doctors of bc

December 17, 2014

Linda Larson, MLA
Chair, Select Standing Committee on Health
Room 224, Parliament Buildings
Victoria, BC V8V 1X4

VIA electronic submission

Dear Ms. Larson,

Thank you for providing Doctors of BC with the opportunity to participate in the Select Standing Committee on Health's ('the Committee') consultation on Health Care Sustainability.

Doctors of BC has been engaged with government on ground-breaking joint initiatives that are changing the face of health care to improve the quality of patient care.

Through our collaborative programs – working with government, health authorities and community partners – physicians are playing a significant role in health system redesign. For instance, there are currently thousands of primary care physicians coming together in 35 Divisions of Family Practice which are working at the grassroots level with partners to develop local solutions for local health care challenges. Collaborative programs also include: incentive fees to target care for the most vulnerable patients; initiatives encouraging seamless care between family doctors and specialists, and funding for innovation projects led by specialists with health authority participation.

We hope the Committee will draw on this body of work when presenting its recommendations to government.

We do wish to point out one significant area of concern. The College of Physicians and Surgeons of BC has called, in its submission, for each Health Authority to have oversight and responsibility for primary care in addition to acute services within region. Currently, Health Authorities have oversight over facilities-based physicians, not family doctors. If the college proposal was ever implemented, it would have repercussions for patients, doctors and the health care system. . To put family doctors under the purview of Health Authorities – by nature administrative bureaucracies – will only hamper the kind of innovation through collaboration that our health care system needs badly. We are very disappointed by the fact that the College made this recommendation without consulting Doctors of BC, the organization that represents 10,000 practicing physicians in our province.

Thank you again for allowing Doctors of BC to provide this submission to the Committee. We would welcome the opportunity to present this submission in-person if the Committee decides to hold formal presentations.

Yours sincerely,

Dr. Bill Cavers
President

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Doctors of BC Submission to:

Select Standing Committee on Health - Health Care Sustainability

December 2014

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Introduction

On June 2, 2011, the Legislative Assembly agreed that the Select Standing Committee on Health ("the Committee") be empowered to:

1. Examine the projected impact on the provincial health care system of demographic trends to the year 2036 on a sustainable health care system for British Columbians,
2. Outline potential alternative strategies to mitigate the impact of the baby boomers on the provincial health system, and
3. Identify current public levels of acceptance toward the alternative strategies.

In October 2012, the Committee released an Interim Report which addressed the first issue above. Doctors of BC (then the BC Medical Association) was an active participant in the initial consultation round, submitting the paper *"Charting the Course: Designing British Columbia's health care system for the next 25 years."* (1)

The Committee has now moved on to the next stage of its consultation and is interested in examining strategies for maintaining a sustainable health care system. Interested stakeholders have been asked to focus on four key areas by answering one or more of the following questions:

1. How can we improve health and health care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health care professionals in rural British Columbia?
2. How can we create a cost-effective system of primary and community care built around interdisciplinary teams?
3. What best practices can be implemented to improve end-of-life care?
4. How can we enhance the effectiveness of addiction recovery programs?

Doctors of BC has been vocal, to varying degrees, on each of these important health topics. This paper presents relevant policies, initiatives and recommendations that our association has made in recent years. It is hoped that the Committee will draw on this body of work when presenting alternative strategies for health care sustainability to the public in its next consultation round.

Health Care Services in Rural British Columbia

Select Standing Committee on Health Question

How can we improve health and health care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health care professionals in rural British Columbia?

Overview of Doctors of BC Response

Doctors of BC encourages the Committee to closely examine the work of the Joint Standing Committee on Rural Issues (JSC) whose primary focus is to address health care recruitment and retention issues in rural BC. The Rural Physician Programs under the JSC have proven successful and Doctors of BC would support any recommendations that build upon or strengthen these existing initiatives. We also recommend the Committee consider options to further support recruitment and licensing of international medical graduates in BC.

Introduction

Doctors of BC is pleased to see that improving health care and health care services in rural BC is an area of focus for the Committee, and we also welcome the government's recent announcements on the development of a Rural Health Strategy for BC. Doctors of BC has always had a strong interest in rural health and works in collaboration with the Ministry of Health and the health authorities on a number of initiatives through the Joint Standing Committee on Rural Issues (JSC). In addition, the Rural Issues Committee, a standing committee of the Doctors of BC Board of Directors, advises on issues affecting rural medicine and the working conditions of physicians practising in rural areas of BC.

When considering the challenges of recruitment and retention of health care professionals in rural BC, it may be helpful to the Committee to consider the range of issues as falling along a continuum. At one end of the continuum are challenges relating to encouraging youth who are already living in rural communities to pursue a career in health care. Given the evidence that medical students from rural areas are more likely to return to rural and remote areas to practice (2), it is important to reach potential students as early as possible. Further along the continuum, there are challenges associated with attracting non-rural medical graduates (or graduates of other health programs) to work in rural areas. This includes finding strategies to attract graduates, and their families, from within BC, other parts of Canada, and other countries.

Once health professionals have been recruited to rural areas, the next, and arguably larger, challenge along the continuum is retention. Systematic reviews of rural physician practices highlight that after recruits pay off any loans that may have been provided to them as a recruitment strategy, they often leave because they and their families are not prepared to live in a rural area permanently. (3) Finally, as rural health care workers reach retirement age it is important to support them and their communities through that transition period.

Rural Physician Programs

The Rural Physician Programs, initiated and funded by the JSC, aim to address challenges associated with recruitment and retention along the whole continuum. The overarching goal of the JSC is to enhance the availability and stability of physician services in rural and remote areas of British Columbia by addressing some of the unique and difficult circumstances faced by physicians in these areas. There are 11 programs in total that are available to rural physicians who practice in eligible communities. A brief description of the programs is provided below. For more detailed information, please refer to *"A Guide to the Rural Physician Programs in British Columbia."* (4)

- **Rural Retention Program (RRP)**: Retention payments paid to physicians working in eligible communities.
- **Rural Continuing Medical Education (RCME)**: Provides rural physicians with enhanced Continuing Medical Education funding.
- **Recruitment Incentive Fund (RIF)**: Funding for physicians recruited to fill current or pending vacancies.
- **Recruitment Contingency Fund (RCF)**: Additional funding to assist communities, health authorities, or physician groups where the difficulty in filling a vacancy is, or is expected to be, especially severe.
- **Isolation Allowance Fund (IAF)**: Funding for physicians providing necessary medical services in eligible Rural Subsidiary Agreement (RSA) communities with fewer than four physicians, and no hospital.
- **Rural Emergency Enhancement Fund (REEF)**: Funding for eligible rural emergency departments to support fee-for-service physicians who collaboratively plan for and provide public access to Emergency Department services on a regular, scheduled basis.
- **Rural Education Action Plan (REAP)**: Supports the training needs of physicians in rural practice, provides undergraduate medical students and postgraduate residents with rural practice experience, and increases rural physician participation in the medical school selection process.
- **Northern and Isolation Travel Assistance Outreach Program (NITAOP)**: Makes available travel assistance to approved physicians visiting eligible rural and isolated communities to provide medical services.
- **Rural Locum Programs**: There are three locum programs (GP, GP Anaesthesia, and Specialist) that support and enable rural GPs and specialists to have periods of leave from their practices for continuing medical education, vacation, and health needs.

Review of Rural Physician Programs

In 2008, the majority of the Rural Programs were independently reviewed (5) to assess their effectiveness and identify opportunities for enhancement. Most of the 90 recommendations in the independent report are quite specific to the individual programs. However, the Committee may be interested in reviewing some of the key observations in the report as they pertain more generally to the challenges of recruitment and retention of health care professionals in rural BC. Overall, the review

found that the Rural Programs have a solid foundation from which to continue to respond to the needs of rural physicians. While the programs are aimed at physicians, some of the observations in the review are likely to apply to other health professionals. Key observations included:

- Non-financial factors, such as career, family, and community, are the strongest determinants of rural physician recruitment and retention but financial incentives still play a role in offsetting the extra burden placed on rural and remote physicians.
- Flexible workload, working hours, and working arrangements are important to retaining physicians.
- Ongoing Continuing Medical Education support for rural physicians is essential to maintaining the level of service required in BC's rural and remote areas. Programs need to be specifically designed to meet the needs of rural physicians, and need to be offered as geographically close to their communities as feasible.
- Increasing the number of rural-based students admitted to medical school could enhance successful recruitment to rural practice.
- Local communities are becoming active participants in successful recruitment and retention of physicians.

While these incentive programs have been successful in most areas of rural BC, it has been recognized by the JSC that in some communities the programs have fallen short of providing BC's rural citizens with appropriate, reliable health services. The JSC has therefore recently committed up to $2.5 million in funding to five rural BC communities that are chronically in crisis. Health authorities that include rural communities, including the First Nations Health Authority, will nominate up to three communities for consideration by the JSC. Once the five communities have been selected, the relevant health authority will work with the community to generate innovative, novel, and sustainable solutions to the local health care access problems. The program is designed as a trial to inform the Ministry of Health, Doctors of BC, health authorities, communities, and community physicians about innovations that address specific needs in rural communities. The Committee may wish to keep abreast of the work being undertaken by the health authorities in these five rural communities.

Doctors of BC is proud to partner with the Ministry of Health and the health authorities on the JSC and would strongly support the implementation of strategies to strengthen and expand the existing Rural Programs. Improvements can certainly be made, but as pointed out in the independent report, these programs do form a solid foundation from which to respond to issues of recruitment and retention. We therefore recommend that the Committee consider using the JSC as an avenue through which to achieve its goals in relation to health care in rural British Columbia.

Other Areas for Improvement

In addition to the Rural Physician Programs, Doctors of BC would like to highlight two other areas where improvements could be made to the recruitment and retention of rural health care professionals. While

there may be scope for these issues to be addressed by the JSC, other stakeholders would need to be involved, particularly in terms of funding some of these potential solutions.

Firstly, as a result of recent changes to the College of Physicians and Surgeons of BC bylaws[1], physicians from some overseas jurisdictions, including 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 South African physicians 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.

In response to this bylaw change, the JSC is funding a Practice Ready Assessment – British Columbia (PRA-BC) pilot program for family physicians that will launch in 2015. The program is a collaboration of the College of Physicians and Surgeons of BC, the JSC, the BC government, and the University of BC, and is being undertaken in partnership with BC's health authorities and Health Match BC. The PRA-BC will consist of four phases: screening and selection, orientation and examination, a 12-week clinical field assessment, and application for a provisional license from the College. Participants in the program must commit to a three-year Return of Service period in a rural community.

Initially, 15 participants will be selected to take part in the PRA-BC program in spring 2015. A second cohort of 15 participants will enter the program in the fall of 2015. The number of participants and cohorts beyond this is to be determined during program evaluations. Through its involvement in the JSC, Doctors of BC is pleased to be a participant in this pilot program. If the program proves successful, we would strongly urge the BC government to ensure that it is expanded in order to offer a more sustainable solution to the challenge of recruitment of international medical graduates into rural BC.

Secondly, we would like to draw the Committee's attention to the new 'Rural Pre-Medicine' program at Selkirk College. (6) The JSC is funding 24 students from rural areas in BC to take part in this 3 year program that is intended to build the foundation of knowledge and experience needed to work in rural medicine. The program is not affiliated with any particular medical school and graduates would be eligible to apply to medical school in the same competitive admission process as any other applicant. While it is unlikely that all 24 participants will be admitted to medical school, it is hoped that many will pursue a career in health care in rural BC. Doctors of BC would encourage the government to closely watch the development of this program and, if successful, consider options for funding more placements in future.

[1] Refer to clause 2-15 (1) of the College of Physicians and Surgeons of BC Bylaws. https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf

Interdisciplinary Teams in Primary and Community Care

Select Standing Committee on Health Question

How can we create a cost-effective system of primary and community care built around interdisciplinary teams?

Overview of Doctors of BC Response

Doctors of BC would like to draw the Committee's attention to the significant work undertaken on primary care reform by the General Practice Services Committee (GPSC), a partnership between Doctors of BC and the Ministry of Health. Many of the GPSC initiatives have a strong focus on multidisciplinary health care and we would encourage the Committee to review these initiatives and consider whether they could be used more widely across the province as a model for delivery of multidisciplinary care. Doctors of BC recommends dedicated long-term sustainable multidisciplinary care funding and resources to primary care. This should include the removal of financial and administrative barriers to incorporating allied health care providers, such as nurse practitioners and physician assistants, within physician offices.

Introduction

Doctors of BC supports efforts to enhance multidisciplinary primary and community care in BC as an important solution to 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. Our association has been a major advocate for primary care reform in BC and is a founding member of the General Practice Services Committee (GPSC), a partnership with the BC Ministry of Health and the health authorities. Doctors of BC agreed, through the Physician Master Agreement, that funds earmarked for physician compensation should instead be directed towards various initiatives and incentive programs to support the needs of primary care patients. One of the priority areas for the GPSC is to increase multidisciplinary care between general practitioners and other health care providers.

To provide the Committee with insight into the successful work of the GPSC, a number of initiatives that involve the enhancement of multidisciplinary care are described below. We would encourage the government to continue to support the innovative work of the GPSC.

General Practice Services Committee Initiatives

One of the most successful initiatives of the GPSC is the Divisions of Family Practice which were established in response to feedback from GPs that they felt isolated and unsupported in their communities. GPs who wish to work together to provide the best possible patient care and improve professional satisfaction needed community infrastructure to support them. The Divisions are groups of physicians who work collaboratively with health authorities and other community partners to achieve

common health care goals in a defined geographic area. There are currently 34 Divisions of Family Practice in BC that encompass more than 230 communities.

Much of the work of the Divisions of Family Practice focuses on strengthening multidisciplinary primary care at a local level. An excellent example of this is the South Asian Health Centre in Surrey which opened in November 2013. The Health Centre is owned and operated by the Surrey North Delta Division of Family Practice and was developed in collaboration with Fraser Health. The Centre focuses on primary care and chronic disease management services, with patient care being delivered in a culturally tailored manner. Patients have access to a multidisciplinary team of health care providers, including nurse practitioners, registered diabetes nurses, and dieticians.

In 2012, the White Rock-South Surrey Division of Family Practice awarded 'multidisciplinary care grants' to a number of practices. The grants were to support practices to optimize clinical scope, increase efficiency, and ultimately increase primary care capacity through enhancement of multidisciplinary care services (largely registered nurses and licensed practical nurses) within the practices. Results from this initiative are available on the Division's website[2], with highlights including:

- 70% of practices reporting increased capacity (adding more patients to their patient panel) as a result of integrating a multidisciplinary care provider.
- 70% of practices reporting increased efficiency (seeing more patients on a weekly basis) as a result of integrating a multidisciplinary care provider.
- 100% of practices reporting improved quality of care for patients able to see the multidisciplinary care provider.

Another Division has been exploring the idea of more flexible models of multidisciplinary care to increase capacity at a more sustainable cost. In some communities, there may be the option for physicians with unused space in their offices to host intermittent visits from allied health care professionals to provide specific services such as counselling, advance care planning, or medication reviews. It has been noted that the Divisions have the potential to provide coordination services and to act as an integrator for the equitable distribution of allied health resources to the population.

The Practice Support Program (PSP), another GPSC initiative, provides family physicians and their staff with specific learning modules and in-practice learning sessions to improve office efficiency and address clinical gaps in patient care. Where relevant, PSP modules cover the importance of working collaboratively with allied health professionals. The 'Shared Care – COPD/Heart Failure' module is an excellent example of this as physicians, specialists, and community-based providers are trained on how to collaborate to provide effective, coordinated care to patients.

The use of multidisciplinary clinical teams is an important component of the GPSC Complex Care and Chronic Disease Management Initiatives. In addition, the GPSC Patient Conferencing Initiative involves the development of conferencing fees to compensate physicians for case conferencing with allied health

[2] https://www.divisionsbc.ca/white-rock-south-surrey/MDCHighlights

professionals in the treatment of patients with complex, mental health, and palliative conditions, as well as the frail and elderly.

We would encourage the Committee to look at the work of the GPSC and consider whether these initiatives can be used more widely across the province as a model for delivery of multidisciplinary care.

Doctors of BC Policy on Multidisciplinary Primary Care

In addition to working on initiatives through the GPSC, Doctors of BC has released a policy statement on multidisciplinary primary care (7), as well as the policy paper "*Working Together – Enhancing Multidisciplinary Primary Care in BC.*" (8) The key recommendations from those papers are as follows:

- The BC government should dedicate long-term sustainable multidisciplinary care funding and resources to primary care. This should include the removal of financial and administrative barriers to incorporating allied health care providers within physician offices. Gains from collaborative multidisciplinary care are unlikely to be realized if there is not the option of teams being based in physician's offices, given that the majority of British Columbians want a physician as their first point of contact with the health care system.
- Funding models for multidisciplinary care must be flexible enough to accommodate variations in population health needs, as well as individual physician preferences for payment mechanisms. They should also take into account the higher practice costs associated with the incorporation of allied health professions into physicians' practices.
- To be effective, multidisciplinary care teams should have a clinical team leader with ultimate responsibility for patient care and who is the best-trained generalist. In the majority of instances, this would be the GP.
- The BC government must support the establishment of an IT infrastructure as a critical element of multidisciplinary care with the goal of enabling communication between physicians and allied health professionals. Health information policies should be developed to protect patients' privacy rights whilst facilitating the effective sharing of information.
- Appropriate regulatory bodies and professional associations must be integrally involved in any proposed changes to the scope of practice for health professionals.
- All health professionals practising in multidisciplinary care settings must have appropriate and adequate liability coverage.

As well as developing overarching policy on multidisciplinary care, Doctors of BC has also prepared policy statements on nurse practitioners (9) and physician assistants (10) and considers that both professions can be valuable members of collaborative care teams. Doctors of BC recommends collaborative care teams as the preferred model for nurse practitioner integration in the province. Doctors of BC also supports the establishment and deployment of physician assistants in British Columbia and recommends that they be recognized by the BC government as a regulated profession, with regulatory oversight by the College of Physicians and Surgeons of BC. Because of their unique practice model, their generalist training, and potentially broad scope of practice there are many opportunities to utilize physician assistants in BC.

Improving End-of-Life Care

Select Standing Committee on Health Question

What best practices can be implemented to improve end-of-life care?

Overview of Doctors of BC Response

Doctors of BC has a strong interest in end-of-life care issues, having recently released a policy paper on advance care planning, as well as proposing a number of resolutions for consideration of the membership of the Canadian Medical Association on end-of-life care issues. From a physician perspective, best practices for end-of-life care include: the integration of the palliative care approach into management of life limiting chronic disease; advance care planning forming part of the required standard of care for patients with chronic or complex illness; support for physicians to assist families develop advance care plans; integration of advance care plans within patient records; and consideration of the time-to-benefit of prescribed interventions and medications for patients approaching end-of-life.

Introduction

In recent years, the debate about end-of-life care has become more public as an increasing number of Canadians begin to appreciate its importance in the context of our aging population. The Canadian Medical Association (CMA) has been at the forefront of this debate, holding an end-of-life national dialogue in partnership with *Maclean's* magazine during the first half of 2014. The CMA has prepared a report (11) which details the findings from the national dialogue. The Committee may be interested in the following key findings:

- All Canadians should discuss end-of-life wishes with their families or other loved ones.
- All Canadians should prepare advance care directives that are appropriate and binding in the jurisdiction in which they live.
- A national palliative care strategy should be developed.
- All Canadians should have access to appropriate palliative care services and many don't.
- More education about palliative care approaches and services, as well as about how to initiate discussions about advance care planning is required for medical students, residents and practising physicians.
- The Canadian public is divided on whether the current Canadian ban on euthanasia and physician-assisted dying should be maintained or not.
- If the law in Canada is changed to allow euthanasia or physician-assisted dying, strict protocols and safeguards are required to protect vulnerable individuals and populations.

Canadian Medical Association Resolutions on End-of-Life Care

End-of-life care was also one of two strategic topics at the 2014 CMA General Council meeting. Doctors of BC has been an active participant in the debate, putting forward a number of resolutions at the General Council meeting. To provide the Committee with an understanding of discussions at the physician level, these motions (all of which have been approved) are set out below.

The Canadian Medical Association supports efforts that will assist physicians in helping patients and families understand and develop advance care plans.

Only a very small number of Canadians have spoken to a health care provider about their wishes for end-of-life care. Various challenges prevent patients from engaging in the advance care planning process. Many patients are reluctant to discuss death and in the absence of an open discussion about end of life, patients may be unaware of their care options. A lack of advance care planning makes it difficult for physicians to recommend the best goals of care and help guide family members through the dying process.

The process of advance care planning can be challenging for all individuals involved. Thus, physicians should be supported in helping patients and families understand and develop advance care plans within the context of each patient's age, life stage, or health status.

The Canadian Medical Association supports the integration of the palliative care approach into the management of life-limiting chronic disease.

People with chronic illnesses are living much longer between diagnosis and death and the burden of chronic disease on individuals, families, and the health care system is growing. A palliative approach to care includes psychological and social support, effective pain and symptom management, and open communication about prognosis and available treatments. It focuses on the quality of life of a patient throughout the illness, not just at the end of life. This approach examines the overall needs of patients and promotes living as well as possible for as long as possible, and providing the best care for patients with serious illness.

The palliative care approach provides greater autonomy for patients by allowing them to be engaged in their own care and decision-making, and address emotional or spiritual concerns. Doctors of BC considers that having a chronic disease strategy that incorporates a palliative care approach will lead to improved relief of suffering, improvement of quality of life, reduced caregiver burden, and better use of health care resources.

The Canadian Medical Association recommends that the time-to-benefit of prescribed interventions and medications be considered when providing care for older adults and patients approaching the end of life.

Many older adults and patients who are at the end of life are at risk of polypharmacy (use of multiple medications), inappropriate medications, and adverse drug events. In order to provide high quality patient-centred care, physicians should optimize pharmacotherapy and reconcile medications for these patients. This may include discontinuing medications for secondary disease prevention that may no longer be of value if the time to therapeutic benefit exceeds estimated life expectancy.

In the absence of formal guidelines, prescribing for older adults and patients at the end of life should aim to maximize quality of life by optimizing symptom control and minimizing medication burden, adverse side effects, and drug interactions.

The Canadian Medical Association supports the integration of advance care plans within patient records.

With the promotion of advance care planning discussions between physicians and patients, more Canadians will have written documentation regarding their end-of-life care wishes. However, without integration of advance care plans within patient records, not all health care providers can gain access to a patient's care goals. Access to care goals is particularly important as a patient moves between care settings. For instance, even when an advance care plan exists, physicians unexpectedly treating a patient, such as in emergency departments, often have little access to information about a patient's end-of-life goals and wishes beyond organ donation status.

As the number of general practitioners with hospital privileges decreases, it is important to find ways to ensure patient wishes are upheld even if the primary care physician is not available. Providers who are unaware of a patient's values and beliefs are less able to counsel family members or others in appropriate decision-making related to care at the end of life. The integration of advance care plans within patient records would reduce the incidence of fragmented care, ensure patient wishes are met, and improve communication between health care providers. Also, when physicians become aware that an advance care plan does not exist, they can encourage patients and families to discuss end-of-life care wishes and develop a plan.

Advance Care Planning

Advance care planning is such an important component of end-of-life care that Doctors of BC developed a detailed policy paper on this topic. In March 2014, we released *"It's Time to Talk: Advance Care Planning in British Columbia."* (12) The paper contains a number of commitments and recommendations which support our overall policy position that physician-initiated advance care planning should be a standard of care for all patients regardless of age, life stage, or health status. The following recommendations are relevant to the Committee's question about end-of-life care:

- Physicians in British Columbia should include in consultation notes, when possible and appropriate, details about prognosis, including details about transitions in health status, as a standard of communication for all patients with chronic, complex, or life-limiting illnesses.
- The British Columbia Ministry of Health should amend or expand upon existing advance care planning resources to increase their relevance for all British Columbians, regardless of age, life stage and/or health status.
- Advance care plans should be integrated with patient records to provide all health care providers with access to patient plans.
- Advance care planning should form part of the required standard of care for patients with chronic or complex illness.

Enhancing Addiction Recovery Programs

Select Standing Committee on Health Question

How can we enhance the effectiveness of addiction recovery programs?

Overview of Doctors of BC Response

Doctors of BC has developed extensive policy on addiction care in BC and considers that the effectiveness of addiction recovery programs would be enhanced by: establishing standards of care for addiction medicine treatment; expanding community addiction programs, case management, and crisis support across all health authorities; ensuring accessibility to addiction care; expanding training and support for physicians in addiction medicine; expanding BC's addiction research capacity; and ensuring that prevention campaigns and programs are evidence based and designed in collaboration with health professionals.

Doctors of BC Policy on Addiction Care

Addiction, whether to alcohol, drugs, or an activity such as gambling, is a very serious issue in British Columbia and a topic that Doctors of BC has been particularly vocal about. We were pleased to see the BC government formally recognize addiction as a chronic treatable disease in 2011. This was the number 1 recommendation in the Doctors of BC Policy paper *"Stepping Forward: Improving Addiction Care in British Columbia."* (13)

In considering how the effectiveness of addiction recovery programs can be enhanced, we encourage the Committee to read our policy paper, paying particular attention to the following recommendations.

Doctors of BC recommends that British Columbia:

- Establish standards of care for addiction medicine treatment. This includes clearly defined wait times for services across the continuum of care developed in conjunction with front-line practising health professionals, health authorities, and the Ministry of Health. This should also include the development of clinical guidelines and protocols for addiction care developed by the Ministry of Health and the Doctors of BC through the Guidelines and Protocols Advisory Committee (GPAC).[3]
- Expand community addiction programs, case management, and crisis support teams across all health authorities; including specific programs for rural communities, First Nations, minority populations, youth, pregnant women, and seniors. Any expansion must include better integration with primary care.

[3] We note that BC Guidelines have now been developed for Alcohol Addiction ("Problem Drinking") http://www.bcguidelines.ca/pdf/problem_drinking.pdf

- Ensure that access to addiction medicine care is accessible without financial and other barriers throughout BC; this includes the elimination of per diem fees, minimization of language barriers, and access to inpatient addiction care.
- Expand training and support for physicians in addiction medicine. This should include formal recognition of addiction medicine as a specialty in British Columbia by provincial and national medical, nursing, and other health profession education bodies.
- Further expand BC's addiction-research capacity, enabling researchers to collect data, conduct utilization research, and evaluate programs. Any research and evaluation should include the participation of practising health professionals.
- Ensure that any prevention campaigns or programs considered for implementation in BC must be evidence-based and designed in collaboration with appropriate practising health professionals, health authorities, and other stakeholders as required.

Principles of Drug Addiction Treatment

We would also like to draw the Committee's attention to the US National Institute on Drug Abuse Principles of Drug Addiction Treatment: A Research-Based Guide. (14) The Guide applies to illicit and prescription drug, alcohol, and tobacco addiction and includes 13 principles of effective treatment. Doctors of BC would like to highlight the following principles for the consideration of the Committee:

- **No single treatment is appropriate for everyone**. Treatment varies depending on the type of drug and the characteristics of the patient.
- **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** Treatment must also address associated medical, psychological, social, vocational, and legal problems.
- **Remaining in treatment for an adequate period of time is critical.** Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.
- **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery.
- **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement, begun at initial patient intake, can improve treatment engagement. (14)

Conclusion

Doctors of BC is pleased that the Committee has chosen to focus on four very important issues that have the potential to impact the sustainability of British Columbia's health care system. Rural health care, interdisciplinary primary and community care teams, end-of-life care, and addictions are all issues that our association has created policy on and/or carried out improvement initiatives in relation to. We hope that the information on our policies, recommendations, and initiatives will assist the Committee in developing strategies for health care sustainability.

We would like to conclude with an overarching comment that applies to each of the Committee's four areas of consultation. Doctors of BC supports the Institute for Healthcare Improvement's Triple Aim Initiative (15) and would encourage the Committee to use that framework as a lens by which to assess any proposed changes to the health care system. The Committee should consider the extent to which its recommendations will: improve the patient and provider experience of care (including quality and satisfaction); improve the health of populations; and reduce the per capita cost of health care. Finally, Doctors of BC would like to stress the importance of involving patients and families as well as health care providers in the design, delivery, and evaluation of health care. We trust that the Committee will consult with a wide range of stakeholders throughout this process and we thank the Committee for providing Doctors of BC with an opportunity to make this submission.

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