Taking the Next Steps: Repositioning Health Care for Older Adults

First, I want to reiterate a big thank you for your engagement and work over the two days of the forum. As promised, this is the follow up to our two day working session outlining the ask for the next steps.

Through *Setting Priorities for the B.C. Health System* (February 2014) and *B.C. Health System Strategy Implementation* (April 2014), we identified a few key areas of health service delivery that we believe require cross-system action where we all collaborate to get to a different place. These are areas where continuing to do what we are doing now will neither deliver the **quality services** we want to deliver to B.C. citizens nor be **sustainable** given the forecast growth in demand for those services. These are areas where there is a need to **reposition** the health sector for sustainable high performance that meets population or patient needs and then taking effective action to get there – they are areas requiring radical or root change based on a clear strategic vision and change logic. The three areas put forward are a sub-set of patients receiving primary and community care (older adults with more complex medical conditions; patients with cancer; patients dealing with moderate to severe mental health and/or addictions); surgical services; rural services.

Last week you were part of a two-day forum exploring one of these areas where, over the coming two years, we want to make substantive measurable progress *to improve the effectiveness of primary, community (including residential care), medical specialist and diagnostic and pharmaceutical* ***services for patients over the age of 70 with moderate to high complex chronic conditions and increasing risks or signs of frailty,*** *such as to significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care.*

As we discussed this is a metro, urban, and rural issue; in particular, we need to establish a coherent and sustainable approach to delivering **rural health services** to older adults with more complex medical conditions (population) and this will certainly include First Nations people living on reserve through our partnership work with the First Nation's Health Authority who were a key part of our meeting.

As you undertake the work, we are asking that you keep the triple aim in mind as a check against your ideas and proposals:

- We are clearly aiming to improve the health and wellness of this population and we talked about this in a holistic way – the physical, emotional, social, and for some of us spiritual dimensions of our lives;
- We want to improve the person/patient experience of care (including quality and satisfaction) inclusive of their family and/or key caregivers. We have also recognized the additional requirement of improving the experience of delivering care for providers and support staff. This is critical to patient centred care, which is in reality built on the efforts of those who deliver services and support patients; and
- We want to do this in a cost effective way linked to being conscious of per capita cost without losing quality (especially effectiveness and appropriateness). In this instance it means looking at

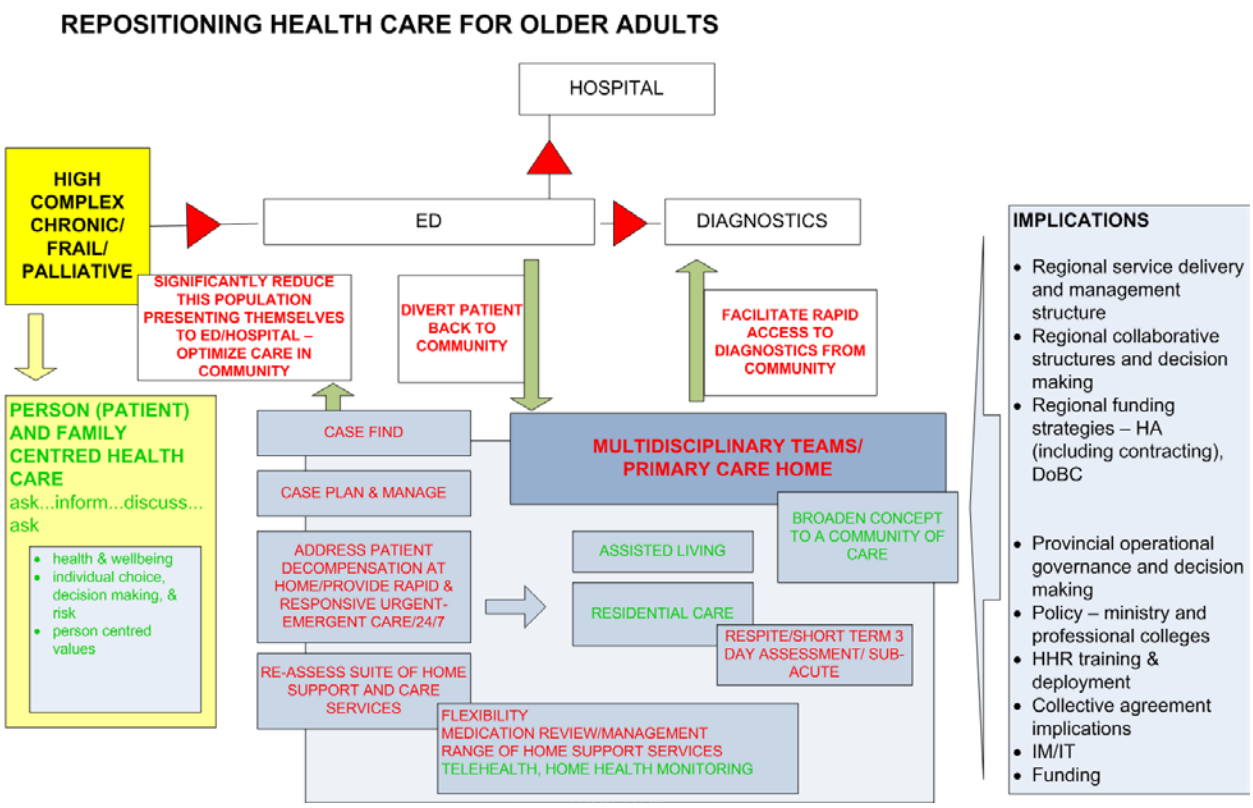
the total budget available inclusive of primary care, physician care, home and community care, assisted living and residential care. We want to know whether there are different ways of mobilizing and mixing these resources to achieve our first two objectives. Beyond the existing global budget there are also options for us to prioritize allocations of the net new budget increases to this area where this is needed.

Another key area we asked you to consider is the way in which we workshop our way through this area:

- First, as this is a repositioning or radical/transformational change area we are asking you to think outside the existing service box. It doesn't mean that you have to land there but at least explore a wide range of options. When we are used to doing things in a certain way we tend to move quickly to incremental change or adjustments. This may be all that is needed but there are also circumstances where the current paradigm no longer works or is suboptimal.
  We are challenging ourselves that this is an area where more radical change is needed. A concrete example of this is that many of you identified that the system is very complex with multiple players, streams and processes. A possible solution brought forward is that we need to add patient navigators into this mix to help people cope with this complex system. This is incremental change that doesn't require that we make big changes to our own practice or the lack of responsiveness of the system. A radical or root change proposal would be that we need to redesign the system and change our practice and ways of working to make it more simple and user friendly and truly person/patient focused.
- Second, we want the change process to start with patients, their families and the outcomes and outputs achieved for individuals in this patient population. As several of you said, we need to check out our assumptions and ideas with patients and their families as a starting point rather than believing that we know best. Based on this starting point we then move on to think through options for optimal service design, then the optimal use of health human resources, IM/IT, and budget allocations enabled by governance, management, collaboration and policy across various key institutional players. This process is somewhat different from the traditional top-down and centrally driven system at the regional and provincial levels, whether it is the health authority, ministry or other large institutional players that pre-determine options based on past history or interests. This doesn't mean that we ignore the need for service coordination, system coherence and budget limitations but it also doesn't mean that we start there and thereby close down the potential of creative options and realities with a "yes…but" or "not possible" attitude.

  More simply said we are asking that you give yourself permission to creatively explore a range of possibilities.

So, where did we get to at the end of the forum?



Based on your work we attempted to structure a draft prototype service/system model.

What next?

For the community groups we asked that you take this material back to your community and continue through the summer to shape up and flesh out a model of health care for older adults by:

- Linking in more patients and their family caregivers into the process and dialogue
- Expanding the dialogue and co-creation of the model with your colleagues including health care practitioners and staff from community health workers, residential care workers, community nurses, family and relevant specialist physicians
- Keep linked to your regional executive team as you build out the model so that they can think through the regional implications or expand out the work to include other communities.
- Stay actively involved in the virtual network of ten communities facilitated by the Ministry of Health through a share point site.
- Participate in a follow-up plenary session in September to show your model of health care

Specifically we talked through that you would wrestle with and flesh out your thinking on the component parts that we identified in the workshop:

- What might a "community of care" for this population and their family care givers look like in your community?

- A key idea is that we step outside of the silos that we are currently in to think of an integrated system that includes and perhaps uses differently family practices, home and community carer, assisted living and residential care.
    - How would and integrated system look like in your community? Allow yourselves the space to think outside the box – for example, could we base service teams out of residential care facilities; could we use the shared areas of residential and assisted living differently (meeting areas, group care, cafes, bathing facilities, laundry, volunteers, exercise, social, etc).
    - A central idea for most of you was the need to create effective and efficient "multidisciplinary teams" as a key building block for an integrated system. An ask is that you think this through in terms of:
        - Governance: What would governance of these teams look like given that we have independent physician practices, HA and contracted out home and community care services, HA provided, for profit, and not-for profit faith based assisted living and residential care providers.
        - Roles: The range of health care providers and their respective roles – wrestling with the issue of health human resource deployment in terms of staff and skill mix.
        - Size: What is the right size for a meaningful patient group and service team and how could we rethink allocation of resources to meet this size.
        - Location: virtual, co-location, location in residential care facilities as an outreach service
        - Funding: how to effectively link together funding streams to the optimal benefit of patients

- Thinking through different pathways for patients that will avoid the preventable need to go to an emergency department and into hospital. We identified a range of ideas:
    - more responsive 24/7 community response and increased levels of care and support in community – what would this look like at a practice level? Should we change the criteria for staying in assisted living with more supports being available?
    - The potential use of residential care to provide short term sub-acute care and respite in both a planned and responsive way. What would be the resource needs to achieve this? Can we increase the number of patients who have a planned entry into residential care rather than going through hospital care?

- Thinking through the elements that you brought forward:

- Case finding the patients we need to focus on – how could you do this?
- Case planning and management – what could this look like?
- How might you provide rapid response and step/step down services to actively reduce de-compensation or address emergent issues?
- What should the range of home and community care services look like?

For the institutional players including health authority executives and management, the ministry, professional colleges, Doctors of BC, associations and unions we asked that you take these ideas and begin to think through what are the implications for your policy and funding frameworks, regional structures, management, collaboration processes:

- How do we build an effective and efficient health system around functional (that is human scale) geographic service areas?
- How do we put in place the capacity for action and leading/managing change?
- What are the implications for regional service delivery and management structures?
- What are the implications for regional collaborative structures and decision making, including the role of Divisions of Family Practice?
- What are the implications for regional funding strategies – HA (including contracting), Doctors of BC?
- What are the implications for provincial bodies?
    - Ministry of Health
    - Health Professional Colleges
    - Doctors of BC
    - Unions
    - Contractors

We will link out to you to support your work and also help pull together the results of your efforts so that we can have a productive day and half plenary session in September that will take us to the implementation of the community models of health care.

Thanks

Steve