doctor and other team members such as nurses, pharmacists or community health workers. Pharmacists, for example, are highly trained clinical service providers who are under-utilized in our primary

Sechelt's Fixed Hours Project

Sechelt is a small Sunshine Coast community with a large aging population. As such, it struggles with attracting sufficient home support staff to meet community needs. Management of the Vancouver Coastal Health Authority's community care division not only acknowledged the staffing problem, but recognized why. They were competing for staff with the acute care hospital, residential facilities, and a private assisted living facility in Gibsons, where several casual and regular staff went to work because they could get steady, reliable hours and better pay. In community care, workers were paid less, had to drive their own cars, didn't get regular or steady hours and, for the most part, worked alone.

"We have been absolutely on our knees by the summer for [lack of] staff for the past three years," says Mona Groves, manager of Home Care Services and Residential Care with Vancouver Coastal Health. "In summer 2005, it was so bad they were on emergency services only."

The solution was a new schedule that improved teamwork, quality of care to clients and workers' job satisfaction. Workers now have better access to case managers, physiotherapists, occupational therapists, dieticians and other professionals. They also have the space and time to do their jobs better. The project took off in June 2007 with the union much involved in the planning process. While management anticipated barriers, there were few. The re-organization cost around \$285,000. Key elements of success included:

- **TEAMWORK.** Home support workers meet mornings with the person responsible for work flow, not a supervisor but a resource person, coordinator and guide. This builds in flexibility, accountability and feedback. It is also an opportunity to share knowledge. By comparing notes, workers experience more teachable moments and discover better ways to do their tasks.
- **COMMUNICATION.** All home support workers received cell phones. It was an expensive move (\$25,000), but before, workers had no way of contacting case managers and case managers couldn't reach them. Also, workers have direct access to care plans so communication is more effective and efficient. Care plans are updated daily rather than being inaccessible as in the old model.
- **FLEXIBILITY AND CLUSTER CARE.** Clients who live near each other are grouped together as much as possible. Work is organized by the services required for specific clients and not by chunks of time. That idea was hard for some workers to accept. Even clients had to overcome the idea that workers "should be here for one hour," even if the required tasks were completed in 45 minutes. But now there is an opportunity to go back and see a client in the afternoon if she didn't look good in the morning.

In the Sechelt program, home support workers meet mornings with the person responsible for work flow, not a supervisor but a resource person, coordinator and guide. This builds in flexibility, accountability and feedback.

Sechelt's Fixed Hours Project continued

- **SATISFIED CLIENTS.** Training needs are focused more on the client and his or her specific circumstances and less on diagnoses so the care better addresses clients with complex needs, multiple chronic conditions and fluctuations in care. As well, amalgamation into a team with other health authority staff produces better care.
- **FEWER WORKERS INJURED.** There was a significant reduction in number of workers who were injured on the job with the introduction of the redesign.¹¹¹ This likely reflects the greater control workers had over their workload and the benefits of increased team work. The reduction in injuries resulted in significant savings for the employers.

An evaluation of a similar home support redesign in Kelowna found that 85 per cent of the community health workers who responded to the surveys felt valued, fewer workers left the program, thereby reducing the need for casual staff, and both paid and unpaid sick time decreased.

care system. Earlier this year, the BC government expanded their scope of practice by permitting pharmacists to renew patients' routine medications for up to six months without first obtaining a doctor's prescription. Under the new rules, pharmacists are also allowed to change the prescribed dosage or substitute drugs where it is appropriate to, for instance, minimize side effects.

A number of our case studies highlight the importance of the interdisciplinary team of health professionals (e.g. physicians, nurses, social workers, physiotherapists). And yet none of these examples include the front line workers who have the greatest contact with clients in residential, home and community care. This is, in our view, a significant shortcoming.

In an exploration of the role of non-professional community mental health workers in England, researchers found that, on average, community nurses made two contacts with clients per month as opposed to six contacts per month made by support workers. Support workers saw each person, on average, 84 minutes per visit while nurses spent, on average, only 30 minutes per person. Significantly, clients rated support workers more positively for "availability, understanding needs and as being someone to trust" than they did professional workers.¹⁰⁷

In BC, community health workers (CHWs), who provide basic care for people living at home, play a similar role primarily with frail seniors. Over the last several years these workers are increasingly expected to provide medically-oriented services to complex clients who previously would have been cared for in residential or acute care. This should have resulted in more emphasis on continuity and co-ordination with more professional care providers, particularly given the research linking continuity to reduced hospitalizations and emergency room visits.¹⁰⁸ But generally this has not been the case. Instead of increased training opportunities and more back-up support from home care nurses or home support supervisors, this support has been less forthcoming.¹⁰⁹ In an effort to serve more clients in less time, CHWs are now more likely to work casually and/or to have split shifts. As a result, there are more

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retention and recruitment challenges for workers and clients are less likely to receive care from the same person on a regular basis. This limits the capacity of workers to get to know their clients, monitor changes in their health and prevent crises.¹¹⁰

Quite recently, however, a growing number of BC communities are working to improve the continuity of care for recipients of home support services through greater team work and improved working conditions for staff. In Sechelt, home support services are a leading example of this type of positive change. Here, the focus is on team work and on linking the quality of employees' working conditions with the quality of the care they provide.

THE ROLE OF PROVIDER AS PATIENT ADVOCATE OR COACH

It is often very difficult for patients and their families to negotiate the health care system in search of the most appropriate care and resources. Such a task is even more onerous for people with multiple, complex needs or for those who are disadvantaged in some way, such as being recent immigrants or having limited literacy skills. For these populations, empowerment requires more than just helping them to manage their own care. Providers also need to advocate for their patients and coach them on how to advocate for themselves.

But who is the right person to be a coach? Physicians are trained to be medical experts, not coaches. Nurse practitioners or case managers are often better suited for this role. Interestingly, a recent BCMA survey describes case managers as “doing an excellent job of integrating services for patients” and urges a stronger role for these providers.¹¹²

Hospitalized patients who received training on how to better manage the transition out of hospital and into the community were about half as likely to require re-hospitalization as those who did not receive training.

Patients also benefit from learning how to advocate for themselves. In a 2004 US study, hospitalized patients who received training on how to better manage the transition out of hospital and into the community were about half as likely to require re-hospitalization as those who did not receive training.¹¹³ With guidance from a coach, participants learned to communicate better, take a more active role in their care, and assert their preferences. The majority reported confidence in self-management, understanding warning signs of a worsening health condition, and the ability to ask needed questions during a follow-up physician visit.

For patients who are frailer or more psychologically or socially vulnerable, it is doubly important for a provider to act as advocate and coach. This is particularly critical for people with lower levels of literacy in English. As researches at the Institute of Medicine observed, older adults, ethnic minorities, people with low levels of education and/or income, and non-native speakers of English are among those being asked to manage their own chronic conditions.¹¹⁴ In Alberta, the Multicultural Health Brokers (MCHB), a non-profit, worker cooperative in Edmonton, links patients to the treatment system and then helps them integrate back into their communities.¹¹⁵ Health brokers are trained community workers who mediate between marginalized citizens and mainstream health providers.

THE POLITICS OF CHANGE

US health service researcher Walter Leutz notes that the move to integrate services will be overwhelmingly shaped by those who wield the most power. Teamwork and patient-centred care depend on doctors and administrators relinquishing their central role, and allowing patients more involvement than simply being taught how to self-manage their conditions. Successful integration of medical services, Leutz concludes, will only occur if all parties—including patients—are involved in planning and implementation.¹¹⁶

One big frustration for people needing complex care is hearing the rhetoric about choice but experiencing the opposite—a lack of choice. For many, choices about treatment simply don't exist. For example, few alternative community programs are available for patients with complex health issues. And families needing residential care placement for frail elders must accept the first available bed, often at a facility they would not choose.¹¹⁷

A progressive agenda for choice would improve public services and empower individuals to make decisions for themselves and their families. The current health care debate in relation to decisions about death and dying is a prime example of where patient and family choice is being tested. Increasingly, families wish to have more public discussion about how and when their loved ones die.¹¹⁸ Fraser Health's palliative care initiative is a positive example of how reforms can be introduced in a way that increases meaningful choices for family members.

Teamwork and patient-centred care depend on doctors and administrators relinquishing their central role. Successful integration of medical services, Leutz concludes, will only occur if all parties—including patients—are involved in planning and implementation.

CASE STUDY

Fraser Health's Palliative Care

Fraser Health is the only BC health authority that allows for palliative end of life support at multiple locations: the person's home, a free standing palliative care unit, a tertiary hospital unit, or a residential care facility. Carolyn Tayler, regional director of Palliative Care for Fraser Health, knew that making such a move required a fundamental shift in practice and in the health authority's relationship with patients and families. She created an education program on "End of Life Care" that involved all levels of the health system, from specialists to GPs to home support workers. She then enabled staff to develop the practice of supporting end of life decision-making and care.

Part of this work involves helping patients and their families come up with advanced directives about their wishes regarding end of life care. In response to many people's desire to die at home, the health authority initiated a significant education program with primary providers, nurses, doctors, care aides, supervisors and home support workers. Families rated this innovation very highly in a post-implementation evaluation.¹¹⁹ Residents in Fraser Health have a regional strategy for transforming end of life care. Other BC health authorities do not.

GIVING CITIZENS A VOICE IN HEALTH CARE DECISIONS

Making choices about how and where to be cared for is not the only way people can be more involved in health care decisions. People can also express their views through complaints procedures, public forums and democratic institutions.¹²⁰ But currently in BC there are few opportunities for citizens to do that.

In 2005, Canadian health system analysts Colleen Flood and Tom Archibald explored how citizens can help improve health care system accountability.¹²¹ According to Flood, “Accountability is the Achilles’ heel of public health care in Canada.” The authors conclude that Canada has much to learn from other countries. One option is establishing a role for citizen governors who would:

- Check on political accommodations made between governments and other interest groups, such as doctors; and
- Ensure that patients’ experiences are considered in decision-making.

They warn, however, that it is the quality, not the quantity, of citizen participation in decision-making that is the key to greater accountability and effectiveness.

Other studies of public participation in the health policy reform process document the value of a deliberative dialogue as a method for influencing policy.¹²² Deliberation is far more “active” than traditional public consultation in that it recognizes the capacity of citizens to discuss and generate policy options independently. It was very effectively employed in the Romanow Commission on the Future of Health Care in Canada in defining the public’s commitment to primary care reform.¹²³

In 2006, the BC government launched the Conversation on Health, a year-long, public engagement of citizens and their ideas and concerns about the health care system. People came out in droves with over 78 public meetings and more than 12,000 people participating. The key themes that emerged were public provision, integrated and accessible service delivery, transparency, and prevention. Those topics are very much in line with the perspectives in this paper.¹²⁴ And yet the government’s promised action plan, based on the input from the Conversation on Health, has yet to materialize.

Today, there are no processes for BC citizens to have meaningful input into how their community health services are organized and delivered. There is, however, one potentially promising development in terms of a complaint process. The 2008 BC budget requires each health authority to create a patient care quality office for addressing quality concerns.¹²⁵ While it is too soon to know how well this new complaint process will work, it is a promising development.

The key themes that emerged from the BC Conversation on Health were public provision, integrated and accessible service delivery, transparency, and prevention. Those topics are very much in line with the perspectives in this paper.

Three Strategies for “Scaling-Up” Innovation

WHEN IT COMES TO HEALTH CARE system change, everyone agrees that successful innovations deserve to be expanded into mainstream practice. After all, good ideas are for sharing. And yet, the successful innovations described in this report exist in a single community or health authority and have not been replicated in other areas of the province. Barriers to scaling up innovations are found not only in BC. In the 2002 Canadian Institute of Health Research report *Governance and Management of Change*, Jean-Louis Denis acknowledges the difficulty health care systems throughout the developed world have in changing organizational and professional practices. He notes that the Canadian health care system has been quite successful at introducing pilot project or “small scale experiments” but as dynamic and effective as these projects often are, “local initiatives very often require transformations on other levels in order to promote lasting, substantial change.”¹²⁶ Denis concludes: “Experimentation alone will not suffice. There must be reliance on the roles, resources and skills of central and regional governance authorities in order to promote, monitor, disseminate and institutionalize experimentation.”

In a complex, multi-sector system like health care, effective leadership, supportive provincial frameworks, and long-term funding agreements are needed to ensure that innovations are implemented system-wide.

The Canadian health care system has been quite successful at introducing pilot projects or small scale experiments but local initiatives often require transformations on other levels to promote lasting, substantial change.

1. Build Leadership at All Levels

In our review of BC community health innovations, we found many examples of small-scale innovation, but rarely any that expanded beyond the pilot stage of a single program in one community. Where we did find innovation going mainstream and region-wide, we were struck by the critical role special leaders played within the organization. This section discusses leadership that expands change, and explores two examples in Northern Health and Fraser Health.

Where we did find innovation going mainstream and region-wide, we were struck by the critical role special leaders played within the organization.

Before moving to the case studies, however, it is helpful to note some distinctions in the literature. First, leaders are different than managers and are not always champions of change. Most organizations have various levels of authority or management, usually involving a hierarchy—upper management, middle management, and the work team and the individual worker—each of whom may have formal and informal leaders. Leaders have different relationships with change: some champion it and some resist it.¹²⁷

The examples in this project are champions who brought creative ideas (which they may or may not have generated) to life. They made a decisive contribution to the innovation process by actively and enthusiastically promoting the innovation, building support, overcoming resistance, and ensuring that the innovation was implemented.¹²⁸

But as we discovered, these champions cannot bring about systemic change alone. They need sponsors. Sponsors are often senior managers who have the authority to supply resources or local support, or both. While champions plan and implement the innovation, sponsors help eliminate organizational barriers to change.

Fraser Health is an example of how, with support from the top, generic planning, evaluation of what works and what doesn't, and collaboration to learn new practices and roles, region-wide innovation can be achieved. Fraser Health's Palliative Care initiative (page 37) is a case in point. Armed with strong support from HA's executives and a three-year strategic plan for providing end of life care, Fraser Health is now a provincial leader in developing a regional palliative care program. Another example comes from Northern Health (page 42).

2. Provide Consistent Direction and Targeted Funding

What is clear from the more than 10 years of funding for primary care reform in Canada is that dedicated funding is critical for sustaining change over time. Also important is the understanding that the right investment can result in reduced costs over the long run. In the US, RAND Corporation scientists demonstrated that realizing significant change from the implementation of a chronic disease management program is a real possibility, but requires long term and consistent investment of 10 years or more.¹²⁹

When Canadian researchers applied this model to our country, they estimated it would take about \$1 billion in upfront costs (capital) and \$780 million in annual operating costs to

implement a similar system of chronic care management.¹³⁰ This effort—if sustained—could realize an annual benefit of \$1.6 billion dollars and 22,360 fewer deaths. The researchers emphasized that while change initially costs more, it breaks even by year 7 and by year 10, the changes begin to save the system money. In this model, the cumulative return on investment after 10 years would be more than \$9 billion to the Canadian health care system. In other words, effective change requires consistent direction over a 10 to 15 year period.

Finally, it is also worth noting that this report includes a number of other specific examples of effective innovations appropriate to specific populations where there is solid evidence they will reduce overall costs. Included in this list is the provision of housing and supports for homeless people with a dual diagnosis of addiction and mental illness (page 21), preventative home health services for the frail elderly (page 30), and early intervention programs for young people living with psychosis (page 32). Unfortunately, as yet, none of these programs have been scaled up province-wide, even though these investments would reduce costs over the long term.

3. Establish Provincial Level Structures

Making the transition from an acute care system to a chronic care system requires supportive structures to help health care champions sustain and expand innovations. Although BC can boast of some exciting innovations, it has no province-wide structural support that would allow those innovations to benefit all British Columbians. This contrasts with Alberta and Saskatchewan where strategies are in place to ensure collaboration at the provincial level. Unlike in BC, separate funding agreements and distinct negotiating processes between doctors and the provincial government, and between the health authority and the provincial government, do not exist in Alberta. Instead, Alberta has a trilateral governance agreement between the regional health authorities, the Alberta Medical Association, and Alberta Health and Wellness. The three parties agree to set up a joint venture between a non-profit corporation (the physician group) and the regional health authority. This venture is called a Primary Care Network.

There has been a general recognition that quality is an issue in health care and that an arm's-length agency responsible for safety and quality is needed. The larger provinces have created provincial quality councils intended to produce information, processes and resources to improve the quality of care at the local level. Saskatchewan's Health Quality Council is the only quality council in Canada with a mandate that includes support for innovation as well as reporting. Led by scientists at arm's-length from government, the council provides information on best practices and educational support to create change at the local level.

Saskatchewan's Health Quality Council (HQC) priorities emerge out of joint discussions with regional authorities, and so while it operates independently in terms of the science, its priorities reflect the concerns of regional authorities. Currently, the HQC's three main priorities relate to chronic illness prevention and management, patient-centred care, and safety. The quality and safety topics, which range from quality of care for cancer patients to prescribing practices in long-term care facilities, are chosen in partnership with the health

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Although BC can boast of some exciting innovations, it has no province-wide structural support that would allow those innovations to benefit all British Columbians.

CASE STUDY

Northern Health's Primary Care Reform

Northern Health has begun an ambitious, very broadly defined, five-year renewal of primary care services. The region has become a provincial leader in primary care reform because of factors that include:

- Strong support from the senior executive team;
- Co-ordination of all reform efforts around the same theme;
- Use of regional funding when federal transition funds expired;
- Designated change management co-ordinators in participating communities;
- Learning from best practices in other jurisdictions;
- Ongoing measurement of progress; and
- A patient-centered focus on people with more complex needs.

The Northern health region has become a provincial leader in primary care reform because of factors that include strong support from the senior executive team.

In addition, Care North adheres to a population-based approach rather than a one-on-one traditional approach. That means a team's work is built around a specific population group, such as the frail elderly. The health authority is either operating or is planning to operate several Shared Care projects, all centred around family physicians as the primary health care practitioner. The one furthest along aims to integrate care for patients with three chronic diseases—diabetes, heart disease and chronic kidney disease—beginning with the family doctor and then involving referrals to services in the community and to specialists. Each of the participating communities—about 14—has a change manager, also known as a Care North coordinator, who integrates the work done in physician offices with health authority services such as home support and community resources.

As well, about 60 per cent of NH physicians are involved in Quality Improvement Primary Care initiatives—50 per cent more than the portion of GPs province-wide who are taking part in the BCMA's Practice Support Program. This means physicians learn about best practices, compare them with what they are doing, and then work toward making necessary changes based on a target they set themselves. A fourth project involves an Aboriginal Health Collaborative, now in eight First Nations communities.

Rolled into this renewal process is a Frail Elderly Collaborative—an integrated health network for at-risk seniors. The collaborative is an example of how innovation need not adhere to a cookie-cutter model but can be tailored to suit what works best in different situations and locales. The one constant is that in Care North primary care physicians are aligned with home and community care. That means case managers working alongside physicians authorize home support services as required. While some managers feared this would drastically increase the demand for home support, this hasn't proven to be the case.

Northern Health's Primary Care Reform *continued*

The process identifies frail seniors with significant health care needs and a care plan is then developed by a community care case manager or, as in the case of Fort St. John, by a team of multi-disciplinary health professionals. When fully implemented the care plan will identify who is responsible for supporting the individual to remain in the home of his/her choice 24/7, devise a clinical action plan that goes across services, and produce a crisis response plan.

Currently, about 80 per cent of frail elderly patients of participating doctors in Fort St. John have a clinical action plan, in Prince George 84 per cent, and in Prince Rupert, 100 per cent. These physicians were frustrated with the traditional solo model of practice and knew they could not continue to work alone.

Most progress has been made in Fort St. John in the form of a care conference that involved doctors, case managers, home support workers, home care nurses, community rehab specialists, and others. A case manager from the home and community care system now coordinates interdisciplinary care planning for elderly patients with about 16 physicians. In Prince George, care is coordinated by a small team composed of a social worker, two part-time RNs, and an occupational therapist. The team works with 22 physicians in about eight practices. The new approach is well-received by clients and caregivers who see it as an extension of what their physician was doing, not as a bureaucratic move from the HA.

"It's a totally different way of looking at change," says Judy Huska, formally Executive Director of Health Service Integration for Northern Health's Primary Care Renewal. "It's looking at 'these are the outcomes' and not necessarily 'this is the model.' That makes it hard for everybody. You don't have all the answers. You try some things and see how it works. Plan, do, study, act."

So far, Care North has established 10 formal integrated health networks (IHN) in seven communities, including Prince Rupert, Valemount, Quesnel, McKenzie, Queen Charlotte City and Fraser Lake, and it is beginning another in Smithers. Also on the agenda are shared care arrangements between family physicians and specialists. And a nurse practitioner initiative is underway.

A major reason Care North is able to put its plan into action is that when the federal Health Transition Fund for primary care renewal ran out in March 2006, Northern Health executives committed to carrying on a similar level of funding, a decision that was unique among BC health authorities. A limited amount of additional money came from the BCMA (Practice support program) and from the federal government for Aboriginal health. Then in 2007 and 2008 Care North requested and received funding — specifically to support innovations for people with complex needs — from the province's Health Innovation Fund and from the fund to support Integrated Health Networks.

Huska explains that successes so far are due to the huge amount of support the project received from NH's CEO, senior executives, and board. Also, the project is patient-centered, and they've been able to measure some of their successes. For instance, clients in the communities involved have reported that their care has either improved or maintained their quality of life, emergency department visits have decreased, and admissions to hospital have decreased by 10 per cent. Another reason is that Prince George physicians were using electronic medical records long before these initiatives started—that allowed them to easily capture data. Uptake is about 50 per cent.

Certain challenges, however, are formidable: poor access due to geography and climate, housing issues and significant human resource problems across the spectrum of health professions.

Primary Care Reform, Alberta-Style

Alberta has—until recently at least—been Canada’s undisputed leader in primary health care reform.¹³¹ Since 1998, the province has allocated \$54 million to 66 projects aimed at finding new ways to improve primary health care. The bulk of the work has been devoted to establishing Primary Care Networks (PCNs) where family physicians lead a team of multi-disciplinary health care providers who link patients with a range of community health services provided by health regions. This initiative is funded up to and including 2011 and health leaders are currently negotiating how to make primary care funding an integral part of the provincial health budget.

The province’s first PCN opened in May 2005 in Edmonton’s Capital Health Region. Today there are 26 PCNs spread throughout every region of the province. More than half of Alberta family doctors (about 1,245) now participate in a PCN, and PCNs care for about 60 per cent of the provincial population. Participation in a PCN is voluntary. Both younger and older family physicians have joined the PCN movement, but at its core is a strong contingent of seasoned professionals who hold huge credibility among their peers.

“They have said ‘We cannot carry on with family medicine this way. There is a better way and I want to be part of leaving a legacy,’” Primary Health Initiatives Director Marion Relf explained. “Without physician leadership, we’d be sunk.”

Before approval, a PCN must provide a three-year business plan where it commits to increase the number of patients and doctors participating. It must also show it will:

- Give more people access to a primary care physician;
- Manage access to appropriate services 24 hours a day, seven days a week;
- Improve care, with more health promotion, disease and injury prevention, and better care for complex or chronic health needs; and
- Better co-ordinate with other health services.

The PCN receives an additional per patient allotment of \$50 annually. However, the money must be spent on resources for change. Most is used to hire multi-disciplinary team members (nurse practitioners, physiotherapists, pharmacists, mental health workers, psychologists, social workers, rehab specialists, dieticians, LPNs, home support workers), but funds are also used for infrastructure, information technology, research and evaluation. Each PCN is unique, employing team members and approaches that are appropriate to local needs. And each, explains Marianne Stewart, Vice President and Chief Operating Officer, Primary Care Division, is responsible for the health outcomes not just of individuals, but of entire population groups.

PCNs are co-ordinated and aligned with *all* services currently offered to regional health authorities, including community-based services such as home care and mental health

In Alberta, before approval, a primary care network must provide a three-year business plan where it commits to increase the number of patients and doctors participating, and show it will manage access to appropriate services 24 hours a day, seven days a week, and improve care.

Primary Care Reform, Alberta-Style, continued

and geriatric services. As well, PCNs are involved in three Shared Care projects—mental health, chronic disease and geriatrics—so specialists such as psychiatrists, endocrinologists and geriatricians are aligned with some PCNs.

“The specialists are being used the way they should be,” says Stewart. “They need to see the complex case. They need to be consultants. They need to be educators and mentors.”

Capital Health has a specialized geriatrics program that all PCNs in the region work with. This regional program is an adjunct to the work being done by CHOICE, the decade-long, community-based program that helps support older people who are experiencing multiple and chronic health problems to remain living independently in their own homes).

The transition to PCNs, however, has not always gone according to plan. The toughest place to persuade doctors to join a PCN is in the centre of Edmonton where most doctors persist in practicing the old way. Another challenge is that while the vast majority of GPs have electronic capability and are paperless, technology was chosen from a wide range of vendors and now many doctors’ offices can’t communicate with others.

Of course the learning process never stops, and Alberta’s triumphs have not come without considerable tribulation. In fact, a major but as yet unknown change looms. Last May, the Alberta government announced it was scrapping regionalization, replacing nine regional health authorities with one centralized Alberta Health Services Board. The AHSB will be responsible for the delivery of all health care services while the Ministry of Health and Wellness will continue to be responsible for policy. Exactly what this change means remains to be seen. Some health care policy analysts fear the move is a dismantling. Others, however, say the result will be a more efficient and effective system. Meanwhile, PCNs continue to operate as usual.

authorities in a three year planning cycle. With an annual budget of \$5 million, the HQC is able to innovate at a province-wide level. It is currently the vehicle for implementing the Chronic Disease Management Program in the province.¹³² Wound care in Saskatchewan is an example of how this process works.

When organizations that had a long term and comprehensive approach to the Chronic Care Model first began, they, like BC, dealt with the easiest patients first—that is, those who had one or two chronic conditions. But with time, health care planners realized that to be truly effective they had to deal with people with more complex needs.¹³⁵ The time has come for BC to move in this direction as well.

Only one health authority—Northern Health—has established a region-wide integrated approach that includes a strategy for addressing the needs of people with more complex needs. Because NH has twice the rate of physicians participating in the CCM initiative as does the province, and has unequivocal support from the HA board and the CEO, their primary care innovations are more robust and can be spread systematically across the health authority.

Only one health authority—Northern Health—has established a region-wide integrated approach that includes a strategy for addressing the needs of people with more complex needs.

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Better Wound Care in Saskatchewan

In October 2003, the Saskatchewan Association of Health Organizations decided that a more consistent approach to wound care was needed. Chronic wounds are an important source of illness, and even death, and often prove difficult and costly to treat, taking weeks, months or even years to heal.¹³³ At the same time, variation in caring for wounds is common and current practices show that the protocols followed make a great difference in patient outcomes. The Saskatchewan Health Quality Council took the lead on developing a comprehensive skin and wound care guideline and provided the funding to develop the necessary tools, engage experts in wound care to teach and offer ongoing support and advice, and to pilot test the implementation of the guideline in selected long-term care and acute care settings.

The Saskatchewan Health Quality Council helped the pilots use the new clinical tools.

Each site created its own wound care committee with people from all disciplines to provide input into the process.

From the outset, the Saskatchewan Health Quality Council helped the pilots use the new clinical tools recommended by the guidelines and effective methods for implementation. Each site created its own wound care committee with people from all disciplines—nurses, special care aides, physicians, occupational and physical therapists, dieticians, recreational therapists, social workers and materials management—to provide input into the process. The committees received special training and support from wound care experts hired by the Health Quality Council.

The results are extremely impressive.¹³⁴ Six per cent of all residents developed a new pressure ulcer in January 2005, but in September of the same year only one patient, 0.02 per cent, had developed a new bed sore. This decrease in incidence indicates an outstanding improvement in preventing pressure ulcers.

In reviewing how this improvement effort unfolded, the authors of the evaluation identified two key elements in their ultimate success: starting small and involving front-line staff at every step.

Now that the results are in, responsibility for better wound care has been passed on to Saskatchewan's Regional Health Authorities. This means each region is at a different stage of development and unfortunately thus far, none have fully implemented the program throughout their facilities.

Unlike Alberta, BC has no requirement, under the CCM initiative, that physicians commit to provide care 24/7 before they receive funding. With the IHN initiative there is more of an attempt to use funding to “buy change.” They are required to spend 18 per cent of their funding building community capacity and inter-disciplinary teams. But still, there is no requirement in either the Primary Care Charter or the IHN for access to be available 24/7—a requirement that would clearly take the pressure off overcrowded emergency services.

While it is unrealistic to talk about importing Alberta’s PCN initiative or Saskatchewan’s Quality Council wholesale into BC, it is clear that much can be learned from both these initiatives as well as from Care North. In any case, the recipe for successful reform demands provincial-level structures and leadership to support innovation that lets complex care clients and community-based providers into the circle of change and supports them with sustained long-term funding over a decade or more. Whether we have the political will to meet this challenge remains to be seen.

The recipe for successful reform demands provincial-level structures and leadership to support innovation that lets complex care clients and community-based providers into the circle of change and supports them with sustained long-term funding over a decade or more.

Conclusion

Change requires more than money. Real change also requires robust forms of governance, and a combination of centralized and decentralized authority.

WE APPLAUD THE WORK being done to reform primary physician care in BC and to bring the CCM (chronic care model) into primary care. But, as the ongoing cycle of health care troubles demonstrates, it is not enough. If BC truly wants to shift health services away from acute care, focus on prevention and community treatment, reduce pressures on hospital and emergency services, improve health status, and control cost increases, it must do more.

Primary care must be integrated with community and home care. The integrated care model differs from the acute care model we all are so used to in two major ways: first, it combines the provision of health and social care; and second, it requires different roles for providers, patients and families. Although those two transitions may appear formidable, as this paper demonstrates, they are not. The solutions are before us. Provincial success stories and international examples of reforms lead the way to the “closer to home” objective. Much can be learned from the success of BC’s initiative for physician involvement in CCM and also from governing structures in Saskatchewan and Alberta. While achieving the goal of “health care closer to home” requires an upfront investment of financial and human resources, funding increases for health care in BC has lagged behind other provinces since 2001 (see Appendix B). What’s more, our research highlights the fact that effective change can not happen without funding that is long term, consistent, and impervious to shifts in the political landscape.

Change, however, requires more than money, as the reforms in Northern Health—a traditionally “have-not” health authority—and in Saskatchewan demonstrate. Real change also requires robust forms of governance. Both of the Saskatchewan Quality Council and Care North combine centralized and decentralized authority, with a sophisticated senior authority establishing a clear provincial and/or regional framework that allows for co-ordination, monitoring and reworking of the policy framework over time, while still supporting local innovation and accepting input from providers and communities on the ground. Research shows that these more sophisticated forms of governance increase “the effectiveness, creativity, and competence of public sector systems.”¹³⁶

The innovative programs and systems this paper explores are supported by leadership at the front line and at the most senior administrative level. Leadership for innovation requires having dedicated resources, ongoing evaluation and monitoring, and strategies for integrating innovations into the mainstream.

With these points in mind, we recommend: A new provincial body (perhaps a Centre for Community Health Innovation) that could evaluate and promote successful innovations and provide the financial incentives and human resource support to health authorities to implement successful innovative models province-wide. The six key change elements and three strategies for scaling up innovation described in this report would provide the organizing framework for this work. They are:

- **FOCUS ON THOSE WITH COMPLEX NEEDS**—We reiterate: 5 per cent of the population uses 62 per cent of in-patient beds and other services. Access to community services 24/7 is critical for many in this population.
- **ACKNOWLEDGE THE LINK BETWEEN INCOME AND HEALTH STATUS**—There needs to be a more direct connection between the provision of social housing, social services, and health care. More attention should be paid to those who provide basic care to people with multiple chronic conditions: community health workers, residential care aides, and mental health outreach workers. In our case studies of local innovation, only the Fraser Health Authority palliative care project and the Sechelt fixed hours project included care aides and community health workers as part of the education and change process.
- **TAKE A MULTI-FACETED APPROACH TO PREVENTION**—While there are some good primary and secondary prevention strategies in BC, initiatives like the Garrett Wellness Centre have not been able to expand or be replicated elsewhere. In mental health services, successful programs such as Fraser Health’s early psychosis intervention need to expand province-wide as do prevention programs for the frail elderly.
- **REALIGN PRIMARY AND HOME AND COMMUNITY CARE**—Aligning case managers with physicians’ offices is a positive step (as is happening in Northern and Vancouver Island health authorities), but needs to be replicated province-wide and broadened to include community health workers. Similarly, in residential care, enhanced staffing and better integration of primary care is key to avoiding unnecessary hospitalizations.
- **EMPHASIZE STRATEGIES FOR INTEGRATING CARE**—Move toward full integration so that health authorities are responsible for all services, either under one structure or through contracting some services to other programs. People with complex conditions who remain in the community need a fully-integrated, interdisciplinary team that is available 24/7.
- **FOSTER NEW ROLES FOR PROVIDERS, PATIENTS, FAMILIES AND CAREGIVERS**—A shift to interdisciplinary teams means all members must learn new ways to work together. At the same time, providers need to advocate for patients, and support patients to advocate for themselves. For these innovations to work patients and families must become more involved in their own care and in health care decisions generally.

A new provincial body (perhaps a Centre for Community Health Innovation) could evaluate and promote successful innovations and provide the financial incentives and human resource support to health authorities to implement successful innovative models province-wide.

- **BUILD LEADERSHIP AT ALL LEVELS**—The importance of having support, not only from local champions, but also senior management, cannot be overstated. As concrete evidence of the difference senior leadership makes, Northern Health has double the proportion of physicians participating in its chronic care management initiative as the rest of the province.
- **PROVIDE CONSISTENT DIRECTION AND TARGETED FUNDING**—Dedicated funding is critical for ensuring sustained change over time. Also, the right investment can result in reduced costs over the long run. For instance, there is solid evidence that innovations such as preventative home health services for the frail elderly and early intervention programs for young people living with psychosis reduce costs over the long term.
- **ESTABLISH PROVINCIAL LEVEL STRUCTURES**—More robust forms of governance are critical to success. BC would do well to look to the governance structure in Saskatchewan where science, not politics, rules and where collaboration with health authorities and local providers is built into the process. Also helpful is Alberta’s decision to bring doctors and health authority leaders to the same table, and to link funding to specific changes such as ensuring 24/7 access to health services.

In closing, we want to repeat that adopting these changes and viewing home and community care as the focal point of reform in BC is critical to health care system sustainability. To ignore this sector is folly not only for the financial state of the health care system, but for some of the most vulnerable citizens of our province.

Interviews

- Anderson, Keith, 28-Sep-07, Former CEO Fraser Health
- Bauer, Jean, 9-May-07, 20-Dec-07, BMRS, CCHRA (C), Patient Services Director, North Okanagan Health Services, IHA, re: North Okanagan Health Services Integrated Care Coordination Program
- Beddow, Joyce, 27-Dec-06, Nursing Assistant I, Ashcroft Hospital
- Berg, Shannon, 13-Mar-07, Director, Community Care Network Integration
- Bergman, Howard, 27-Sep-07, MD, The Dr. Joseph Kaufmann Professor and Director, Division of Geriatric Medicine, McGill University; Co-director, Solidage: McGill/Université de Montréal Research Group on Services for Older Person, re: SIPA
- Bethune, Dr. Graeme, 19-Feb-07, MD, CCFP, COE; Family Physician, Halifax, NS; Medical Advisor, Ocean View Manor, re: House Physician Project
- Bingham, Maureen, 1-Feb-07, Director, Linkage and Exchange Health Quality Council, Saskatoon, Saskatchewan
- Brolin, Scott, 14-May-07, Physiotherapy Professional Practice Leader, Royal Columbian Hospital, Fraser Health Authority, re: Early Support Discharge Rehabilitation program
- Brown, Brenda, 22-Nov-07, BC Government and Service Employees' Union
- Bruce, Ted, 2-Mar-07, Director, Population Health, Vancouver Coastal Health
- Bush, Pam, 3-May-07, Researcher, Health Sciences Association of BC, re: assertive rehabilitation programs
- Campbell, Alan, 07-Jun-07, Director Mental Health and Addiction, re: Vancouver Island Health Authority
- Dauphnee, Ann, 12-Jan-08, Coordinator, Richmond Garratt Wellness Centre, Vancouver Coastal Health, re: Richmond Garratt Wellness Centre
- Davis, Connie, 14-May-07, Geriatric Clinical Program Development Specialist, Abbotsford and Mission, Fraser Health Authority, re: Fraser Health Authority Care Transition Initiatives
- Dunderdale, Jo, 27-Feb-07, 21-Dec-07, Program Development and Planning Leader Home and Community Care, Vancouver Island Health Authority, re: Primary Health/Home and Community Care Partnership Program
- Gallagher, Dr. Romaine, 16-Mar-07, MC, CCFP, Head, Division of Residential Care, Department of Family Practice, re: VCH – Providence Health Care and Haro Park Centre Primary Care Reform in Residential Care: House Physician Model and Nurse Practitioner Project
- Geary, Vanessa, 22-Nov-07, BC Government and Service Employees' Union
- Goldner, Dr. Eliot, 10-Jan-07, Director, Centre for Applied Research in Mental Health and Addictions, Simon Fraser University
- Groves, Monica, 16-Jan-08, Dec-08, Manager, Home Care Services and Residential Care, VCH, Sechelt
- Hill, Katie, 27-Apr-07, Leader, Home and Community Care, Interior Health Authority, re: Trail Seniors at Risk; Vernon Integrated Care Coordinator; Kelowna Street Front Clinic
- Hood, Louise, 22-Nov-07, 17-Dec-07, home support worker Sechelt, BCGEU
- Howes, Lorna, 15-Feb-07, Director, Mental Health, Vancouver Coastal Health
- Howey, Liz, 04-Mar-08, Clinical Nurse Specialist, Psychiatry
- Huska, Judy, 17-Sep-07, 21-Jan-08, (former) Executive Director Health Services Integration Primary Care Renewal, Northern Health Authority

Janz, Dr. Trevor, 8-May-07, Medical Coordinator, Royal Jubilee Manor and Mountain Lakes Seniors Community, Interior Health Authority, re: Nelson House Physician Model

Kallstrom, Lisa, 30-May-07, Director of Policy, BC Medical Association

Korabek, Barbara, 05-Sep-08, VIHA, Executive Director, Continuing Health Services

Leslie, Barb, 12-Jan-07, RD, Former Clinical Nutrition Professional Practice Leader, Richmond Hospital and Minoru Residence, VCHA, re: Richmond Garratt Wellness Centre

Mah Wren, Alice, 2-May-07, Director Health Services, Central Okanagan, Interior Health Authority, re: Okanagan Home Support Pilot Study; Kelowna Urban Outreach project

McBryde, Dr. Michael, 18-Apr-07, Medical Director of Business Partnerships and Residential Services Fraser Health Authority, re: Hawthorne Care Facility Nurse Practitioner Project

McDermott, Jan, 14-Mar-07, Team Leader of the NetCARE Program, Fraser Health Authority

McGowan, Patrick, 06-Aug-08, Head, Chronic Disease Self-Management program, University of Victoria

Murphy, Carrie, 18-Mar-08, Nurse Practitioner, Senior's Clinic, Abbotsford, Fraser Health

O'Reilly, Paddy, 16-Jul-07, Executive Director, IMPACT BC

Parke, Belinda, 2-Jan-07, RN, MN, GNC(C), PhD, former Clinical Nurse Specialist, Older Health Services, Chilliwack Health Services, re: NetCARE

Porterfield, Pat, 2-Mar-07, Director Palliative Care, Vancouver Coastal Health

Radons, Barb, 25-Mar-08, Nurse Practitioner, New West Home Health

Raymond, Dr. R. J., C.C.F.P. (E.M.), 30-Apr-07, 25-Dec-07, Physician, Parkside Care Facility, Northern Health Authority; Clinical Assistant Professor, UBC Family Practice Residency Program, Prince George Site, re: Northern Health Authority Long-term care Physician Project

Reid, Kelly, 10-Sep-08, VIHA, Project Manager, Mental Health and Addiction Services, Tertiary and Residential Care

Reid, Morag, 4-May-07, 14-May-07, Facilitator, Trail Seniors at Risk Initiative, Interior Health Authority

Relf, Marion, 28-Feb-08, Alberta Health and Wellness, Director Primary Care Initiatives for Capital Health Region

Rodriquez, Denis, 04-Mar-08, RN, Victoria Mental Health Centre Relief Case Manager

Rolph, Susan, 18-May-07, Home and Community Care Client Support, Interior Health Authority, re: Kamloops CHOICE program

Roskell, Opal, 2-Jan-07, RN, Ashcroft Hospital

Schellenberg, Rod, 29-Jan-08, Mar-08, 17-Sep-08, 14-Jan-09, former Regional Lead, Frail Elderly Collaborative, Care North, now Executive Director, Primary Care Renewal, NHA

Seeley, Janice, 11-Jun-08, Wound Care Project leader, Saskatoon Health Region

Shore, Sharon, 20-Jun-08, Dec-08, Communications Director, BC Medical Association

Stewart, Marianne, 25-Feb-08, 03-Sep-08, Alberta Health and Wellness, VP, Primary Care Renewal

Tayler, Carolyn, 5-Feb-07, Manager, Palliative Care, Fraser Health

Tee, Karen, 31-Jan-07, Manager, Youth & Young Adult Mental Health & Addictions, Fraser Health

Tregillus, Val, 24-Feb-07, 26-May-08, Dec-08, Executive Director, Chronic Disease Management and Primary Health Care Renewal, BC Ministry of Health

Val, Waymark, 11-May-07, Community and Health, Northern Health Authority, re: NHA CHOICE-type project

Wilson, Gavin, 09-Sep-08, Acting Regional Director, Public Affairs, Vancouver Coastal Health

Woollard, Dr. Bob, 26-Sep-07, Head, UBC Family Practice

Wright, Dr. Bruce, 16-Feb-07, subsequent email, Associate Professor, Department of Family Medicine, University of Calgary, Associate Dean of Continuing Medical Education, re: Comprehensive Community Care – C3 Program

Yukes, Karen, 9-Feb-07, RN, MN, Director of CHOICE and Community Programs, The Capital Care Group

Interprovincial Comparison of Increases in Per Capita Health Expenditures, 2001 and 2007

	2001		2007		Annual % change
	\$ per capita	Ranking (\$ per capita)	\$ per capita	Ranking (\$ per capita)	
Alberta	2,301.09	4	3,695.21	1	12.8
Newfoundland	2,555.02	1	3,636.86	2	8.9
Saskatchewan	2,266.09	5	3,580.07	3	8.4
Manitoba	2,426.92	3	3,499.10	4	7.0
New Brunswick	2,127.56	7	3,273.56	5	6.2
BC	2,480.95	2	3,153.58	6	4.3
Nova Scotia	2,021.76	10	3,144.47	7	6.2
Ontario	2,122.90	8	3,082.32	8	5.0
PEI	2,235.93	6	3,010.09	9	8.6
Quebec	2,100.30	9	2,853.09	10	5.2
Canadian average	\$2,209.65		\$3,155.96		6.1

Integrated Health Networks: Number of Patients and General Practitioners

Health authority	Target populations	Communities	2009/2010 estimated IHN patients	2009/2010 estimated IHN GPs *	IHN patients as % of pop'n 65+	IHN GPs as % of total GPs
BC	All projects – total		50,550	614	7.93%	14.67%
FHA	Chronic disease	New Westminster, Surrey, White Rock/South Surrey	9,800	50	5.07%	
	Fraser Health Authority total		9,800	50	5.07%	4.08%
IHA	Chronic disease	Cranbrook, Kimberley, Kamloops, Central Okanagan, South Okanagan, Penticton, Vernon, Nelson, Armstrong/Spallumcheen, Castlegar, Trail, Arrow Lakes	9,100	110	6.86%	
	Marginalized population	Kamloops Downtown	400	4	0.30%	
	Seniors at risk	Trail	450	5	0.34%	
	Interior Health Authority total		9,950	119	7.50%	13.77%
NHA	Frail elderly	Entire Health Authority with teams in Fort St. John, Fraser Lake, MacKenzie, Queen Charlotte City, Quesnel, Prince George, Prince Rupert, Valemount	800	30	2.75%	
	Mental health		1,800	30	6.18%	
	Chronic disease		12,000	30	41.20%	
	Northern Health Authority total		14,600	90	50.13%	27.61%
VCHA	Chronic disease	Richmond	3,000	50	2.04%	
	Co-morbidity	Richmond, Vancouver, North & West Vancouver	1,500	105	1.02%	
	Mental health/addictions	Downtown Eastside Vancouver	600	30	0.41%	
	Vancouver Coastal Health Authority total		5,100	185	3.46%	13.35%
VIHA	Chronic disease	Campbell River, Nanaimo, Victoria	4,800	100	3.57%	
	Under-served communities	Alberni, Oceanside, Sooke	4,200	30	3.12%	
	Seniors at risk	South Island	2,100	40	1.56%	
	Vancouver Island Health Authority total		11,100	170	8.26%	17.00%

Sources: Population estimate as of July 1, 2008 provided by BC STATS, Ministry of Management Services (P.E.O.P.L.E 33).

* CIHI National Health Expenditure Trends, 1975–2007 Table B.4.2

NOTES

- 1 British Columbia Medical Association, 2008.
- 2 Vogel et al., 2000.
- 3 Cohen, 2005; Cohen et al., 2006; and Morrow, 2006.
- 4 Morgan et al., 2007.
- 5 Hollander and Prince, 2002.
- 6 Advisory Committee for Health Services, Health Canada, 1996.
- 7 In some jurisdictions, pharmacists, nutritionists and public health nurses are also considered to be part of the community care system but, except for rare instances, this is not the case in BC.
- 8 Romanow, 2002, pp. 115-135.
- 9 Ibid, p. 117.
- 10 British Columbia Medical Association, 2002.
- 11 Lorig et al., 1999; Lorig et al., 1993.
- 12 Interview, Val Tregillus, Executive Director of Primary Care, BC Ministry of Health, February, 2007.
- 13 Ibid.
- 14 University of Victoria, Centre on Aging, 2003–2006.
- 15 Hollander, 2001.
- 16 Goldner, 2002.
- 17 Knock, 2001.
- 18 Accessed at www.bcma.org/public/news_publications/publications/policy_papers/ensuringexcellence/recommendations.htm.
- 19 Russell, 2002.
- 20 The Chronic Care Model was developed by researchers at the McColl Institute affiliated with the Group Health Cooperative in Seattle, Washington.
- 21 The initial results showed a shift from 24 to 93 per cent of patients on ACE-1 inhibitors; from 21 to 89 per cent on beta blockers; from 22 to 75 per cent with documented ejection fractions, and from 4 to 56 per cent of patients with documented self-management plans.
- 22 Barr et al., 2003.
- 23 Tregillus, supra note 12. According to Ministry of Health data, lipid testing had shown improvements in each of the four years and exceeded the target goal of 70 per cent. Micro albumin testing also has increased since 2001; however, it was still below the 50 per cent benchmark. Eye examination rates have fallen throughout the province.
- 24 BC Ministry of Health, Primary Health Care Charter, Accessed at www.primaryhealthcarebc.ca/.
- 25 Interview, Val Tregillus, Executive Director of Primary Care, BC Ministry of Health, December 2008.
- 26 Interview, Sharon Shore, Communications Director, BCMA, December 2008.
- 27 BC Ministry of Health, 2006.
- 28 Tregillus, supra note 25.
- 29 Morgan, 2007.
- 30 British Columbia Medical Association, 2008.
- 31 Leutz, 1999.
- 32 Reid et al., 2003.
- 33 Ibid. Accessed at jhsrp.rsmjournals.com/cgi/content/abstract/8/4/215
- 34 Morgan et al., 2007.
- 35 Canadian Institute for Health Information, 2006.
- 36 Rosengard et al., 2007.
- 37 World Health Organization, 2007.
- 38 Lightman, 2008.
- 39 Prus, 2004.
- 40 Canadian Institute for Health Information, 2008.
- 41 Patterson et al., 2007.
- 42 Ibid.
- 43 Pathways to Housing, 2005.
- 44 Ibid.
- 45 Tsemberis et al., 2004.
- 46 World Health Organization, 2004.
- 47 Kirby et al., 2002.
- 48 BC Government Select Standing Committee on Health, 2006.
- 49 Lorig et al., 1993; Lorig et al., 1999; Holman and Lorig, 2000.
- 50 Lorig et al., 1999.
- 51 Lorig et al., 2001a; Lorig et al., 2001b.
- 52 McGowan, 2006.
- 53 Interview, Patrick McGowan, Head, Chronic Disease Self-Management program, University of Victoria, August 2008.
- 54 Accessed at www.improvingchroniccare.org/about/index.html. The Stanford CDSMP (Chronic Disease Self-Management Program) and its community-centred focus is the foundation of the centre.

- 55 Interview, Barb Leslie, Coordinator, Garratt Wellness Centre, Clinical Nutrition Practice Leader, RHS, January 2007.
- 56 BC's Ministry of Health's Health Transition Fund provided the initial money to open the Garratt Wellness Centre.
- 57 S.U.C.C.E.S.S. is the acronym for the United Chinese Community Enrichment Services Society.
- 58 Wellness Centre Steering Group—Community and Health Partners and Community Representatives include: R. Baker, Family Physician; P. Chan, RHS Director, Primary Care Strategic Initiatives; A. Dauphinee, RHS Leader Health Promotion and Nutrition; A. Dennis, City of Richmond Fitness and Wellness Services Coordinator; M. Elfstrom, City of Richmond Area Coordinator, Department of Recreation and Cultural Services; P. McGowan, Program Director, University of Victoria's Centre for Aging, Chronic Disease Self Management; K. Higo, RHS Program Manager, Environmental Health & Community & Family Health; B. Leslie, RHS Clinical Nutrition Practice Leader; J. Lu, RHS Medical Health Officer; C. Rauscher, Coordinator, VCH Chronic Disease; D. VanWallegghem, Regional Director CDA Vancouver Coastal and Fraser Valley Regions; and J. Weaver, RHS Director Primary Health, Community and Family Health, Mental Health and Addictions.
- 59 Non-profit groups present their program ideas to the Wellness Centre Steering Committee, and if approved, bring their own money to the table and fund and market their own programs, draw in their own participants and do their own booking; therefore, most of the funding for programs at the centre are through other agencies.
- 60 McGuire, Colleen and Catherine Morley, March 2006, Summary of *Client Evaluation of Garratt Wellness Centre*. In a client self-assessment evaluation, Wellness Centre participants with chronic disease reported the following improvements in clinical outcomes and in self-perceived health and self-efficacy: 66 per cent reported lower blood sugar; 63 per cent had lost weight; 49 per cent reported lower blood pressure; 89 per cent reported changing the type or amount of food they ate or drank; 71 per cent reported they improved their type or amount of physical activity; 50 per cent reported experiencing less stress and anxiety; and 81 per cent reported feeling better or healthier.
- 61 Interview, Barb Leslie, Coordinator, Garratt Wellness Centre, Clinical Nutrition Practice Leader, January 2007.
- 62 Dewolfe and Millan, 2003.
- 63 British Columbia Medical Association, 2008.
- 64 Hollander and Tessaro, 2001.
- 65 Szebehely, 2005.
- 66 Ehmann et al., 2004.
- 67 Ehmann and Hanson, 2002.
- 68 Tee et al., 2003.
- 69 Ehmann, 2004.
- 70 Addington, 2002; Normal et al., 2004.
- 71 Access Economics Pty Limited, October 2008, p. 5.
- 72 Interview, Barbara Korabek, VIHA executive director, Continuing Health Services, September 2008.
- 73 Interview, Jo Dunderdale, Program Development and Planning Leader Home and Community Care, Vancouver Island Health Authority, December 2007.
- 74 Vancouver Island Health Authority, 2006.
- 75 Bethune, 2007.
- 76 Canadian Medical Association, 2005.
- 77 Interview, R.J. Raymond, Clinical Assistant Professor, UBC Family Practice Residency Program, Prince George Site, April 2007.
- 78 Loeb et al., 2006. Overall, the clinical pathway treatment, although costing \$104 CDN per resident, resulted in cost savings of \$1,219 CDN per resident (residents requiring hospitalization incurred, on average, costs of \$1,323 CDN, including transportation costs and professional billings).
- 79 Bethune and Clarke, 2004.
- 80 Hoek et al., 2003.
- 81 Bethune and Clarke, 2004.
- 82 Hospital Employees' Union, 2009, p. 10.
- 83 McGregor et al., 2006.
- 84 Interview, R.J. Raymond, Clinical Assistant Professor, UBC Family Practice Residency Program, Prince George Site, April 2007.
- 85 Although no formal evaluations have been conducted because of the early stage of the project, Dr. Raymond reports fewer numbers of residents having to go to the emergency department because of physicians attending to calls.
- 86 The Northern Health Authority (NHA) Medical Director, Dr. Dan Horvat, has been a strong supporter and provided funding for the physicians' sessions from leftover sessional funds from the past year.
- 87 The Emergency Room Decongestion Initiative funded the new equipment.
- 88 Availability of MOCAP (Medical On-Call Availability Program) funding by the Medical Service Plan (MSP) for the LTC Project physicians has not been confirmed.
- 89 Leutz, 1999, p. 84.
- 90 Hébert et al., 2005.
- 91 PACE program information source: "Ask the Expert" (December 2003), a regular monthly column from the Alberta Division of Continuing Care. Accessed at www.calgaryhealthregion.ca/clin/cme/ccmed/askexprt/askq0312_2.pdf. As noted by Mui, 2001: "The Program

- of All-Inclusive Care for the Elderly (PACE), [based on the San Francisco Chinatown On-Lok Program, which is in turn modelled on the British day hospitals], has been emerging since the 1970s, particularly because most frail elders prefer community-based to institutional care. The Balanced Budget Act of 1997 made PACE a permanent provider type under Medicare and granted states the option of paying a capitation rate for PACE services under Medicaid. The PACE model is a managed long-term care system that provides frail elders alternatives to nursing home life. The PACE program's primary goals are to maximize each frail elderly participant's autonomy and continued community residence, and to provide quality care at a lower cost than Medicare, Medicaid, and private-pay participants, who pay in the traditional fee-for-service system. In exchange for Medicare and Medicaid fixed monthly payments for each participating frail elder, PACE service systems provide a continuum of long-term care services, including hospital and nursing home care, and bear full financial risk. Integration of acute and long-term care services in the PACE model allows care of frail elders with multiple problems by a single service organization that can provide a full range of services."
- 92 Ibid.
- 93 CHOICE (Comprehensive Home Option of Integrated Care for the Elderly, Edmonton), C3 (Comprehensive Community Care, Calgary), and Bridges (Lethbridge).
- 94 Fraser Valley Health Region, Health Profile 2000, Abbotsford.
- 95 The Chilliwack district, including Yaro, Greendale, Cultus Lake, Popkum, and Rosedale, is the catchment area for the program.
- 96 Interview, Jan McDermott, Team Leader, NetCARE, March 2007. Eligibility criteria for the NetCARE watch program are: must be a NetCARE client, with ongoing risk despite assessment, and tentative coping ability. Criteria for discharge from the NetCARE watch program: stable for six months, functionally and medically, and supports are in place. Criteria for ongoing participation in the NetCARE watch program: isolated, limited support, cognitive impairment, deteriorating function and caregiver burden.
- 97 The Fraser Health Authority "home health" program was formerly referred to as "home and continuing care."
- 98 Stein et al., 1980.
- 99 Drake, 1998.
- 100 Bond, 2002; Allness et al., 1998.
- 101 Marshall et al., 2000.
- 102 Latimer, 1999.
- 103 Burns et al., 2006.
- 104 Interview, Alan Campbell, VIHA Director Mental Health and Addiction Services, June 2007.
- 105 Interview, Barbara Korabek, VIHA Executive Director Continuing Health Services, September 2008.
- 106 Wasylenki, 1997.
- 107 Murray, 1997.
- 108 Sherman, 2008.
- 109 BCMA, 2008.
- 110 Cohen, 2006, pp. 32-34.
- 111 For the year prior to the redesign (July 2006 to June 2007), there were 11 WorkSafe claims and a time loss of 1,427.5 hours compared to a year after the redesign (July 2007 to June 2008), when there were four claims and a time loss of 284.5 hours. The result is a cost savings of \$28,030 or a cost reduction of 21 per cent.
- 112 BCMA, 2008.
- 113 Coleman et al., 2004.
- 114 Nielson-Bohlman et al., 2004.
- 115 Pollack, 2006.
- 116 Leutz, 1999
- 117 Cohen, 2009.
- 118 Accessed at www.hospicebc.org/advocacy.php.
- 119 Interview, Carolyn Tayler, Regional Palliative Care Structure, 2007.
- 120 Rankin, 2008.
- 121 Flood et al., 2005.
- 122 Cohen, 2005.
- 123 Maxwell et al., 2002.
- 124 British Columbia Conversation on Health, Accessed at www.bcconversationonhealth.ca.
- 125 BC Ministry of Health, press release, B.C. to Establish Patient Care Quality Review Boards, April 2008, Accessed at www2.news.gov.bc.ca/news_releases_2005-2009/2008HEALTH0051-000666.htm.
- 126 Denis, 2002.
- 127 Krall, 2001.
- 128 Howell et al, 1990.
- 129 Bigelow et al., 2005.
- 130 Morgan, 2007.
- 131 Ibid.
- 132 Interview, Maureen Bingham, Manager from the Saskatchewan Health Quality Council, January 2007.
- 133 Lyder, 2002.
- 134 Delaney, Catherine and Wendy Timmerman, *Improving Skin and Wound Care in Saskatchewan*. Power Point Presentation, October 2007. See also Timmerman et al., 2007.
- 135 Dixon, et al. 2004.
- 136 Cohen, 2005a.

REFERENCES

- Access Economics Pty Ltd. 2008. *Cost Effectiveness of Early Intervention for Psychosis*. Melbourne: Orygen Research Centre. October.
- Addington, D. 2002. "Pathways to care: help seeking behaviour in first episode psychosis." *Acta Psychiatrica Scandinavica*: 106(5):358-64.
- Advisory Committee on Health Services. 1996. *A Dialogue on Primary Health Care: It's Your Choice*, Health Canada, Cat. No. H39-365/1996E. April.
- Allness, D.J., W.H. Knoedler. 1998. "The PACT model of community based treatment for persons with severe and persistent mental illness: A manual for start up." *National Association for Mental Illness*. Arlington, VT.
- Barr, Victoria, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts, Darlene Ravensdale and Sandy Salivaras. 2003. "The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model." *Healthcare Quarterly*: 7(1):73-82.
- Bethune, G. 2007. "The role of the medical director in long-term care." *The Canadian Review of Alzheimer's Disease and Other Dementias*: 9(1):18-23.
- Bethune, G. and B. Clarke. 2004. "How the Dutch do it: The role of the nursing home in the Netherlands." *Journal of the Canadian Geriatrics Society*: 7(3). Accessed at www.canadiangeriatrics.com/pubs/GTSept2004/GTSept2004_BethuneClarke.pdf.
- Bigelow, J.H., K. Fonkych, C. Fung, J. Wang. 2005. "Analysis of Health Care Interventions that Change Patient Trajectories." *RAND Monograph*. Accessed at www.rand.org/pubs/monographs/MG408/.
- Bond, Gary R. 2002. *Assertive Community Treatment for People with Severe Mental Illness*. Chicago: Illinois Department of Human Services, Alcoholism and Substance Abuse. Accessed at www.bhrm.org/guidelines/ACTguide.pdf.
- British Columbia Government Select Standing Committee on Health. 2006. *A strategy for combating childhood obesity and physical inactivity in British Columbia*, pp. S145-153. Accessed at www.leg.bc.ca/cmt/38thparl/session-2/health/reports/Rpt-Health-38-2-29Nov2006/Rpt-Health-38-2-29Nov2006-Tracking.htm.
- British Columbia Medical Association. 2008. *Bridging the Islands: Re-Building BC's Home and Community Care System, A Policy Paper by BC's Physicians*. May.
- British Columbia Medical Association. 2002. *Ensuring Excellence: Renewing BC's Primary Care System, A Discussion Paper by BC's Physicians*. September.
- British Columbia Ministry of Health. 2006. Full services family practice incentive program. Accessed at www.health.gov.bc.ca/cdm/practitioners/fullservice.html.
- Burns, T., J. Catty, C. Wright. 2006. "Deconstructing home-based care for mental illness: can one identify the effective ingredients?" *Acta Psychiatrica Scandinavica* 113 (s429)33-35.
- Canadian Institute for Health Information. 2006. *Hospital Mental Health Services in Canada 2003-2004*. November.
- Canadian Institute for Health Information. 2008. *Reducing Gaps in Health: A Focus on Socioeconomic Status in Urban Canada*. November.
- Canadian Medical Association. 2005. "Long-term care memos from the front line." *Elder Care*: 20-21. Accessed at www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/WhatWePublish/LeadershipSeries/English/pg20EC.pdf.
- Cohen, Marcy. 2005. *Democratizing Public Services: Lessons from Other Jurisdictions and Implications for Health Care Reform in BC*. Canadian Centre for Policy Alternatives – BC Office. March.
- Cohen, Marcy, Janice Murphy, Kelsey Nutland and Aleck Ostry. 2005. *Continuing Care: Renewal or Retreat? – BC Residential and Home Health Care Restructuring 2001–2004*, Vancouver: Canadian Centre for Policy Alternatives – BC Office. April.
- Cohen, Marcy, Arlene McLaren, Zena Sharman and Stuart Murray. 2006. *From Support to Isolation: The High Cost of BC's Declining Home Support Services*. Vancouver: Canadian Centre for Policy Alternatives – BC Office. June.
- Coleman, Eric, Jodi Smith, Janet Frank, Sung-Joon Min, Carla Parry and Andrew Kramer. 2004. "Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention." *Journal of the American Geriatrics Society*: 52:1817-1825.
- Denis, Jean-Louie. 2002. *Governance and Management of Change in Canada's Health Care System*. Canadian Institute of Health Research.
- Dewolfe, J. and C. Millan. 2003. "Dietary intake of older adults in the Kingston area" *Canadian Journal of Dietetic Practice and Research*: 64(1):16-24.
- Dixon J., R. Lewis, R. Roen, B. Finlayson and D. Gray. 2004. "Can the NHS learn from US managed care organizations?" *British Medical Journal*: 328:223-225.
- Drake, R.E. 1998. "Brief history, current status and future place of assertive community treatment." *American Journal of Orthopsychiatry*: 68:172-175.
- Ehmann, T.S., 2004. *A Quiet Evolution: Early Psychosis Services in British Columbia. A survey of hospital and community resources*. Unpublished manuscript. Accessed at www.bcscs.org/a_documents/pdf/EarlyPsychosisStudy.pdf.

- Ehmann T.S., M. Gilbert and L. Hansen. 2004. *Early Psychosis Intervention: A Framework for Strategic Planning*. Ottawa: Canadian Mental Health Association. Accessed at www.cmha.ca/english/intrvent/.
- Ehmann, T.S., L. Hanson (editors). 2002. *Early Psychosis: A Care Guide*. Vancouver: University of British Columbia.
- Evans, R.G., M.L. Barer and T.R. Marmor (Eds). 1994. *Why are Some People Healthy and Others Not?: The Determinants of Health of Populations*. New York: Aldine de Gruyter.
- Flood, Colleen and Tom Archibald. 2005. *Hamstrung and Hogtied: Cascading Constraints on Citizen Governors on Medicare*. Canadian Policy Research Network.
- Forest, P.G., K. Jackson, B. Legowski, L. Lozowchuk, J. Maxwell, S. Rosell, D. Yankelovich. 2002. *Report on the Citizens' Dialogue on the Future of Health Care in Canada*. Accessed at www.cprn.org/doc.cfm?doc=32&l=en.
- Goldner, E. 2002. *Sharing the Learning: the Health Transition Fund Synthesis Series: Mental Health*. Ottawa: Health Canada.
- Hébert, R., A. Tourigny and M. Gagnon (editors). 2005. *Integrated service delivery to ensure persons' functional autonomy*. Quebec: Edisem.
- Hoek, J.F., M.W. Ribbe, C.M.P. Hertogh and C.M.P. van der Vleuten. 2003. "The role of the specialist physician in nursing homes: The Netherlands' experience." *International Journal of Geriatric Psychiatry*: 18:244-249.
- Hollander, M., M.J. Prince. 2002. *Final Report: The Third Way: A Framework for Organizing Health Related Services for Individuals with Ongoing Needs and Their Families, An Analysis of the Interfaces along the Continuum of Care*. Victoria: Hollander Analytic Services Ltd.
- Hollander, M. 2001. *Evaluation of the Maintenance and Preventive Model of Home Care*. Victoria: Hollander Analytic Services Ltd.
- Hospital Employees' Union. 2009. *Quality of Care in BC's Residential Care Facilities: Input to the Office of the Ombudsman's on Seniors' Care*. Vancouver: Hospital Employees' Union. Accessed at www.heu.org/%7EDOCUMENTS/2009_seniors/OmbudsmanReportSeniorsCareJan09.pdf
- Howell, J.M. and C.A. Higgins. 1990. "Champions of change: identifying, understanding and supporting champions of technological innovations." *Organizational Dynamics*: Summer:18(1):40-55.
- Kirby, M.J.L., M. LeBreton, C.S. Callbeck, J. Cook, J. Cordy, J. Fairbairn, W. Keon, Y. Morin, L. Pépin, B. Robertson and D. Roche. 2002. *The Health of Canadians – the Federal Role: Final Report on the State of the Health Care System in Canada: Volume Six: Recommendations for Reform*. Ottawa: Standing Senate Committee on Social Affairs, Science and Technology.
- Knock, Marion. 2001. *BC Primary Care Transition Projects Final Report*. BC Ministry of Health.
- Krall, M.A. 2001. "Clinician Champions and Leaders for Electronic Medical Record Innovations." *The Permanente Journal*: 5(1). Accessed at xnet.kp.org/permanentejournal/winter01/HSchamp.html.
- Holman, H. and K. Lorig. 2000. "Patients as Partners in Managing Chronic Disease." *British Medical Journal*: 320:526-527.
- Latimer, Eric. 1999. "Economic Impacts of Assertive Community Treatment: A Review of the Literature." *The Canadian Journal of Psychiatry*: 44:443-54.
- Leutz, W.L. 1999. "Five laws for integrating medical and social services: Lessons from the United States and the United Kingdom." *The Milbank Quarterly*: 77(1):77-110.
- Lightman, Ernie et al. 2008. *Poverty is making us sick: A comprehensive survey of income and health in Canada*. Wellesley Institute and Community Social Planning Council of Canada. December.
- Loeb, M.S.C., R. Carusone, S.D. Goeree, K. Walter, P. Brazil, A. Krueger, L. Simor, T. Moss, and T. Marrie. 2006. "Effect of a clinical pathway to reduce hospitalizations in nursing home residents with pneumonia." *Journal of the American Medical Association*: 295:2503-2510.
- Lorig K.R., P.D. Mazonson and H.R. Holman. 1993. "Evidence suggesting that health education for self-management in chronic arthritis has sustained health benefits while reducing health care costs." *Arthritis and Rheumatism*: 36:439-446.
- Lorig, K.R., D.S. Sobel, A.L. Stewart, B.W. Brown, A. Bandura, P. Ritter et al. 1999. "Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial." *Medical Care*: 37:5-14.
- Lorig, K.R., P. Ritter, A.L. Stewart, D.S. Sobel, B.W. Brown, A. Bandura, V.M. González, D.D. Laurent and H.R. Holman. 2001. "Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes." *Medical Care*: 39(11):1217-1223.
- Lorig K.R., D.S. Sobel, P. Ritter, D.D. Laurent and M. Hobbs. 2001. "Effect of a self-management program on patients with chronic disease." *Effective Clinical Practice*, Journal of the American College of Physicians: 4(6):256-262.
- Lyder, C.H. 2002. "Pressure ulcer prevention." *Annual Review of Nursing Research*: 20:35-61.
- McGowan, Patrick. 2006. *Chronic disease self-management program: Program evaluation. British Columbia 2003-2006*. Accessed at www.coag.uvic.ca/cdsmp/downloads/CDSMP%20Evaluation%20BC%202003-2006.pdf.
- McGregor, M.J., R.B. Tate, K.M. McGrail, L.A. Ronald, A. Broemeling and M. Cohen. 2006. "Care outcomes in long-term care facilities in British Columbia, Canada: Does Ownership Matter?" *Medical Care*: 44(10):929-935.

- Marshall, M. and A. Lockwood. 2000. "Assertive Community Treatment for People with Severe Mental Disorders." (Cochrane Review) *The Cochrane Library*. Oxford.
- Morrow, Marina. 2006. *Community Mental Health in BC: Changes in Income, Employment and Housing Support*. Vancouver: Canadian Centre for Policy Alternatives – BC Office. August.
- Morgan, M.W., N.E. Zamora and N.F. Hindmarsh. 2007. "An Inconvenient Truth: A Sustainable Healthcare System Requires Chronic Disease Prevention and Management Transformation." *Healthcare Papers*: 7(4)7.
- Mui, A.C. 2001. "The Program of All-Inclusive Care for the Elderly (PACE): an innovative long-term care model in the United States." *Journal of Aging and Social Policy*: 13(2-3):53-67.
- Murray, A. et al. 1997. *More Than a Friend: The Role of Support Workers in Community Mental Health Services*. London: The Sainsbury Centre for Mental Health.
- Nielson-Bohlman, L., A. Panzer and D. Kindig (editors). 2004. *Health Literacy: A Prescription to End Confusion*. Committee on Health Literacy, Institute of Medicine. Washington: National Academy of Sciences.
- Norman, R.M., A.K. Malla, M.B. Verdi, L.D. Hassall, C. Fazekas. 2004. "Understanding delay in treatment for first-episode psychosis." *Psychological Medicine*: 34(2): 255-66.
- Pathways to Housing Inc. 2005. "Providing Housing First to Homeless Adults with Severe Mental Illness." *Psychiatric Services* 56 (10) 1303-1305.
- Patterson, M. et al. 2007. *Housing and Supports for Adults with Mental Illness and/or Severe Addictions in British Columbia*. Centre for Applied Research in Mental Health and Addiction, unpublished document. Simon Fraser University, BC.
- Pollak, Nancy. 2006. *Cooperation for Health: A discussion about building union and community support for health care cooperatives*. Vancouver: Hospital Employees' Union.
- Prus, S.G. 2004. "A Life Course Perspective on the Relationship between Socioeconomic Status and Health: Testing the Divergence Hypothesis," *Canadian Journal on Aging Supplement*: Volume 23 Supplement, p. S145-S153.
- Rankin, A. 2008. "Mature Policy on Choice." *Institute for Public Policy Research*. Accessed at www.ippr.org.uk/publicationsandreports/publication.asp?id=322.
- Reid, R.J., R.G. Evans, M.I. Barer, S. Sheps, K. Kerluke, K. McGrail, C. Hertzman, N. Pagliccia. 2003. "Conspicuous consumption: Characterizing high users of physician services in one Canadian province." *Journal of Health Services Research and Policy*: 8 (4): 215-224.
- Romanow, Roy. 2002. *Commission on the Future of Health Care in Canada*, Health Canada. November.
- Royal Commission on Health Care and Costs. 1991. *Closer to Home*. Summary of the Report of the BC Royal Commission on Health Care and Costs. Chaired by Justice Peter Seaton.
- Rosengard, A., I. Laing, J. Ridley, S. Hunter. 2007. "Literature Review on Complex Needs", *Scottish Executive Social Research*. Accessed at www.scotland.gov.uk/Publications/2007/01/18133419/0.
- Russell, G. 2002. "Primary Care Reform: View from Australia." *Canadian Family Physician*, Editorial. March.
- Sharman, Zena, et al. 2008. "We Only Own the Hours: Discontinuity of Care in the British Columbia Home Support System." *Canadian Journal on Aging*: 27:1, pp. 89-99.
- Statistics Canada. 2007. *Residential Care Facilities 2005-06*, Catalogue no. 83-237-X, pp. 60-71. November.
- Stein, L.I., M.A. Test. 1980. "Alternatives to mental hospital treatment. I: Conceptual model, treatment program, and clinical evaluation." *Archives of General Psychiatry*: 37:392-397.
- Szebehely, Marta. 2005. *The woman-friendly welfare state? Scandinavian elder care in transition*. Paper presented at Imagining Public Policy to Meet Women's Economic Security Needs conference, hosted by the Canadian Centre for Policy Alternatives and Simon Fraser University, Economic Security Project, Vancouver, BC. October.
- Tee, K., T.S. Ehmann, G.W. MacEwan. 2003. "Early Psychosis Identification and Intervention." *Psychiatric Services*: 54(4):573.
- Timmerman, T., G. Teare, E. Walling, C. Delaney, L. Gander. 2007. "Evaluating the Implementation and Outcomes of the Saskatchewan Pressure Ulcer Guidelines in Long-Term Care Facilities." *Ostomy Wound Management* (in press).
- Tsemberis, S., L. Gulcur, M. Nakae. 2004. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis." *American Journal of Public Health* 94(4) 651-656.
- University of Victoria – Centre on Aging. 2003–2006. *Effectiveness of the Chronic Disease Self-Management Program*. Accessed at www.coag.ubic.ca/cdsmp/information_cdsmp_research.htm.
- Vancouver Island Health Authority. 2006. *Primary Health Care Strategy: 2006/07 – 2008/09*, p. 11. June. Accessed at www.viha.ca/NR/rdonlyres/453A2276-E33E-400E-82A7-F618D65A922B/0/PHCStrategyFinal.pdf.
- Vogel, Donna, et al. 2000. *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care*, Canadian Centre for Policy Alternatives. November.
- Wasylenki D. 1997. "A Home-based Program for the Treatment of Acute Psychosis." *Community Mental Health Journal*. 33:..2.
- World Health Organization. 2007. Commission on Social Determinants of Health. Accessed at www.who.int/social_determinants/en/.
- World Health Organization. 2004. Global Forum on Chronic Disease Prevention and Control. Geneva: World Health Organization Press.

ECONOMIC SECURITY PROJECT

The Economic Security Project is a research alliance led by the CCPA's BC Office and Simon Fraser University, and includes 24 community organizations and four BC universities. It looks at how provincial policies affect the economic well-being of vulnerable people in BC, such as those who rely on social assistance, low-wage earners, recent immigrants, people with disabilities, seniors, youth and others. It also develops and promotes policy solutions that improve economic security. The project is funded primarily by a grant from the Social Sciences and Humanities Research Council of Canada (SSHRC) through its Community-University Research Alliance Program.

www.policyalternatives.ca/economic_security



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