All Policy Papers: Key Highlights relevant to Continuing Care Sector

- Existing expenditures will be protected, appropriate reallocations from the acute to the community services sector must become part of go forward health authority planning and going forward a majority of net new funding must be assigned to developing primary and community services.
- Available primary and community care operational and capital funding will be used to improve community-based services in a manner that is reflective of the changing population health care needs and the principles of community based services, integration, quality and value for money.
- Recommendations will be subject to consultation and refinement over winter but it is intended that the final recommendations will be implemented as part of a multi-year primary and community care transformational plan, starting April 2015.
- The Ministry of Health will collaboratively conduct a review of the major primary and community care policy, initiatives and incentives reviewed in this paper late spring of 2015 to ensure they are aligned with the common set of principles set out above and streamlined into a coherent go forward policy framework.
- A single oversight and shared governance model will be developed for primary and community care that includes representation from key players involved in primary and community care. There will be a two day forum in late spring to discuss the outcome of the review and feedback on the proposed directions set out.
- A range of multidisciplinary practices will be developed across communities with the capacity to address longitudinal health care needs of older adults with chronic medical conditions, potentially requiring home support, cancer care, and/or palliative care; they will have ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services.
- These practices will be linked to residential care services that include bed capacity designated for short term acute medical care needs including short-term stays for respite, end-stage palliative care or more short stay interventions than can be provided through home physician and nursing care.
- Over the next 3 years, implement the Refreshed Dementia Action Plan including the four priorities with their concrete actions: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care facilities and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care.
- Continue the implementation the End-of-Life Care Action Plan and its key actions to improve the way health care providers meet the needs of people coping with end of life, including their families and caregivers.
- Improving geriatric care across the continuum of health service delivery is a key factor in ensuring appropriate care designed to promote the best outcomes and quality of life.
- Related to the above challenges is the way that home and community care services are currently funded, with a co-payment model with user fees charged to clients based on their income for home support, assisted living and residential care services.
- With redesign of services and the transition to new innovative care models focused on interdisciplinary teams, new options for subsidizing clients who may not be able to afford the cost of necessary services need to be explored. This will include exploring how other jurisdictions fund

home support, assisted living and residential care services and include a dialogue with health authorities and major stakeholders on how to provide the services.

- For the balance of 2015/16 through 2016/17 it is proposed that there will be three cross sector health sector strategic service priorities that will result in substantive first steps to a repositioning of the BC health system over the coming five years to better position it to meet both increasing and changing patterns of demand:
    - Improving the effectiveness of primary, community (including residential care), medical specialist and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use such as to significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care.
    - Significantly improving timely access to appropriate surgical treatments and procedures.
    - Establishing a coherent and sustainable approach to delivering rural health services
- B.C. utilization and current funding approaches to residential care services are suboptimal from a number of perspectives:
    - There are opportunities to provide support services to patients both in the community and assisted living facilities that could reduce the need for residential care;
    - There are opportunities to increase planned admissions to residential care rather than admissions through the ER and in-hospital bed use;
    - There are opportunities to better meet the care (including the increasing number of patients with dementia) and health needs of elderly patients in residential care facilities rather than through hospitals, including the development of short term respite beds for community patients with less acute medical conditions and complications;
    - There is increased fiscal capacity to add placements through private capital funding and longer term publicly funded contracting of placements.
- Over the coming three months we will be asking people across the health sector to read, think and dialogue the Cross Sector Policy Discussion Papers. We will be seeking feedback through a formal process with Health Authorities, Patients as Partners, Professional Colleges/Associations, the Doctors of BC, ARNBC, Post-Secondary Academic Institutions and the research community, and Health Service Unions.
- Following consultation with Health Authority Boards and the Minister of Health, we will report out by mid-spring on the feedback, our assessment of consensus, any changes to the policy direction, and the concrete actions we are proposing to move forward on over the coming two years.
- The Ministry of Health will create further space for dialogue with stakeholders and Patients as Partners by hosting a primary and community care public forum in late spring 2015. By attending the forum to share your experiences and by taking advantage of other opportunities for dialogue in your communities you could help shape the pace of change.
- The Ministry of Health in collaboration with Health Authorities, Colleges, Associations and Unions, Educators, and other stakeholders, will establish a single provincial Health Human Resource Framework that will be used to plan, link and coordinate go-forward actions and initiatives.
- British Columbia has the fastest growing senior's population in Canada. The number of seniors in BC is expected to almost double by 2036, and the 75+ population will grow by almost 130 per cent over the same time. While the majority of seniors are comparatively healthy and have few serious health concerns, others within this age cohort are not as fortunate.
- Residential care accounts for, by far, the majority of expenditures in this area. Although frail seniors in residential care represent only one per cent of the population, they use 21 per cent of all health

system expenditures included in the matrix. A large driver of this cost is the provision of 24/7 residential care.

- British Columbia's 303 residential care facilities are home to almost 42,000 residents, with an average age of 85 years. Many of these residents have one of more chronic conditions at varying levels of severity. For example, 61.4 per cent have dementia and 20.2 per cent have diabetes. In addition, 6.7 per cent have cancer while almost one-third have severe cognitive impairment. These seniors require a wide range of health supports to help manage such medical challenges, which are often what precipitated the entry into residential care in the first place.
- Most seniors prefer to remain in their homes and communities rather than move to a care facility. When community care provides a viable alternative, patient experience is enhanced. When seniors are admitted to acute care, they can experience prolonged periods of inactivity during which time their level of functional ability is reduced and may never recover. The quality of life is better when an individual is able to be sustained in their home and community.
- The per-person cost of caring for a frail senior through home and community support is less than half the cost of caring for them in residential care (e.g., residential care: $59,210; community: $20,290; community with high chronic condition: $29,690). This is true even though frail seniors in the community have a higher number of emergency department visits than those who live in residential care (i.e., 18 per cent for frail seniors living in the community versus 7.1 per cent for those living in residential care).
- In 2015/16, Regional Health Authorities will develop three year local community plans for all rural and remote communities to create environments that foster healthy behaviours and programming that improves the health of the population. These plans will be developed in collaboration with local communities. The plans will be referenced in their Service Plans, be available on the health authority web site, and attached to their Detailed Service and Operational Working Papers.
- By September 30, 2015, each of the Regional Health Authorities will provide an assessment of the status of primary and community care services across all rural, small rural and remote communities and a specific three year plan on how they intend to move forward with this policy direction as a region. This plan will be referenced in their Service Plans, be available on the health authority web site, and attached to their Detailed Service and Operational Working Papers. It is recognized that this process will take time and engagement.
- **Home Support and Residential Care in Rural Communities (Section 2.2):** In collaboration with communities and patients, Regional Health Authorities will initiate work on exploring innovative and cost effective service options to better support aging in place but also clarity on residential care options for when they are required to allow active preplanning by older adults and their families. This work will be reported in their Service Plans, be available on the health authority web site and attached to their Detailed Service and Operational Working Papers starting 2015/16.
- The Provincial Surgery Executive Committee (PSEC) has been given the mandate and authority to drive a common vision and a comprehensive policy framework, inclusive of the entire surgical care continuum, that gives priority to improving the quality of surgical services and embed the philosophy of patient centered care into strategic and operational processes. PSEC will facilitate collaborative partnerships between patients, health authorities, physicians, the Ministry of Health, the BC PSQC, Doctors of BC and other relevant nursing and allied health stakeholders.
- A growing number of elective surgeries are now being undertaken when patients are into their 80s. The increasing longevity of the seniors' population is a key driver of surgical repair following hip fracture. The elderly are at a higher risk of fracture from falls due to poorer vision, poorer coordination and reduced strength. As the 85 year old plus age group increases, the demand for hip replacement following fracture will increase, particularly in the female population.

Primary and Community Care Paper: Key Highlights

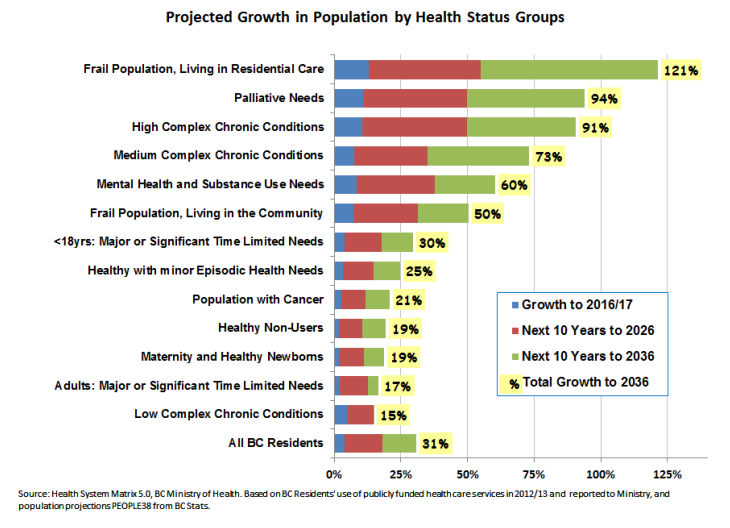
Key Points:

- Primary and community care is a major component of the British Columbia (BC) health system, delivering over thirty million health care services each year to BC's 4.5 million residents, with a total expenditure of approximately $5.4 billion.
- ***Responsible Operational and Capital Investment*:** Existing expenditures will be protected, appropriate reallocations from the acute to the community services sector must become part of go forward health authority planning and going forward a majority of net new funding must be assigned to developing primary and community services. Available primary and community care operational and capital funding will be used to improve community-based services in a manner that is reflective of the changing population health care needs and the principles of community based services, integration, quality and value for money.
- Recommendations will be subject to consultation and refinement over winter but it is intended that the final recommendations will be implemented as part of a multi-year primary and community care transformational plan, starting April 2015.
- The Ministry of Health will collaboratively conduct a review of the major primary and community care policy, initiatives and incentives reviewed in this paper late spring of 2015 to ensure they are aligned with the common set of principles set out above and streamlined into a coherent go forward policy framework.
- A single oversight and shared governance model will be developed for primary and community care that includes representation from key players involved in primary and community care. There will be a two day forum in late spring to discuss the outcome of the review and feedback on the proposed directions set out below.
- As outlined in Section 1.6 (Systematically and opportunistically establish Linked Community and Residential Care Service Practices for Older Adults with Moderate to Complex Chronic Conditions)
    - An emerging idea to better meet the needs of older adults with moderate to complex chronic conditions, linked to increasing frailty as they age into their seventies, eighties and nineties, is to provide continuity and flexibility of care linked to rapid mobilization of services through specialized community-based practices. These are practical in urban and metro areas but might be adaptable to some rural areas.
    - First, a range of multidisciplinary practices will be developed across communities with the capacity to address longitudinal health care needs of older adults with chronic medical conditions, potentially requiring home support, cancer care, and/or palliative care; they will have ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services.
    - Second, these practices will be linked to residential care services that include bed capacity designated for short term acute medical care needs including short-term stays for respite, end-stage palliative care or more short stay interventions than can be provided through home physician and nursing care. These beds would also provide step-down capacity for older patients who have been hospitalized in one of the level four or five acute hospitals (A Level 4 Hospital is a hospital with limited specialty services, while Level 5 hospital is a Regional Hospital with more specialty and complex services available – see Rural Paper).

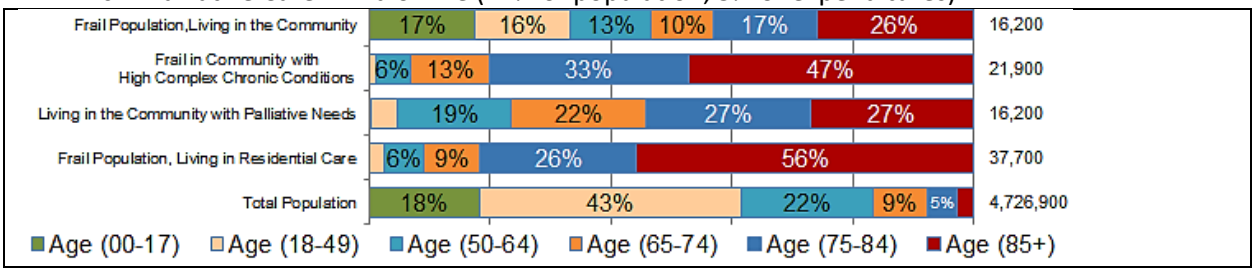
Referrals to these facilities will come primarily from the group of affiliated multidisciplinary practices. This will provide continuity of care, allow proactive care management and rapid mobilization in emergencies, and bypass the often-damaging process of going through a traditional Emergency Department.
    - Third, these practices will be linked to assisted living and residential care services to provide proactive care planning, transitions, and continuity of care.
    - This approach will include protocols to admit being developed in collaboration with hospitals ensuring hospitals operate a 'choose to admit' policy so that only those frail older people who have evidence of underlying life-threatening illness or need for surgery are admitted as an emergency to an acute bed.
- Section 1.7 (Systematically opportunistically establish Community and Residential Care Services Practices for Patients w Moderate to Severe Mental Illnesses and/or Substance Use Issues)
    - Similar to the above, a model to meet the needs of patients with moderate to severe mental illness and/or substance use will be explored to create a more coherent and comprehensive set of services building from the current frameworks but built as a community-based system of care in contrast to the current fragmented service continuum including health promotion and illness prevention activities. These are practical in urban and metro areas but might be adaptable to some rural areas.
    - These practices will be linked to residential/hospital mental health care and substance use services that include bed capacity designated for short term acute psychiatric care or substance use needs including short term stays for respite or more intensive work-ups than can be provided through community-based services.
    - In 2015, the Leadership Council, in collaboration with the Ministry of Health, health authorities and mental health and substance health providers will develop a policy and budget framework to support the development of these practices across urban and metro centres of BC based on population and patient analysis and a five year roll out plan.
- **As outlined in Section 2.4 (Implement the Refreshed Dementia Action Plan)**
    - Over the next 3 years, implement the Refreshed Dementia Action Plan including the four priorities with their concrete actions: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care facilities and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care.
    - Key priority actions include a strategy to keep people who are prone to wandering safe and to facilitate their safe return; and, focus in all care settings – from acute hospital admission to palliative and end of life care – on the specific needs of people with dementia and their caregivers with the development of a care pathway to ensure the needs of people with dementia are being respectfully met.
- **As outlined in Section 2.5 (Palliative and End-of-Life Care)**
    - Continue the implementation the End-of-Life Care Action Plan and its key actions to improve the way health care providers meet the needs of people coping with end of life, including their families and caregivers.
    - Further pursue the population needs assessment currently underway to support the development of models of care and targets for hospices spaces and services based on demographics.

- Also, develop policy to support a standardized approach to hospice palliative care across the health system to ensure the needs for palliative and end of life care are being addressed.

- **Section 3.2 (Significantly Strengthen Human Resources Planning and Management for the Primary and Community Care Sector)**
  - Working collaboratively with HEABC, health authorities, professional associations and unions, regulators, educators over 2015/16 a detailed primary and community care human resource policy and data set will be developed that aligns with and supports the direction set out in this section.
  - The policy paper and its enabling actions will identify priority improvements in a number of key functional areas (i.e. changes to education / training and regulation, etc…)
- In BC, people with chronic conditions of medium or high complexity represent 13% of the provincial population and use 26% of health services. Those with highly complex chronic conditions use the most hospital, PharmaCare, and home and community care services. They are also are high users of general practitioner and specialist services. Both high and medium complex chronic conditions are expected to increase by over 70% when projected to 2036 (see below)



- For those with a life-limiting illness, coping with end of life focuses on comfort, quality of life, symptom management, respect for personal health care treatment decisions, support for the family, psychological and spiritual concerns. Age-related health concerns may either require residential care or substantial community based health care and support. While accounting for less than two percent of the provincial population, this group uses 35% of all services accounted for in the health system matrix ($3.7 billion):
  - Frail in Community (<1% of population; 9% of expenditures);
  - Frail in Residential Care (1% of population; 21% of expenditures); and
  - Palliative Care – End of Life (<1% of population; 5% of expenditures).



- Analysis shows that health care costs, especially hospitalization expenditures, rise in the year before a patient enters residential care; often due to a health concern that precipitates need for this type of care. This same analysis points to the need for community-based, coordinated care that: (a) defers, where possible, the need for residential care; or (b) when residential care is required, facilitates access in a planned manner rather than through a health crisis requiring an emergency visit and inpatient stay in the hospital.
- The per-person cost of caring for a frail senior through home health care services and/or assisted living services is less than half the cost of caring for them in residential care (e.g., residential care: $59,210; community: $20,290; community with high chronic condition: $29,690). This is true even though frail seniors in the community have a higher number of emergency department visits than those who live in residential care (i.e., 18 % for frail seniors living in the community versus 7.1 % for those living in residential care).
- British Columbia's 303 residential care facilities are home to approximately 42,000 residents, with an average age of 85 years. Many of these residents have one of more chronic conditions at varying levels of severity. For example, 61.4 % have dementia and 20.2% have diabetes. In addition, 6.7% have cancer while almost one-third have severe cognitive impairment.

Residential Care in British Columbia	
Number of Residents	41,619
Average age	85
Younger than 65 (%)	5.2
85 and older (%)	58.7
Female	65.3
Diagnosis of Dementia (%)	61.4
Diagnosis of Hypertension (%)	45.9
Diagnosis of Cancer (%)	6.7
Diagnosis of Diabetes (%)	20.2
Severe Cognitive Impairment (%)	32.6
Signs of Depression (%)	21.4
Daily Pain (%)	20.6
Some aggressive behavior (%)	34.5
1+ ER Visits (%)	7.1
1+ Admissions to Hospitals (%)	6

- Although frail seniors in residential care represent only 1% of the population, they use 21% of all health system expenditures included in the matrix. A large driver of this cost is the provision of 24/7 residential care.
- Improving geriatric care across the continuum of health service delivery is a key factor in ensuring appropriate care designed to promote the best outcomes and quality of life. A range of surveys point to what patients would like to see in their care:
    - Frail seniors living in the community greatly value continuity of care, with health professionals and carers who are familiar with their needs and who can help them to navigate multiple services.
    - Frail seniors want to remain at home and enjoy clean and warm accommodation.
    - Want to feel safe and to maintain independence, control, personal appearance & dignity.

- Frail seniors don't want to be a burden on their families, therefore they want their needs assessed in partnership with their families to ensure the family members can continue their role as caregivers.

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

Home and Community Care Services (pg. 72)

- Home and community care services are generally designed to:
  - Help individuals remain independent in their own homes for as long as possible;
  - Provide short term care at home where possible to either avoid hospitalization or to minimize extended hospital stays;
  - Provide alternate extended care options, like assisted living and residential care, when it is not possible to stay at home; and
  - Support individuals at end of life.
- A growing number of hospital admissions are through the emergency department, and increased numbers of 'alternate level of care' patients in acute beds suggest strongly that there is a need for more capacity in the community – for proactive care management to prevent or reduce the need for hospital admission and for responsive options to provide the appropriate care for convalescence and long-term care.
- In 2012/13, home and community care services were provided to 127,786 individual clients across the province, with 80,734 receiving professional services; 38,810 receiving home support services; 6,147 receiving adult day programs; 6,028 receiving assisted living services and 38,527 receiving residential care services.
- Of the 127,786 individuals receiving home and community care services in 2012/13; 98,250 or 77% were 65 or older. However, for those receiving residential care or assisted living services, 40,490 of 43,443 or 93% were 65 and older. Publicly subsidized residential care services are provided to approximately 5% of the total senior's population (65 and older).
- Over the past decade, growing numbers of clients with urgent needs, and the need to reduce pressure on the acute care system has drawn community care disproportionately towards urgent and acute response, and residential care settings now manage clients with more complex care needs, as well as post- acute convalescence and palliative care. Clients discharged from hospital now have very high medical and/or rehabilitative care needs, and are much less stable than was the case when many of the current service models were designed.
- As of March 31, 2014, 34% of subsidized residential care beds and 37 % of subsidized assisted living units were privately owned and operated; 33% of all subsidized residential care beds are owned and operated by health authorities directly, but only 4% of subsidized assisted living units are owned and operated by health authorities. Almost 60% of all publicly subsidized assisted living units are owned and operated by not-for-profit enterprises (Figures 13 and 14).

- Health authorities have contracts with service providers that establish deliverables based on compliance with policies and standards as well as reporting requirements. Each health authority has a mix of ownership types used to provide subsidized services, but there are notably a higher percentage of not-for-profit enterprises in the Vancouver Coastal Health Authority (52.8%), and less contracted (of either for profit or not-for-profit) service providers in Northern Health Authority where 76% of residential care and assisted living services are owned and operated by the health authority.
- BC has mandated the use of two interRAI assessment tools for clients receiving long term services (home support, assisted living, adult day services, group homes, family care homes and residential care services). However, in most health authorities, there is no standardized assessment tool being used for many clients receiving short term acute care, short term rehabilitative care or palliative care. This represents a significant gap in the home health sector, and could be addressed through the introduction of other interRAI instruments, such as the Contact Assessment, which is being used in Vancouver Island Health Authority and Ontario, or the Community Health Assessment, also used in Ontario, to ensure standardized comprehensive assessments are carried out on all home health clients.
- Despite many changes over the past 20 years, home and community care services remain organized in large part around eligibility criteria and service guidelines that limit who may receive services and in what format. Clinical services such as community pharmacy, social work and dietician services are available in some communities, but not others. Other ministries or community agencies may share responsibility for services in some cases. As a result, home and community care services can be complex and restrictive in their coordination and delivery.
- Related to the above challenges is the way that home and community care services are currently funded, with a co-payment model with user fees charged to clients based on their income for home support, assisted living and residential care services. With redesign of services and the transition to new innovative care models focussed on interdisciplinary teams, new options for subsidizing clients who may not be able to afford the cost of necessary services need to be explored. This will include exploring how other jurisdictions fund home support, assisted living and residential care services and include a dialogue with health authorities and major stakeholders on how to provide the services.
- In 2013, the Ministry of Health committed to revisit the details of the Ombudsperson's report with a commitment to greater specificity of action and reporting on the recommendations going forward. This work is now underway and will remain a focus over the coming two years.
- The Refreshed Dementia Action Plan has four priorities: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care facilities and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care.
- The Refreshed Dementia Plan is structured around the journey travelled by people with dementia, their families and caregivers. It was designed to address the health care needs of the BC population into the four areas of focus: staying healthy, getting better, living with illness and disability, and coping with end of life. Finally, the four priorities touch on the transitions along the way. Transitions include: receipt of a diagnosis of dementia; changes in the living environment (e.g., need for family and/or caregiver support to allow independent living); and decisions about residential and end-of-life care. These transitions often increase the need for additional support from health care or other support services.
- A skilled, informed, collaborative and respectful health care workforce is needed to implement the Refreshed Dementia Action Plan. This includes actions aimed at strengthening the

workforce's ability to provide quality dementia care, especially requirement for health care providers to engage in open and respectful communication with those living with dementia, their families and caregivers and to provide care that is person centred and dementia specific.

- Research increasingly suggests that Canadians prefer to die at home or in their home communities instead of in hospital settings. In BC in 2014, for cancer deaths, 15.4% have occurred in the home setting, 10.2% in the residential care setting, 34.5% in the hospice setting and 38.2% in the hospital setting. While the percentage of deaths in hospitals has decreased slightly in the last 3 years, and the percentage of deaths in hospices has increased slightly, the percentage of deaths in home and residential care settings has remained relatively unchanged.
- The Ministry of Health is leading a provincial End-of-Life Working Group comprised of Ministry representatives as well as palliative care physicians and health authority leads for palliative and end-of-life care. The End-of-Life Working Group identified as one of top three priorities identified the need for a population needs assessment. This assessment – which is currently underway - aims to support the development of models of care and targets for hospices spaces and services based on demographics.
- Moving forward, other partner organizations such as the BC Centre for Palliative Care, iPANEL and the BC Hospice Palliative Care Association will play a vital role in working with the Ministry of Health on advancing the palliative approach to care and fostering collaborative transitions in care across the system.

Sources:

Executive Summary: http://www.health.gov.bc.ca/library/publications/year/2015_a/primary-and-community-care-policy-paper-exec.pdf

Full Report: http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf

Patient-Centred Care Paper: Key Highlights

- The *B.C. Health System Strategy Implementation: A Collaborative and Focused Approach* calls for us to collectively take action in three areas:
    - Enable and deliver population and patient-centred services and care.
    - Identify, prioritize and engage in action at the practice, organizational, and provincial levels to continuously improve outcomes and health services for the citizens of BC and the ability of providers and support staff to deliver those services.
    - Engage in the prioritized cross sector actions identified to realize an overall improvement in the quality and sustainability of the B.C. health system.
- For the balance of 2015/16 through 2016/17 it is proposed that there will be three cross sector health sector strategic service priorities that will result in substantive first steps to a repositioning of the BC health system over the coming five years to better position it to meet both increasing and changing patterns of demand:
    - Improving the effectiveness of primary, community (including residential care), medical specialist and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use such as to significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care.
    - Significantly improving timely access to appropriate surgical treatments and procedures.
    - Establishing a coherent and sustainable approach to delivering rural health services
- With a changing demographic and changing health care needs, the use of emergency departments and in-hospital medical beds has been increasing driven by an older population with moderate to complex chronic illnesses and/or the experience of general frailty as the body ages. The utilization of emergency departments and in hospital medical by these patient groups has gradually driven bed utilization from 85% of funded capacity to now often in excess of 100% capacity for significant periods of the year (especially for the larger hospitals).
- B.C. utilization and current funding approaches to residential care services are suboptimal from a number of perspectives:
    - There are opportunities to provide support services to patients both in the community and assisted living facilities that could reduce the need for residential care;
    - There are opportunities to increase planned admissions to residential care rather than admissions through the ER and in-hospital bed use;
    - There are opportunities to better meet the care (including the increasing number of patients with dementia) and health needs of elderly patients in residential care facilities rather than through hospitals, including the development of short term respite beds for community patients with less acute medical conditions and complications;
    - There is increased fiscal capacity to add placements through private capital funding and longer term publicly funded contracting of placements.
- With respect to delivering patient-centred care and continuous improvement we are looking to you to take action supported by your health authority in collaboration with relevant employers, professional colleges, Doctors of BC, ARNBC and other relevant associations and unions. The Ministry of Health will support this approach by using existing collaborative mechanisms between the Ministry health authorities (including the First Nations Health Authority), colleges, Doctors of BC, ARNBC, unions and other key stakeholders to dialogue and build a shared commitment and leadership in supporting these engines of change.

- Over the coming three months we will be asking people across the health sector to read, think and dialogue the Cross Sector Policy Discussion Papers. We will be seeking feedback through a formal process with Health Authorities, Patients as Partners, Professional Colleges/Associations, the Doctors of BC, ARNBC, Post-Secondary Academic Institutions and the research community, and Health Service Unions.
- Following consultation with the Health Authority Boards and the Minister of Health, we will report out by mid-spring on the feedback, our assessment of consensus, any changes to the policy direction, and the concrete actions we are proposing to move forward on over coming two years.
- The Ministry of Health will create further space for dialogue with stakeholders and Patients as Partners by hosting a primary and community care public forum in late spring 2015. By attending the forum to share your experiences and by taking advantage of other opportunities for dialogue in your communities you could help shape the pace of change.
- Providing patient-centered care is the first of eight priorities for the BC health system as articulated the Ministry of Health's strategic plan, Setting Priorities for the BC Health System (February 2014). Under the strategic plan, the province will strive to deliver health care as a service built around the individual, not the provider and administration.

Sources:

BC Patient Centred Framework: http://www.health.gov.bc.ca/library/publications/year/2015_a/pt-centred-care-framework.pdf

Delivering Patient Centred Framework – Message from Minister of Health

http://www.health.gov.bc.ca/library/publications/year/2015/delivering-patient-centred-health-BC.pdf

Health Human Resources Paper: Key Highlights

- The province currently lacks a coherent, comprehensive and sustained health human resource strategy. The *Health Human Resource Strategy* advanced here is a key enabling strategy identified to support the priorities of the health system and to produce an *engaged, skilled, well-led and healthy workforce* that can provide the best patient-centred care for British Columbians.
- Those *Living with Illness or Disability* accounts for over 40 percent of the population and almost 50 per cent of all health system expenditures accounted for in the matrix ($5.2 billion). This group requires significant, sustained, and coordinated effort on the part of health service providers to achieve the best possible health outcomes. The Living with Illness or Disability dimension is subdivided as follows:
    - Low Complex Chronic Conditions (29 per cent of population; 15 per cent of expenditures)
    - Medium Complex Chronic Conditions (9 per cent of population; 12 per cent of expenditures)
    - High Complex Chronic Conditions (4 per cent of population; 12 per cent of expenditures)
    - Mental Health and Substance Use Needs (2 per cent of population; 5 per cent of expenditures)
    - Cancer (1 per cent of population; 5 per cent of expenditures)

- Those coping with end of life account for less than two percent of the provincial population, this group uses 35 per cent of all services accounted for in the matrix ($3.7 billion):
    - Frail in Community (<1 per cent of population; 9 per cent of expenditures)
    - Frail in Residential Care (1 per cent of population; 21 per cent of expenditures)
    - Palliative Care (<1 per cent of population; 5 per cent of expenditures)
- In 2015, the Government of BC will launch a pilot program for internationally-educated doctors who have completed their residency program in another country. The Practice Ready Assessment-British Columbia (PRA-BC) program will provide qualified family physicians with a pathway to being licensed in BC. Similarly, the province is working collaboratively with the province's three nursing regulatory bodies to develop a "nursing community" assessment service for internationally educated nurses who may qualify to practice in B.C. as registered nurses, licensed practical nurses or care aides.
- The majority of the health care budget is spent on compensation for HHR. Compensation for service delivery represents approximately 70 cents of every health care dollar spent in the public system. The total compensation cost for the public health sector is roughly $12.6B a year, which covers over 170,000 health professionals including physicians, nurses, allied health workers, supporting staff, community workers, dentists, optometrists, midwives and managements/excluded staff.
- The Ministry of Health and the Health Employers Association of BC are now developing a new Integrated Health Human Resource Planning (IHHRP) model that will further improve the province's HHR planning ability. The IHHRP model will use information on the health of the population, utilization of health services from the Health System Matrix, and data from MOH and HEABC to generate specific health service provider information geographically and by designation (i.e. metro, urban, rural and remote). The model will forecast number, type and location of providers required to provide appropriate health care services on annual basis over five and 10 year projection.
- The Ministry of Health in collaboration with Health Authorities, Colleges, Associations and Unions, Educators, and other stakeholders, will establish a single provincial Health Human Resource Framework that will be used to plan, link and coordinate go-forward actions and initiatives.

- The starting point for consultation will be framework used in this paper subject to modification and development but with an expectation that the consultation will be completed and the framework start to be used in the spring of 2015 for planning, coordinating action and quality assurance.
- The Ministry of Health and the Health Employers Association of BC (HEABC) will complete the development of a new Integrated Health Human Resource Planning (IHHRP) tool to improve the province's HHR planning ability.
- A safe and healthy workplace is a vital requirement for a healthy, engaged and productive healthcare workforce. Healthcare workers are one-and-a-half times more likely than the average Canadian to be off work due to illness or disability (Canadian Healthcare Association, 2013).
- Although a psychologically healthy and safe workplace is a clear priority for enabling a healthy, engaged and productive healthcare workforce, efforts to address this issue have thus far been limited to the local/regional health authority level. British Columbia currently lacks a common approach to creating a psychologically healthy and safe workplace (e.g., collectively adopting the CSA standard).
- The implementation of an HHRM strategy will be an ongoing multi-year process, and the directions set out here are intended as the more immediate actions to be undertaken over the next two fiscal years (2015/16 - 2016/17) to shape and enable implementation of the HHRM strategy over the longer term.

	Residents of BC by Health Status Group and their Use of Selected Health Care Services, 2012/13 $ PER PERSON	People (thousands)		Primary Care General Services	Physician Specialised Medical Services	Physician Surgical Services	Physician Diagnostic Services	Physician Laboratory Services	Publicly Funded Prescription Drugs	Hospital Care (Inpatient and Day Procedures)	Emergency Department (Physician and Hospital Costs)	Supports for Activities of Daily Living	Residential Care including Physician visits and Rx	Share of Selected Publicly Funded Health Care, 2012/13
Staying Healthy	Healthy Non-User	651.6	14%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	0%
	Healthy / Minor Episodic Health Needs	1,617.6	34%	$90	$50	$10	$30	$30	$10	$0	$100	$0	$0	$310	5%
	Maternity and Healthy Newborns	109.6	2%	$250	$1,060	$120	$30	$120	$50	$1,770	$310	$0	$0	$3,710	4%
Getting Healthy	Major or Significant time limited health needs: <18 yrs	43.0	1%	$180	$690	$210	$50	$60	$120	$3,910	$370	$0	$0	$5,580	2%
	Major or Significant time limited health needs: Adults	113.8	2%	$210	$380	$330	$180	$110	$360	$1,760	$300	$0	$0	$3,630	4%
Living with Illness and Chronic Conditions	Mental Health & Substance Use needs	71.4	2%	$230	$1,130	$70	$80	$170	$1,680	$2,990	$500	$0	$0	$6,860	5%
	Population with Cancer	55.2	1%	$510	$990	$410	$350	$240	$510	$5,440	$390	$190	$10	$9,050	5%
	Low Complex Chronic Conditions	1,369.7	29%	$170	$160	$60	$80	$70	$140	$310	$130	$0	$0	$1,130	15%
	Medium Complex Chronic Conditions	404.5	9%	$380	$310	$160	$200	$140	$530	$1,120	$200	$0	$0	$3,030	12%
	High Complex Chronic Conditions without Frail ADL supports	198.4	4%	$640	$630	$260	$290	$230	$1,010	$3,820	$370	$0	$20	$7,280	14%
Towards the End of Life	Frail Population, Living in the Community	16.2	<1%	$1,140	$680	$290	$180	$150	$1,670	$6,500	$570	$8,760	$350	$20,290	3%
	Frail in Community with High Complex Chronic Conditions	21.9	<1%	$1,820	$1,050	$300	$270	$230	$2,090	$12,140	$910	$10,430	$440	$29,690	6%
	Living in the Community with Palliative Needs	16.2	<1%	$2,020	$1,510	$330	$360	$290	$1,630	$17,930	$1,040	$2,120	$3,000	$30,230	5%
	Frail Population, Living in Residential Care	37.7	1%	$680	$780	$130	$90	$170	$290	$10,130	$440	$1,200	$45,290	$59,210	21%
	All Population Segments	4,726.9	100%	$190	$200	$70	$70	$70	$200	$800	$150	$100	$380	$2,210	100%
	Summary from Health System Matrix 5.0, 2012/13.			8%	9%	3%	3%	3%	9%	36%	7%	4%	17%	100%	

- As outlined above, three population segments stand out as using a significant percentage of health services and health dollars: The frail senior population living in residential care; Patients with low, medium or high complex chronic conditions; and Patients with severe mental illness and/or substance use issues. The aging population is a key driver of this projected growth, as the prevalence of chronic conditions increases with age. Ninety one per cent of seniors have at least one or more chronic conditions and three-quarters have two or more.
- British Columbia has the fastest growing senior's population in Canada. The number of seniors in BC is expected to almost double by 2036, and the 75+ population will grow by almost 130 per cent over the same time. While the majority of seniors are comparatively healthy and have few serious health concerns, others within this age cohort are not as fortunate.

- Residential care accounts for the majority of expenditures in this area. Although frail seniors in residential care represent only 1% of the population, they use 21%of all health system expenditures included in the matrix. A large driver of this cost is the provision of 24/7 residential care.
- British Columbia's 303 residential care facilities are home to almost 42,000 residents, with an average age of 85 years. Many of these residents have one of more chronic conditions at varying levels of severity. For example, 61.4 per cent have dementia and 20.2 per cent have diabetes. In addition, 6.7 per cent have cancer while almost one-third have severe cognitive impairment. These seniors require a wide range of health supports to help manage such medical challenges, which are often what precipitated the entry into residential care in the first place.
- It is to say the obvious that most seniors prefer to remain in their homes and communities rather than move to a care facility. When community care provides a viable alternative, patient experience is enhanced. When seniors are admitted to acute care, they can experience prolonged periods of inactivity during which time their level of functional ability is reduced and may never recover. The quality of life is better when an individual is able to be sustained in their home and community.
- The per-person cost of caring for a frail senior through home and community support is less than half the cost of caring for them in residential care (e.g., residential care: $59,210; community: $20,290; community with high chronic condition: $29,690). This is true even though frail seniors in the community have a higher number of emergency department visits than those who live in residential care (i.e., 18 per cent for frail seniors living in the community versus 7.1 per cent for those living in residential care).
- Analysis shows that health care costs, especially hospitalization expenditures, rise in the year before a patient enters residential care; often due to a health concern that precipitates need for this type of care. This same analysis points to the need for community-based, coordinated care that, a) defers, where possible, the need for residential care or, b) when residential care is required, facilitates access in a planned manner rather than through a health crisis requiring an emergency visit and inpatient stay in the hospital.
- In BC, the oldest segment of the population is expected to grow the fastest. As a consequence of the aging of our population, more people are living with advancing, chronic and life-limiting illness and often with multiple, interacting medical and social problems.
- In March 2013, the Provincial End-of-Life Care Action Plan for British Columbia (the Action Plan) was released. The Action Plan is designed to increase individual, community, and health care services' capacity for palliative and end-of-life care services and support people to remain in their homes and communities longer. Three priority actions were identified by the End-of-Life Care Working Group for development and implementation over the short-term.
    - Implement a population needs-based approach to planning palliative and end-of-life care services that identifies individuals earlier who would benefit from a palliative approach and who would receive quality care in the most appropriate settings.
    - Improve the capacity to provide quality end-of-life care in residential care facilities and other housing and care settings
    - Address issues related to the BC Palliative Care Benefits Program

Sources:

Executive Summary: http://www.health.gov.bc.ca/library/publications/year/2015_a/health-human-resources-policy-paper-exec.pdf

Full Report: http://www.health.gov.bc.ca/library/publications/year/2015/health-human-resources-policy-paper.pdf

Rural Health Services Paper: Key Highlights

- In 2015/16, Regional Health Authorities will develop three year local community plans for all rural and remote communities to create environments that foster healthy behaviours and programming that improves the health of the population. These plans will be developed in collaboration with local communities. The plans will be referenced in their Service Plans, be available on the health authority web site, and attached to their Detailed Service and Operational Working Papers.
- The first set of community plans will start 2016/17, be refreshed every three years with updates on progress provided annually. These plans will:
    - Provide health status profiles for individual communities that will be refreshed every three years to assist in planning, targeting efforts and tracking progress.
    - Identify specific areas where they are working with communities, departments across government and other partners as they undertake work to address broad determinants of health, such as education, housing, healthy infrastructure, and food security.
    - Identify specific actions and initiatives to promote healthy behaviours in collaboration with communities to promote and support individual responsibility for health and healthy living.
    - Reference specific actions and initiatives that are being undertaken in collaboration with Aboriginal communities to close health status gaps and efforts to encourage holistic approaches to health and wellness that incorporate traditional Aboriginal healing and wellness practices.
- Regional Health Authorities will implement an integrated, multidisciplinary primary and community care practice in each of the rural and small rural communities (based on population size it is recognized that certain rural communities may need more than one practice) that has:
    - The capacity to address the episodic and longitudinal health care needs of the community/catchment area;
    - The capacity to meet the needs of specialty populations (including maternity care, chronic medical conditions, frailty home support, cancer care, mental illness, substance use, and palliative care);
    - For specialty populations, key service elements consistently applied across communities will include effective attachment and intake to the practice; assessment; case planning; case coordination; and rapid mobilization of services;
    - Services will include primary and community care; and
    - The capacity to respond effectively to 24/7 urgent and emergency care where required for short periods of time with effective linkages to higher levels of services.
- By September 30, 2015, each of the Regional Health Authorities will provide an assessment of the status of primary and community care services across all rural, small rural and remote communities and a specific three year plan on how they intend to move forward with this policy direction as a region. This plan will be referenced in their Service Plans, be available on the health authority web site, and attached to their Detailed Service and Operational Working Papers. It is recognized that this process will take time and engagement.
- The objective is for these services to be fully put in place over a three year period from April 1 2015/16 through September 30, 2017/18 with subsequent continuous improvement and refinement. The Regional Health Authorities will report out on progress against the plan to the Ministry of Health and on their website starting spring 2016.

- Home Support and Residential Care in Rural Communities (Section 2.2): In collaboration with communities and patients, Regional Health Authorities will initiate work on exploring innovative and cost effective service options to better support aging in place but also clarity on residential care options for when they are required to allow active preplanning by older adults and their families. This work will be reported in their Service Plans, be available on the health authority web site and attached to Detailed Service and Operational Working Papers starting 2015/16.
- With an aging population in many rural and remote communities, this service area will present an increasing challenge. Several issues are unique to rural and remote communities, including First Nations communities, that must be addressed as part of an effective rural health services strategy including:
    - Determining what the practical capacity is to provide access to specialized geriatric/ psychogeriatric services and home and community care services in rural, and especially, remote communities and in their absence what are realistic, innovative and flexible local solutions and/or pathways for patients to access services elsewhere.
    - In rural and remote communities that may not have local access to a hospital, assisted living, or a residential care facility what are the practical, innovative and flexible local solutions and/or pathways for patients to access services elsewhere.

Sources:

Executive Summary: http://www.health.gov.bc.ca/library/publications/year/2015_a/rural-health-policy-paper-exec.pdf

Full Report: http://www.health.gov.bc.ca/library/publications/year/2015_a/rural-health-policy-paper-exec.pdf

APPENDIX F: Surgical Services

- The Provincial Surgery Executive Committee (PSEC) has been given the mandate and authority to drive a common vision and a comprehensive policy framework, inclusive of the entire surgical care continuum, that gives priority to improving the quality of surgical services and embed the philosophy of patient centered care into strategic and operational processes. PSEC will facilitate collaborative partnerships between patients, health authorities, physicians, the Ministry of Health, the BC Patient Safety Quality Council, the Doctors of BC and other relevant nursing and allied health stakeholders.
- Fundamental to the success of this work is the need for accurate and timely data and an effective and adequately resourced change management process that engages stakeholders and works effectively with the existing organization and professional cultures.
- The Ministry of Health in collaboration with PSEC and Health Employers of BC (HEABC) will develop and implement a provincial surgical health human resources strategy. The strategy will need to use accurate data, and include the productive capacity of the members of the health care team (not simply raw numbers) by taking into account age, demographics, stages in career, location (urban/rural, etc.), and practice supports. The strategy will examine College regulations and scope of practice as warranted in order to enhance the use of available health human resources (e.g., anesthesia assistant scope and oversight; nurse practitioner scope of practice; registered nurse surgical first assist scope, specialty nurse scope, physician assistants).
- Building on the analysis of the existing funding approaches currently underway (PNBF, ABF, and Pay for Performance) align funding methods to support the policy directions. Over the next two years analyze options where funding follows the patient or where the patient directs the funding.
- Introduce a costing methodology in BC to quantify costs of care along the surgical care continuum. This methodology will inform decision making and support planning for future services.
- A growing number of elective surgeries are now being undertaken when patients are into their 80s. The increasing longevity of the seniors' population is a key driver of surgical repair following hip fracture. The elderly are at a higher risk of fracture from falls due to poorer vision, poorer coordination and reduced strength. As the 85 year old plus age group increases, the demand for hip replacement following fracture will increase, particularly in the female population.
- Aging is strongly linked to an increasing incidence of chronic illness and/or disability. The population living with illness or disability now accounts for over 40 percent of the population and almost 50 percent of all health system expenditures accounted for in the BC Health System Matrix ($5.2 billion). From a health service delivery perspective, the focus for this group is three-fold: to help manage their health conditions as best as possible over time; to help prevent their condition from becoming more severe or complicated; and if possible, to return them to their optimal level of health. This group requires significant, sustained, and coordinated efforts on the part of health service providers to achieve the best possible health outcomes.

Sources:

Executive Summary: http://www.health.gov.bc.ca/library/publications/year/2015_a/surgical-services-policy-paper-exec.pdf

Full Report: http://www.health.gov.bc.ca/library/publications/year/2015/surgical-services-policy-paper.pdf