Section 3

Update on the implementation of recommendations from:

Preventing and Managing Diabetes in British Columbia

December 2007

October 2008

June 13, 2008 726919

Mr. Morris Sydor
Assistant Auditor General
Office of the Auditor General of British Columbia
8 Bastion Square
Victoria BC V8V 1X4

Dear Mr. Sydor:

Re: **Follow-up Review of the Report from the British Columbia Office of the Auditor General on *Preventing and Managing Diabetes in British Columbia***

As requested by the Office of the Auditor General, I am pleased to enclose an update on the significant progress the British Columbia Ministry of Health has made in implementing the Auditor General's recommendations from their report titled *Preventing and Managing Diabetes in British Columbia* as of March 2008

The Auditor General's recommendations included:

1. Search out potentially effective and research-supported methods of preventing diabetes and its consequences, and determine through pilot projects or other means the effectiveness of these methods when applied in British Columbia
2. Develop and provide to Government, well supported strategies for prevention including documentation of the costs and benefits (in medical, social and financial terms) of applying the recommended methods of prevention, and of not doing so.
3. Implement the strategies chosen by Government in such a way that they can achieve their optimum effectiveness and be sustained long enough to be effective.

The update has been additionally organized around the areas of primary prevention and secondary prevention with most recommendations being partially implemented and ongoing.

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Ministry of Health Office of the Deputy Minister 5-3, 1515 Blanshard Street
Victoria BC V8W 3C8

The recommendations were directed both to the Ministry of Health for action and the Government of British Columbia to impact the underlying determinants of health, such as: income, transportation, and levels of education. Diabetes is a multifaceted, societal problem and requires action by government, public institutions, communities, and individuals, as well as the health system.

Sincerely,

Gordon Macatee
Deputy Minister

Attachment

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Cliff # 726919

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION

THE PREVENTION AND MANAGEMENT OF DIABETES IN BRITISH COLUMBIA

June 13, 2008

In October 2004, the British Columbia Office of the Auditor General issued the report, the *Prevention and Management of Diabetes in British Columbia*. In 2008, the Office of the Auditor General (OAG) requested an update on the status of the implementation of the recommendations issued in the report. Below is a summary of status of implementation by recommendation:

	Implementation Status				
Auditor General's Recommendations: We recommend that the provincial government engage in an organized process to:	Fully	Substantially	Partially	Alternative Action	No Action
1. Search out potentially effective and research-supported methods of preventing diabetes and its consequences, and determine through pilot projects or other means the effectiveness of these methods when applied in British Columbia (BC).			✓		
2. Develop, and provide to Government, well supported strategies for prevention including documentation of the costs and benefits (in medical, social and financial terms) of applying the recommended methods of prevention, and of not doing so.			✓		
3. Implement the strategies chosen by Government in such a way that they can achieve their optimum effectiveness and be sustained long enough to be effective.			✓		

The prevention and management of chronic conditions involves two main approaches. Primary prevention involves broad population health initiatives focused on helping British Columbians to avoid developing a chronic condition to begin with. Secondary prevention involves strategies for helping British Columbians who do develop chronic conditions to cope with their condition and to avoid complications resulting from the condition. Responses to each of the Auditor General's recommendations are documented in each of these two categories since the approaches are different.

Recommendation #1: Search out potentially effective and research-supported methods of preventing diabetes and its consequences, and determine through pilot projects or other means the effectiveness of these methods when applied in British Columbia (BC).

Recommendation #1 - Primary Prevention Strategies: Preventing Diabetes

Diabetes is a chronic condition that results from the body's inability to sufficiently produce or use insulin. Of the three types (Type 1, Type 2, and gestational diabetes), the most common is Type 2, which accounts for more than 90 per cent of diagnosed cases. Risk factors include individuals being overweight or obese, and physical inactivity. [1]

The BC Ministry of Health addresses the prevention of diabetes, and other prevalent chronic disease categories including Type 2 diabetes, cardiovascular disease, chronic respiratory disease and cancer, through an integrated, cross government, cross sector, risk factor-based population health and wellness strategy targeting the risk factors that are common to these health conditions: tobacco use, physical inactivity, poor nutrition, and overweight/obesity.

The Ministry's role in chronic disease prevention is one of stewardship: the Ministry sets direction and provides a framework of legislation, regulation, monitoring and evaluation to ensure a robust system of investment, program delivery and awareness-raising is in place to help British Columbians make healthy lifestyle choices, and avoid the chronic diseases that impact quality of life, increase morbidity and mortality, and threaten the sustainability of the health care system.

The following are three significant initiatives that support Government's population-based approach to promotion of health and wellness and chronic disease prevention, including prevention of diabetes:

i. A Framework for the development, delivery, measurement and evaluation of evidence-based core public health functions in BC;

ii. An integrated, cross government, cross sector, risk-factor based, chronic disease prevention strategy (ActNow BC); and

iii. First Nations Health Plan is a tripartite agreement between the province, the First Nations and the federal government to support the health of First Nations in British Columbia.

Core Public Health Functions in BC

Core public health functions are the primordial, primary and early secondary prevention activities of a comprehensive health system. Since 2002/03, the Ministry has been working with the Health Authorities to redefine and implement the core public health functions in BC. In March 2005, A Framework for Core Functions in Public Health was released (http://www.health.gov.bc.ca/prevent/#core), identifying 21 core public health programs that would lead to a renewed and modern public health system in British Columbia. The following core public health programs are specifically related to the risk factors most commonly linked with diabetes prevention: Healthy Communities, Healthy Living that includes healthy eating, physical activity and tobacco use, and Food Security, a program that looks at access to safe healthy foods in key settings. The implementation of these core programs by Health Authorities, in collaboration with key partnering organizations such as the Canadian Diabetes Association, will create supportive

[1] Food, Health and Well-Being in British Columbia, Provincial Health Officer's Annual Report 2005

environments where British Columbians are supported and can make choices to be more active and eat healthier foods, leading to a reduction in diabetes and other chronic diseases.

The core public health programs are being implemented through a performance improvement process over a number of years. Health Authorities are participating in the definition of model core programs for all program areas, based on best available evidence and best practice. Once the model core programs are approved, the Health Authorities will develop their own public performance improvement plans, with targets, tailoring their actions to the unique needs of their populations. These plans will be reviewed by the Ministry, and made public to ensure the Health Authorities are accountable to their communities and citizens.

In 2006/07, Health Authorities developed performance improvement plans for Food Security. Food Security is a concern as diabetes is more prevalent in food insecure populations.[2] Obesity occurs at a higher rate in low income children and adults and in Aboriginal populations.[3] Food-insecure diabetics have more costly and life-threatening complications to their illness and require greater levels of care.[4] The Food Security performance plans are tailored to Health Authority needs and priorities, but focus on components such as development of regional food policy frameworks, and an appropriate array of programs and services at the community level to assist residents to have greater access to safe healthy food. The Food Security Performance Improvement plans are now in the second year of implementation.

Health Authorities will identify how best to address the next two core programs, Healthy Living and Healthy Communities. The process is to undertake a needs assessment, gap analysis and performance improvement planning of policies and services related to Healthy Living and Healthy Communities. The focus is on increasing systemic supports for "making the healthy choice the easy choice" at the individual, family and community level, preventing and reducing the high-risk behaviours of unhealthy eating and physical inactivity, particularly in young people and vulnerable populations, and enhancing surveillance, monitoring and evaluation of healthy living trends and interventions. It is anticipated that the Health Authorities' performance improvement plans will include strategies such as development of partnerships to create healthy schools and workplaces, and strategies to engage in advocacy within communities to promote involvement in addressing these issues. The Ministry has facilitated the work to support healthy communities and healthy living through ActNow BC initiatives such as Healthy Communities, Active Communities and Action Schools! BC.

ActNow BC: Government's integrated, Cross Ministry, Cross Sector Health Promotion and Chronic Disease Prevention Strategy

ActNow BC is an integrated, cross government, cross sector, risk factor-based population health and wellness strategy targeting the risk factors that are common to these health conditions: tobacco use, physical inactivity, poor nutrition.

ActNow BC adopts a best practice approach that is comprehensive, multi-sectoral, partnership-based, results-focused and measurable. By engaging British Columbians where they live, learn, work and play, ActNow BC extends responsibility for population health beyond the healthcare sector and takes advantage of the reach and resources and active participation of non-traditional sectors like transportation, agriculture, forests and labour.

[2] Vozoris, N.T., and Tarasuk, V.S. 2003. Household food insufficiency is associated with poorer health. *Journal of Nutrition* 133 (1):120-126.

[3] Riches, G., Budkingham, D., MacRae, R, and Ostry, A. 2004. *Right to food case study: Canada.* Rome: Food and Agricultural Organization of the United Nations.

[4] Vozoris, N.T., and Tarasuk, V.S. 2003. Household food insufficiency is associated with poorer health. *Journal of Nutrition* 133 (1):120-126.

ActNow BC has both a social marketing campaign assisting British Columbians to have the information and access to programs and resources that will support and assist citizens to make healthier choices in a variety of key settings. The ActNow BC website (www.actnowbc.ca) has been developed, and specific promotions for physical activity and healthy eating occurred in 2007 and will again in 2008. The ActNow BC Road to Health Community Tour visited 18 communities in 2007. The tour included fun, free activities to promote active, healthy living, and health screening including height, weight, BMI, waist circumference and blood glucose monitoring. The tour will occur again in 2008.

The following are examples of programs, delivered in partnership with other ministries or key partnering organizations that are helping British Columbians make healthier choices to be more physically activity and eat more nutritious foods, thereby reducing their risk of developing Type 2 diabetes:

- Action Schools! BC is a best practices model designed to assist schools in creating individualized action plans to promote healthy living. Action Schools! BC provides **more** opportunities for **more** children to make healthy choices **more** often. There are 1,486 schools registered to participate affecting 406, 350 students in these schools.
- Active Communities is an initiative that assists communities to create programs and resources for their residents to have more opportunities to be active. There are 161 registered active communities.
- The School Fruit and Vegetable Nutrition Program provides a fresh B.C. grown vegetable or fruit to students twice a week, raising awareness of the importance of healthy eating. By 2010, all interested elementary schools will have participated in the program. There are currently 364 participating schools.
- The Sales of Foods and Beverages in BC Schools (2007) are guidelines developed to create healthier choices for sales of foods and beverages to students in the school environment. Elementary schools have implemented the guidelines. Middle and Secondary schools require full implementation by September 2008. The Nutrition Guidelines for Vending Machines in Public Buildings (2007) extends the policy to public buildings including recreation centres. These guidelines create an environment where the healthy choice is the easy choice; reducing the availability of high calorie, low nutrient foods that contribute to poor nutrition and unhealthy weight gain.
- The Community Food Action Initiative is implemented through all health authorities across the province to support communities to take action on increasing access to safe healthy foods in their local communities. Grants are provided to communities based on their needs and specific plans. In 2007/08, 155 specific projects were funded in communities across BC. Projects included community gardens or kitchens, school programs, food policies and bringing residents together to plan.

ActNow BC's success will be measured in terms of the 2010 targets: reducing tobacco-use by 10%; increasing the percentage of BC adults who are moderately or physically active by 20%; increasing the percentage of BC adults who eat five or more servings of fruit and vegetables per day by 20%; reducing the percentage of BC adults who are overweight or obese by 20%; and increasing the percentage of women counselled on the dangers of alcohol use in pregnancy by 50%.

Measuring Our Success (2006), the ActNow BC baseline document, identifies the baseline measures as of 2004/05. Regular published reports will monitor progress toward the targets. A discussion of the monitoring and evaluation framework for ActNow BC and its programs and services is documented in the report "Measuring Our Success".

First Nations

The First Nations Health Plan is a tripartite agreement between the province, the First Nations and the federal government to support the health of First Nations in British Columbia. There are four distinct areas for collaboration, one of which is Health Promotion/ Disease and Injury Prevention.

The First Nations Health Plan has recognized that prevention and management of diabetes in First Nations is a priority and many of the actions in the plan are intended to reduce the incidence in this vulnerable population.

The Ministry of Health is working with the National Collaborating Centre on Aboriginal Health (the Centre), located at the University of Northern BC, to develop an Aboriginal-specific ActNow component.

The Centre is working with the First Nations Health Council, the BC Association of Aboriginal Friendship Centres, and the Métis Nation British Columbia to promote wellness and support chronic disease prevention; promote physical activity in communities; promote wellness and healthy lifestyles in British Columbia; increase the capacity of Aboriginal communities to create and sustain health promoting policies, environments, programs and services; and enhance collaboration between Aboriginal communities, government, non-government and private sector organizations.

The Honour Your Health Challenge is funded by the BC Ministry of Health – Aboriginal Health Branch. This Challenge is a province-wide, community-based health initiative which uses small grants, incentives, and provincial grand prize draws to mobilize individuals and communities to live active, healthy & strong lifestyles, free from tobacco misuse. This year 187 community grants were provided.

Under the Honour Your Health Challenge umbrella, this year, the Province of BC (Ministries of Health and Tourism, Sport and the Arts) and Health Canada (First Nations and Inuit Health Branch, Aboriginal Diabetes Initiative) have partnered with Sportmed BC to offer an Aboriginal specific in-training program to prepare participants for the Vancouver Sun Run. The goal of this program is to improve the health and fitness of Aboriginal communities in British Columbia. Over 300 participated in the Sun Run event through this training program.

Prevention Support Program

The Prevention Support Program, a province-wide initiative that included 50 physicians and 35 nurses with 13 Nurse Facilitators/Coordinators, was piloted in 2005/06 through an evidence-based "Prevention" Structured Collaborative. A clinical guideline on primary prevention of cardiovascular disease – including guidelines for providing advice, counselling and referral regarding diet and physical activity – was distributed to family physicians in March 2008 by the Guidelines and Protocols Advisory Committee (GPAC, co-chaired by the BCMA and the Medical Services Plan). In addition, a prevention fee was launched by the General Practice Services Committee in April 2007. By supporting individuals to reduce their risk factors and therefore their risk of cardiovascular disease in particular, this initiative supports government's work to address chronic disease in general, including diabetes.

Recommendation #1 - Secondary Prevention Strategies: Preventing the Consequences of Diabetes

In order to close gaps in care between recommended diabetes care and the care that patients actually receive, the BC Ministry of Health adopted the Expanded Chronic Care Model for province-wide implementation. The research literature has reported that implementation of all the model's components invariably results in improved care and ultimately patient outcomes. British Columbia has embedded the components of the model into BC health care system as follows:

Decision Support:

The following tools have been distributed to BC physicians across the province, and are publicly available on both the Ministry of Health and the BCMA websites:

Clinical Guidelines Development - The BC Diabetes Management Guidelines (developed through the MSP/BCMA Guidelines and Protocols Advisory Committee) identify recommended diabetes care based on the best scientific evidence currently available

Patient Flow Sheet – The Diabetes Care patient flow sheet (which is part of the BC Diabetes Management Guideline) is a useful tool for summarizing clinical information important in effective diabetes management.

The BC Diabetes Management Clinical Guidelines and Patient Flow Sheets are periodically reviewed and updated by the Ministry of Health/BC Medical Association Guidelines and Protocols Advisory Committee to ensure consistency with the current state of evidence based medical knowledge.

Information Technology

The Diabetes Patient Register was developed through administrative data to identifying the population of patients with diabetes, and to accurately monitor of the quality of patient care and population health status. The Diabetes Patient Register has been updated yearly as the latest data becomes available.

The chronic disease management (CDM) toolkit information technology gives general practitioners easy access to BC Clinical Guidelines, and a patient reminder and recall system. It also includes electronic versions of the BC Diabetes Patient Flow Sheets, the CDM Toolkit enables members of practice networks to securely share information (including consult notes and referral letters) needed to ensure continuity of patient care. In 2008/09 1307 family physicians are using the CDM Toolkit to organize patient care.

The Physician Information Technology Office (PITO) is an outcome of the Government/BC Medical Association 2006 Agreement where the provincial government and the BCMA agreed to work collaboratively to co-ordinate, facilitate and support information technology planning and implementation for physicians, including the development and implementation in British Columbia of standardized systems of electronic medical records" (EMR). 1,000 BC family physicians are involved PITO in 2008/09. Chronic disease management is a business requirement for the six PITO vendors of EMRs.

Patient Self-Management

Since 2003, the Ministry's Primary Health Care Branch has funded the University of Victoria Centre on Aging to make the evidence-based Chronic Disease Self Management Program available across the Province since 2003. This program helps people develop the self-efficacy skills needed to care for their own health, and better cope with emotional, social and physical effect of chronic illness, including diabetes. In 2008/09, the Ministry provided $500,000 to Centre on Aging to continue this valuable service in the community.

In 2008, the Ministry's Primary Health Care Branch hired a Director of Patients as Partners. This portfolio is working with stakeholders across the health system and non-governmental organizations to develop a strategy to make patients more informed and activated partners in their health care and well-being.

Also in 2008, in collaboration with the Fraser Health Authority, the GP Services Committee (a joint committee of the Ministry of Health and BC Medical Association) is pilot testing the distribution of patient passports to patients – the patient passport provides a record of the patient's health concerns, medications, and other important health information required by health professionals for informed diagnosis and treatment.

Often patients with chronic illness (including diabetes) also suffer from depression. It is often the case, patients cannot get their diabetes under control until their depression has been addressed. In June 2008, the Ministry in partnership with the Canadian Mental Health Association launched the Bounce Back Program – this program provides depression self-help to patients via telephone (toll free to patients) by a community-based coach. The coaches will provide patients with motivational support and instruction to work through a series of self-help modules that are part of a structured program called "Overcoming Depression, Low Mood, and Anxiety". This program is available in both workbook and web-based format.

Delivery System Design/Re-Orient Health System

Practice redesign focuses on supporting family physicians, their practice staff and other health professionals to be innovative, improve and sustain practice changes that result in better improved patient health outcomes. Activities implemented in BC to support practice re-design were:

Alignment of physician compensation for improved chronic disease management: Through the *Full Service Family Practice Incentive Program*, BC GPs are eligible to receive a $125 per patient/per year payment for each patient with diabetes managed to best practice guidelines. This payment remunerates GPs for the non-direct patient care involved in reviewing the patient's chart and undertaking a planned, proactive approach to diabetes management.

In addition, in May 2007 a *complex care fee* was introduced to better support family physician care for their patients with two or more chronic illnesses – diabetes is one of the co-morbid chronic illnesses eligible for the complex care payment.

Structured Collaboratives: The MoH, with the health authorities, has used best practice quality improvement methodology of Plan/Do/Study/Act, to implement guidelines based diabetes care through a structured collaborative process, to enhance management of chronic disease at the primary care level. The initial pilot collaborative that focused on congestive heart failure resulted in improved processes of care for patients, as shown below. The success of this initial structured collaborative led to the implementation of ten collaboratives involving approximately 1100 practitioners across the province in diabetes management quality improvement.

The Practice Support Program (launched May 2007) is funded through the 2006 Ministry of Health/BC Medical Association Agreement. This is a provincially coordinated, two year practice enhancement program in which physician champions will work in partnership with local family physicians and health authority staff in realigning health care services to attain better patient health outcomes, and improve practitioner professional satisfaction. Through this program, GPs can access training in the following areas of practice redesign which are relevant in the management of all chronic illnesses, including diabetes:

1. Advanced Access - a new way of scheduling appointments that ensures patients see their physicians closer to the time they need an appointment
2. Group visits - GPs and their office staff can offer care, education and advice in a group setting that is efficient for the practice, and supportive for patients. Patients benefit from the opportunity to learn from, and share their experiences with their peers
3. Chronic disease management – developing patient registers to help identify patients with chronic conditions; using a planned recall approach to proactively monitor the care provided based on the clinical guidelines recommendations; and using the CDM Toolkit to help track progress and patient outcomes
4. Patient self-management - Helping GPs support patients to set and work toward their own health goals, in addition to managing the medical aspects of the patients' illnesses.

As of March 30, 2008, 1207 general practitioners and their medical office assistants participated in the Practice Support Program (this is approximately, 40% of all BC general practitioners).

In 2008/2009, twenty five *integrated health networks* have been funded for development. The purpose of the integrated health network approach is to formalize the linkages between family practice, specialist services, health authorities, and community based services for improved health outcomes of complex patients. An integrated health network will serve a geographic community that links patients and family physicians with existing health authority and community-based resources. It will also add other key resources to improve coordinated community care through an integrated team of providers organized around high-need priority patient populations—chronically ill patients with diabetes are one of these high-need priority populations.

In June 2008, the *Quality Improvement Network* will be launched as a partnership of the Ministry, BC Medical Association, BC Health Authorities, and IMPACTBC. The Quality Improvement Network's goal is to enhance regional health authority staff knowledge, skills, and cultural shift toward primary care practice improvement and integration of services (in particular extending the quality improvement strategies used in the practice support program to integrated health networks) for improved patient health care, especially chronic disease management. Community development to improve the health status of target populations and communities, as opposed to only the individual patient is also the mandate of the Quality Improvement Network.

Recommendation #2: Develop, and provide to Government, well supported strategies for prevention including documentation of the costs and benefits (in medical, social and financial terms) of applying the recommended methods of prevention, and of not doing so.

Recommendation #2 - Primary Prevention Strategies: Preventing Diabetes

- In 2006/07, approximately 4.8 percent of British Columbians were diagnosed with diabetes. Complications of diabetes include cardiovascular disease, kidney disease, damage to sight, and limb amputation[5] (see attached appendix A).
- In 2006/07, approximately 6.7 percent of Status Indians (the proportion of First Nations population for whom data is available) in British Columbia were diagnosed with diabetes[6]. The prevalence rate of diabetes is 1.3 times higher among Status Indians than other BC residents. On average, each year, more than 100 Status Indians with diabetes die in British Columbia[7].
- The estimated direct costs for diabetes to the healthcare system in BC including hospitalization, Medical Services Plan and PharmaCare costs were approximately $1.04 billion in 2003/04. These costs could rise to $1.9 billion by 2015/2016[8].
- In 2005, the Ministry of Health Services, Population Health Surveillance and Monitoring, estimated that through the implementation of a Lifestyles Modification program, the BC government could reduce the incidence of diabetes by 25% and save $200 million in health care dollars[9]. A 50 per cent reduction would decrease annual costs for persons with diabetes by $400 million.[10] See also response to Recommendation 1: Strategic Population Health Initiatives.
- The 2004 Provincial Health Officer's Report "The Impact of Diabetes on the Health and Well-being of People in British Columbia" reinforces that for prevention programs to be successful, governments and communities need to work together to provide effective, aligned, multi-sectoral strategies as well as committed resources and funds to maintain programs for a long period of time.

Responding to the changing demographics and increased incidence of chronic illness in BC, the Chronic Disease Prevention Framework provides a broad strategic overview of the factors that lead to chronic diseases and the range of interventions needed to prevent or reduce their occurrence. This framework together with the Chronic Disease Evidence Paper, documenting costs and benefits, informed the ActNow BC framework which was announced by Government in the throne speech of 2005. The goal of ActNow BC is to improve the health of all British Columbians by addressing the common risk factors for chronic diseases, including diabetes, rather than focusing on one disease, or risk factor, at a time. ActNow BC has been designed to support Government's second great goal to counteract the broader societal trends linked to poor health outcomes, and to set hard targets for improvements. These initiatives will make an important contribution to the primary prevention of diabetes.

[5] Population Health Surveillance and Epidemiology, Ministry of Health, 2008
[6] Population Health Surveillance and Epidemiology, Ministry of Health, 2008
[7] The Impact of Diabetes on the Health and Well-being of People in British Columbia, 2004 Provincial Health Officer's Report.
[8] Follow-up of 2004/05 Report 3:Preventing and Managing Diabetes in British Columbia, Office of the Auditor General, December 2007
[9] Population Health Surveillance and Epidemiology, Ministry of Health Services, 2005.
[10] *ibid*, pg 37

In 2005, Premier Campbell announced the launch of ActNow BC, the health promotion and chronic disease prevention initiative aimed at encouraging British Columbians to make healthier lifestyle choices to improve their quality of life, reduce their risk of developing preventable chronic disease, and reduce the burden on our health care system. See response to recommendation #1 for information on the implementation of ActNow BC.

Recommendation #2 - Secondary Prevention Strategies: Preventing the Consequences of Diabetes

Improving Chronic Disease Management: A Compelling Business Case for Diabetes was developed in 2001 to identify the potential costs savings that could be accrued through the province-wide identification of people with diabetes and the implementation of the expanded chronic care model for the management of diabetes. Preventing the complications of diabetes was addressed in the business case, along with projections of health system burden of disease expected if action is not taken to effectively manage diabetes.

Effective management of chronic diseases is pivotal to an overall sustainable health system. To this end, the Ministry launched the BC Primary Health Care (PHC) Charter in May 2007. The PHC Charter outlines primary health care challenges, identifies priorities and actions, and establishes outcome measures to set the strategic direction of the Ministry of Health with the regional health authorities. One of the seven priorities identified in the Charter is chronic disease management, which includes the prevention of the complications of diabetes. The PHC Charter sets out a strategic agenda for other health system key stakeholders who want to align their efforts with a systems approach, and in 2008 a consultation was taken with BC health system stakeholders to re-state the PHC Charter – the revisions arising from the consultation will be completed in Fall 2008.

MoH initiated the Chronic Disease Management Initiative in January 2002, and since then has been implementing the components of the Chronic Care Model on a province-wide basis to realize the business case. In order to move providers and patients to a chronic care model that optimizes prevention, empower self-management, and support providers to manage care to best practice recommendations, the work of the Ministry has been to align:

- Compensation Strategies: Through the joint Ministry of Health/BC Medical Association Full *Service Family Practice Program,* general practitioners receive compensation for providing diabetes care according to the BC Diabetes clinical guidelines.
- Information Technology Strategies: BC's E-health Strategy will ensure that provincial funded electronic medical records include CDM Toolkit functionality (e.g., register of diabetes patients, diabetes guidelines and flow sheets, patient recall reminders).
- Legislation: Bill 29 (enacted March 2007) introduced changes to the Freedom of Information and Protection of Privacy legislation to authorize indirect collection of patient personal health information for the following purposes of managing chronic disease, and for use in health service development, management, delivery, monitoring and evaluation.
- Policies: The Ministry of Health developed a BC Primary Heath Care Charter (launched May 2007) to set a Province wide strategic direction for the re-design of primary health care that emphasized patients as partners in their own care.

- Service Delivery Models: Through the implementation of structured collaboratives and the Practice Support Program, Integrated Health Networks, and the Quality Improvement Network, BC GPs and other health care professionals are receiving training and support in
- re-designing their practice to better enable a proactive, planned approach to chronic disease management including diabetes management.
- Patients As Partners: The Ministry is developing a comprehensive strategy to empower patients to be informed and activated partners in their own care.

Recommendation #3: Implement the strategies chosen by Government in such a way that they can achieve their optimum effectiveness and be sustained long enough to be effective.

Recommendation #3 - Primary Prevention Strategies: Preventing Diabetes

1. The Ministry facilitated, and is a funder and non-voting member of the BC Healthy Living Alliance (BCHLA), the goal of which is to improve the health of British Columbians through leadership that enhances collaborative action. The BCHLA has developed four distinct strategies for supporting government's agenda of healthy living: healthy eating, physical activity, tobacco reduction and community capacity building. BCHLA is also working from an evidence based approach of focusing on common risk factors to chronic diseases such as diabetes, cardiovascular disease and certain types of cancer.

   The BCHLA, formed early in 2003 under the leadership of the BC Ministry of Health. There are nine voting members including the Canadian Diabetes Association, Heart and Stroke Foundation, Canadian Cancer Society,BC Lung Association, British Columbia Recreation and Parks Association, Dietitians of Canada, Public Health Association of BC, Union of BC Municipalities, and the BC Pediatric Society. Non-voting members include the Ministry of Health, the Public Health Agency of Canada, and the six Health Authorities. In February 2005 the Alliance released their strategic document The Winning Legacy – A Plan for Improving the Health of British Columbians by 2010 containing 29 recommendations for actions government could take. In March 2006, Government responded with a $25 million grant to the Alliance to support action on their recommendations. The Alliance has undertaken extensive strategic planning and is also working from an evidence based approach of focusing on common risk factors to chronic diseases such as diabetes, cardiovascular disease and certain types of cancer, aligned with the ActNow BC targets and Government's prevention targets in coming weeks. Investing in BCHLA and supporting strategic action across the large disease related organizations will support sustainability and action on promotion of health and wellness and prevention of chronic diseases such as diabetes.

2. In March 2005, the Premier launched ActNow BC, a multi-sector, partnership-based initiative that draws upon the reach and resources of all levels of government, non-government organizations, communities, schools and the private sector to create a assist British Columbians in making healthy lifestyle choices to improve their quality of life, reduce their risk of preventable chronic disease, and help create a sustainable health care system in BC. By engaging all sectors of society in creating a health-supporting environment where the healthy choice is the easy choice, ActNow BC broadens responsibility for population health beyond the traditional health care sector and creates a more sustainable network of health promotion and prevention initiatives that will ensure BC meets its goal of improved population health over the long term. A list of ActNow BC partners is available at www.ActNowBC.gov.bc.ca.) See response to recommendation # 1 for more information on implementation of ActNow BC.

3. MoH has a comprehensive framework for monitoring progress towards ActNow BC targets. Logic models have been developed for ActNow BC and for each ActNow BC target.

4. As part of its renewal strategy for public health, the MoH has adopted A Framework for Core Functions in Public Health, which will form the basis for a new Public Health Act. Health authorities will be required to reflect the "Healthy Living - core program paper" in their service delivery system beginning in the 2007/08 fiscal year. See response to recommendation # 1 for more information.

5. The MoH is involved nationally with diabetes surveillance. The diabetes probabilistic patient register developed from the case definition and work developed through participation in the National Diabetes Surveillance System, has been verified through a series of patient surveys.

Recommendation #3 - Secondary Prevention Strategies: Preventing the Consequences of Diabetes

1. The Ministry facilitated, and is a funder and non-voting member of the BC Healthy Living Alliance, the goal of which is to improve the health of British Columbians through leadership that enhances collaborative action to promote physical activity, healthy eating, and living smoke free, thus focusing on a wide range of chronic illness including diabetes.

2. In March 2005, the Premier launched ActNow BC, a multi-sector, partnership-based initiative that draws upon the reach and resources of all levels of government, non-government organizations, communities, schools and the private sector to create and assist British Columbians in making healthy lifestyle choices to improve their quality of life, reduce their risk of preventable chronic disease, and help create a sustainable health care system in BC. By engaging all sectors of society in creating a health-supporting environment where the healthy choice is the easy choice, ActNow BC broadens responsibility for population health beyond the traditional health care sector and creates a more sustainable network of health promotion and prevention initiatives that will ensure BC meets its goal of improved population health over the long term. A list of ActNow BC partners is available at www.ActNowBC.gov.bc.ca.)

   An important and active partner in supporting government's chronic disease prevention strategy (and helping to ensure its sustainability) is the BC Healthy Living Alliance (BCHLA). The BCHLA, formed early in 2003 under the leadership of the BC Ministry of Health, is an alliance of health sector stakeholders who are working together to prevent chronic disease. The nine voting members include the Heart and Stroke Foundation, Canadian Cancer Society, Canadian Diabetes Association, BC Lung Association, British Columbia Recreation and Parks Association, Dietitians of Canada, Public Health Association of BC, Union of BC Municipalities, and the BC Pediatric Society. Non-voting members include the Ministry of Health, the Public Health Agency of Canada, and the six Health Authorities. BCHLA members individually and collectively lobbied government regarding the need for investments in health promotion and chronic disease prevention. In February 2005 the Alliance released their strategic document *The Winning Legacy – A Plan for Improving the Health of British Columbians by 2010* containing 29 recommendations for actions government could take. In March 2006, Government responded with a $25 million grant to the Alliance to support action on their recommendations. The Alliance has undertaken extensive strategic planning and will be releasing plans for investments aligned with the ActNow BC targets and Government's prevention targets in coming weeks, specifically healthy eating and physical activity strategies.

3. MoH has a comprehensive framework for monitoring progress towards ActNow BC targets. Logic models have been developed for ActNow BC and for each ActNow BC target.

4. MoH supported the Provincial Health Services Authority (PHSA) in the planning and development of the BC Population and Public Health Data Evidence Network established to gather, coordinate and interpret key population and public health data and evidence.

5. As part of its renewal strategy for public health, the MOH has adopted *A Framework for Core Functions in Public Health,* which will form the basis for a new Public Health Act. Health authorities will be required to reflect the "Healthy Living - core program paper" in their service delivery system beginning in the 2007/08 fiscal year.

6. The MoH is involved nationally with diabetes surveillance. The diabetes probabilistic patient register developed from the case definition and work developed through participation in the National Diabetes Surveillance System, has been verified through a series of patient surveys.

7. Emerging evidence published in the New England Journal of Medicine June 2008, indicates previous evidence-based chronic disease management measures appear to be dangerous in some populations, causing higher mortality and morbidity. This evidence contributes to the complexity of approaches for the MoH and clinicians. We are currently reviewing our strategies to ensure the art as well as the science of clinical practice is well supported in BC.

The MoH/BCMA 2006 Agreement has identified significant additional resources to support expanded activity. It has increased the annual incentive payment for appropriate management of diabetes per patient per year from $75 to $125. It has also introduced a payment to better support family physicians care for patients with complex co-morbid conditions (of which diabetes is an eligible condition). The agreement has included new resources to address hypertension supported by new clinical practice guidelines. The guideline includes a management flow sheet, which is shared with the patient. It is anticipated that a focus on hypertension will make an important contribution to diabetes prevention, because high blood pressure is often associated with the onset of diabetes.

The Government/BCMA 2006 Agreement includes significant investment in BC's e-health strategy, designed to support clinical improvements across the system. e-Health will take the successes of the CDM electronic toolkit, which enables substantial improvements in patient care for people with diabetes and other diseases, and will embed these critical functionalities into Electronic Medical Records, which will be available to all general practitioners and specialists in the province.