JCC Joint Collaborative Committees

SharedCare Partners for Patients

CHRONIC DISEASE COMMUNITY OF PRACTICE // SECOND ANNUAL ENGAGEMENT EVENT

SUMMARY REPORT // APRIL 28, 2023

British Columbia

doctors of bc

OVERVIEW

The second annual engagement event to build a Chronic Disease Community of Practice (CoP) took place on Friday, April 28, 2023, at the Sheraton Vancouver Wall Centre. Ninety-one participants from across the province gathered for the six-hour event, hosted by the Chronic Disease CoP Steering Committee.

Participant Profile

Family Physician	Primary Care Pharmacist Lead	Shared Care Committee Representative
Patient Partner	Project Manager	FPSC Core Member
Specialist Physician	Division of Family Practice Representative	Co-Chair, Rural JSC
Nurse Practitioner	Ministry of Health Representative	Networks Director, RCCbc
Family Caregiver	Chair, Medical Services Commission	Pathways Physician Lead
Registered Nurse	Health Authority Representatives	PQI Faculty
Clinical Nurse Specialist	CEO, Institute for Health System Transformation and Sustainability	President, Doctors of BC
Clinical Improvement Advisor	Director Health System Improvement, BCPSQC	Doctors of BC Staff
Clinical Pharmacist	Health Data Coalition Representatives	CYMHSU CoP Co-Chair

Event Objectives

- Share patient, family caregivers, and clinician stories to capture key issues and ground us in a common purpose.
- Leverage networks, resources, and partnerships to work towards a common vision for the Community of Practice.
- Build upon priorities for the Chronic Disease Community of Practice (CoP) — Communication & Connection, Education, and Innovative Approaches.
- Explore resources, linkages, and innovative approaches in chronic disease prevention and management to identify collaborative opportunities to improve the patient journey (within CoP scope).

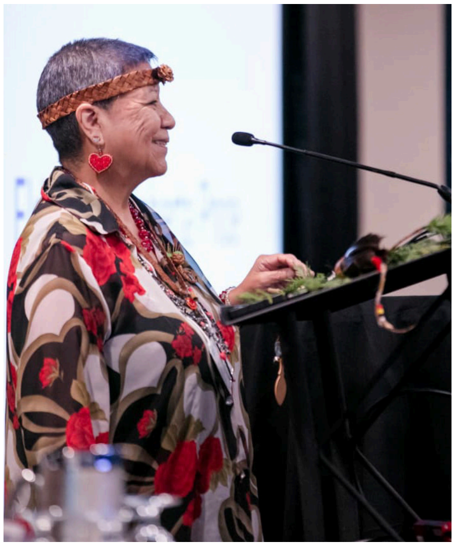
DAY IN BRIEF

The day's activities are briefly summarized below.
You can also view the full agenda here.

- **Opening** - **Dr Gordon Hoag**, CoP Co-Chair, opened the meeting by greeting participants and acknowledging the privilege of using and sharing the land on which the meeting was being held, and expressed the intention of the CoP to provide continuous care to First Nations, Inuit, and Métis people.

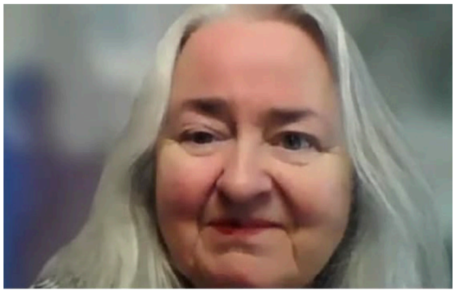
- **Welcome** - **Elder and Dr Roberta Price**, Coast Salish Matriarch, extended a warm welcome to the unceded, ancestral and occupied lands of the Coast Salish peoples, shared teachings from Elder Vince Stogan, and offered a wholesome opening prayer.

- **Context Setting** - **Dr Gordon Hoag** and **Dr Dan Horvat** set the context for the day by highlighting where the work of the CoP fits within the JCCs (Joint Collaborative Committees), describing Shared Care as a collaboration between family physicians and specialist physicians, reviewing the CoP roadmap and milestones, describing the CoP and its structure, and outlining preliminary CoP priorities:
  - Connecting people and strengthening relationships
  - Facilitating learning and awareness.
  - Sharing innovative approaches.



> *"The CD CoP provides an opportunity to best support people to live well with chronic disease(s) or to prevent chronic disease by leveraging relationships and resources."*
> *~ Dr Gordon Hoag*

PATIENT, FAMILY CAREGIVER, & CLINICIAN STORIES



- **Patient partners, Peggy S** (rural) and **Jenny M** (suburban/rural) shared their unique journeys of living with type II diabetes and heart failure, respectively, including the following **challenges**:
  - Access to basic primary care in rural communities.
  - Need for regular in-person visits by a diabetic educator to serve residents who cannot travel to obtain care and support.
- **Peggy & Jenny** also highlighted their **key learnings** including the importance of **support networks**, **advocating** for oneself with medical professionals, and **ensuring the patient is part of the healthcare team** to best manage chronic disease.
- **Barb MacLean** shared her personal story involving a family physician providing support for a family member who experienced a cardiac arrest. **The triad of care** — patient, family, and physician — working together in a meaningful partnership, is integral to management of chronic disease.
- **Dr Daisy Dulay,** cardiologist, shared her journey of being a family caregiver at a young age:
  - A significant amount of responsibility is placed on family caregivers.
  - Family caregivers are usually women and are at higher risk of depression.
  - Family caregivers often face loss of earning power due to devoting significant time to care for their family member.
  - Family caregivers need support.

EXPLORING RESOURCES & SKILLS TO SUPPORT CHRONIC DISEASE PREVENTION & MANAGEMENT – PART 1

Drs Baldev Sanghera, Nicole Ebert, Elizabeth Swiggum, and Anurag Singh, family medicine & chronic disease specialists, discussed their perspectives on approaches to chronic disease prevention and management.

What's Working Well?

- Providing support for the triad with a circle of support from Divisions, PCNs (primary care networks), and team-based care within individual practices
- Providing care to the patient and family in the way the patient and family needs.
- Recognizing there will be individual differences and reactions to chronic disease.
- Patient stories (although not everyone wants to share their story).

What Can We Build Upon? What Can We Do More Of?

Communication & Connection

- Investing in **communication** to improve patient care.
- FP and team **relationships**.
- Using **team-based care** to help patients focus on the health goal developed collaboratively with the FP.

Education

- Providing caregivers with the information required to appropriately treat the patient.
- **Engaging the community** to disseminate and receive information and impact social determinants of health (e.g. weekly walk with the mayor).
- Maintaining focus on **equity and access** (e.g. reach out to rural and remote communities).

Innovative Approaches

- Using **data** to better support patients.

Opportunities

Communication & Connection

- Develop a **patient engagement strategy** to create tools to manage chronic disease (CD).
- Ensure all team members have specific skills to provide care for the patient with CD.

Education

- Apply two lenses for education – 1) Physicians 2) Patient & Family Caregiver
- Curate **resources for specific patient populations** with what they need to know now.
- Develop **resources to support primary care teams** in rural communities, especially nurses (e.g. microlearning videos).

Innovative Approaches

- Leverage **pharmacists** in providing care equitably.
- Use **EMRs** more effectively (recognizing many patients do not have access to a family doctor).

BREAKOUT DISCUSSIONS

Building on the panel discussions, participants organized into three breakout groups around the CoP priorities to identify resources (relationships, tools, programs, initiatives) that can be leveraged to best help people live well with chronic disease. Results will inform strategies and concrete activities to be overseen by the CoP Steering Committee and implemented through CoP Working Groups.

Communication & Connection

What's Working Well? What Can we Build Upon?

+ **Co-location** of allied + interdisciplinary team members (team-based care) and team huddles.
+ **Group Medical Visits** to effectively connect patients to each other.
+ **New LFP payment system** enabling more time for physicians to manage care with patients.
+ **Coaching and mentoring** re: communication skills for peer rural providers to engage patients and families in their care.
+ **QI projects** (various sites & communities) influencing positive communication and team building.

Opportunities

+ **Define commonalities** across workflow to streamline implementation.
+ **Leverage PCNs** to share care plans among providers.
+ **Optimize online forums** for clinical connections
+ **Promote online peer support groups** for patient & family connections.
+ **Connect FPs + SPs** to enable better communication
+ Enable non-clinical staff, including MOAs, to be change makers and connectors of care.

Education

Opportunities

For Clinicians

+ Start with identifying patient and community needs.
+ Increase awareness about existing patient resources; support incorporating into workflow.
+ Identify appropriate approaches (e.g. coaching & mentoring) based on clinician needs.
+ **Support training on prevention screening** — Lifestyle Prevention Approach (Doctors of BC).
+ **Support training re: communication with patients** — compassion, active listening, safety.
+ Work with different partners to **disseminate CD guidelines.**
+ Educate clinic staff/providers/teams - how to teach patients, what's available, how to access.
+ **Connect with GPAC to explore their clinical care pathways**

For Patients & Families

+ Facilitate sessions re: Pathways, other resources, optimizing the doctor visit (e.g. stories).
+ Support standardization of CD care plans & curriculum (with equity lens [e.g., Indigenous, elderly]).
+ Develop and/or amplify patient & family friendly material (e.g. short YouTube clips, handouts).

Innovative Approaches

What's Working Well? What Can we Build Upon?

- Pathways — an effective tool for providers and patients.
- Using case studies during learning sessions to enable application to patient care.
- Cardiology Coaches
- Innovation through QI work (JCC-funded).
- Consultations to Conversation approach (RCCbc)
- UBC + Pathways + HDC + SCC collaboration on CD clinical care pathways, leveraging guidelines.
- Bringing together a team, capturing patient journeys, designing care (e.g. W360 health collaborative).

Opportunities

- Start with understanding the environment (through data) to ensure work fits the community.
- Partner with patients and families to understand their unique needs, before assigning resources.
- Explore 24/7 access to support model for cancer patients (available in some health authorities).
- Embed evaluation (measures, metrics) to capture key learnings and provider experience.

"One of the things we're doing in rural is coaching and mentoring. Small groups are testing this in the Interior – connecting lower mainland experts with rural providers (nurses, FPs) for real time support."

Data & Technology (As Enablers)

Opportunities

Leverage panel management (EMR), Health Data Coalition (HDC), Pathways, and Artificial Intelligence to identify, learn more about, and best support patients (e.g. create care plans, identify key resources).

EXPLORING RESOURCES & SKILLS TO SUPPORT CHRONIC DISEASE PREVENTION & MANAGEMENT – PART 2

+ **Dr Tracy Monk**, Pathways Physician Lead, and **Dr Kathleen Ross**, Pathways Patient Referral Association Chair, presented Pathways as a tool to support
CD prevention & management.

  + Pathways is available to all physicians in BC and their teams.
  + Enhanced (Integrated) Care pathways have been created in cardiology (advanced heart failure), gastroenterology, psychiatry (adult depression), and more than 20 additional paths are in development.

+ **Kim Williams**, Network Director RCCbc, and **Dr Brent Ohata**, rheumatologist, introduced RTVS (Real Time Virtual Support), a tool for rural, remote and Indigenous communities, which can enable communication and connection between patients and providers. Key features include:

  + 24/7 pathways for provider support (emergency, critical care & internal medicine - coming soon)
  + Quick Reply pathways for Providers.

Improving the Patient and Family Journey through the Chronic Disease Community of Practice

All participants engaged in final tabletop discussions to describe the most important roles the CoP can play and actions it can take to improve the patient and family journey, improve the clinician experience, and to identify what partners need from the CoP.

What role can the CoP Play for Patients, Families, and Clinicians?

Communication & Connection

- Continue to gather a diverse group of people to connect and share stories.
- **Cultural Broker** — Bridge the gap between physicians & local community.
- **Foster relationship building** and ongoing connections between FPs, SPs, other providers.

Education

- **Knowledge translation** — Help to create and promote simple effective messages for patients and clinicians to better understand CD and care pathways; help to create best practice.
- **Foster more patient & family education around mental health** and chronic disease.
- Increase awareness of and access to useable resources (e.g. via Pathways).
- **Foster clinician sharing** of knowledge, learnings, and experiences.
- **Explore different models of care**

> *"CoP is not about the disease but about the people it serves."*

Feedback, Next Steps and CloseFamilies, and Clinicians?

Drs Gordon Hoag and **Dan Horvat** reflected on the day, highlighting the impact of patient and family stories, and concluded by outlining next steps including CoP Working Group formation, CoP expansion, and continuing to "leverage natural opportunities to bring bright people together to figure out how to work together."

APPENDIX — EVALUATION FEEDBACK

- Participants: 91
- Participants who indicated interest in joining the CoP (during registration): 57
- 37 participants completed the evaluation:
  - **100% Agree/Strongly Agree** they now have a better understanding of the Chronic Disease CoP.
  - **97% Agree/Strongly Agree** that the event allowed ample opportunities to connect and communicate with colleagues and health system partners.
  - **89% Agree/Strongly Agree** that the event allowed for ample opportunities to explore resources, linkages, and innovative approaches in Chronic Disease Management.
  - **81% Agree/Strongly Agree** that the event allowed for ample opportunities to identify skills, tools, and relationships to improve the patient journey.
  - **92% Agree/Strongly Agree** that the event was a valuable use of their time.

WHAT WAS THE MOST VALUABLE AND/OR INTERESTING ASPECT OF TODAY'S EVENT?

- **Connection** was one of the most frequently mentioned positives of the day, both in the room learning from each other and connection to patient experiences. Quotes from the evaluation echoed the priorities set out for the event:

Hearing patient and caregiver stories and discussing what's working and not working in our current health care system from different professionals. Networking with so many passionate people working in a very challenging aspect of heath care. Creating connections with others and hearing the proposed solutions and existing resources. I most appreciated networking with several well-known colleagues but having the time to consider and discuss fresh initiatives.

- **Education** was also highlighted as a most valuable aspect of the day. The event covered this in a number of ways, including sharing resources that many were unaware of or under utilizing in their day-to-day practice.

I really enjoyed learning about how Pathways can help me in my practice. Pathways and opportunity to hear about all the components that can support CDM including the enhanced care pathways with links, and emailing pt info and messaging features etc. And role that enhanced care pathways can play as centerpiece for education and measurable KPIs. Learning about... Pathways. Also connecting with other individuals with power and influence to make these changes.

- **Innovative Approaches** and allowing the space to foster new ideas within chronic disease management was prevalent in the feedback. Many identified that the energy, level of knowledge in the room and opportunity to connect allowed the ideas to flow.

Working within the profession with specialist and FP to improve communications and integrate care. How to leverage existing resources and make them relevant and timely at point of care. How to increase awareness of resources i.e. Heart Failure that at present is not readily evident to the average FP or patient. The event was carefully and thoughtfully conceived, orchestrated, and executed. The information presented was impactful and succinct. This was an event of smart, high agency doers. The incorporation of families when dealing with patients with chronic disease.

WHAT COULD HAVE IMPROVED YOUR (EVENT) EXPERIENCE?

- More real-life examples and stories
- More time to discuss resources that exist now.
- Improving the cultural relevance to the work and bringing in the family and care partner into the conversations is important.
- Smaller Breakout groups
- Need further discussion about how to improve integration of programs.
- Landing on some actionable items to continue this work.

Chronic Disease Community of Practice Steering Committee, Shared Care Co-Chair, Support Team

CONNECT!

Join our CoP by emailing ***kpurych@doctorsofbc.ca***

Register for ***Pathwaysbc.ca***