

Charter 1

Patients As Partners: Individual Health Care
Working Draft: 17 Aug 2009

What are we trying to accomplish?

In alignment with the BC PHC Charter initiatives and in partnership with our key stakeholders, we aim to enhance the collaborative relationship for individual health care between patients (and their families and caregivers) and health care professionals so that patients can achieve better health and patients have a better experience at a reasonable cost. We will support patients to plan and manage their health. We will also help health care professionals to work with patients in ways that patients find meaningful. Our goal is that 60% of patients have confidence that they can manage most of their health problems.

In the upcoming year, we will focus on building confidence of health care professionals in supporting patients to self-manage and enhancing patient experience/confidence in their provider's abilities to support self-management through the IHNs and PSP modules. We will continue the work to spread self-management education in BC.

By 2012 we will have created meaningful relationships between BC citizens and their primary care providers.

It is important to remember that patients vary in the level of involvement they want in their health care and that patients are the providers of the majority of their own care. We need to focus on building will, knowledge, skills, and resources for both patients and providers. This work applies to all health care experiences, including chronic disease management and preventive care. The emphasis is on building confidence so that a productive collaboration can exist.

How will we know that a change is an improvement?

Topic	Measure	Typical Value	Goal & Date
Access to self-management programs	1) Percentage of English-speaking British Columbians with a chronic health condition that have access to self-management education programs within a year. Access = the program is offered at least once a year within a 50 km radius. 2) Establish number of programs using SM techniques (SME mapping project). Use information for establishing future directions.	1) (UVic data) 2) NA	1) 75% by 2010
Action planning	Number of patients in IHNs or whose physicians have participated in CDM, self-management, mental health or COPD PSP modules who have an action	unknown	80% by 2010

	plan documented in their chart in the last 6 months divided by number of patients involved in IHNS and PSP modules X 100 (per cent). HA staff may sample for this measure, checking 20 charts in an IHN or from a CDM practice. Quarterly through 2010.		
Self-management support training	Count number of health care professionals in IHNS or PSP who have attended a SMS training program of at least 2 hours length. Track monthly. NOTE: Would prefer that this measure be a percentage of IHN health care professionals so that we would know the reach of the training into an IHN but that presents challenges in defining the denominator that we cannot tackle at this time.	unknown	200
Experience	Number of IHN patients who strongly agree with the statement "My primary care provider gives me exactly the help I want and need when I want and need it" divided by number surveyed X 100 (per cent) <i>Howyourhealth</i> .	Unknown	70%
Patient confidence in self-management	Number of IHN patients who state they are very confident they can manage most of their health problems divided by number of patients surveyed X 100 (per cent). <i>Howyourhealth</i> .	Unknown	60%
Provider confidence in supporting patients to self-manage	Number of IHN staff who interact with patient that state they are very confident that they can use self-management support tools of goal setting, action planning, problem solving and follow-up divided by number surveyed X 100 (per cent). Measured every 6 months.	Unknown	80%

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