RESPONSE TO BC MINISTRY OF HEALTH POLICY PAPERS

doctors of bc

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EXECUTIVE SUMMARY

Issues of sustainability of health care systems are complex and not unique to British Columbia. Governments across Canada and around the world are struggling to meet increasing pressures on funding of health care, among other priorities.

The recently released BC Ministry of Health (MoH) Policy Papers reflect a commitment of the MoH to address these issues through a collaborative process. There is a clear opportunity for government, patients, providers, administrators, and other stakeholders to work together to address the financial objectives required, through a collaborative, effective, and lasting process.

Doctors of BC commends the MoH for providing this opportunity to participate in discussions and collaboratively shape the future of the health care system. The key to achieving the goals outlined in the Policy Papers will rest in the process, timelines and participants as proposals move forward to the implementation phase. Doctors of BC believes strongly that, to effect lasting system level change, it must be undertaken collaboratively, incrementally, through application of a continuous quality improvement approach, and supported through positive incentives.

While Doctors of BC recognizes the immediate and longer term fiscal pressures in health care, we strongly believe that change must be undertaken to meet all components of the Triple Aim. In addition to reducing the per capita cost of health care, efforts must also be made to improve the patient and provider experience of care and improve the health of the population. Initiatives outlined in the Policy Papers will clearly require additional funding, particularly in the short term as key models of health care transition from the current to the proposed state. Overemphasis on reduction of system cost as the primary driver behind the initiatives could potentially erode patient and provider support and result in unintended consequences with respect to quality of care. A balanced approach that considers all three elements of the triple aim is essential to successfully meet the financial objectives required.

In this paper, Doctors of BC provides an overview (at Section two) of our response, which reflects extensive physician input on the Policy Papers. Generally, there was considerable physician support for what is proposed in terms of goals and objectives. Improvements in integration of primary and community care, communication among health care providers, supports for target populations, access to specialized services, and supports for physicians and allied health professionals in rural areas are goals that received broad physician support. It was the lack of clarity regarding how the proposals will move forward that raised questions and, in places, concern. These questions and concerns are identified in a summary of our response to each of the three principal Policy Papers, set out in Sections three through five.

A key component of the Doctors of BC Strategic Plan is engaging with government on the development of policies and programs that promote the best standard of health care. It is clear from our consultation with members that they are interested in participating and contributing to effective and lasting change where structures and supports are in place to facilitate such change. Physicians are committed to providing the best patient care possible and advocating on behalf of patients and their families. Doctors of BC looks forward to further discussions as specific actions are developed.

1 INTRODUCTION

In February 2014, the MoH released *Setting Priorities for the BC Health System*, outlining the strategic and operational priorities for the delivery of health services across the province. One year later, in February 2015, the MoH released a suite of cross-sector policy discussion papers (the Policy Papers) that build upon its earlier strategic document. The principal Policy Papers are:

- *Delivering a Patient Centred, High Performing and Sustainable Health System in BC: A Call to Build Consensus and Take Action*
- *Primary and Community Care in BC: A Strategic Policy Framework* (the Primary and Community Care Policy Paper)
- *Future Directions for Surgical Services in British Columbia* (the Surgical Policy Paper)
- *Rural Health Services in BC: A Policy Framework to Provide a System of Quality Care* (the Rural Policy Paper)

In addition, the MoH released the following two enabling papers:

- *The British Columbia Patient-Centred Care Framework*
- *Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Human Resources*

Doctors of BC understands that the MoH intends to release two further enabling policy papers relating to information management/information technology (IM/IT) and funding mechanisms.

In this paper, Doctors of BC provides feedback on proposals contained in the Policy Papers, specifically commenting on those that address the primary and community care system, surgical services, and rural health care. Where issues of health human resources and patient centered care emerge in those papers, they are discussed. The enabling papers themselves were not consulted nor commented on.

The following section describes the member consultation process that Doctors of BC undertook in relation to the Policy Papers. Section two provides an overview of key issues raised by our members in relation to the Policy Papers generally, while Sections four through six provide more detailed input on the Primary and Community Care, Surgical, and Rural Policy Papers respectively.

For the purpose of consultation with our members, Doctors of BC re-organized the key proposals based on the objectives of the proposals, rather than use the ‘practice level, organizational level, and provincial level’ categories set out in the Policy Papers. This approach is also taken in responding to the Policy Papers in Sections three, four and five below.

1.1 CONSULTATION PROCESS

Following the MoH’s release of the Policy Papers, Doctors of BC undertook an immediate and thorough review of the papers to obtain input from our members. To facilitate feedback, enable meaningful engagement, and invite input on the proposals, an online consultation survey was developed. The survey was posted on the Doctors of BC website and members were invited to comment during the month of March. In addition to the online consultation, Doctors of BC held in-person meetings with various committees and physician Sections.

Doctors of BC received considerable input from our members during the brief one month consultation period, indicating their interest in contributing to the conversation on the future of health care. The degree of input and thoroughness of response illustrates physician appreciation for the issues of quality improvement and sustainability of the health care system and their interest in being part of the solution.

2 RESPONSE OVERVIEW

Physicians appreciate the opportunity to participate in necessary health care system change and the MoH's collaborative approach in sharing the documents for comment. Doctors of BC also appreciates the acknowledgement that the Policy Papers reflect proposed actions and that, over the coming months, further discussion of the proposals will allow meaningful input into what the specific actions should be.

The MoH identified a number of goals, including improved integration of primary and community care, improved communication among health care providers, increased supports for target populations, improved access to specialized services, and strengthening of supports for physicians and allied health professionals in rural areas. Doctors of BC supports these goals and acknowledges the MoH for its work to identify and prioritize these issues.

However, there remain some significant concerns and questions. Physicians noted that the Policy Papers do not outline how implementation of the proposals will occur. The papers also did not indicate the extent to which physicians will participate in implementation or when and how evaluation will occur. What structures will be in place to support the proposals? Who will drive this change? How will physicians be able to effectively participate in the design of the initiatives?

What the MoH proposes to achieve, at a high level, generally received considerable physician support, but details (or lack of details) on *how* the proposals will move forward raised questions and, in places, concern. For example, issues related to funding of the proposals, supporting structures and, where applicable, compensation mechanisms will require further consideration and development.

The timelines contemplated in the papers were widely viewed as unrealistic. This also raised doubt as to whether real, informed consensus building or consultation could occur within the timelines provided. Given that further collaboration on implementation steps will require time to be effectively completed, the timelines were seen to imply that such collaboration may not be forthcoming.

We recognize that the two enabling papers related to funding models and IM/IT are yet to be released. Without the benefit of understanding the MoH's intention of how the proposals would be supported by appropriate funding and IM/IT models, there is insufficient detail on these important aspects to comment in a robust manner. Doctors of BC feels strongly that all enabling papers should have been released in parallel with the key strategic papers. Physician comment and feedback outlined in this document is subject to further consideration and revision based on the content of the IM/IT and funding papers.

A significant and overarching area of concern is that the Policy Papers impose unrealistic expectations on existing structures such as the Leadership Council, Regional Health Authorities

(HAs), the Provincial Surgery Executive Committee (PSEC), and Divisions of Family Practice to effect the changes contemplated. Questions were raised as to whether these structures would be provided additional supports to complete the new work and whether the skills, resources, and collaborative orientation currently exist to undertake immediate and large scale coordinated system change. These concerns arose most in relation to the references throughout the Policy Papers to increased oversight, involvement, influence, and control of the HAs. While Doctors of BC recognizes that the HAs are now embarking on collaborative processes, it is questionable whether there has been adequate time for relationships and trust to develop.

A number of the proposals contemplate increased accountability of physicians to HAs. While HA oversight of health care delivery is appropriate and necessary in many respects, certain proposals were seen to pose a significant threat to the professional autonomy of physicians, both administratively and clinically, and to the collaborative innovation that is currently occurring in primary care. For example, the potential erosion of the leadership role that physicians play in team-based care decisions could impact the ability of physicians to advocate on behalf of their patients and therefore have significant ramifications for patient care. Given physician liability for patient outcomes, these aspects of the proposals raised significant concern. It should be added that physician objection to these aspects of the proposals was reasonably balanced with recognition that the physician leadership role must also include responsibility to facilitate the effectiveness of health care teams.

In the Sections that follow, input is provided on each of the Primary and Community Care, Surgical Services and Rural Health Services papers in turn. Where there are areas of overlap between the Policy Papers, input is generally provided once, in connection with the proposals most significant to physicians.

3 PRIMARY AND COMMUNITY CARE

The Primary and Community Care Policy Paper is premised on the MoH's view that, over the coming two years, the health sector needs to make substantive and measurable progress to significantly reduce demand on emergency departments, medical in-patient bed utilization, and residential care. The MoH considers that improving the effectiveness of primary and community care is key to achieving this goal.

Doctors of BC generally agrees that the strategy for reducing hospitalizations should be to improve primary and community based services. However, some concerns were raised that the paper may overestimate the impact the primary and community care initiatives may have. It was felt that considerable additional investment in non-acute beds in the community would be required to make significant improvements to hospital capacity.

It was also noted that hospital capacity could be improved by increased home visitation, more investment in advance care planning and palliative care, and improved patient education on appropriate use of health care system resources. Enhancements to the level of care provided in residential care/assisted living facilities could also help reduce transfers to an acute setting.

Before addressing specific proposals in the Primary and Community Care paper, we highlight one area of significant concern. To implement changes proposed, the MoH contemplates that the General Practice Services Committee (GPSC) could evolve into a multidisciplinary primary and community care committee to take a strategic leadership role in moving forward with the

primary and community care strategy. The proposal further suggests that this may involve including representatives of community health services on the GPSC.

While it is recognized that significant change to the GPSC's mandate would require amendment to the Physician Master Agreement, Doctors of BC is concerned that this strategy for implementation reflects a lack of appreciation of the important role of the GPSC within the profession. The GPSC is supported primarily by funding negotiated for GPs and is intended to provide a voice for general practitioners in the province. The proposal could potentially dilute the physician voice, undermining the significant efforts made by the MoH, physicians and HAs to provide an effective GP forum.

This proposed evolution of the GPSC is a good example of physician support for *what* the MoH would like to achieve, namely improved communication and collaboration among physicians and allied health professionals, but concern about *how* this will occur.

3.1 New Model of Primary and Community Care

The following sections provide Doctors of BC's feedback on a number of specific proposals set out in the Primary and Community Care Policy paper. Section 3.1 addresses a number of proposals that Doctors of BC believes would result in a new model of primary and community care.

3.1.1 Team-Based Family Practices

The MoH proposes working with the GPSC to develop a plan and support for establishment of multi-disciplinary, team-based family practices as full service sole practitioners retire. This is intended to develop family practices based on population and patient needs, rather than "relying on individuals or groups of physicians randomly establishing practices". The MoH notes that the objective will be to incrementally attach individuals/families to a team practice rather than an individual practitioner, while supporting the practice of most responsible family physician. Consideration could be given to compensation models that include salaried, contractual, and population need-based approaches.

While there is general support for team-based family practices, members strongly emphasized the importance of a longitudinal relationship and that patients prefer attachment to an individual family physician who is supported by a multidisciplinary team. This is supported in literature on the benefits of continuity in primary care.[1] Considerable concern was expressed that attachment to a team/practice would not be effective and would not serve patients well. To the extent that patient attachment to a team/practice is promoted, it is imperative that the following principles of enhanced primary care be upheld:

- Quality patient-centred care based on a strong physician-patient relationship.
- Continuity of care over time.
- Comprehensive care for most health needs.
- Coordination of care when it must be sought elsewhere.

There is also reference in the Primary and Community Care Policy Paper to an assessment and review of the 'A GP for Me' initiative. This would include a review of options to expand the definition of 'patient attachment', taking into account the type of attachment required by different

[1] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457–502.

sub-populations. While there is no objection to a review of this initiative, our members are generally of the view that the goal should continue to be attachment of patients to individual physicians.

Doctors of BC is encouraged by the reference in the paper to the most responsible practitioner (MRP) under a team-based model being the family physician/GP. It is appropriate that the primary care provider who has the broadest scope, skill set, and training take on the leadership role in terms of patient care, and in the large majority of cases this will be the GP. This is consistent with the statement in BC's *Primary Health Care Charter*, that the family physician is the cornerstone of primary health care. In addition to taking on the role of MRP, family physicians should have the opportunity to be involved in the recruitment of allied health practitioners to these practices. This will support creation of effective teams.

A number of our members were concerned that this would be implemented province wide as a "one-size fits all" solution. Doctors of BC considers physicians should have the ability to practice under a variety of models, including solo-practice. The practice model itself does not determine quality or patient-centredness of care and, in many cases, supported solo-practices may be the best alternative. If this proposal is implemented, it is imperative that the shift towards team-based practice be undertaken collaboratively with physicians, in an incremental and measured manner and supported by incentivized rather than prescriptive approaches. It is important that, as we move forward, lessons are learned from experiences with similar clinics in Ontario and closure of a number of community clinics in Vancouver.

Finally, Doctors of BC considers that there needs to be real and sustained investment in Electronic Medical Records (EMRs) and information technology in order for a team-based model of care to be successful. The objective of this should be to allow for sharing of information in a meaningful and practical way between physicians and allied health providers. There is reference to the need to strengthen information technology in the Primary and Community Care Policy Paper, but we look forward to seeing the details set out in the MoH's yet to be released IM/IT discussion paper.

3.1.2 Linked Community and Residential Care Practices

Doctors of BC supports the MoH's conclusion that the current primary and community care system is not optimally designed to address the needs of an aging population with increased chronic disease or patients with moderate to severe mental illness and/or substance use issues. To address the needs of these target populations, the MoH proposes to develop a framework to support linked community and residential care services in urban and metro centres. This would involve:

- development of multidisciplinary practices to provide 24/7 compassionate care, including outreach services,
- linking these practices to assisted living/residential care/hospital services, and
- provision of direct specialist support to the primary and community care teams.

The proposal contemplates that HAs, in collaboration with the Divisions of Family Practice, would create the enabling structures and processes for these linked community and residential care practices.

Doctors of BC has previously developed a policy statement and paper in support of efforts to enhance multidisciplinary primary and community care in BC. Accordingly, there is strong support for the MoH's focus on provision of care by multidisciplinary teams, as well as specialized teams, to meet the needs of vulnerable target populations.

However, our members do have concerns with the MoH's proposed model. Of most concern was the suggestion that patients may be transferred from the care of their current physician to the care of a specialized multidisciplinary care clinic. Physicians have significant concern that this proposal would undermine existing longitudinal relationships and contribute to fragmentation of care. Also, if the intention is to build new standalone clinics, this will be costly and it is not clear that there is a need for this. Instead, it may be more effective to develop mobile 'wrap around' multidisciplinary care teams with expertise in chronic conditions and/or mental health and substance use issues. These mobile teams could have a footprint in, and provide support to, a number of existing physician practices. This would allow patients who have a longitudinal relationship with a family physician to continue that relationship. Patients who are not attached to a physician and/or who have little contact with the health care system would likely need to be supported through the outreach and home support components of the MoH's proposal.

With respect to the proposed involvement of the Divisions of Family Practice in helping to establish these practices, it is important that the MoH recognize that the Divisions are at varying stages of readiness and capacity to expand their scope. There is potential for the Divisions to play a bigger role in managing local health care needs, but the structure and support mechanisms would need to evolve to allow this. There are also some concerns that the Divisions would become service delivery organizations rather than continuing as the autonomous organizations that they currently are. The Divisions and the GPSC would obviously need to be involved in any conversation about a potential change to their role within the primary and community care system.

3.1.3 Walk-in Clinics and Urgent Care Centres

The MoH considers that walk-in clinics are inadequate for providing continuity of care for major or time limited health needs and are unsuitable for patients living with chronic conditions or for providing end-of-life care. The MoH therefore proposes to review policy and regulatory options regarding the role of walk-in clinics. This would include a Medical Services Commission review of compensation levels and the fee-for-service (FFS) requirements for this level of health service.

In addition, the MoH proposes a review of policy and regulatory options to create 24 hour Urgent Care Centres for treatment of injuries or illnesses that require immediate care but are not life-threatening or serious enough to require an emergency room visit.

To the extent that a review of walk-in clinics is aimed at supporting the highest level of primary care, Doctors of BC is supportive of such a review. However, any review of policy and regulatory options regarding walk-in clinics must recognize that there is a range of walk-in clinic models within the province, making them difficult to define. This includes stand-alone clinics, blended full-service family practice and walk-in models, and advanced access within full-service family practice. The number and scope of clinics differs from community to community, with some clinics operating like an Urgent Care Centre while others provide after-hours access to

GPs within the community. Given that walk-in clinics provide primary care services for the many patients who do not have a GP, any regulatory changes will need to be carefully considered so as to avoid inadvertent consequences for patient access to primary care and/or increased pressure on emergency departments. It will also be important to develop a transition plan for any changes to the walk-in clinic model.

In reviewing whether there is a need to develop new policy and/or regulations for walk-in clinics, it will be important to consider this practice model in the context of the entire primary and community care system. We note that significant work has already been undertaken through the GPSC to create incentives for full-service family practice and more time may be needed to recognize their full benefit. Doctors of BC considers that if the right incentives are put in place for GPs to work in team-based full-service family practices there should be less of a role for walk-in clinics, particularly if after-hours care is offered via call-groups or another mechanism.

Doctors of BC encourages the MoH to further develop its new model of primary and community care before reviewing compensation levels and the fee for service requirements for walk-in clinics. This should be done collaboratively, including physician representation, with the goal of developing the appropriate support and incentives to ensure the success of the new model of care.

Once extensive consideration and development has occurred with respect to the new model of care, if the MoH wishes to pursue a review of compensation models and fee for service requirements, it is not appropriate for this to be undertaken by the Medical Services Commission. Rather, the review should be conducted by government and follow the process outlined in the current Physician Master Agreement.

Members expressed concern that Urgent Care Centres will be an expensive model and have questioned the need for 24/7 facility-based urgent care outside of emergency departments. In many situations, the cause of emergency room overcrowding is not low acuity patients (i.e. those who would use an Urgent Care Centre). Rather, it is the inability to efficiently admit patients on to a hospital ward.

As with walk-in clinics, the development of more team-based practices and linked community and residential care practices may reduce the need for Urgent Care Centres. If this model is pursued, physicians should be consulted to ensure that services align with and do not overlap with the primary care services already available. It has also been noted by our members that patient education to assist with judgement as to whether urgent care is required would be a necessary component to development of a model of Urgent Care Centres.

3.1.4 In-Patient Care in Metro and Urban Areas

The MoH states that there is a need to consider the practicality of physicians working in hospitals in metro and urban communities, especially under the individual practice model that continues to dominate practice. It is therefore proposing to assess and review in-patient care in these communities, giving consideration to the integrated community-hospital approach of rural physicians as a potential model. This review will consider the accountabilities of specialists for their patients as well as an expanded role for Registered Nurses and Nurse Practitioners in caring for and discharging patients.

While Doctors of BC supports this review of in-patient care, our members are of the view that hospitalists are well equipped to address the increasingly complex care needs of hospitalized patients in large metro and urban areas. In non-metropolitan urban, rural, and remote communities, other models of in-patient care may be more appropriate. Also, it is important to note that HAs manage bed utilization by the minute, not by the hour or day, which can only realistically be achieved by on-site management of these patients, as opposed to GPs visiting the hospital at set times during the day. In larger hospitals, moving to a community model that involves GPs supporting hospital patients will likely lead to a longer discharge process, and may have unintended consequences in terms of non-hospitalized patients' access to their GP.

Although Registered Nurses and Nurse Practitioners can be very effective in managing patients within well-defined areas, Doctors of BC does not consider that they are a suitable substitute for hospitalists who can deal with a wide range of complex issues. However, they may be very effective as part of multidisciplinary teams as evidenced in current practice in several facilities.

Doctors of BC considers that the main issues that should be addressed as part of the review of in-patient care are communication between hospitals and GPs and consistency of care from within the hospital team. There is a need to create and value a strong relationship between the hospital team and community physicians.

3.2 Services for Key Populations

The MoH has proposed the following actions related to provision of services for specific key populations:

- **Mental Health/Substance Use Services:** Review policy and regulatory options to create a more coherent system, monitor and evaluate existing services, and clarify the roles and functions of the Provincial Health Services Authority.

- **Maternity Care:** Assess and review maternity care to make recommendations on the pros and cons of establishing birthing centres in BC.

- **End-of-Life Care:** Continue to implement the End-of-Life Care Action Plan, including adoption of a palliative approach to care across the health continuum.

- **Dementia Care:** Implement the refreshed Dementia Action Plan, ensuring all care settings focus on specific needs of people with dementia and their caregivers, and develop care pathways.

Doctors of BC agrees that these four populations require special attention and is therefore pleased to see there will be a continued effort on the part of the MoH to address some of the issues faced by these populations. However, our members also noted that the Primary and Community Care Policy Paper pays little attention to the health care needs of children and youth, even though this is a population that could also benefit from improved services. Also, while recognizing the MoH focus on older adults with chronic conditions, end-of-life care, and dementia care, it has also been suggested that a broader seniors' health strategy should be developed.

In addition to these specific proposals, Doctors of BC considers that the proposed improvements to team-based care and community services under the new model of care will go

a long way towards supporting these populations. Accessibility, consistency, and integration of services for these populations will be crucial, particularly for mental health/substance use and dementia patients, and those patients requiring end-of-life care.

The proposal relating to birthing centres generated considerable feedback during our member consultation. In particular, it was noted that the paper only refers to consultation with obstetricians, gynecologists, and midwives in relation to this proposal. Any consultation must also involve GPs and pediatricians, and the review must identify the objective of creating birthing centres as this is not clear in the paper. Some members raised concerns that creation of birthing centres would result in fragmentation of care, and most members consider that these will need to be located in or very close to a hospital so that emergency care is easily accessible.

4 SURGICAL SERVICES

The following section provides a response to the MoH's Surgical Policy Paper. Relevant to this topic, Doctors of BC acknowledges that the MoH has identified the need for better collaboration within health care facilities, has invested capital to develop structures to improve collaboration, and has met with some early successes. Development of these structures will require physician participation in meaningful change to address the issues identified by the MoH in the Surgical Policy Paper.

4.1 Timely Access

The following proposals relate to the MoH's objective to increase timely access to surgery, eliminate backlogs, and mitigate over-capacity pressure.

4.1.1 Waitlist Management

With an aim to increase timely access to surgery, the MoH proposes to:

- determine goals for wait time performance that will be achieved within 5 years,
- introduce a standardized approach to management of surgical patient waitlists by 2016,
- adopt standardized waitlist definitions and processes across all HAs
    - Wait Time One (GP to Surgical Consult),
    - Wait Time Two (Access to Diagnostics),
    - Wait Time Three (Surgical Consult to Surgery Completed), and
    - Wait Time Four (Recovery),
- complete reviews of diagnostic codes in 2015 and audit procedure codes in 2016, and
- use prioritization code information to determine the most appropriate locations for consolidation of specialized services.

Doctors of BC supports the MoH's goals of increasing timely access to surgery and elimination of backlogs and generally sees the emphasis on transparency and standardization as positive. However, our members strongly emphasized that wait times are dependent on numerous variables, requiring careful consideration of the data used to manage surgical waitlists. There are significant issues of variability in prioritization and access that aren't reflected in simple waitlist data.

Direct comparison of surgical waitlists is impractical when there is significant variability across HAs and facilities in access to diagnostics, OR time, and health care provider resources. Politics

and front page news stories too often strongly influence resource allocation and, therefore, waitlists for certain populations.

Doctors of BC believes it is questionable whether real-time accurate data are truly achievable. Despite significant dedication of time and resources, many physicians note that they have had to accept a certain degree of inaccuracy in their waitlist data. Perhaps it is best to recognize these inaccuracies and use waitlist data as a trending tool for resource allocation, rather than as a comparator of physicians or service delivery.

Additional points raised by our members related to:

- concerns that patient care could be impacted if management of waitlists directs physician time to additional administrative tasks and away from treatment of patients,
- questions regarding the administrative capacity of the HAs to adequately manage waitlists,
- the need to ensure that the waitlist definitions and processes align with reporting outside BC to ensure consistency and appropriate transparency across all jurisdictions,
- as with other proposals in the Surgical Paper, a sense that the waitlist management initiatives were not necessarily novel and the real issue is whether there is sufficient will and determination to implement and follow through on these proposals,
- the need for an overarching coordinated provincial strategy, which includes facilitation of IM/IT aspects of waitlist management, and
- concern regarding oversimplification and over use of protocols in waitlist management, failing to recognize variability in access and prioritization.

Doctors of BC is interested in contributing to solutions to increase timely access to surgery, but stresses the importance of undertaking change collaboratively and incrementally and ensuring that appropriate infrastructure and supports are in place to make the necessary changes.

4.1.2 Alternative Practice Models

With the goal of increasing timely access to surgical services, the MoH seeks to encourage, support and implement alternative practice models through facilitation of team-based practices (co-located or virtual) and surgeons working in partnership with multidisciplinary teams. In connection with this, the MoH proposes implementing alternative funding approaches for physician services. The MoH further proposes introducing pooled referrals, central intake for referrals, and first available surgeon models in HAs.

As noted in response to the Primary and Community Care Policy Paper, Doctors of BC supports the notion of involving all health care providers, including surgeons, more effectively and facilitating as seamless a patient journey as possible. However, Doctors of BC recognizes practical barriers that are fundamental to surgeons and multidisciplinary teams working in effective partnerships, such as gaps in communication and consistency of language that will need to be addressed.

Examples, such as Rebalance^{MD}, illustrate the potential of team-based practices, colocation of surgeons working in partnership with multidisciplinary teams to collaborate and improve patient and provider experience of care, and pooled referrals. It is important to note that Rebalance^{MD} was created by health care professionals who sought solutions on how to bring together physicians and allied health professionals to simplify the patient experience and provide more efficient and effective musculoskeletal care in their community. Creation of and participation in

such team-based models should be facilitated, enabled and incentivized, not mandated, by facilities, HAs, and the MoH. Requiring physicians to participate in such models would not likely meet with the success that provider-developed models such as Rebalance^{MD} have achieved.

With respect to the MoH's proposal as it relates to pooling of referrals, Doctors of BC believes pooled referrals make sense in most cases in terms of efficiency, patient satisfaction and consistency of the patient journey. However, they may be most appropriate for conditions with little practice and outcome variation. For example, BC Children's hospital has successfully implemented pooled referral practices for hernia operations in children as they are generally straightforward procedures with very little practice and outcome variation. Similarly, obstetrical practices used to operate on a single provider model, but what is essentially a group practice/pooled referral model has become almost universally accepted.

It is clear that pooled resourcing/referrals has worked successfully when appropriate situations are identified and undertaken by physicians and other health care providers. Doctors of BC has significant questions and concerns as to how similar models would be created, funded, and sustained by HAs as contemplated by the MoH proposal. It is important that physician and patient/family choice be respected and that patients and physicians be included in further consideration of this proposal. Unintended consequences, such as increased travel requirements and negative impact on patient and physician autonomy must be central to the consideration of pooled referrals.

4.1.3 Surgical Infrastructure

To optimize existing surgical infrastructure, the MoH proposes using third-party facilities to offer day procedures, moving appropriate surgical procedures from the operating room to procedure rooms, from inpatient care to day care/short stay care, and to private surgical centres using public funds.

While supportive of efficient and safe use of private facilities for medically necessary publicly funded procedures, Doctors of BC's members emphasized that we can and should make better use of existing surgical infrastructure. Operating rooms are currently underutilized due to staff or operational funding shortages, surgeons are underemployed, and waitlists are getting longer. Surgical infrastructure and resources need to be closely examined and efforts made to support effective and efficient use of surgical facilities.

Current inadequacy of inpatient resources, as evidenced by overflow of medical patients into surgical wards, needs to be addressed and operational efficiencies identified. Surgical suites sit unused throughout the day and night and it is possible that currently underemployed surgeons would be willing to work evenings and/or weekends to facilitate timely access to surgical services.

It is also important to ensure that use of private facilities or centralization of services doesn't destabilize hospitals. Simply taking the "easy" procedures out of hospitals could prove detrimental to the current balance of procedures in hospital settings.

Centralization of surgical services and use of third-party facilities must also consider the impact on patients in rural and remote locations. Thought must be given to the time required for rural patients to travel to centralized and/or third-party facilities and to who will provide aftercare when they return to their rural or remote home.

4.2 Quality of Surgical Services: Monitoring and Reporting

With the goal of improving quality monitoring and reporting, the MoH proposes developing and implementing a comprehensive performance measurement, reporting and accountability framework for surgical services. This would include defining the optimal state of quality performance for surgical services, establishing public reporting, monitoring, and impact/outcome assessment mechanisms, introducing the National Surgical Quality Improvement Program (NSQIP) to all hospitals in BC, and providing provincial level reports to the Provincial Surgery Executive Committee (PSEC).

Doctors of BC supports continuous quality improvement initiatives that foster non-punitive quality improvement through education and access to appropriate, relevant, timely information. Such initiatives are most successful when they are driven by the health care providers who provide the input data and benefit most from access to the information for quality improvement purposes.

Doctors of BC recognizes that individual peer to peer comparison can provide tremendous benefit in a continuous quality improvement approach. But, if the data are used individually for summative, punitive, quality assurance processes, it is counterproductive and harmful to health care providers and their patients.

Doctors of BC warns that any public reporting component should be carefully considered and involve meaningful provider and patient input. Public reporting that seeks to rank or identify poor performance and provide punitive consequences for poor performance is associated with considerable risk. Unintended consequences, such as diminished physician and/or facility interest in taking on complex surgical procedures at risk of damage to reputation, may result. Poor data interpretation or misuse of data can have long-lasting damaging results. Anonymity and aggregation of data can serve to protect individual physicians and/or facilities from detrimental consequences of unfavourable rankings, reports or indicators. Data need not be so anonymized and aggregated as to prove useless, but it is important to recognize the potential unintended consequences of public reporting of data.

Doctors of BC recognizes the benefit to patients and physicians of including patient voices and perspectives in assessment of quality surgical services. Adding patient representation on health care committees such as PSEC is beneficial to increased understanding of patient experience. However, it is important to ensure that patient experience is one factor, among many others, that receives consideration when measuring quality of health care.

It is also important that measurement activities are simple, logical, and provider-driven. If the purpose of the data generation is quality improvement, the data generated must be relevant and provided back to those who can effect change on the ground and who have the ability to improve quality in their day-to-day activities. The measurement activities must not be so complex, and time consuming that they are undertaken at the expense of quality patient care and the results so remote and abstract as to be meaningless to the providers who generated the data in the first place.

In terms of measurement of quality, Doctors of BC also notes that not everything can be measured. Some of the most important aspects of quality care, such as decisions based on multiple factors and combined application of art and skill, cannot be measured. A decision about whether to undertake a surgery is complex and crucial to patient experience of care, but it

cannot be easily measured, illustrating the various immeasurable components of quality health care.

Lastly, the impact of health human resources on quality of surgical services can't be understated. For example, while orthopedic surgeons are said to be in oversupply, that is only true in terms of access to facilities and operating room time. In terms of patient volume, orthopedic surgeons are actually in tremendous undersupply. Issues of quality require attention be focused on thorough, long term hiring processes to avoid reactionary hiring processes that negatively impact quality. A provincial perspective on hiring in terms of development of appropriate processes and infrastructure should be developed and prioritized.

4.3 Patient-Centred Approach to Care

The MoH has identified that patients need more understandable and accessible information about their condition, options, their status, and the steps to optimal recovery. To this end, the MoH proposes implementation of a "patient and family centred approach to care", which involves:

- Requiring fully informed patient consent based on comprehensive, plain language material along with fulsome discussion between patient (and family as appropriate), family physician, and the surgical specialist,
- Developing informational material to cover benefits, risks, limitations, pre-op preparation, post-op recovery, and expected timelines,
- Developing standardized care pathways and evidence-based timelines (including all the steps in the process) for specific surgical patient groupings linked to high volume routine surgical procedures, and complex high resource surgical procedures. The pathways will address patients living in a variety of geographic settings,
- Increasing plain language information available on hospital and surgeon performance quality indicators,
- Developing an easily accessible mechanism for patients to provide feedback during their care journey,
- Introducing provincial, standardized patient satisfaction surveys and follow-up calls from nursing/allied health staff to patients after surgery,
- Inviting patient advisors/representatives to join senior level Surgery Committees and Surgery Quality Councils in each HA, and
- Implementing practice guidelines for consulting with patients on treatment options.

Doctors of BC questions why issues of improved communication with patients are emphasized so strongly in the Surgical Policy Paper as compared to the other Policy Papers. Our members agreed that patient communication could be improved, but that such improvements are required by all participants in health care delivery and throughout all aspects of care. Where improvements could be made in the surgical context, responsibility does not rest solely with surgeons.

While noting that the number of variables involved makes it difficult to develop standardized information and guidelines along patient care pathways, there is an interest among physicians

to identify those areas where the family physician, patient, family, allied health practitioners, facility, and HA can be better engaged and coordinated along the surgical journey.

It is important to humanize the process and consider the needs and wants of each patient. Increased health literacy is about patients receiving and understanding information in their own language, in a culturally appropriate way, and at a level at which they can act on it appropriately. While our members do a good job at surgery-specific informed consent, there are opportunities for improved patient-centred care during the pre-operative preparation and post-operative recovery time. It is necessary to identify the appropriate health care provider who is best placed to provide process specific information at each phase.

While this suite of the MoH's proposals focus on patient experience of care and Doctors of BC supports of efforts to make the patient's journey more informed and understandable, it is important to consider impacts, both intended and unintended, on provider experience and the per capita cost of health care. For example, if efforts to improve patient experience do not consider the potential administrative and clinical burden on providers and associated increases in costs, health system performance may be negatively impacted. Overly complex processes can divert physician and other provider resources away from patient care and, despite limited resources, reallocate money from the provision of good care to the provision of information.

5 RURAL HEALTH SERVICES

The following section provides a response to the Rural Policy Paper. While Doctors of BC is supportive of the proposals put forward, we are only able to provide qualified support for the general principles that have been described, given that the detail of many of these proposals is yet to be determined. Relevant to all the Policy Papers, it will be necessary for the MoH to undertake a cost-benefit analysis of these proposals before proceeding with implementation.

5.1 Access to Quality Primary and Community Care

5.1.1 Integrated Multidisciplinary Practices

With the goal of improving continuity and comprehensiveness of care, the MoH proposes that HAs implement integrated multidisciplinary primary and community care practices across rural and remote communities. The MoH's proposal notes a preference for co-location of all team members, with physicians being fully incorporated into the team, with some scope for teams to be virtually linked.

Doctors of BC considers flexibility is extremely important in the context of creating integrated multidisciplinary teams, given that co-location of allied health professionals may not be economically or practically viable, particularly in the most remote communities. Every community is unique in terms of demographics, population health needs and health human resources and this uniqueness is particularly pronounced in rural and remote locations. Therefore, we would advise against a standardized approach to implementation of these types of practices in favour of a flexible, incentivized approach.

As noted in our response to the Primary and Community Care Policy Paper, Doctors of BC supports efforts to enhance multidisciplinary primary and community care in BC. This is needed in order to meet the challenges of the increasing prevalence of chronic disease, the growing needs of an aging population, and the ongoing concerns of patient access to primary care. We

therefore support, in principle, the MoH's proposal to develop integrated multidisciplinary practices in rural and remote communities.

As with a number of these proposals, however, that level of support is dependent on yet to be determined details, including how these clinics will be funded and managed. We note that in order to support these practice models the MoH intends to collaborate with HAs, Doctors of BC, and other stakeholders to develop and implement funding and compensation mechanisms, and review and optimize scope of practice, skill mix, and skill flexibility. Doctors of BC looks forward to participating further in these discussions.

Our members' main concern with this proposal relates to the potential loss of physician autonomy, which will be dependent on the level of HA involvement in these practices. Doctors of BC considers it is crucial that physicians maintain clinical autonomy so that they can continue to advocate for the best care for their patients. The MoH has stated that the organizational model can be HA operated, provider-led by contract, or delivery through establishing a not-for-profit agency. While every rural community will be different, there is likely to be a preference for provider-led models.

As noted earlier in connection with the Primary and Community Care Paper, a number of our members have raised concerns regarding the economic viability of this practice model, particularly in rural areas and in light of the recent experience with similar clinics in Ontario and closure of a number of community clinics in Vancouver.

This proposal envisages that telemedicine services may be used to support this practice model. As such, we refer the MoH to our recently released policy statement on *Telemedicine in Primary Care*[2]. It is important to note that such technology can be used to enhance patient-health care provider relationships in both rural and urban health care settings.

5.1.2 Health Promotion and Disease Prevention

The MoH proposes that regional HAs develop three-year local community plans on health promotion and disease prevention for all rural and remote communities. The stated purpose is to create environments that foster healthy behaviours and programming that improves the health of the population.

Doctors of BC supports health promotion and programming targeted at improvements in population health. However, it is imperative that the plans be community driven and collaboratively developed with meaningful input from physicians, allied health professionals, and community leaders. Communities will need to take ownership of these plans, with support from HAs, in order for them to be successful. Also, if these plans are truly intended to address issues related to social determinants of health, this will require significant funding and resources which may not be realistic in all communities.

Aside from a collaborative role in the development of the plans, it is unclear whether the MoH proposes an increased role for physicians in terms of health promotion and disease prevention in rural communities. If this is the case, there may need to be consideration of alternative remuneration models for physicians currently compensated under a fee-for-service model.

[2] Doctors of BC, *Policy Statement: Telemedicine in Primary Care*, December 2014. https://www.doctorsofbc.ca/sites/default/files/final-telemedicine-in-primary-care-policy-statement.pdf

Consideration could be given to expansion of the Lifetime Prevention Schedule to cover a wider range of health counseling activities.

5.2 Ensuring Pathways to Specialized Services

5.2.1 Formal Regional Networks of Specialized Teams

The MoH has identified the need to increase primary and community care access to specialist consultation and support in rural and remote areas. In support of this goal, the MoH proposes that HAs, in collaboration with the Provincial Health Services Authority, establish formal regional networks of specialized teams (and a provincial network as appropriate) that can be accessed by primary and community care practices in rural and remote communities. Specialists would be available via telephone, telepresence and/or in-person visits.

Doctors of BC supports increased connection to specialists for rural physicians but notes that, in order for these networks to be successful, there will need to be either real-time or rapid access to specialists. The RACE (Rapid Access to Consultative Expertise) line is a good example of how a model like this can work in practice and it may make sense for this to be used as a starting point. Additionally, rural physicians and patients would benefit most if these networks facilitate relationships with specialists to whom GPs can actually refer their patients.

5.2.2 Information on Rural Hospitals

The MoH proposes that HAs publish information on their websites about the range of hospitals available by region, the level of care provided at those hospitals, access pathways linked to primary and community care practices, and quality indicators. The purpose of publishing this information is to provide rural residents with confidence that they will have sensible access to quality emergency services whether provided in a traditional hospital setting or in the community.

While Doctors of BC supports increased transparency and information for patients in rural and urban areas, our members raised a number of concerns with this proposal. These concerns largely relate to the routine reporting of quality indicators on hospitals. Due to low volumes in rural hospitals, quantitative data will not always be a fair indicator of the quality of care in rural communities. In developing quality indicators, the MoH and HAs, in collaboration with physicians and allied health professionals, will need to consider each community on a case by case basis. In some cases it may be more appropriate to base reports on a blend of quantitative and qualitative data.

Additionally, any publication of data must be balanced, relevant to patients and providers, and recognize that a range of community-specific factors can influence outcomes. Meaningful consultation with all stakeholders will need to take place before data are released in order to avoid unintended consequences. There should also be opportunities for physicians and allied health providers to use the data to effect change, with quality indicators and their use being continuously reviewed to ensure they remain appropriate.

5.2.3 Inter-facility Patient Transfers

The MoH recognizes a need to improve emergency response capacity and ensure timely, quality pre-hospital care in rural and remote communities. Therefore, the MoH proposes that BC Emergency Health Services (BCEHS) conduct a review of inter-facility patient transfers that

occur by ground ambulance, including consideration of appropriate deployment of BC Ambulance Services' transportation resources.

Given the significance of this issue for rural and remote communities, Doctors of BC strongly supports a review of inter-facility patient transfers, but urges the MoH to have the review conducted by an independent third party (possibly informed by input from BCEHS) rather than the review being undertaken by BCEHS. Ideally, the review would consider the needs of patients with different levels of acuity and not simply those patients requiring inter-facility transfers. The financial and emotional impact of transfer on patients and their families should also be considered.

There is reference in the Rural Policy Paper to bypassing of rural centres that do not have the capacity to provide the necessary trauma care. While this may be appropriate in some situations, it needs to be recognized that rural centres can also act as 'stabilizers' and should not necessarily be bypassed. There needs to be a robust triaging process based on open communication between emergency services and local providers who are best placed to comment on the appropriateness of resources available in their community.

5.2.4 Role of Paramedics

To enable effective use of Advance Care Paramedics in rural communities, the MoH proposes undertaking, in collaboration with BCEHS, changes to the regulatory framework to expand roles for paramedics. The MoH notes that this work would be linked to the introduction of a minimum of 80 new FTEs in community paramedicine at the Primary Care Paramedic or Advanced Care Paramedic level between April 2015 and March 2018.

Doctors of BC agrees that retaining paramedics in rural communities is a major challenge, largely due to dramatic fluctuations in volume of work. We are therefore supportive of proposals to make better use of paramedics in these communities, provided they are adequately trained and there is a clear process for their integration into hospitals/clinics. If there is a higher volume of work for rural paramedics, this will likely influence the stability of the ambulance service.

5.3 Health Human Resources

5.3.1 Generalist Model of Physician Practice

In the Rural Policy Paper, the MoH states that the need for generalist practice in rural and remote communities is a practical reality and that this must be balanced against the need for quality and safety of those services. Accordingly, the MoH proposes working in collaboration with Doctors of BC, the Joint Standing Committee on Rural Issues, the Rural Coordination Centre of BC, and the UBC Faculty of Medicine and Continuing Professional Development, to better elaborate and support training of generalist models of physician practice in rural and remote communities.

As a proponent of the generalist model of physician practice in rural and remote communities, Doctors of BC supports the MoH's proposal to collaborate with stakeholders to strengthen training in this area. At the outset, it will be important to clearly define and obtain agreement on what is meant by generalist practice in the rural context. For example, a distinction can be drawn between a generalist who works to the full scope of their practice and a generalist who

expands their practice to include other specialized skills such as obstetrics. It is not clear from the Rural Policy paper if the MoH intends to support one or both of these models.

Doctors of BC considers that it is important to support and encourage the generalist model throughout the full spectrum of medical training and also once physicians are in practice. Increased exposure to rural practice during medical school and residency will help to better prepare graduates to work within a generalist model. Consideration should also be given to ongoing support for practicing physicians through retraining/re-entry opportunities as well as exchanges with physicians from other countries. While there tends to be a focus on training rural GPs to be generalists, the model can and should also be applied to rural specialists. Practitioners such as general surgeons, general internists, and general pediatricians are an asset to rural medicine and should be actively supported.

Doctors of BC notes that, while not specifically raised in the Rural Policy Paper, a number of our members expressed concern that the Provincial Privileging Project, currently being undertaken by the Physician Quality Assurance Steering Committee, may seriously jeopardize the generalist model of practice in rural areas. While Doctors of BC supports renewal of the existing privileging process, there are significant concerns that the changes being proposed have the potential to drive rural physicians away from generalism and away from rural practice itself.

One specific concern relates to the division of rural generalism into five different categories. This division and the allotment of specific hours or number of repetitions of a procedure will likely encourage physicians to focus on one skill only. There are also concerns with the use of quality assurance as a sole mechanism for privileging as this offers little encouragement for better practice. Instead, Doctors of BC strongly supports a peer-led Continuous Quality Improvement (CQI) approach.

We encourage the MoH to consider its proposal to support the generalist model of practice in light of the changes that are being proposed to privileging across the province. Privileging should occur in a collaborative way to encourage physicians to work to the full scope of their practice and provide more services locally to their patients. We would be happy to provide further detail on this matter as part of the collaborative process described in the paper.

5.3.2 Rural Incentive and Support Programs

The MoH recognizes the challenges of attracting and retaining physician, nursing, and allied health care workers in rural and remote communities and, therefore, proposes to review and make recommendations for improvements and additions to incentive and support programs for health human resources in these communities. This would include introducing more flexibility into existing physician incentive programs to better respond to community service needs, and developing incentive programs and supports for nurses and allied health professionals. The MoH also proposes to address barriers to recruitment resulting from changes to the Temporary Foreign Worker program, and implement a provincial Practice Ready Assessment program to prepare internationally-educated physicians for practice in rural and remote settings.

Doctors of BC, through its involvement in the Joint Standing Committee on Rural Issues, is a strong supporter of the rural incentive programs and considers that they form a solid foundation from which to respond to issues of recruitment and retention. However, in some communities these programs have fallen short of providing BC's rural citizens with appropriate, reliable health

services. Doctors of BC, therefore, supports the MoH's proposal to strengthen and expand these programs, including developing programs for allied health professionals.

In considering issues related to health human resources, the MoH may wish to widen its scope and look at ways to encourage and support young people already living in rural areas to pursue a career in health care. Given the evidence that medical students from rural areas are more likely to return to these areas to practice[3], it is important to reach potential students as early as possible. Doctors of BC would encourage the MoH to closely watch the development of the new 'Rural Pre-Medicine' program at Selkirk College and, if successful, consider options for funding more placements in the future.

As a result of recent changes to the College of Physicians and Surgeons of BC bylaws[4], physicians from some overseas jurisdictions, for example South Africa, are now required to complete an "assessment of competency" prior to receiving a provisional license to practice. The bylaws were revised to reflect the evolving national standards for provisional registration. Over time, these changes have the potential to significantly impact rural and remote areas in BC because physicians from some of these countries have historically been more likely than physicians from other countries to set up practices in rural areas. At the time the bylaw was changed, there was no process in place in BC to provide an "assessment of competency". Other provinces that require this assessment, including Ontario, Saskatchewan and Alberta, provide an assessment at no cost to the physician.

We appreciate that the Practice Ready Assessment program will go some way towards resolving these issues. However, we would note that this was first initiated 3 years ago and is yet to be fully implemented. We understand that one of the major obstacles has been finding physicians who are able to train and assess internationally-educated physicians. The MoH may wish to consider building more flexibility into the program with regard to the training and assessment function.

5.3.3 Recruitment and Deployment of Health Professionals

In order to improve timely recruitment and deployment of health professionals to rural and remote communities, the MoH proposes working in collaboration with the Health Employers Association of BC (HEABC) to develop:

- a provincial forecast and resource planning model,
- a provincial approach to best practices in marketing and recruiting health professionals in rural and remote communities, and
- contingency service action plans for high risk communities with very small numbers of health professionals.

The MoH also proposes examining policy tools available for government and HAs to have more effective influence on distribution of health care professionals throughout the province.

Doctors of BC is generally supportive of these proposals given that recruitment and deployment of health professionals to rural areas is a significant challenge. However, one concern with the proposal as currently drafted is that it could result in centralization of recruitment committees.

[3] Laven G, Wilkinson D. Rural doctors and rural backgrounds: how strong is the evidence? A systematicreview. Australian Journal of Rural Health. 2003;11(6):277-84.
[4] See clause 2-15 (1) of the College of Physicians and Surgeons of BC Bylaws. https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf

This is not likely to be the most effective approach due to the varied needs of each community. Instead, Doctors of BC would like to see HAs and rural communities working together to recruit physicians. While it may be useful to develop provincial best practices for marketing and recruitment, there should be enough flexibility built in to enable communities to adapt strategies to suit their needs.

In terms of the resource planning model, it will be important that the MoH and HEABC ensure that it reflects the differing practice styles of physicians as well as demographics. A number of our members have also noted that resource plans should allow for some oversupply of health resources in rural communities to ensure sustainability over time. This would reduce dependence on recruitment of new physicians or allied health professionals in crisis situations.

6 CONCLUSION

Again, Doctors of BC of thanks the MoH for the opportunity to participate in this policy development process and reiterates that the success of the initiatives proposed will be dependent upon continued stakeholder involvement in their development and implementation. While not yet clearly laid out in the Policy Papers, we expect that the necessary structures for ongoing collaboration will be developed and that physicians will be provided with ongoing opportunities for effective involvement.