

PHABC Conference: November 23

## **Plenary 3 – Themes 4 and 5**

**Chair: John Millar**

Review of Previous Day

John Millar

Major points:

- Encouraging that ministry of health has agreed that major thrusts in health care in future: Improving population health, quality of patient service and reduction of costs
- Also encouraging “alignment” between primary health care and public health
  - Divisions of family practice are a major step forward and something we can build on
  - A recurrent theme is concerns from both primary health care and public health, trepidation to integrate more
  - Some of these concerns may be addressed by increased funding for public health and prevention
  - Needs to be better training for collaboration to work
  - Need infrastructure and people who understand how to operationalize the notions of distributive leadership
- Excellent news: community profiles are now being developed for every community across the province – will drive community activation
  - Is there capacity in community to act on this? - A question that we'll have to look at
- No accountability in government structure at community level – a challenge to overcome
- transformation will go ahead fairly quickly, cannot be achieved without involvement of public health and we need to solve these challenges

## **Theme 4: Changing Cultures, Transforming Practice**

**Speakers: Allan Best, Bill Clifford and Lynda Foley**

Allan Best

Changing cultures, Transforming Practice: Research to System Transformation

- Can research add value to the Public Health community?
- Systems science is used in other disciplines
  - Health sector is far behind
  - What, if anything, can systems science add to the health sector?

When you start talking about complexity, like in the health sector, you talk about a true paradigm shift, we have to come to terms with that and start developing new tools

Increasingly that means inter-organizational partnerships, which must have:

- Clear common aims
- Trust
- Collaborative leadership
- Sensitivity to power issues

- Membership structure
- Action learning
- Process: framing the strategy, taking stock of assets, measuring investments and returns, monitoring progress

#### Potential Tools:

- concept mapping,
- rapid review
  - Try to better meet need of decision makers that gets a handle on complexity issues
  - Follow same steps as Cochrane review, but then ask not *what works*, but *what works where and why?*
  - Then find best guess of what would work in your situation
- Social Network Analysis
  - What are the strengths
  - Where are the gaps
  - How does it change over time?
- Dynamic map
  - Show what you think is going on in a project
  - Each individual factors
  - Things that are known to affect knowledge transfer, but shows how they work in this particular context
  - Shows where the strengths and weaknesses are
- Simple rules for system transformation:
  - Blend designated leadership with distributed leadership
  - Establish feedback loops
  - Attend to history (make it fit with natural culture)
  - Engage physicians
  - Include patient and families

If innovation is going to occur, we must make it a priority to get better indicators and do it in a way that maximizes use of them as population information as well as enabling accountability

- Bridge between research and its application – public health and primary health care have to live on the bridge together

#### Burning Platform of Perfect Storm?

- Increasing complexity and fragmentation
- Costs rising at unsustainable rate
- Increasing chronic disease and aging population

[
 Bottom line: *if problems are complex, we need complex solutions*
]

## Bill Clyford

Since Hippocrates, some things have stayed the same in health care:

- one patient at a time
- one provider at a time

In northern health today:

- One patient can equal 12 records, most paper, some electronic
  - 95% engagement with electronic records
- Vast majority of healthcare is in primary care
- To enhance health care experiences:
  - Improve population health
  - Improve value for money
  - Recognize importance of social determinants of health
    - No profession on its own can change them – collaborative effort

When asked if they thought the health care system was good, those who said yes were more likely to:

- Be over 55, or 18-35
- Have less than a high school education
- *Have a family doctor*

Bring it on home: care is coordinated, continuous and comprehensive with patients having access to interdisciplinary team

- How do we do that?
  - Identify functions that need to be executed
  - Determine systems maps for each area/profession/discipline and interweave them – shows where overlaps are so coordination can be achieved
  - Real time information within practices, disease prevalence, indicators for cancer screening, STD screening, other screening

## Lynda Foley

“B.C.’s Commitment”

Integrated health networks

- Built around relationship with patient and extended health care team
- District nurse partnered with doctor and responsible for the same patients– especially necessary with seniors

Culture change

- Without it, we will not make ubiquitous change we need
- “Home is best” strategy and philosophy
- Because of aging demography, 7200 in acute care is being used by “individuals in wrong place, because we don’t have the right place for them”
  - This part of the transformation is critical

Pay for performance initiative

- Home first strategy – prevent avoidable emergency visits, delay residential care, decrease stay
- proof of concept – over 320 clients in residential care that are now supported outside residential care

This prototype strategy for admission avoidance has exceeded target of admission avoidance

Breathe well at home program

- Improve management of COPD for frail seniors living at home
  - Early recognition
  - Anxiety management
  - Better self care
  - Kept away from emergency room for unnecessary visits
- Worked with individuals who had at least 3 ER visits and one admission annually
  - seeing 40% decrease in ER visit, 38% decrease in admission, 36% decrease in length of stay

## Questions and answers:

**For Bill:** Tell me about the 95% coverage of EMR,

**Response:** Around 18 people are not using EMR (and we know who they are), it is not all one vendor, 60% are represented by one vendor, the rest are from other vendors. As far as vendors go, if you meet the standards, you can be a vendor.

**For Lynda:** You discussed pay for performance, the concern is that you may end up with people who are inappropriately discharged early, or not admitted. How do you guard against that, and did you look at patient satisfaction?

**Response:** If you have an acute care admission, the pathway is in to home health with case manager, in partnership with physician. A huge piece of energy has been put in to promoting patients as partners. Physicians are encouraged to build a flare up plan in conjunction with patient, and they may have medication at home that doctor has pre-prescribed, so they understand when hospital is necessary. Safeguarding against inappropriate discharge is about the pathway, physician follow up in community is critical.

**For Bill:** Duplication around primary care and public health, a lack of shared e-health records, are real problems, but resistance on part of either group to reduce duplication doesn't seem to be present. Do you have any plans or ideas for addressing that?

**Response:** The problem is lack of clarity, communication channels are not good, shared understanding is vital. Divisions of family practice are great ways to organize physicians, they are proving very good at tackling issues together.

**For Bill:** How do you get GPs out of offices? Public health will lose the war if we don't work together with primary care. No matter what we do, this work will come to desk of GP, how do we help and support them, how do we develop structure to get them out of office and work with Public health? GPs don't understand language we're using, what made it easier for you to integrate GPs? The first thing GPs ask is who is going to pay for my time, how do you get them in to a meeting?

**Response:** I think the traditional thing was that physicians stayed locked in their offices. I am now

seeing much bigger appreciation of public health and “working upstream”.

**For all:** How do we create a shared mental model between PHC and PH?

**Response:** The challenge in Saskatchewan was, “How do you scale up so these ideas are built in to culture”. How do you measure culture change? It becomes clear that we don’t yet have clear idea on how we change culture, some people say there is no culture, culture changes depending on who is on shift, but I think it is clear there is a culture and we need to address that, we have a lot more work to do.

## **Theme 5: Engaging With the Populations we serve”**

**Speakers: Caryl Harper and Michelle DeGroot**

### **Caryl Harper**

*Definition of patient:* includes individuals receiving treatment, that must be supported throughout care journeys.

“Patients as partners”

- Engagement – foundational documents
  - Getting public participation right is essential, striking right balance of competing priorities, getting it wrong requires time to rebuild trust and re-engage
- Why the impetus for engagement?
  - Evidence – results in improved quality, safety, experience and outcomes
  - Shifting expectations – activated patients, families and communities, share responsibility for health, self-management
    - Growing “civil society” discourse; public calls for transparency
  - Mandated engagement – senior levels of government or the courts mandating engagement, accreditation standards setting expectations
  - Triple aim = happy, healthy people with affordable health care
    - Improving the health of the population
    - Improving the quality of care
    - Making cost sustainable
- What is patients and public engagement?
  - Nothing about me without me
- How? Engaging with patients and public?
  - Increase awareness of same language
  - Training workshops and resources
  - All partners increase awareness
- Who are we? Who are we engaging with?
  - multiple partners
- How we do it?
  - Patient journey mapping
  - Patient voices network – provincial registry provides support to the patient voice in improvement by recruiting, orientating and supporting
  - We need to “bridge the valley” between positions, interest and values with goodwill
  - Key elements of successful transformation
  - Quality and system improvement as core strategy
  - Developing organization capabilities and skills
  - Engaging patient in their care and in design of care

- Robust primary care teams

***Vision for future:***  
*A health care system that actively reflects the needs and interests of people it serves... patients.*

## Michelle DeGroot

The First Nations Health Authority engagement framework – a model for public health program and service delivery

Introduction to First Nations Health Authority

Four pillars

1. First Nations Health Authority
2. First Nations Health Council
3. First Nations Health Directors Association
4. Tripartite committee on First Nations health
  - Moving forward with health governance agenda and shared vision

***Vision:***  
*Healthy, self-determining and vibrant First Nations children, families and communities*

Shared values – respect, discipline, relationships, culture, excellence and fairness

- Community driven, nation based
- Increase First Nations decision making
- Improve services
- Foster collaboration
- Develop human and economic capacity
- Be without prejudice
- Function at high operational standards

First Nations Wellness Model

- Wellness, not illness

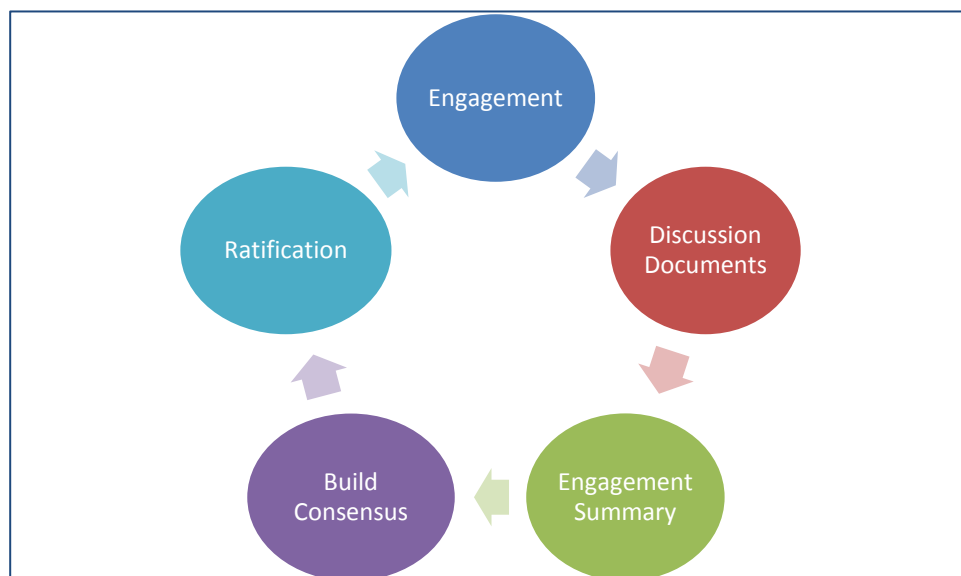
Building foundation through engagement - priority since day one

- Broad spectrum: communities; health directors; health service providers; First Nations

- leadership; tripartite partners, aboriginal partners
- All four pillars play critical role
- Gathering wisdom: gathering of First Nations leadership and health care professionals in community to discuss issues
- Puts First Nations at the front and center of health and wellness planning
- Informs policy planning and development at all levels
- Builds consensus
- Solidifies a commitment to collectively work together to make the system better – we understand where partners are coming from
- Engagement activities:
  - Community Engagement Hubs – communicate, collaborate, plan
  - FNHDA HDA
  - Gathering Wisdom
  - Strategy tables
  - Regional Caucuses – Regional Tables – mirror those of Health Authorities
  - Partnership accords – relationship with regional health authorities to work together to insure all priorities are addressed
  - MOU's – Aboriginal Partnerships
  - Community Health and Wellness Initiatives – gain information from communities on what needs are
  - Virtually: email, surveys

#### Engagement Pathway

- Guided by 7 directives
- Outlines how each pillar contributes
- A new level of dialogue for First Nations health service improvements: health directors, dialogue throughout regional/sub-regional caucuses



## Questions:

**For both:** When we look at civic engagement, there are functions that keep coming up, one is organizational readiness. Are there other things that could be happening in terms of partnership, what makes a good partner?

**Response:** Readiness of engagement - each level of engagement involves prior commitment before engagement occurs. Senior secretary was consulting on what function that role should involve, so it doesn't set anyone up for false expectation. A good partner will listen to concerns and acknowledge how input affected decisions.

A good partner is someone you have a common ground to start with, otherwise you won't know what your partnership will look like. It must be developed and may take merging of world views or systems, but you must have similar view, and that helps with engagement.

We need capacity within community to address transformation and structures to do that. Mainstream system has a lot to learn from First Nations Health Authority, particularly around level of engagement.

**For Carol:** What is the vision that you have for engagement of most marginal and underserved populations that don't have a voice so that we're creating a system that meets needs of diverse population?

**Response:** Focus on patients as partners, engaging through home and community care. So far, we haven't done a very good job with mental health and substance misuse, this year we are developing a framework for engaging those populations, that is forthcoming. As for people whose first language is not English, we work with UBC to target those populations, using mobile e-health strategies. We have had further strategic conversations, and there is much work yet to come.