BC Rural Health Network

June 25, 2018

Report on the Policy Discussion between the BC Rural Health Network and the BC Ministry of Health - June 21, 2018

The BC Rural Health Network would like to thank the BC Ministry of Health for providing the opportunity to participate in the policy discussion on Community Health Centres.

Here in BC and elsewhere in Canada, the Community Health Centre model has proven to be effective in addressing the health care needs of vulnerable and hard to reach populations. This community governed, patient centred, interdisciplinary team based model is seen as an important step toward improved access to health care in rural BC. The establishment and development of CHCs in rural communities represents a promising approach for the province-wide improvement of health care.

The response to the policy discussion has elicited a very positive reaction from our members. This report is a summary of our comments and questions and the response we received from the Ministry. It is intended to inform both the BCRHN membership and the Primary & Community Care Policy Division of the Ministry of Health.

The BCRHN looks forward to continued participation in the ongoing efforts to improve access to healthcare services for people living in rural and remote areas of the province.

For ease of understanding the following abbreviations will be used:

MoH - Ministry of Health
PCN - Primary Care Network
CHC - Community Health Centre
PMH - Patient Medical Home
HA - Health Authority
LHA - Local Health Area
CHSA - Community Health Service Area
BCACHC - BC Association of Community Health Centres

Ministry of Health - Primary Health Care Strategy

The MoH used the first part of the meeting to identify its goals and to make the following points regarding PCN policy:

- CHCs utilize a team based approach intended to provide faster response to patient needs; get patients to the correct care provider in a timely fashion
- MoH intent is to be moving away from a physician-centric, fee for service model
- visits to health service providers are expected to last more than 15 minutes and to serve the patient's entire needs; some visits could last as long as 45 minutes and the patient could see more than one professional during their appointment
- Primary Care Network model will be the backbone of the reform of primary care with a full team of care providers
- PCNs will be rolled out in 5 communities over the next 12 months
- 70% of the PCNs will be established within 3 years
- the framework will include:
    - Urgent Care Centres
    - Primary Medical Homes
    - Health Authority CHCs
    - community governed CHCs
- Community Health Centres will focus on:
    - the social determinants of health
    - wrap-around care with follow up provided by an interdisciplinary team work cooperatively
    - meeting the needs of vulnerable and hard to reach populations
- the MoH recognizes the flexibility of the CHC model
- the established CHC stakeholders in the province are unanimous in their support for including CHCs in the PCN framework
- the Ontario CHC model will be used as an example but the MoH wants to develop a "made in BC" model
- the urban model of care may not be well suited to a rural setting; "when you've seen one rural community, you've seen one rural community"

Previous policy discussions

Prior to the policy discussion with BCRHN, the MoH held three meetings with CHC stakeholders. The June 5 draft policy overview includes several changes based on those meetings. The discussion focused on the following:

- there are two distinct models
    - Health Authority CHCs
    - community governed CHCs
- HA CHCs are not community governed but community "informed"
- community governed CHCs is the model that's being included in the CHC policy
- there may be a need to find a new name for HA CHCs
- clarification of the definition of healthcare and health has been included in the policy; Primary Health Care refers to a team approach while Primary Medical Care refers to that care provided by a medical doctor.
- definition of community has also been clarified

    - "community" refers to "residents" not the PCN. Under governance of the PCN, the CHC must be at the table.
    - the use of the terms 'vulnerable' and 'hard to reach' is seen as being too restrictive - access has to be open to everyone
- the #1 theme coming out of previous policy discussions was a concern about governance; CHCs want to be included in a PCH without losing their autonomy
- fiscal channels still to be determined. The preference is that funds will flow through the health authority, but it is now recognized that this might not be the best way for the community. MoH may look at funds flowing directly to a CHC. Another possibility is for the funds to flow through another third party like the BCACHC.
- it's expected that the draft policy will go to the Minister in early July (2018)

Questions and Answers (reference: Draft CHC Policy Overview - June 6, 2018)
The following discussion points resulted from the Q and A portion of the policy discussion:

- assessment tools will be in place to provide performance indicators for CHCs
- a "gap analysis" tool with performance indicators will define individual community conditions
- tools will be developed to complete a community needs assessment; this information will be used to help develop a "business plan" for the establishment of a CHC
- there needs to be a funding stream available to assist communities in planning for the establishment of a CHC; funding needs to go beyond assessment to include implementation and development; grants to assist communities to create a CHC will be considered
- for team based approach to work there needs to be electronic medical records that are available to all members of the team; gap analysis might be use to determine if this is a problem
- rural communities need assurances that their voice will be heard; they feel that there is a communication breakdown between the community and HAs
- how does a HA operate in a PCN? It could be one member on a PCN community steering board that reflects all partners. There must be a partnership between the HA and the community.
- setting up a community board to govern a CHC will require assistance, both financial and administrative
- to be truly team based care, funding needs to go beyond the medical profession and provide services that address the social determinants of health
- the spirit and intent of the PCN model is that they will be less HA driven and reflect all team partners; a separate policy may need to be developed for HA controlled CHCs
- existing services will be "leveraged" into the team based model
- patient attachment and increased access to services are the main goals of the PCN model; patient attachment is a huge issue and it's hoped that the CHC model will deal with it
- in rural and remote areas where the full range of health services, e.g. specialist care, is not available, virtual care will be utilized whenever clinically appropriate
- to create a PCN, the HAs, Divisions of Family Practice, and the community will be required to work collaboratively and cooperatively

- the MoH has created a map showing new CHSA boundaries; this document will be made available to BCRHN members
- communities need to know who they should work with to develop a CHC; MoH will work with communities to help develop a formalized request
- application for a CHC should not need the approval of the Local Health Authority, Division of Family Practice or government

Final thoughts
Although this policy discussion was an important opportunity for members of the BCRHN to provide input, it is important to note that the discussion was limiting in terms of time allowed and topics covered. As one BCRHN member stated, "I could talk for at least three hours on what I've learned in the past year . . . hmmmm . . . [I only have] seven minutes eh?" It's recognized that the goal of the policy discussion was to gather information regarding CHCs. However, it's hoped that in the future the BCRHN will have the opportunity to discuss a broader range of issues that identify the unique aspects of rural communities and the difficulties they encounter in accessing timely and efficient health care.

These issues include the following:

1. How will the MoH address the chronic shortage of healthcare professionals in rural BC? Developing a team based approach based on a community needs assessment is pointless if there are not enough team members to fill the need.
2. How are communities with HA owned CHCs going to be included in the decision making process? What assurances are there that HAs will be receptive to and respectful of community based governance?
3. How is data collected and how is it used to determine service area boundaries e.g. LHAs, CHSAs? In what has been referred to as the "flawed lens" issue, incorrect statistics are being used to determine community needs.
4. What is the definition of "rural"? "remote"? "isolated"? How will the unique concerns of each community be addressed without using a "cookie cutter" approach to service delivery?
5. What is the most effective way for health services to respond to a community's changing demographic and therefore its changing needs? What might appear to be a minor issue in a large urban centre can have a huge impact on a rural community, e.g. the closing of a business or the opening of a new industry
6. Will improved availability be coupled with improved access to transportation? For many rural residents, especially the frail and elderly, getting to services is the main challenge.

Next steps
The BCRHN hopes this will be the beginning of a collaborative and cooperative relationship with the Ministry. We recognize that policy development is an important first step; we also recognize the importance of the implementation phase of this initiative and would request that the Ministry of Health include the BC Rural Health Network in future discussions.