VCHA Urban Primary Care Clinic Review
Fall 2013
External Reviewer Report
December 2013

Prepared by:
Dr. Garey Mazowita
Head, Family and Community Medicine,
Providence Healthcare
&
Vicki Farrally
Praxis Management

Final, January 22, 2014

Section One: Background and Approach

1.1 Background

- Vancouver Coastal Health (VCH) is conducting a review of its six Urban Primary Care (UPC) Clinics to assist in determining the future direction for its primary health care services, including which "high-needs" populations should be served by these clinics and the right service model within the context of available funding.

- Six UPC Clinics are included in this Review: Evergreen, Ravensong, Pacific Spirit, South, and Pine Street Clinics, each owned and operated by VCH, and the Mid Main Community Health Center, a non-profit society receiving partial funding from VCH. This review is intended to provide the opportunity to revitalize and better support these clinics, consistent with the provinces' ambitious agenda for a more integrated and interdisciplinary primary health sector.

- VCH operates a number of similar clinics in the inner city and funds the REACH Community Health Center. It is understood these may be the subject of a separate review. Several other primary care services, such as Primary Care Outreach Teams, are not funded by VCH's Community Division and so are outside of the scope of the review.

1.2 Approach

- Two external reviewers, Dr. Garey Mazowita (Head, Family and Community Medicine, Providence Healthcare) and Vicki Farrally, a health system consultant, (the reviewers) were invited to participate the review process to provide an independent perspective. Specifically, we were asked to conduct a set of interviews with senior administrative and clinical representatives from each UPC Clinic and with several community stakeholders and provide VCH with a summary of our observations and conclusions and a brief set of recommendations.

- VCH provided orientation materials, including descriptions of each clinic; a recently completed analysis of panel size, workload, and complexity data for each site and the program as a whole; and a questionnaire completed by each to describe its role, functioning, and current challenges.

- We met with VCHA representatives twice to review these materials, consider their observations, and explore their preliminary thoughts as to potential opportunities for change and improvement across the UPC Clinics.

- The interviews were conducted in a single day, each less than an hour in duration. Because of this limited time, each UPC Clinic was invited to summarize their completed questionnaire, highlight areas they wished to emphasize, and add any additional information they felt would be useful. Community

stakeholders were asked about their knowledge of the role of the UPC Clinics and their services and queried as to their perception of the utility and relevance of these clinics to their respective organization.

- Despite the brevity of the interviews they were viewed as having been very productive, with respondents being forthright in outlining their key issues and responding to questions. We are cognizant of the limitations of brief subjective interviews and anecdotal comments so have focused the majority of our comments on the key themes that emerged repeatedly during the interviews.

- We note that the UPC Clinics serve a relatively small, albeit important, proportion of Vancouver's population, since the majority of primary care is provided by private fee-for-service (FFS) physician practices. Given this, one reviewer attended the November 2013 meeting of the Inter-divisional Collaborative Services Committee, at which the Co-Chairs tabled the issue of the management of high-high-need patients for general discussion, a summary of which is included in the following section.

Section Two: What We Heard - Key Observations

2.1 Interviews

A. Program and Service Model

- VCH's six UPC Clinics were established at different times between the 1960s through to the mid 2000s. Although the precipitating factors were different for each clinic, the overriding purpose was to improve access to primary health care for populations recognized as not being well served by traditional FFS primary care. Each clinic focuses on a different population segment or target group, each with unique health and social care needs, as described in more detail in the following section.

- The most recent clinics were established specifically to demonstrate new models of multidisciplinary primary health care, a key objective of the 2000-2006 Primary Health Care Transition Fund (PHCTF). However, with the end of the PHCTF funding stream, the province's primary care policy shifted to strengthening traditional private practice. The 2006 negotiated agreement between the government and the British Columbia Medical Association (BCMA) formalized the General Practice Service Committee, establishing its mandate to improve the existing primary care system rather than adopting new structural changes, such as community health centers with salaried family physicians (Cavers, et al., 2010)[1].

[1] Cavers, W.J., Tregillus, V.H., Micco,A., & Hollander, M. J. (2010). Transforming family practice in British Columbia: the General Practice Services Committee. *Canadian Family Physician, 56(12)*, 1318-1321.

- Consequently, further development and expansion of interdisciplinary clinics and non-fee-for-service (FFS) physician payment models was largely abandoned. Existing clinics were maintained, possibly because the majority of their operating budgets are physician payments from the provincial Alternative Payment Funding Program (APP) and can't be reallocated to other purposes. Some clinics also benefited from new nurse practitioner (NP) positions and funding made available by the provincial Nurse Practitioner Program. However, in the absence of provincial policy support for interdisciplinary models, the UPC Clinics have had little scrutiny or additional resources in the last decade.

- Give this, it is not surprising that we heard little during the interviews to suggest that the six UPC Clinics operate as a cohesive and coordinated program, for example with a common vision or a defined team or service delivery model. There is no overall strategic plan setting out the program's goals and objectives and clinics do not share common operating policies and procedures or collaborate on processes such as professional development or education.

- We were told that VCH has not regularly monitored service utilization metrics (e.g. referrals, new cases, closed cases, etc.), nor has quality and outcome evaluation been conducted. We also heard that internal quality assurance processes, such as routine chart review, rounds, professional education, etc. have not been put in place.

- A first step in most program evaluations is the assessment of fidelity against a defined program or service model, its operation within defined parameters, and its results, i.e. structure, process, and outcomes. We saw no evidence of documented program model and so we are unable to comment on the extent to which the UPC Clinics, individually or as a group, align with VCH expectations.

B. Interdisciplinary Team/Professional Practice

- The composition of the clinical teams varies from clinic to clinic, seemingly based mostly on whatever resources became available over a number of years rather than reflecting a specific service model intended to meet the health needs of a specific target population.

- Although described as interdisciplinary clinics, we observed that the majority of providers are physicians, paid on sessions, clinical service contracts or salary through the provincial APP. Although most clinics also have a registered nurse (RN) and in some cases a NP, counselor, and/or part time pharmacist, the ratio of physicians to other providers is much higher than one would expect in an interdisciplinary community clinic serving a high-need clients.

- There were several reports of vacated RN and NP positions not being filled for long periods of time due to budget restraints. Where the vacated position represented the sole non-physician provider, this delay virtually eliminated that

team's "interdisciplinary" aspect. We also heard that in some clinics, the respective roles and responsibilities for NPs, RNs, and other providers have not been clarified and this has led to confusion and practice inefficiencies.

- We heard that the overhead payment associated with each APP physician FTE has been eroded over time and this reduction in medical office assistant (MoA) support is perceived to contribute to inefficiencies and suboptimal patient care. Some physicians also expressed frustration with their lack of control over how this MoA support is determined and managed.

- These observations suggest that many UPC Clinic physicians practice more as independent primary providers than as members of an interdisciplinary collaborative team. As well, many provide clinical services likely better managed by a RN or counselor and assume administrative work, such as data entry and file management, more efficiently handled by a support staff.

- Although we noted recently increased physician administrative leadership, we observed little evidence of organized physician *clinical leadership* on key policy and practice issues, either within individual clinics or across the program as a whole. Several physicians commented they have little opportunity to provide input to or influence clinic policy or operational decisions. Coupled with the aforementioned absence of formal quality improvement processes or an established professional development agenda, this gives us concern.

- In the case of NPs, we heard that despite widely recognized sensitivities associated with introducing NPs into existing teams, in some cases the physicians were not consulted or included in the hiring process. We also heard that there had been little work devoted to articulating their new roles and responsibilities or establishing appropriate working relationships. This is seen to have led to professional conflict and even resignations. Clearly the potential associated with adding new NPs to these teams has not been optimized.

- Clinic respondents also noted the staffing levels in such small clinics is a major barrier to providing the 24/7 access required by many high-need clients, although VCH advised they have worked with the clinics to develop an on-call roster of physicians or NPs to respond to patient's calls after regular hours.

- In conclusion, we observed a lack of what may be best described as the overarching "culture of care" that is essential to fostering patient access, creating team ethos, and providing mutual support for all staff. From the VCH perspective, we saw little to suggest a participatory management style that would encourage the clinics to be invested in providing effective and efficient patient care or providers to feel they "have a voice" in the design or operation of the UPC Clinic program.

C. Target Population

- We heard that each clinic services a different high-needs target population recognized as not being well served by traditional private practice:
  - The South Clinic reported serving predominately refugees and new immigrants, many of whom do not speak English and have recently arrived in Canada with "delayed" primary health care needs. Many of its female clients are culturally unable to be seen by male physician and so the clinic has assumed a major role in reproductive health;
  - Pacific Spirit CHC reported accepting an increasing number of referrals of patients residing in residential care facilities and homebound, frail elderly, and palliative care patients, many referred by private physicians who no longer are willing to manage their complexity of care or provide the outreach service to home and facilities;
  - Evergreen and Ravensong reported providing comprehensive primary care to marginalized people with complex care issues, the majority with serious mental illness and/or addiction issues;
  - Pine Street Clinic has focused on the needs of at-high-need youth and young adults from across the city since the 1960s and also provides urgent primary care services for uninsured individuals; and
  - Mid Main has a large population of low-income seniors, young families, and new immigrants living in that community and like Pacific Spirit, reports increasing number of residential care patients.

- VCH communicated to us their preference to focus the UPC Clinics on "the most vulnerable", estimated as 5% of the Vancouver population. We also noted that a number of need-descriptors were used interchangeably throughout our discussions with VCH, e.g., medically complex, high-high-need, high-needs, high-users, frequent-users, unattached, orphan, under-served, etc. On the other hand, the UPC Clinics described their clients by population segments, i.e. new immigrants, marginalized people, people with mental health and addictions problems, frail elderly, and street youth, etc., not by the need-descriptors, with the understanding that these populations have high-needs.

- This simple difference in how the target population is described reflects the current confusion about clinic purpose, focus, and role and thus patient eligibility. VCH advised us that initiatives to refocus the UPC Clinics on vulnerable and more medically complex patients were introduced in 2009. Several clinic respondents expressed confusion with this direction, believing they are already serving high-needs patients who otherwise would go without primary care or use more expensive services such as emergency departments. They acknowledge that not all patients are high-need all of the time, but suggest they already have discharged most of those suitable for regular FFS practice.

- We also heard that the clinics recently were directed to identify their lower complexity patients and transfer them into FFS practices and to develop a "flow through" policy, i.e. a process by which patients initially accepted on the basis of their need for intensive or interdisciplinary care are referred to FFS practices as they stabilize.

- This direction has met with considerable resistance, clinics perceiving it as contradicting a core principle of family medicine, i.e. continuity of care, and at odds with the current focus on increasing patient attachment, especially for high-need patients. Importantly, it is seen to substantively change the overall and long-term mandate of the UPC Clinics from providing better access to longitudinal comprehensive primary health care for underserved populations to triage and brief transitional care.

- Respondents asked the very real question of where these "transitioned" patients will receive their longitudinal primary care in future. It is widely recognized that few private practices are accepting new patients and virtually none currently have the additional resources, staff and expertise to manage patients with complex and intertwined health and social needs. The assumption that high-needs, often-chaotic patients, who bounce in and out of acute care and have a long history of failure to engage with or "attach" to a regular primary care provider, can be successfully transitioned and attached to family practice was frankly challenged. We agree that expecting private practices to absorb and maintain potentially unstable and high-needs patients without additional support is unrealistic.

- As well, we understand that each UPC Clinic must make its own arrangements with private practices to transfer lower-acuity patients and presumably also make arrangements for these patients to return if their relationship with the private physician fails (we note that most private practices respect patient choice in the selection of a provider, and so "assignment" of patients is unlikely to be seen as acceptable). This burden on individual UPC Clinics also appears unrealistic.

- We were advised that early in 2013, VCH introduced a centralized screening and referral process for its CHCs and clinics, operated by Home and Community Care. During out interviews, every clinic described this new system, which relies on voice mail messaging and call-back, as slow and unresponsive. In addition, there were reports of considerable confusion about its purpose. VCH staff suggested the system is intended to make the UPC clinics more visible and accessible to emergency departments and family practice. However, *all* of the clinic respondents interviewed advised us that the new system is widely perceived to be the sole referral mechanism to the UPC Clinics and rather than expediting appropriate referrals, has virtually eliminated *all* new referrals.

- Representatives from Vancouver's emergency departments (ED) indicated that they have little awareness of the UPC clinics and don't consider them as a resource. However, a respondent from associated with MH&A services reported on a recent review of 40 emergency department-identified "familiar faces" (previously known as frequent fliers or high users) identified as mental health and substance use clients and rated low acuity for the purpose of that ED visit. Three-quarters of these patients reportedly had an open file with a VCH community health centre offering primary care, although not necessarily with a UPC given the majority resided in the Downtown Eastside. Importantly, the ED patient review highlights that the primary care needs of people with serious mental illness may not be adequately met even when they are registered with a primary care clinic or a fee-for-service primary care provider. This gap needs to be better understood.

- Although the ED representatives expressed interest in having a basic primary care resource more available for "familiar faces", they also suggested that it would need to be located close to the emergency department and be open 24/7, given their experience that many of these patients are unable or unwilling to follow-through on referrals, even where these services are merely across the street. They also commented on the reality that although many of their "frequent faces" make what are generally seen as "unnecessary" visits, these often require very little time and don't necessarily contribute to ED congestion.

2.2 Review of Data Analysis

- VCH conducted an extensive analysis of UPC Clinic physician shadow billing data to determine panel size, attachment, and complexity. VCH reports that the findings reveal a mismatch between the capacity at some clinics and the demand and needs of those patients currently accessing the services, as follows:
  - Panel size 40 to 78% of target of 1250 per physician FTE
  - Attachment 20 to 40% higher than provincial average
  - Complexity 86 to 122%, against a target of 125%
  - Approximately 40% of UPC clinics considered highly complex/vulnerable.

- These findings suggest unrealistically low panel sizes for clinics and individual providers, even given a high-need caseload. At the same time, complexity measures suggest a lower level than would be anticipated for this type of program. VCH suggests these findings indicate clinic inefficiency and low provider productivity, noting they are relatively consistent across clinics and even providers and have not increased since 2010 despite direction to the clinics to serve the more vulnerable and medically complex population.

- Although the magnitude and the consistency of the findings of the VCH's analysis of the UPC Clinics clearly is worrisome and as such cannot be disregarded, we have reservations about the use of shadow billing data and the metrics examined. Although we agree these findings are of concern and warrant further

investigation, we do not view them as necessarily diagnostic. Rather, we suggest they be interpreted cautiously and within the context of the observations provided from the interview process. Our concerns are as follows:

a) Shadow Billing Data

- We have reservations about the use of APP physician shadow billing data and in particular, its use in the comparison of APP and FFS provider performance. There is good reason [and research] to suggest that in the absence of the payment incentive enjoyed by FFS physicians, APP shadow billings routinely and significantly underreport actual physician activity, making comparisons with FFS practice less meaningful.

- MSP billing codes are limited to activities and procedures agreed to by government and the BCMA. In 2006, BC introduced incentive payments for FFS practices in recognition that caring for high-needs patients requires additional time and often involves non-billable activities, such as counseling, case conferences, support to families, system navigation, etc. APP physicians providing these same services cannot bill these incentive fees and these activities cannot be recorded using MSP billing codes, serving to underreport APP physician activity.

b) Panel Size

- The policy context within which the Ministry of Health established 1250 as a target for APP physician panel size is not known. We have reservations that this target may no longer be appropriate for the UPC Clinic environment and suggest more consideration be given to how to best measure panel size and establish targets for physicians working in interdisciplinary teams, a topic of current interest across the country.

- We also have reservations that comparing panel size across APP and FFS practices is not meaningful without taking numerous factors into consideration. This is not to suggest that APP productivity is not a concern or that it should not be maximized and monitored, only that it should be done within a specific policy and operational context.

- Muldoon et al. (2012)[2], having had experience in the development of new interdisciplinary primary health care models in Ontario, suggest that before panel size be used as an accountability measures for individual physicians or practices, its relationship to quality and outcomes at the individual and population level and the contextual factors that affect it must be understood.

---

[2] Muldoon, L., Dahroug, E, S., Russell, G., Hogg, W., Ward, N. How many patients should a family physician have? factors to consider in answering a deceptively simple question. Healthcare Policy Vol.7 No.4, 2012.

- Relevant contextual factors for VCH's UPC Clinics identified during our interviews included: composition of the interdisciplinary team; roles and responsibilities of different types of providers; scope of practice; ratio of physicians to other providers; clinical administrative support levels; availability of information technology supports for clinical care; building space and equipment.

- The unique characteristics of the target population also influence establishment of panel targets, e.g. medical complexity, ESL/translation needs, demand for out-reach and home care, etc. We also note that most CHCs require physicians to be involved in clinical leadership and mentorship, program and policy development, community prevention, etc., all of which need to be taken into consideration when developing realistic panel targets.

- Alberta's new interdisciplinary Family Care Clinics (FCC), developed to serve their highest-need populations, are considering whether to measure by physician FTE or by the interdisciplinary team FTE's. As of the spring of 2013, the fully interdisciplinary FCC teams were operating with panels of about 800 patients per physician full time equivalent.

c) Complexity

- We understand that ACGs and RUBS are calculated to individuals using available diagnostic information derived from outpatient or ambulatory physician visit claims records, encounter records, inpatient hospital claims, and computerized discharge abstracts. A patient is assigned to a single ACG based on the diagnoses *assigned by all clinicians seeing them during all contacts.* Therefore, to receive a high RUB score, a patient needs to have engaged with these health services. We think more consideration needs to be given to the use of this metric with the high-need population given they frequently are recognized as being underserved.

d) Value

- Our final concern in this regard is the absence of a "value" perspective in these analyses. While we recognize efficiency and productivity are important, quality and outcomes at the individual and population level also are important considerations (Muldoon et al. Ibid), such as better access, improved clinical outcomes, and more appropriate utilization, such as reduced avoidable emergency department visits. The current analysis does not address these broader questions.

2.3 Interdivisional Collaborative Services Committee

- The management of high-needs patients was tabled for general discussion at the November 2013 Interdivisional Collaborative Services Committee (CSC) by the Co-Chairs, Dr. Dean Brown and Carol Park, VCH.

- The existing UPC Clinics were noted to be limited to the Vancouver area. On the North Shore, local physicians and VCH staff have collaborated to develop a high-needs clinic, which accepts patients in need of urgent care and endeavors to connect them with regular practices for ongoing primary care. Richmond and Powel River currently do not have dedicated services for high-needs patients.

- The CSC agreed that there is limited knowledge about the high-needs patient population and developing a better understanding of the size, location and needs of this population should be the first priority. It was noted that the CSC's current Attachment Initiative work may help to answer some of these questions but at the same time, not all unattached patients are necessarily high-need. There was agreement that the high-needs group, however ultimately defined, is not easily served in a traditional practice environment and new solutions are needed.

- A number of cautions were expressed. First, it was suggested a single solution or model might not sufficiently take into consideration the differences across communities, physicians, and patients. For example, smaller communities might not have sufficient number of high-needs patients to warrant a separate service and yet still need to have some type of additional support, while for *some* patients, a state of "high-need" may be transitory and so the capacity to add interim support to regular primary care might be a better solution than relegating those patients to a dedicated program.

- Consideration of a "laddered" response was suggested, based on community, physician, and patient need. Examples discussed included: a transition clinic (North Shore Model) operated by physicians with the support of VCH; additional support provided to a practice with a handful of high-needs clients; a formal arrangement with VCH to provide comprehensive support to a practice choosing to manage a large number of high-needs patients; and the dedicated clinic model (e.g. VCH UPC Clinics).

- It was noted that previous inquiries or requests for alternative funding arrangements to provide more flexible support for high-needs patients, such as APP sessions, have not met with success.

- The discussion concluded with the following observations:
    - The term "high-need" needs to be defined. i.e. who, where, and what do they need and how can they be best served.
    - This work might overlap with the Attachment Initiative, although not all unattached patients are necessarily high-needs.
    - "High-needs" for some patients may be a transitory state; consideration needs to be given to how services can be developed to support these individuals when required, rather than assigning them permanently to more intensive services.

- Solutions to serving high-needs patients need to reflect local realities and reflect a gradient of service intensity.
- Specific solutions should be developed in collaboration with VCH.

Our Conclusions

VCH's review of the UPC Clinics is not a simple project. Rather, it involves a number of complex considerations and challenges, including understanding the history and the current state of six diverse clinics, diagnosing and rectifying longstanding operational and management issues, determining VCH's future PHC role in the context of the new provincial community integration agenda and the Interdivisional CSC, contributing to reducing avoidable ED and acute utilization, and meeting VCH's current budget targets.

Although all of these issues are intertwined, for purposes of clarity we have distilled our conclusions in to four themes, as follows:

1. Current management
2. Implementation of major changes to program mandate and role
3. Collaboration with the Interdivisional CSC
4. Policy and research considerations

1. In regard to the ***current management*** of the UPC Clinic Program:
   - The UPC Clinic managers, physicians, NPs and RNs expressed a strong commitment to serving high-needs and vulnerable populations and want the resources and supports required to do a good job.
   - However, the program appears to have been undermanaged for many years, only recently beginning to receive the attention required to optimize its resources. In particular, there has been a long-standing absence of physician clinical leadership.
   - Specifically, we understand there is no overall program strategy, plan or service model *for the program as a whole*. As well, operating policies, procedures, and standards are not shared across clinics and explicit outcome expectations and critical success factors have not been established. Each of the six clinics operates in relative isolation from each other.
   - Despite the external perception of robust interdisciplinary teams, the long-term reliance on APP as the majority source of clinic funding have left these teams with a much higher ratio of physicians compared to other types of providers typically included in a team focusing on a high-needs population. We think that this imbalance is contributing to some of the recently identified inefficiencies and productivity concerns.
   - We also observed considerable confusion and frustration on the part of both managers and providers, which we attribute to the lack of clarity around program operation and expectations.
   - Regardless of the ultimate focus of these clinics, they need a more formalized management structure and process, including a documented plan, service

model and strategy, and increased attention to important internal processes, such as quality improvement and professional education. Once these plans and expectations have been agreed and documented, managers and all providers should be held accountable for ensuring their implementation.

2. In regard to *implementation of program changes*:
   - VCH needs to be much clearer as to the purpose of the UPC program as a whole in advance of making policy decisions intended to change or reduce clinic numbers or role/function, i.e. what are the goals, objectives and critical success factors and where will a redesigned program fit within the overall continuum of primary health care.
   - Key is determining the appropriate population for the intensity of care the UPC Clinics potentially can deliver. As illustrated in Figure 1, about 5% of the population is known to have the highest health needs. For example, in BC Reid et al (2003)[3] used health service utilization data to describe the top 5% of users. This group consumed a disproportionate amount of physician and hospital services (about 30% of each in 2002) and was characterized by a significant burden of morbidity, with over 80% having at least six different morbidities. These individuals also were much more likely to have both major acute and chronic diagnoses and psychosocial co-morbidities and chronic medical conditions.
   - Another 15% or so of the population, many of whom have complex care needs or multiple health and social issues, are recognized not to be well-served by traditional physician practice. However, recent enhancements introduced by the General Practice Service Committee (GPSC) to encourage full-service family practice and improve the management of chronic disease, complex care, and mental health are beginning to blur the line between this group and the 80% of the population generally thought to be well served by traditionally fee-for-service.

   a. The Highest Need 5%:
      - As observed above, VCH has directed the UPC Clinics to serve the "most vulnerable and medically complex 5%", presumably with the intent of reducing demand on EDs and other intensive acute care services. However, we observed considerable confusion between VCH and the UPC Clinics as to who exactly is considered to be included in the 5%, with most UPC Clinics working under the belief that they are in fact already serving high-needs patients. As noted above, this confusion needs to be resolved.
      - The challenges of efficiently and effectively addressing the needs of the 5% are well documented and consequently, refocusing the UPC Clinics on this population requires not only policy direction from VCH, but introduction of a wide range of program changes and supports, such as

[3] Reid, R., Evans, R., Barer, S., Sheps, S. Kerluke, K., McGrail, K., Hertzman, C., Pagliccia, N. Conspicuous consumption: characterizing high users of physician services in one Canadian province. J Health Serv Res Policy. 2003 Oct;8(4):215-24.

admission criteria[4] to ensure appropriate intake, reconfigured professional teams providing a more appropriate provider mix and skills (especially community psychiatry), sufficient capacity to provide outreach and extended hour coverage, close interface with other community services, real-time information transfer between clinics and hospitals, and formal shared-care or referral protocols with EDs.

b. The High Need 15%:
   - The 15% includes, although is not necessarily limited to, the population segments currently being served by the UPC Clinics, e.g. people marginalized due to poverty, mental health or addictions issues, or with complex and multiple comorbidities, the frail, the disabled, street youth, and refugees and new immigrants (not to suggest that the clinics do not also serve a proportion of the 5%). However, for the reasons discussed above, i.e. absence of monitoring and evaluation and management and operating concerns, we are unable to comment as to how well the UPC Clinics currently fulfill this role.
   - The critical issue for the individuals commonly included in the 15% is *time* – their complex interplay of multiple health and social issues generally require more provider time, in terms of both duration and frequency of visits, than most FFS practices can afford. Their primary health care needs are often best met by interdisciplinary teams that include physicians and/or NPs as well as RNs, counselors, social workers translators, pharmacists, etc.
   - Providers serving this group also often need specialized skills, especially in behaviorally-oriented interventions such as cognitive behavioral therapies for anxiety and depression; self-care education for chronic disease such as diabetes and COPD; and understanding of cross cultural health service issues, etc.
   - There is good evidence to suggest that by ensuring the complex needs of these individuals are met with regular, appropriate, and continuous primary care they can avoid slipping into the highest-need 5%.
   - As noted above, during the past few years GPSC has introduced a number of practice supports to encourage better care for this population. These include a comprehensive program of clinical guidelines, practice supports, and incentive payments, as well as integrated interdisciplinary initiatives beginning to be introduced by Divisions of Family Practice.
   - Together these enhancements to traditional family practice are establishing an environment that encourages and enables more intensive high-quality care for people with chronic disease, mental health, and complex care needs. The circles crossing the boundaries between the 80% and 15% in Figure One below are intended to depict this shift.

[4] For illustration: 3 or more acute hospitalizations in proceeding 14 months, 3 or more chronic diseases/conditions, and 8 or more medications.

- However, as the Interdivisional CSC observed, this is a slow process and few family practices are yet able to absorb and sustain large numbers of high-need patients without additional resources, staff, and training.
- As well, many of the important key levers, such as alternatives to or augmentation of FFS payment models and initiatives to better link/integrate family practice and health authority programs and providers, still are in their infancy.
- Clearly the impact of any significant change to the role or number of UPC Clinics needs to be thoroughly explored and understood and realistic alternatives put into place in advance of making such changes so as to avoid creating a "treatment gap" between VCH services and FFS primary care practice. There will be no gain if this "in between group" fails to access needed primary care.

3. In regard to *collaboration with the Interdivisional CSC*:
    - The Interdivisional CSC has expressed interest in better understanding the scope and nature of the high-need population and considering the resources and supports needed to assume the care of high-needs patients, including what a care-continuum eventually could entail.
    - Although unlikely to be a quick process, given government's current community integration agenda and expansion of interdisciplinary practice into physician offices, it is essential that this issue be considered within this joint context.

4. In regard to *policy and research considerations*:
    - In considering changes to the current UPC Clinics, VCH needs to take into account the increasing international recognition of the value of interdisciplinary teams in meeting the needs of high-needs clients as well as the rapidly aging population. The World Health Organization recently acknowledged that 40 years of research has confirmed the value of interdisciplinary care to good clinical outcomes (WHO, 2010)[5].
    - Although consolidation of some clinics may help to address some of VCH's immediate concerns, i.e. inadequate building infrastructure, small clinic size, and inappropriate team composition, the optics appear contrary to the government's current integration and interdisciplinary care agendas.
    - Consolidation also is likely to reduce access to primary care for many high-needs patients and will eliminate the opportunity to customize individual clinics to meet individual community needs. A large group of patients is likely to be affected, yet it private practice alternatives are not reliably in place.
    - Importantly, VCH's community clinics offer the sole community-based opportunity for employment in multidisciplinary primary health care

[5] World Health Organization. (2010). Framework for action on interprofessional education and collaborative practice. Retrieved November 2, 2013, from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf

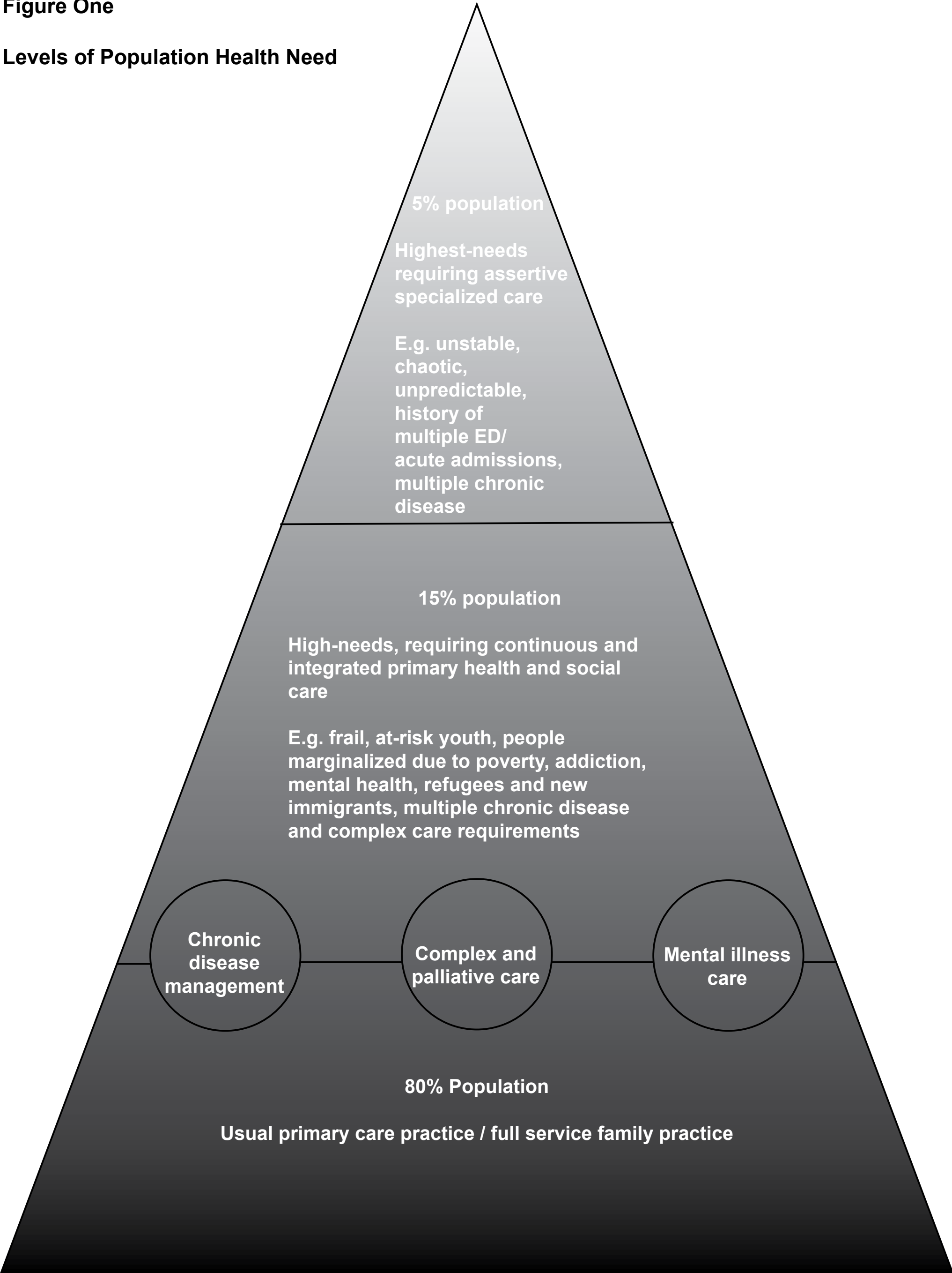
teams. This is particularly important for NPs who represent a valuable resource trained specifically for primary care but who are underutilized and underemployed in BC, largely due to the lack of employment opportunities in precisely such settings (MSFHR, 2013)[6]

- Finally, in light of these policy considerations, the optics of undertaking significant change to the handful of interdisciplinary clinics already serving primarily marginalized high-needs populations and their redirection to largely inaccessible private practice may be difficult to address.

[6] Michael Smith Foundations for Health Research. (2013). The Utilization and Impact of Nurse Practitioners and Physician Assistants: A Research Synthesis. Retrieved November 18, 2013, from http://www.msfhr.org/sites/default/files/Utilization_of_Nurse_Practitioners_and_Physician_Assistants.pdf

Figure One

Levels of Population Health Need



Our Recommendations

1. Develop more clarity as to the "problem" to be solved by the UPC Clinics in advance of making policy decisions intended to change or reduce their number or current role, i.e. establish the program's purpose and critical success factors, and take steps to develop a coherent overall program, including:
   - Target population;
   - Service eligibility criteria and screening tools;
   - An interdisciplinary team model appropriate to the health needs of the population to be served;
   - Program policies, processes and procedures and standards aimed to improve the appropriateness, quality, and accountability of the service provided/patient care;
   - Regular performance reporting based on an appropriate set of metrics; and
   - Clarity as to how the primary health care needs of clients no longer served by these clinics will be addressed within the broader primary care community.

2. Consistent with the provincial Community Integration agenda, consider strengthening and diversifying the current UPC Clinic interdisciplinary teams by integrating additional RNs, mental health and addiction counselors, social workers, etc. from other VCH community programs. This also would contribute to improving physician efficiency and increase clinic capacity. This new focus on truly interdisciplinary teams will require:
   - Clear definition of provider roles and responsibilities;
   - Investment in developing and supporting collaborative interdisciplinary teams (i.e. not merely co-location of providers); and
   - Establishment of clinical physician leadership support for physicians.

3. Working within the context of the Interdivisional Collaborative Services Committee, develop a medium to long-term plan (three- to five year) for the management of all high-need patients that includes CSC jointly-developed solutions to maximize opportunities for physician practices to increase their ability to appropriately meet the needs of some yet to be determined proportion of those patients.