# Nursing Synthesis and Review of the Ministry of Health Policy Papers

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This is intended to be a living document, and will be updated over time as additional information, reviews, suggestions and recommendations are provided by BC LPNs, NPs, RNs and RPNs. Contributions from nurses of any designation, through their professional association or directly to aburton@arnbc.ca will be valued, considered, and included going forward. The goal is to begin to develop a strong, shared nursing voice that can respond to policy issues such as those raised by the Ministry in this document.

## Introduction to the Policy Papers

In February 2014, the Ministry of Health set out a refreshed strategic direction for the health system in *Setting Priorities for the BC Health System*. In April 2014, it was followed up with the *BC Health System Strategy Implementation: A Collaborative and Focused Approach*. This document set out three key areas of focus:

1) Delivering patient-centred services and care.
2) Driving performance management through continuous improvement across service and operational accountabilities.
3) Driving a cross sector focus on five key patient population and service delivery areas linked to the eight priority areas:
    - Priority 1: Provide patient-centred care
    - Priority 2: Implement targeted and effective primary prevention and health promotion through a co-ordinated delivery system
    - Priority 3: Implement a provincial system of primary and community care built around interprofessional teams and functions
    - Priority 4: Strengthen the interface between primary and specialist care and treatment
    - Priority 5: Provide timely access to quality diagnostics
    - Priority 6: Drive evidence-informed access to clinically effective and cost-effective pharmaceuticals
    - Priority 7: Examine the role and functioning of the acute care system, focused on driving interprofessional teams and functions with better linkages to community health care
    - Priority 8: Increase access to an appropriate continuum of residential care services

The policy direction set by these documents is to be executed in a disciplined and systematic approach through five phases:

- Phase 1: Policy Development (including stakeholder consultation and engagement)
- Phase 2: Accountability, Action Planning and Communication
- Phase 3: Implementation
- Phase 4: Reporting and Monitoring
- Phase 5: Impact and Outcome Assessment

In February 2015, a set of Policy Papers were published to begin taking the direction set out in the previous documents to the next level of planning and implementation. These Policy Papers are Phase 1 of the policy direction set by the BC Ministry of Health. Each has its own specific goals and initiatives, but all must take into consideration the three overarching goals of the Triple Aim (developed through the Institute for Health Improvement):

1. Improving the health of populations;
2. Improving the patient experience of care (including quality and satisfaction), to which B.C. has recognized the additional requirement of improving the experience of delivering care for providers and support staff as critical to patient-centred care built on efforts of those who deliver and support health services; and
3. Reducing the per capita cost of health by focusing on quality (especially effectiveness and appropriateness) and the efficiency of health care delivery.

The Policy Papers also all refer to the need to shift how health care dollars are spent by considering where

individuals stand with their health and ensuring the funds follow where they are needed most. Individuals are considered to be in one of the following categories:

Staying healthy = 60% of the population = 9% of healthcare costs
Getting Better = 3% of the population = 6% of expenditures
Living with Illness = 40% of the population = 50% of expenditures
End-of-Life = 2% of the population = 35% of expenditures

When reviewing the three priority documents, it can be helpful to recognize and follow the patterns developed in the "Next Steps" section of each paper. For each of the Policy Papers the "Next Steps" are split into three parts:

1 – Practice Level – Service Delivery
2 – Organization Level – Organizational Supports
3 – Provincial Level – System Supports

In other words, if you wish to read only the most vital components of these papers, read "The Case for Change" and the "Next Steps" and consider the larger portions of the document to be background or reference material.

Please note, this document is a synthesis. For a complete and detailed overview of the Policy Papers, please refer to the original documents as some points may have been omitted or shortened for brevity. The document is laid out with each Policy Paper synthesized, followed by a section entitled "Nursing Analysis/Assessment". It is in this Analysis/Assessment Section where the thoughts and values of the nursing community will be recorded, developed and brought forward. The final section encapsulates a number of over-arching, priority comments and recommendations. Please feel free to provide insight and suggestions to any part of this document to aburton@arnbc.ca

On July 15, 2015, the five nursing groups (ARNBC, ARPNBC, BCNPA, LPNABC and NECBC) will co-host a forum that will identify and bring forward the feedback we have heard from nurses so far, as well as any new ideas or recommendations from the nursing community.

## Primary and Community Care Summary

The Primary and Community Care Paper can basically be divided into three key parts. The first sections which include the Executive Summary, Introduction and Strategic Context consume the first 107 pages of the 127 page document. These sections, while providing important background information, are very generally described here under the section entitled Introduction**.** The Introduction section highlights successes in primary and community care in B.C., what is working, what the programs are, who the providers are, etc. While the information is useful as a resource, those who are invested in the healthcare system as providers, managers or administrators will be familiar with the programs and services that are discussed.

The 'meat' of the document is from page 108 – 126 and encompasses "The Case for Change: Learning from Experience and Building on What Has Been Achieved" as well as "The Next Steps: Focusing and Reenergizing the Commitment to Realize Patient Centred Integrated Primary and Community Care".

**<u>Introduction</u>**

The range of primary and community care services includes:

1. Primary Care
    a. GP Offices and Clinics
    b. Primary and Community Care Professionals
    c. Supportive Medical Specialist Services
2. Maternity Care Services
3. Developmental Disability Services
4. Mental Health and Substance Use Services
5. Cancer Care Services
6. Home and Community Care Services
7. Palliative Services

The document goes on to list primary care service providers, where they practice, what types of initiatives fall under primary care, how they work together, etc. It highlights various programs and initiatives that are underway at the provincial, health authority and GPSC level – detailing them at a high level. In some cases this is just a matter of listing all of the different programs that exist for something like palliative or cancer care. For the purpose of this summary, this information has been omitted as it is fairly rudimentary knowledge for those who work within the healthcare system and is really not the 'meat' of the document.

The recommendations put forward in this paper are intended to push the boundaries of what has been done in healthcare so far, and emphasize a need for timely, short and longer term action. MOH notes that there are a set of principles that will be used to drive decision-making related to restructuring and shaping primary and community care:

1. Patient-Centred
2. Integrated and Comprehensive
3. Quality and Value for Money
4. Responsible Operational and Capital Investment

The Leadership Council is currently working on developing a renewed governance structure, which will see the Leadership Council and its Standing Committees play a key role in the implementation policy directions, including the primary and community care action items.

## The Case for Change: Learning from Experience and Building on What Has Been Achieved

This section of the document (which begins on page 108), actually moves the document from being a summary of programs and services/report card, and begins to address the change that must take place in order to move forward. The document lists a number of observations and directions that affirm efforts underway in B.C. and points to next steps.

A key overall objective will be to reduce the complexity and fragmentation of the current service delivery system in a way that is both understandable and practical for patients and their families, providers and organizational stakeholders. An immediate review will be undertaken of the numerous action plans, strategic initiatives and incentives set out above to reduce the complexity of service delivery policy and go-forward actions and initiatives. The document leans heavily on Edwards (2014) to provide an overview of key strategic directions in community based health care.

1) **Reduce Complexity of Services**
   Services should be simplified by creating larger community teams with a single, shared assessment process that can be undertaken by any team member. The team will include specialists (e.g., respiratory problems, Parkinson's palliative care, etc.) but in a role that is more focused on education, support and providing expertise in difficult cases.

2) **Wrap Services Around Primary Care**
   Care teams should include generic and specialist staff including GPs, nurses, support workers, therapists and social workers so that tasks can be delegated to the most appropriate level. Key features of this model include co-location where possible, coherent geography, and organizational leaders that promote collaboration and communication between staff.

3) **Build Multidisciplinary Teams for People with Complex Needs, Including Social Care, Mental Health, Substance Use and Other Services**
   Clear responsibility for patient oversight is needed as the patient moves through the system. Therefore, new models should not remove responsibility for patient oversight from GP practices but instead provide support, case management and other complementary services.

4) **Support These Teams With Specialist Medical Input and Redesigned Approaches to Consultant Services – Particularly For Older People and Those With Chronic Conditions**
   The role of specialists in chronic conditions is to provide direct support, education, clinical governance and specialist consultation to primary and community care teams via joint consultations and case review meetings focused on the patients with the most complex needs. Community providers such as specialist nurses then support these changes by developing specialist disease management services.

5) **Create Services That Offer an Alternative to Hospital Stay**
   Preventing and reducing hospital stays requires high-quality expert decision making as early as possible in the process and rapid access to alternative services and diagnostics. Community-based ambulatory medical units are one promising approach to delivering acute assessment and rehabilitation of frail patients. Edwards offers a set of service design changes that are required to make this happen (Page 111)

6) **Build an Infrastructure to Support the Model Based on These Components Including Much Better Ways to Measure and Pay For Services**
   The model outlined above requires a number of system-wide changes (see Page 112 for complete list)

7) **Develop the Capability to Harness the Power of the Wider Community**:
To substantially improve outcomes, community and primary care services will need to develop very different approaches that are focused on earlier action and health promotion and disease prevention, target particular communities and mobilise the wider community.

## The Next Steps: Focusing and Reenergizing the Commitment to Realize Patient Centered Integrated Primary and Community Care

In addition to reviewing the action plans and strategic initiatives listed above, the following specific policy directions are also proposed and are aimed at the practice, organizational, and provincial levels

### 1. Practice Level - Service Delivery

These practice recommendations will be refined and adapted to the different contexts of metro, urban, rural, and remote areas (see the Rural Health Services in B.C. Policy Paper).

**1.1 Clarify The Role Of Walk In Clinics**

- MOH will look at policy and regulatory options to frame the role of walk-in clinics and ask the MSC to complete a review of compensation levels and the fee for service requirements for this level of health service (completed end of 2015/early 2016)
- Leadership Council will look at policy and regulatory options to provide urgent care in Urgent Care Centres which will be 24/7/365. The Centres will be linked to hospital ERs by location or ambulance for rapid response to emergent higher level medical needs.

**1.2 Support the continued development of full-service family practices that support patients across their life spans but incrementally plan for and support the establishment of team-based family practices as full service sole practitioners retire**

- Leadership Council and the Divisions of Family Practice will identify, certify and list all full-service family practices (sole and group) by community (Local Health Area) in 2015/2016.
- A policy framework for team-based family practice teams will be developed in collaboration with GPSC with the objective that individuals/families will be incrementally attached to the team practice rather than an individual practitioner while supporting the practice of most responsible family physician for continuity of care to patients and their families.

**1.3 Assess and review Patient Attachment (the GP for Me) initiative**

- Complete an assessment of current progress and likely outcomes for the initiative's targeted end date of 2015/2016
- Explore options to expand the definition of patient attachment (including analyzing the level/type of attachment required by sub and priority populations and addressing the need for patient transition from one form of attachment to another).

**1.4 Assess and review In-Patient Care**

- Leadership Council, MOH and DoBC will take a fresh look at the practicality of physicians working in hospitals especially under the individual practice model that dominates practice.
- Will require a broader rethink and debate about the accountabilities of specialists for their patients and the potential expanded role of RNs and NPs in caring for and discharging patients (completed fall 2015 with action undertaken starting April 2016).

**1.5 Assess and review Maternity Care**

- PHSA/Women's Hospital in consultation with obstetricians, gynaecologists and midwives will review and make recommendations on the pros and cons of establishing birthing centres in B.C. (late fall 2015)

**1.6 Systematically and opportunistically establish Linked Community and Residential Care Service Practices for Older Adults with Moderate to Complex Chronic Conditions.**

- Provide continuity and flexibility of care linked to rapid mobilization of services through specialized community-based practices.
- Leadership Council, MOH, HAs, etc, will develop a policy and budget framework to support the development of these practices based on population, patient analysis and a five year roll-out plan.
  a) A range of multidisciplinary practices will be developed across communities with the capacity to address longitudinal health care needs of older adults with chronic medical conditions
  b) These practices will be linked to residential care services that include bed capacity designated for short term acute medical care needs including short-term stays for respite, end-stage palliative care or more short stay interventions than can be provided through home physician and nursing care.
  c) These practices will be linked to assisted living and residential care services to provide proactive care planning, transitions, and continuity of care.

**1.7 Systematically and opportunistically establish Community and Residential Care Services Practices for Patients with Moderate to Severe Mental Illnesses and/or Substance Use Issues**

- Similar to above but changing the older adults to patients including children and adolescents with moderate to severe mental illnesses and/or substance use issues and linking to assisted living, residential care and psychiatric hospital services.

**1.8 Support full service practice teams with appropriate medical specialist shared care and consultations and redesigned approaches to consultant services for older people, those with chronic conditions and patients with moderate to severe mental illnesses.**

- Leadership Council and DoBC will identify and list all relevant medical specialist practices (sole and group) by community (Local Health Area) and develop policy and budget strategies to better align these services.

**1.9 Standardize mental health and substance use treatment and monitor and evaluate services.**

- Begin a dialogue with the PHSA regarding their roles and functions related to MHSU with the intent of clarifying roles and functions with respect to developing standardized treatment modalities for the major presenting MHSU disorders; moving to a scalable and sustainable service delivery system; and monitoring and evaluation of those services provided by the HAs.

## 2. Organizational Level – Operationally Based Enabling Supports

**2.1 Regional Health Authorities in collaboration with Divisions of Family Practice will create the enabling organizational structures and processes in support of the practice directions set out above.**

- HAs and stakeholders will implement an integrated, interprofessional primary and community care model of service delivery in each of their respective communities, based on the population demographics
- Models and specific action will be fully articulated in plans and communication materials for 2015/16 – 2017/18.

**2.2 Increase Practice Support Change Management**

- HAs and stakeholders will establish regionally designated Practice Support leadership team(s) to enable the implementation of integrated, multidisciplinary/inter-professional primary and community care models of service delivery across their rural and remote communities

**2.3 Increase Appropriate Access to Specialist Consultation and Support**

- HAs will establish a formal regional, and where appropriate, provincial network of specialists available by telephone, telepresence and/or visits with rapid access capacity to support primary and community care practices across rural and remote communities (including support for cancer patients through BCCA)
- These services will be provided as a supplement/augmentation to community based, integrated, co-located primary and community care teams providing longitudinal care

**2.4 Implement the Refreshed Dementia Action Plan**

- Over the next three years, implement the Refreshed Dementia Action Plan including the four priorities: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care facilities and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care.

**2.5 Palliative and End-of-Life Care**

- Continue the implementation the End-of-Life Care Action Plan and its key actions
- The MOH will work with partner organizations such as the BC Centre for Palliative Care, iPANEL and the BC Hospice Palliative Care Association on advancing the palliative approach to care and fostering collaborative transitions in care across the system.

## 3. Provincial Level – System Based Enabling Support

**3.1 Governance and Strategic Leadership Review**

- The Ministry of Health will explore with the Doctors of BC refreshing the mandate of the GPSC and expanding its membership to include representatives of community health services.

**3.2 Significantly Strengthen Human Resources Planning and Management for the Primary and Community Care Sector**

- **3.2.1** Workforce optimization and team development actions
- **3.2.2** Recruitment and retention actions
- **3.2.3** Changes to education, training and professional development to support quality improvement
- **3.2.4** Utilization of compensation and practice incentive strategies
- **3.2.5** Changes to professional regulation and oversight
- **3.2.6** Ensuring integrated forecasting and planning and associated policies, to better address issues of supply, mix and distribution of primary and community health care professionals throughout the province.

**3.3 Improve Data and Analytics to Support the Strategic Direction**

- In 2015, MOH will complete work on developing a standardized data set to be used across primary and community care services

**3.4 Strengthen Information Technology**

- In 2015, MOH will complete work on developing a standardized data set to be used across primary and community care services to support continued and improved use of IM/IT in primary and community care services across the province

**3.5 Complete Telemedicine Review**

- MOH will develop telemedicine policy recommendations to ensure that emerging telehealth technologies are leveraged to support current strategies and objectives and deliver benefits to key populations.

**3.6 Complete Legislative, Regulatory, and Policy Review**

- In 2015, MOH will conduct a review of the relevant statutes, regulations, policies, standards and guidelines to ensure they are positioned to support primary and community care transformation and bring forward any recommendations for change by late September 2015.

**3.7 Mental Health and Substance Use Regulatory and Policy Review**

- MOH will review its policy and regulatory options to create a more coherent provincial system of mental health and substance use services including health promotion and illness prevention to ensure the services are well-coordinated and integrated into a broader provincial system of health care.

**3.8 Improve Accountability and Implementation**

- MOH through the Health Service Policy and Quality Assurance Division, will establish primary and community care public reporting, monitoring and impact/outcome assessment mechanisms for deployment by the end of 2015.

## Nursing Analysis/Assessment of the Primary and Community Care Paper

Given that this document is a synthesis of more than 128 pages, it clearly does not cover every single detail that is included in the overall Primary and Community Care Strategy. However, there are some salient points that the nursing profession can draw from this paper. The following analysis includes observations made from nurses across a range of consultations and from all nursing groups (LPNs, NPs, RNs and RPNs). It will continue to build and develop as further discussion with nurses occurs across B.C. Observations and suggestions are welcome and will add to this inventory or recommendations.

1) For the first time, the Ministry of Health (the "Ministry" or "MOH) links primary health care together with home and community care. This is an interesting decision, not only because it makes this particular paper huge, but it also signals a shift in thinking, while shedding some light on a problem the Ministry has had for years: defining primary care (described here as the foundation of Canada's health care system – providing a critical entry point of contact to the health care system and serving as the vehicle for ensuring continuity of care across the system.) This paper notes that primary and community care delivers more than 30 million health care services each year in BC, at a cost of $5.4 billion. It is, without question, the part of the health care system that most British Columbians have contact with each year.

2) This document follows on the heels of two others: the 2007 Primary Health Care Charter, which set a goal of creating a strong, effective, accessible and sustainable health care system for British Columbians. Despite consultation with almost 30 stakeholder groups, the Charter has always been controversial within the nursing community, painting a strong picture with physicians while largely ignoring all other health professions; and the more recent (April 2014) *Setting Priorities for the BC Health System*. To be fair,

government has improved markedly on including other health professions as part of the discussion. It has come a long way towards using more inclusive language. However, there continues to be enormous focus on Doctors of BC and the Divisions of Family Practice as the vehicles through which these projects and solutions will be developed, operationalized and sustained. Nursing needs to be more than patronized in documents such as this. In particular, while there are some 'shout-outs' to nurse practitioners, the section on GP4Me and Attachment still takes a very physician-centric approach. There is still work to be done. Now that nursing has been included as part of the vernacular, it needs to be included as well in operations.

3) Most references appear to be missing. This is a government document, and it is important to understand where information is being drawn from. When referring to academic work or research, there are references to various experts. However, when listing its own services and programs, government has included few references to how the information was gathered and considered for publication in these documents. If readers are aware of how government documentation is created, this is not a problem, but if readers are not, then the assumption should be similar to when reading a favourite newspaper or watching a specific news channel – there are biases, omissions and 'spin' that make a story sound better or worse, depending on the desires of the reporter. It is worth being cautious and recognizing that a great deal of the background information in these Policy Papers contains the government's 'spin' on its own programs. Nursing presents itself as being evidence-informed – which makes the inclusion or omission of references significant.

4) The first 107 pages of this document, while written as a 'case for' primarily highlight the good work that government believes itself to have been doing (at least in the past 14 years since this particular government came into power). What is missing are the programs and services that have effectively worked but are now defunct or discontinued, or the programs and services that didn't work. NP4Me is not mentioned once in this document, yet it was a program and project with significant dollars committed and was advertised as a solution in primary care. Aboriginal is mentioned 29 times in the document – all within the first 88 pages, with no mention of Aboriginal people or solutions in the Next Steps section.

5) One of the comments about this particular paper is that while primary care has been evolving for some time in Canada, B.C. appears to be a bit behind some of the other provinces in terms of moving forward. This paper appears to recognize that, but the general feeling of nurses is that some of the slowdown and lack of progress is likely due to electronic record keeping, a project which has moved much slower than anticipated, with each health authority having its own idea of how to progress.

6) There appears to be a lot of power given to Divisions of Family Practice – many of which refuse to include the nursing family. Government should consider framing this so that all professions are included in creating structures and that the most responsible provider is the one who is on hand as the primary caregiver.

7) With respect to the walk-in clinics recommended in the document (section 1.1), it is important that nursing be engaged in the planning and implementation of these clinics. All four of B.C.'s nursing groups (RNs, LPNs, RPNs, NPs) have skills that would be beneficial for these clinics. It has been noted that primary health care networks seem to have been fizzling away, and there continues to be concern that this is occurring. When there is strong evidence that these networks and clinics have positive outcomes for patients, why are we closing them down rather than building them up? Instead of a GP4Me or NP4BC, why not PC4Me (Primary Care for Me) that is inclusive of all healthcare providers including all four nursing groups (RNs, LPNs, RPNs, NPs)?

8) LPNs and RPNs are nurses, but it is not entirely clear when they are and are not included in primary care. For example in section 1.4, "This will also require a broader rethink and debate about the accountabilities

of specialists for their patients and the potential expanded role of registered nurses (RNs) and Nurse Practitioners in caring for and discharging patients." Sentence should read "This will also require a broader rethink and debate about the accountabilities of specialists for the patients and the potential expanded role of nursing (RNs, NPs, LPNs, RPNs). This limits the work to RNs and NPs and does not necessarily accurately reflect the work that LPNs and RPNs do and their engagement in caring for and discharging patients.

9) Section 1.6 indicates that government will systematically and opportunistically establish Linked Community and Residential Care Service Practices for Older Adults with Moderate to Complex Chronic Conditions. This is all about services and flow, rather than an approach to practice that considers how to transform the system so that individuals can take care of themselves. We need to move away from 'fixing' people and focus on providing them with the tools they need to look after their own best health.

10) Section 1.9 states that government will standardize mental health and substance use treatment and monitor and evaluate services. RPNs, in particular, have noted that a heavier focus on health promotion and psychosocial rehabilitation is needed.

11) While Section 2.5 does not mention specific health professions in terms of palliative and end-of-life care, this is an area where the failure to mention RPNs as a possible solution really stands out. RPNs can deal with the medical and mental health concerns experienced during end-of-life. Some units in B.C. hire RPNs for palliative and end-of-life care, but others still insist on only hiring RNs. This is not the best use of health professionals and is not considered to be best practice by those who work within the mental health community. Further integration of RPNs into end-of-life care would be beneficial for patients and the system.

12) Section 3.3 notes that there needs to be changes to how government handles and measures Information management/information technology (IM/IT). Nursing needs to be prepared to submit metrics that are reasonable as this process moves forward and not wait until metrics are levied. We have seen this particularly with NPs, where data and information has been requested that was not efficient or effective and did not further the practice of NPs or benefit patients. Involving nursing in deciding what is measured will be an important part of the success of any new developments in this area.

Despite some challenges, this Policy Paper is a refreshing change from previous primary care documents published by government. It will require some careful consideration of where the nursing voice is not adequately engaged, and how to ensure the knowledge, expertise and innovation of the nursing community is brought forward. It needs to be noted that nursing would like to participate on equal footing at these discussions, not merely as a subset of whatever discussion the physicians are having.

There is great opportunity for the four nursing associations to work together to achieve some of the tangibles mentioned in this document. There is specific mention of potentially changing the GPSC to include additional health providers, and this is something nursing needs to advocate hard for. Most of the structures listed in this document – GPSC, MSC, Divisions of Family Practice – continue to exclude health providers aside from physicians (e.g. most Divisions of Family Practice do not welcome nurse practitioners). This is a significant challenge, and worrisome when the document continues to talk about these historical structures as being the "leaders" in moving these policy initiatives forward. Specifically there are numerous opportunities for nursing to take a leading role in informing government about the role nurses can and should have in strategizing around these papers, developing proposals and support mechanisms to ensure the goals of the papers are achievable and implementing many of the options that are laid out. It is important to remember (and occasionally remind), that none of this will be possible without the support of the nursing profession.

## Surgical Services Summary

The Surgical Services Paper can be divided into three key parts. The first sections which include the Executive Summary, Introduction and Strategic Context consume the first 41 pages of the 55 page document. These sections, while providing important background information, are very generally described here under the section entitled Introduction. The Introduction section highlights the context and successes in surgical services in British Columbia. While the information is useful as a resource, those who are invested in the healthcare system as providers, managers or administrators, will be familiar with the programs and services that are discussed.

The 'meat' of the document is from page 42 – 55 and encompasses "The Case for Change" as well as "The Next Steps: What We Propose to Do, When and How it Can Be Achieved".

**Introduction**

This paper describes a planning and action framework that will be used to drive the policy direction which will be built on five elements:

1) understanding population and patient surgical health care needs
2) developing quality and sustainable surgical care delivery models; recruiting and retaining engaged, skilled health care providers
3) using IT/IM tools and processes as supports to allow innovation and effective coordination and delivery of surgical services
4) using financial models to support the achievement of intended health system outcomes
5) using all of these elements across the province.

**The Case for Change**

Surgical Services were selected as a key priority for these policy papers for a number of reasons:

1) From a patient as consumer perspective, information about the dimensions of quality of surgical services is neither robust nor easily accessible.
2) Patients can experience less than optimal or expected outcomes because the steps to optimize their recovery at home after the surgical procedure are not consistently well mapped out before surgery.
3) The system is still built predominantly around individual surgeon practices interfacing with a complex array of surgical supports that includes a wide range of health care providers, physical resources (hospitals, operating rooms, clinics, inpatient services, among others), laboratory and diagnostic services, technology, specialized equipment and pharmaceuticals.
4) At the local level, OR capacity is not used in the most efficient and effective way to optimize access to surgical services.
5) Inadequate surgical health human resources management can also create additional challenges through shortages of required care providers (surgeons, anesthesiologists, specialized nurses, perfusionists, among others) or oversupply of others.
6) Hospitals which experience over-capacity pressures in their ER and medical inpatient units may cancel scheduled surgery to accommodate patients who need to be admitted to hospital.
7) There is incomplete information for the patient about the steps in their surgical journey, leading to the "black hole" phenomenon about what will happen, when, and by whom.

## The Next Steps: What We Propose to Do, When and How it Can Be Achieved

The Provincial Surgery Executive Committee (PSEC) has been given the mandate and authority to drive the identification and implementation of surgical improvement actions built on the principle of a collaborative partnership between patients, the health authorities and physicians supported and enabled by the Ministry of Health, the BC Patient Safety & Quality Council, relevant health professional Colleges, the Doctors of BC and relevant unions.

### 1. Practice Level - Service Delivery

**1.1 Implementing a Patient and Family Centred Approach to Care**

- This starts with acceptability and information.
- Will include a requirement for fully informed consent based on comprehensive, plain language material available on-line and in printed format given to the patient, along with fulsome discussion.
- Will ensure there are easy-to-access and well-known ways for patients to provide feedback during their journey in care.

**1.2 Implement Practice Guidelines for Consulting with Patients on Treatment Options**

- Consultation on whether surgery, or which type of surgery, is the best option is a key issue for a range of conditions and/or contingent on the age and/or other medical conditions of a patient.

**1.3 Encourage, Support and Implement Alternative Practice Models**

- HAs will work with surgeons, anesthesiologists, nursing and allied health professionals at a different level of collaboration than experienced to date, to opportunistically and systematically pursue these options as alternates to the current provider-centric model

### 2. Organizational Level

**2.1 Patient Engagement**

- HAs will ensure patient advisors or representatives are welcomed as members of the senior level Surgery Committee and Surgery Quality Council in each health authority to add their contribution to planning, implementation, and care delivery improvement.
- Patients will participate as advisors on local quality, planning, service implementation and care delivery committees

**2.2 Implement a Patient Centred System for Surgical Care**

- HAs will work with surgeons, anesthesiologists, nursing and allied health professionals to develop standardized care pathways and evidence-based timelines for specific surgical patient groups linked to: high volume routine surgical procedures; complex high resource surgical procedures
- LEAN methodology will be applied to the patient journey map for surgical care, including all the steps in the process, such as time for diagnostics and laboratory tests, and follow up care after discharge from hospital
- HAs will expand the use of telehealth services for pre-surgical assessment and consultation, post-surgical follow-up visits, and education for rural and remote areas where possible

**2.3 Optimize Surgical Infrastructure, Eliminating Backlogs, Ensuring Flow Based on Appropriate Timelines**

- HAs will continue to move appropriate surgical procedures from the operating room to procedure rooms, from inpatient care to day care or short stay care, and to private surgical centres using public funds.
- Shift thinking from the resources being owned by the providers, to viewing the resources as

available to serve patients.
- Get clear on what service is appropriate to be provided where a difficult conversation needs to occur.
- The range of options adopted must address timely access, eliminate backlogs and mitigate overcapacity pressures from Emergency Departments and medical inpatient units that result in cancelling scheduled surgery.

**2.4 Optimizing Surgical Supply Costs**
- Leverage the use of Health Shared Services BC given the high importance of procurement of surgical supplies in service delivery.

**2.5 Improve Quality Monitoring and Reporting**
- Introduce NSQIP to all hospitals in B.C.
- Consistently report and monitor the quality indicators pertaining to surgery at the local and health authority level and provide provincial level reports to PSEC.

## 3. Provincial Level – System Support

**3.1 Optimize Wait List Management**
- Develop a five-year plan (based on population growth projections, an aging population, etc.)
- Determine the optimal targets for wait time performance to achieve in five years
- Define and rename wait times to use words that mean something to patients

**3.2 Develop and Implement a Comprehensive Performance Measurement, Reporting and Accountability Framework for Surgical Services**
- Define the optimal state of quality performance for surgical services, meaning "what will it look like in five years?" including accurate, comprehensive, transparent performance data, including what the patients and providers say
- MOH and PSEC will establish a public reporting, monitoring and impact/outcome assessment mechanism starting April 2016

**3.3 Implement a Surgical Health Human Resource Strategy**
- MOH, PSEC and HEABC will develop and implement a provincial surgical health human resource strategy
- Population health needs will drive the health human resources strategy

**3.4 Implement a Provincial Surgical IM/IT and Technology Strategy**
- Establish the Surgical Enterprise Architecture model in 2015 as the solution for surgical wait list management, surgical booking, and synchronization of wait list data between the various stakeholders to create a single and reliable source of information for surgical services.
- Complete implementation of a fully functional EHR
- Expand the telehealth services for pre-surgical assessment and consultation, post-surgical follow up visits and patient education
- Prototype electronic referrals between family physicians and surgeons
- Align the surgical services framework with the Health Technology Review
- Continue to strengthen the quality, robustness, and access of health related data in B.C. that results in evidence to improve policy, make health care stronger, and enhance the health of the population

### 3.5 Align Funding and Costing Strategies to Support Policy Directions

- Analyze options where funding follows the patient or where the patient directs the funding
- Introduce a costing methodology in B.C. to quantify costs of care along the surgical care continuum that will inform decision making and support planning for future services.

### 3.6 Align Legislation, Regulation and Policy

- Changes will be required to the Hospital Act if select surgical services are to be performed outside the acute care hospital setting by private surgery centres using public funds
- Establish a link with the private surgery facilities to enhance dialogue and planning as it pertains to surgical services and options available to patients to support their own choices

### 3.7 Provincial Surgery Executive Committee Role

- PSEC will drive a common vision and comprehensive policy framework, inclusive of the entire surgical care continuum, that gives priority to improving the quality of surgical services and embeds the philosophy of patient centred care into strategic and operational processes
- PSEC will publish a three year action plan on next steps and targets to improve surgical services in B.C. in March 2017
- MOH will establish a Surgical Services Secretariat to support and facilitate.

## Analysis/Assessment of the Surgical Services Paper

This document does not cover every single detail that is included in the overall Surgical Services Paper. However, there are some salient points that the nursing profession can draw from and should consider.

1) While it would seem that this document would have the least nursing elements (aside from pre and post surgical care), it is actually written from a very strong patient perspective, and tackles systemic issues such as wait times head on. As a result, this is an important paper for the healthcare system and will have great impact on nursing.

2) The concept of changing the common terminology around wait times, to language that resonates with patients, is something that will certainly be important to nursing, as nurses can be the educators and early adopters for this important system change. “Wait times” has become a bit of a curse, but does not accurately reflect how patients view their surgical journey – “what is the wait time before I go into surgery” is not the same question as “what is the wait time before I can drive my car post-surgery”. This small point could be ground-breaking for patients and change the discussion around wait times in British Columbia to more accurately reflect the situation patients face as they await a procedure.

3) The role of nursing (LPN, NP, RN) is not highlighted at all in this document. It will be important for nursing to engage on this topic, and would be useful for the Coalition to engage with the Peri-Operative Registered Nurses Association of BC and other similar organizations (ie, ORNAC) to understand and inform nurses’ perspectives on the role of each nursing group and provide opportunities for the nursing community to contribute their expertise and advice on implementing some of the directives recommended in this paper.

4) It has been noted that there is a clear lack of opportunities for LPNs to access education that supports both scrub and circulating roles in peri-operative, ambulatory and surgical day care. This would support the broader use of LPNs in the system, and is within the LPN scope of practice. These roles for LPNs need to be supported by government and the LPN regulatory body (CLPNBC).

5) The paper does not touch on the concept of Nurse Anesthetists which have been introduced very successfully in the United States (in the US, approximately 70% of anesthesia is given by advanced practice nurses). There is a shortage of anesthetists in British Columbia and this could be somewhat alleviated with the introduction of Nurse Anesthetists.

6) Section 3.1 deals with optimizing wait list management. There is a huge opportunity for nursing to engage and make recommendations on this topic, particularly around triage and case management – re-evaluating patients, bringing, them back when necessary, etc. There has been great and innovative work done in this area (ie, Hip and Knee), where patient outcomes have been optimized. Nursing has a wealth of best practices and innovative solutions that can inform this issue.

7) It was noted that there is not much discussion in this document about Advanced Care Planning, which has been a particular focus of a number of B.C. groups and is strongly encouraged for families and patients. It would be welcome to have more discussion of the importance of this in the document, including education around how to encourage patients and their families to plan in advance.

This paper particularly focused on patients, which is a good sign. Rather than focus on specifics set out by the CPSBC and Doctors of BC, it instead focuses on the patient journey from initial diagnosis, through pre-op and post-op care. This is a strong step in the right direction for the healthcare system, and if implemented correctly, will have enormous impact on the BC healthcare system.

## Rural and Remote Summary

The Rural Health Services Paper can be divided into three key parts. The first sections which include the Executive Summary, Introduction and Strategic Context consume the first 18 pages of the 42 page document (excluding the Community and Hospital Classification Framework which begins on page 45). These sections, while providing important background information, are very generally described here under the section entitled **Introduction.** The Introduction section highlights the context and successes in surgical services in British Columbia. While the information is useful as a resource, those who are invested in the healthcare system as providers, managers or administrators, will be familiar with the programs and services that are discussed.

The 'meat' of the document is from page 19 – 44 and encompasses "The Case for Change" as well as "The Next Steps: What We Propose to Do, When and How it Can Be Achieved".

### Introduction

This introduction sets the state for rural and remote health service in British Columbia, covering demographics, Aboriginal Peoples, Population Health Status and Trends, and some of the social determinants of health which are unique to rural areas such as employment, socio-economic status, lifestyle, prevalence of chronic disease, maternal health, higher rates of mortality and lower life expectancy. Generally speaking, unlike the other three priority papers in this series, this section focuses on the statistical disadvantages living in rural areas can have on health, and does not go into detail on all the programs and services that are offered by the Ministry. This is a good primer to understanding the disparities between rural and urban living in British Columbia.

### The Case for Change – Strengthening Current Service Delivery and Capacity

**1) The Scope and Challenge of Providing Health Care Services in Rural British Columbia**

- Those consulted for this paper have noted that the unique character and demands of rural life require specific delivery principles:
  - Population Health Need
  - Shared responsibility – responsibility for a healthy population is shared between individuals, the community and health service providers
  - Flexibility and Innovation – emphasis will be placed on sharing and spreading innovative approaches
  - Team based approaches
  - Cultural Safety
  - Close to Home

**2) Structuring Service Delivery Structure for rural BC**

- Population Health and health Promotion
- Integrated Primary and Community Care Practice as the Key Building Block for Rural Health Services
  - Generalist Health Care Providers – can be recruited and deployed using two approaches – staff mix and skill management
  - Linkages to Specialized Regional or Provincial Service Expertise
  - Perinatal Care
  - Home and Community Care and Access to Residential Care
  - Emergency Health Services and Access to Higher Levels of Emergency Health Care
- Hospital Services in Rural Communities – includes classification of hospitals (who has acute, who is 24/7, what is the service mix, what support services are available.) The immediate focus of the

rural strategy will be:

- Clarifying and publicizing the regional distribution of hospital services and any plans for changes
- Clarifying referral pathways and timelines
- Focusing on and reporting the level of and quality of services provided in rural hospitals

**3) Health Human Resources in BC**

- Focuses on physicians, nurses (certified registered nurses, nurse practitioners), allied health professionals
- Recommends additional incentives for nursing and allied health professionals to work in rural areas and recognizes the disparity with physician incentives

4) **Information Management and Technology**

- Need for a common EHR
- Increased Telehealth

## The Next Steps

In addition to reviewing the action plans and strategic initiatives listed above, the following specific policy directions are also proposed aimed at the practice, organizational, and provincial levels

### 1. Practice Level - Service Delivery

**1.1 Health Promotion and Disease Prevention**

- HAs and local communities will work together to develop three year local community plans for all rural and remote communities to create environments that foster healthy behaviours and programming that improves the health of the population

**1.2 Primary and Community Care**

- Regional Health Authorities will implement an integrated, multidisciplinary primary and community care practice in each of the rural and small rural communities (based on population size it is recognized that certain rural communities may need more than one practice)
- Will be co-located and linked to additional services
- Will link to FNHA and incorporate traditional medicine models

### 2. Organizational Level – Operational Supports

**2.1 Practice Support Teams**

- HAs and partners will put in place Practice Support teams by June 30, 2015 to enable the implementation of integrated, multidisciplinary primary and community care practices across their rural and remote communities
- Will establish Collaborative Support Committees
- Will play a role in supporting the assignment and/or recruitment of health professionals

**2.2 Home Support and Residential Care in Rural Communities**

- HAs will explore innovative and cost effective service options to support aging in place and seek clarity on residential care options

**2.3 Access to Specialist Consultation and Support**

- HAs and PHSA will establish a formal regional provincial network of specialized teams available by telephone, telepresence or visits with rapid mobilization capacity (end of 2015)

### 2.4 Emergency Health Services and Access to Higher Levels of Emergency Care

- BCEHS will review inter-facility patient transfers that occur by ground ambulance to improve emergency response capacity and ensure timely, quality pre-hospital care in rural and remote areas (October 2015)
- BCEHS will report out on demand analysis and deployment modelling to ensure air ambulance resources and critical care paramedics are optimally located and deployed
- BCEHS and MOH will make changes to the regulatory framework and expand roles for paramedics to enable more effective use of advance care paramedics in rural and small urban centres

### 2.5 Rural Hospitals

- Regional HAs will provide information for their communities on their websites on the range of hospitals available across their region, the level of care provided by those hospitals, pathways to accessing care at those hospitals
- Will establish a rolling three year plan for their hospitals that gives clarity to patients and community around service directions
- No later than April 2016/17, quality indicators will be routinely reported on hospitals through the MOH and HA websites

## 3. Provincial Level – System Supports

### 3.1 Health Human resources Planning and Management

- Develop and implement funding and compensation mechanisms to support health professional staffing models for the primary and community care practices in rural and remote communities, as well as the formal regional and where appropriate, provincial network of specialized teams.
- Optimize scope of practice, skill mix, and skill flexibility to support the rural primary and community care practice model.
- Work with the Doctors of BC, the Joint Standing Committee on Rural Issues, RCCBC, the UBCFOM and Continuing Professional Development Department and others, to better elaborate and support, through training, generalist models of physician practice in rural communities throughout the province.
- Complete a review and make recommendations for improvements and additions to incentive and support programs for health human resources in rural and remote communities linked to the evolving practice models.
- Work with HEABC to focus on improving timely recruitment and deployment of health professionals to rural and remote communities.
- Review opportunities for expansion and distribution of education and training programs specifically for nursing and allied health care workers within Interior, Northern and Island Health Authorities, in order to support education and training of individuals closer to their communities
- Examine policy tools available for government and health authorities to have more effective influence on distribution of health care professionals throughout the province.

### 3.2 Accountability And Implementation

- Establish public reporting, monitoring and impact/outcome assessment mechanisms for deployment

## Analysis/Assessment of the Rural and Remote Paper

This document does not cover every single detail that is included in the overall Rural and Remote Paper. However, there are some salient points that the nursing profession can draw from this paper and should consider.

1) Although the Rural and Remote Paper fits the template of the other two Priority Policy Papers, it is less direct, and potentially less effective, than its counterparts. While the document does a decent job of describing the challenges of provide rural and remote health services, it is limited in terms of specific details for moving forward. Unlike the other documents, there is very little discussion of the types of taskforce, committees and consultations that will be required to move this plan forward. For example for "Home Support and Community Care", the next step is basically to review the programs to see what needs to be done. This feels a bit 'lean' (and not in the LEAN way referred to elsewhere).

2) Hidden way in the back of this strategy is the line, "No later than April 2016/17, quality indicators will be routinely reported on hospitals through the MOH and HA websites". This is something that many jurisdictions do, and ARNBC has been championing to have occur in B.C. for quite some time. What is included in the quality indicators is of concern to nurses (e.g., mortality rates, infection rates or simply positive results?) Will this information be 'spun' or standardized to include even harsh and unfortunate statistics which imply room for improvement? Will there be stats on errors by staff? It would be helpful for the nursing associations to have input into what these quality indicators are that will be reported.

3) Health promotion and health maintenance is a major focus of psychiatric nursing and has been for some time. RPNs have moved away from the medical model and focus primarily on health promotion, therapeutic relationships and therapeutic use of self and diversity. The recovery model found in psychosocial rehabilitation matches well with psychiatric nursing. RPNs look at the patient holistically – individuals are not seeing RPNs for a medical condition but rather complications with it and the emotional, social, mental and environmental aspects that surround the life of the client. RPNs have been working within a case management model for some time and as a result, what would work better is to have the best professional oversee the client - and that may not be a GP. This is especially true in mental health. The many cases, the client can be well managed with a multi-disciplinary team approach which would include RPNS, NPS and psychiatrist – but not the GP.

4) Although the document does recommend the accelerated integration of nurse practitioners into the system, the section on nurse practitioners does not explore the possibilities of further integration, nor does it appropriately describe NP4BC (merely suggests it was a great program that increased the number of NPs in rural areas). While NP4BC was the vehicle for hiring NPs, the program was not well developed or executed by the MOH or HAs. It could be argued that more NPs would have been hired had the program been completely different. There is opportunity to utilize all types of nurses in a much more integrated and cohesive way across rural and remote communities.

5) The fact that there is one small section on nursing (primarily focused on RNs and NPs) in this document is somewhat disappointing. Rather than integrating them throughout, or calling attention to the strengths of improving the position of nursing in rural healthcare, there are short subsections for each. There must be space made for discussion with nursing (LPNs, NPs, RNs, RPNs) about how it can inform and innovate within the system in a similar way as physicians.

6) There is limited discussion around engagement and supply inequity, and this is something that must be explored. It is much more difficult, for example, to get a walker in the far northern parts of rural B.C. than it is to get one in Burnaby. There needs to be more adept ways to supplement and enhance supply and delivery in rural areas. At the same time, telehealth should play a greater role.

7) The hospital classification of rural community hospitals and the services attached appear to be problematic in terms of risks around labour issues and geopolitical implications. Further exploration of this system, and discussion around its benefits and oversights would be helpful and should include nursing as part of the discussion.

8) Nurses should have autonomy over what and how they are educated. If a nurse wishes to take a course to further their knowledge or specialization, they generally have to go through many approvals in order to get funding, time off, etc. However, nurses are professionals, and should be afforded the opportunity to decide what education they need and what courses or activities will help them achieve their career goals. Funding to support ongoing continuing education is a 'given' for physicians, and needs to be considered for all nurses (excluded, management, clinical, research, etc.)

9) Section 1.1 references the three-year community plan, but raises a number of questions. Who is responsible for developing and implementing the plan? Are Divisions of Family Practice responsible for this? Nursing needs to be engaged in these plans, however government has not implemented structures similar to the Divisions that would enable this type of planning for the nursing community and for the most part, nursing is not welcome within the Divisions.

10) This document does not mention a significant rural concern which we have heard frequently from rural nurses – that nurse managers have been replaced often with mid-level business people and that this is a glaring problem in small, rural hospitals where understanding of the business of healthcare is not present in those who are hired. Ontario has enacted a policy that requires all hospitals of any size to have a designated Chief Nurse. Nursing Associations will continue to advocate for this type of model in B.C., particularly as there is a lack of nursing leadership across the province. Section 2.1 speaks of leadership, but does not note that often businesspeople are now managers in charge of health care teams. This has been a significant change in our health care system, and has been troublesome for many professions, but nursing possibly the most. Nurses are needed for operational leadership.

11) In Section 2.4, the role of emergency health services is touched upon. There are a number of very successful models that include paramedics within the broader health services, and in particular to support home support – advance referrals, NPs riding with paramedics, etc. There is a large body of literature, as well as case studies, of how EHS can be more broadly used within the health care system. The ARNBC Select Standing Committee on Health Submission discussed using paramedics more broadly in 1) Emergency Room, 2) Home Health, 3) Long-term/Residential Care.

## SUPPORTING DOCUMENTS

### BC Patient-Centred Care Framework

The BC Patient-Centred Care Framework is a short document which is intended to build on existing efforts and accelerate the adoption of patient-centred care practices in B.C. by creating a common understanding of what patient-centred care is and a shared vision for adopting it.

The document cites four core principles for patient-centred care that will provide a foundation:

1) Dignity and Respect
2) Information sharing
3) Participation
4) Collaboration

Four patient-centred care practices are presented to help guide health care organizations in the pursuit of patient-centred care:

1) Organization Wide Engagement
2) Workplace Culture Renewal
3) Balanced Patient-Provider Relationships
4) Tool Development

This is a good, high level document. Discussion is underway for all four nursing associations to consider endorsing this document, as the principles and objectives are quite strong.

## Health Human Resources Summary

The Health Human Resources Paper can be divided into three key parts. The first sections which include the Executive Summary, Introduction and Strategic Context consume the first 34 pages of the 73 page document. These sections, while providing important background information, are very generally described here under the section entitled Introduction. The Introduction section highlights the context and successes in health human resources in British Columbia. While the information is useful as a resource, those who are invested in the healthcare system as providers, managers or administrators, will be familiar with the programs and services that are discussed.

The 'meat' of the document is from page 35 – 73 and encompasses "The Case for Change" as well as "The Next Steps: What We Propose to Do, When and How it Can Be Achieved".

### Introduction

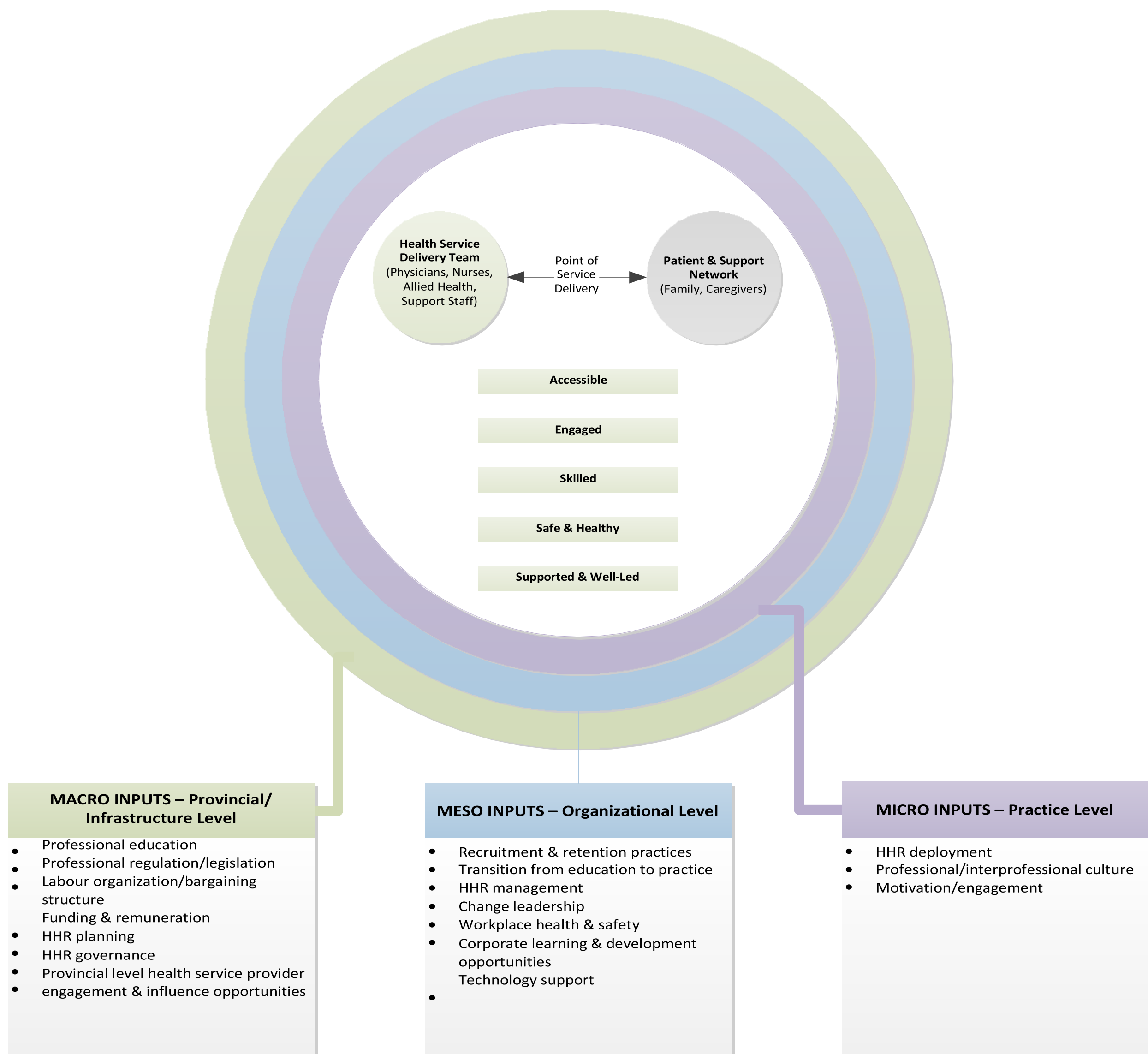
The HHR paper sets out a proposed framework to structure and align actions across different levels (practice, regional/organizational and provincial), across the scope of service delivery (public health, community, diagnostics and pharmacy, and hospital), and across delivery settings (metro, urban, rural, remote). The two key assumptions are 1) a successful HHR strategy will require health system stakeholders to build a substantial level of consensus and 2) implementation of this strategy will require significant collaboration.

The challenge of HHR Management

1) Health care is made up a large and complex system of health service provider groups and the organizations that represent, regulate or employ them.
2) The effective execution of an HHR strategy requires buy-in, cooperation, and coordination with this large and complex system.
3) B.C. must provide a distributed service delivery system across a large geographic area which includes metro, urban and rural communities.
4) It is difficult to forecast future HHR needs

In addition to this summary document, each of the policy papers has different implications for HHR (to see the specific linkages to each of them, view page 31 - 33 of the full Policy Paper *Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Human Resources).*

## The Case for Change – a Conceptual Model for HHR Management and Assessment of Current Capacity




## The Next Steps

### 1. Establishing a Coherent Policy Framework

**1.1 The Ministry of Health in collaboration with Health Authorities, Colleges, Associations and Unions, Educators, and other stakeholders, will establish a single provincial Health Human Resource Framework that will be used to plan, link and coordinate go-forward actions and initiatives.**

## 2. Enabling Effective Cross Sector HHR Management

**2.1 Leadership Council will establish a Standing Committee on Health Human Resources (SCHHR) as BC's senior level HHR governance structure, reporting into Leadership Council.**

- The Committee will report to Leadership Council, and consist of core membership from the Ministry of Health, the health authorities, HEABC and the First Nations Health Authority. Health authority representatives will consist of Vice Presidents, Human Resources; Vice Presidents, Medicine; Chief Nursing Officers, and other representatives as determined.
- Ad hoc participants will include other government agencies, regulatory agencies, educational institutions, professional associations, unions, non-profit organizations and patient representatives.
- Draft terms of reference for the Committee are currently out for consultation with the parties affected.

**2.2 Develop and implement an HR Deployment methodology linked to an effective, thoughtful workplace redesign methodology.**

- Develop a provincial approach to managing HR deployment and thoughtful workplace redesign processes

**2.3 By September 30, 2015, Health Authorities will complete an organizational change management assessment of their organization's current capacity, approaches and infrastructure.**

**2.4 By September 30, 2015, Health Authorities will complete an HHRM (including physician human resource management) assessment of the organization's current capacity, approaches and infrastructure.**

**2.5 The Ministry of Health and the Health Employers Association of BC (HEABC) will complete the development of a new Integrated Health Human Resource Planning (IHHRP) tool to improve the province's HHR planning ability.**

- The IHHRP model will use information on the health of the population, utilization of health services from the Health System Matrix, and data from the Ministry of Health and HEABC to generate specific health service provider information geographically and by designation (i.e., metro, urban, rural and remote).
- The model will forecast the number, type and location of providers required to provide appropriate health care services on an annual basis over a five and 10 year projection. Authorized staff from the Ministry of Health, HEABC, and the health authorities will be able to adjust the forecasts according to real or hypothetical changes in service delivery approaches and trends.

**2.6 Inventory of public and private post-secondary education and training programs, including clinical placement capacity.**

- Will identify opportunities to re-align these programs with population health needs. The inventory will be completed by September 2015.

**2.7 Patient-centred, culturally sensitive and inter-professional learning opportunities.**

- Ensure curriculum for health care workers supports development of patient-centred, culturally sensitive and inter-professional professional and organizational cultures.

**2.8 Enable effective transition to practice in the BC health system**

- Health authorities, in partnership with academic institutions, the colleges, and the associations and unions representing health professional staff; will form a task force on transition to practice and develop recommendations with respect to
  - a) priority objectives for improving transition to practice,
  - b) an action plan of strategies and tactics for achieving those objectives
  - c) methods, indicators and success criteria for measuring achievement of those objectives.
- The task force will report its recommendations to the Leadership Council by March 31, 2016.

**2.9 The SCHHR will lead the development and implementation of a leadership and management development framework for both the senior management and senior executive management of the B.C. health system.**

- HAs will conduct a current state inventory of health leadership and management operational capacity; programs being used to develop leadership and/or management skills; as well as a comprehensive literature review and analysis of best practice and emerging trends in health leadership and management development nationally and globally with a specific focus on health care transformation.

**2.10 The SCHHR in collaboration with the Doctors of BC and health unions will round out and ensure the implementation of an inter-professional multilevel engagement strategy that builds from existing agreements and processes to support the creation of inclusive, vibrant and healthy workplaces across the health sector.**

- The framework will ensure rigorous discussion with physicians, nurses, allied health workers, and health support staff about healthcare practices and change.
- Clearly articulated, specific and measurable healthy workplace objectives linked to the engagement framework will be developed by each health authority. Achievement of these objectives will be monitored, measured and reported to Leadership Council on a quarterly basis.

### 3. Enabling Strategic Policy Paper Directions

**3.1 The SCHHR in collaboration with Health Professional Colleges, the Doctors of BC, health unions and other relevant provincial stakeholder groups, will undertake specific planning to take coordinated HR actions across different levels (practice, regional/organizational, and provincial), across the scope of service delivery (public health, community, diagnostics and pharmacy, and hospital), and across delivery settings (metro, urban, rural, remote) in support of the directions set out in the Primary and Community Care, Surgical Care and Rural Health policy papers.**

## Analysis/Assessment of the HHR Paper

The HHR Supporting Document pulls together the ideas raised in each of the preceding priority papers, which include small sections on the need for HHR. It has some strong ideas that will need to be investigated further, but it also includes a lot of information that has been widely discussed and written about previously in British Columbia.

The MOH has had a difficult time managing health human resources. It has been a singular file, with a dedicated ADM and it has been a distributed model with HR 'policy analysts' integrated in all departments of the Ministry. Neither function has worked well, although there have been moments of brilliance.

1) Data and information management has always been a challenge for the Ministry – different health authorities have different tools to measure data (and most don't agree), AVED has different numbers than MOH, the Minister uses information he or she is given, which then are recorded (right or wrong) by the media. If improving the data management piece is the only part of the HHR Strategy that moves forward, it will be well worth it.

2) A number of nurses have commented that this often feels like a siloed approach instead of looking at population health needs. There is recognition that the Ministry has begun to look at this more accurately, but at the same time there is still a lack of interprofessionalism at the Ministry level. The Ministry structures themselves do not reflect the interprofessional nature of what is discussed in these papers.

3) All four nursing groups (LPNs, NPs, RNs, RPNs) should be represented on the HHR Committee and have an opportunity to establish strong relationships (perhaps a liaison) with the health authorities where big changes will occur, to ensure the health plan unfolds well.

4) The document does not address some very critical issues facing the nursing profession. For example, in many cases, LPNs are not working as LPNs, but instead are working as care aides because the care aide scope is creeping up. Some reflection needs to be given around regulation – are lists of what a professional can or cannot do really the best way to determine scope?

5) Nurses, like other health providers, need access to continuing professional development and the associated funding. This is not available to nurses the way it is to doctors and ends up limiting opportunities and creating gaps in the healthcare system.

6) Nurse navigators have been mentioned in many conversations in B.C. but are rarely included in discussion. In this HHR paper, it would be useful to see the concept of nurse navigators discussed, particularly as the Ministry has indicated its preference for focusing on patient-centered care.

## Overall Assessment of the Policy Papers

1) **The Papers are very well done, creative and innovative**. **They are also very ambitious.**
These policy papers are probably the best documents ever produced by the Ministry in terms of their potential to radically and permanently transform the healthcare system and address some of the challenges the system has struggled with. However, these papers are also extremely ambitious and in a perfect storm, may not be achievable. They assume that there either will not be a change in government in the next 3-5 years, or that if there is, change in government will not impact the direction the Ministry is taking. It is questionable whether or not these can be followed through, in their entirety, with a different team or leader in place. It is also hard to imagine what will happen if these are only 'half' finished when a change occurs. Something we can't worry about, but must keep in mind as we move forward.

2) **Nurses vs. LPN, NP, RN, RPN**
It has been noted by numerous individuals across the four groups, that these documents sometimes refer to nurses or nursing, but when not, generally refer only to RNs and NPs. It is the recommendation of the Coalition, and all of the organizations which are part of it, that throughout these documents, a conscious effort be made to speak of nurses (in general), or refer to each of the four professional groups individually (LPN, NP, RN, RPN). For example, RPNs work in Rural BC, but are not mentioned in the rural and remote paper along with their counterparts. The nursing community recognizes the value and importance of all four nursing groups (LPN, NP, RN, RPN) and would applaud government in being more inclusive about mentioning all four nursing groups, as appropriate, within these papers.

3) **How much is the nursing voice REALLY included in these documents?**
While government is clearly saying that it will 'consult' with nurses, there are still some questions. These documents contain hundreds of committees, task groups and initiatives that professional associations will be asked to comment on, but one has to wonder at what point? Much of this policy work has already been reviewed by the Doctors of BC, and they have had their own private consultation. History tells us that nursing has had to ask each time to become part of consultations. Will this hold true for these documents?

4) **Some key issues have been left out**
A key concern with the papers is the omission of 'next steps' and planning for key groups. This is a touchy problem, because while some groups (ie, Aboriginal) are included, they are not mentioned in the next steps or planning. Nurses, nurse practitioners, certified nurses, have their own 'place' in some of the documents, but not in an integrated and meaningful way. There is a recognized and obvious need for a strong nursing voice and presence at all stages of the consultation – from all four nursing groups, LPNs, NPs, RNs and RPNs.

5) **Interprofessional must be the ACTION not just the popular phrase of the day.**
Nothing happens in healthcare without a team. While government speaks about interprofessionalism and teamwork, there are still old concepts around referrals and linkages between physicians and specialists that suggest there is still not complete understanding of what interprofessional means. This will require ongoing work, and is something that the nursing community needs to continue to advocate for, explain, and describe. Government needs to recognize that without all health professions, the system would grind to a halt. In particular, government needs to recognize the role that nurse practitioners can play in providing healthcare and reducing some of the logjam that is occurring in the system. It would be very helpful if the nursing associations could develop a joint campaign that talks about all FOUR nursing groups and the value they bring to healthcare –

recognizing that they are all different but equal.

**6) Other professions on GPSC**

Review of GPSC, and the consideration to include other professions on it, is mentioned in passing in two of the documents. This is, however, HUGELY important and nursing must not let this opportunity pass by. GPSC is one of the most powerful healthcare organizations in the province, and has enormous sway over funding, programs, initiatives, policy and regulation.

There is opportunity here for the nursing associations to build a strong rapport and response to these papers. Nurses know change is coming, and want to be prepared to play a significant role in guiding, directing and implementing that change. These papers give great hope and nursing must seize this opportunity.

# Acronyms

**BCEHS** British Columbia Emergency Health Services

**EHR** Electronic Health Record

**EMR** Electronic Medical Record

**EMSC** Emergency Medical Services Committee

**GPSC** General Practice Services Committee (Doctors of BC, Ministry of Health)

**HEABC** Health Employers Association of BC

**HHR** Health Human Resources

**MOH** Ministry of Health

**MSC** Medical Services Committee

**NSQIP** National Surgical Quality Insurance Program (US)

**PSEC** Provincial Surgery Executive Committee