CYMHSU Community of Practice

Report from 2nd Gathering: April 6th, 2018

Background

On September 29th, 2017, 60 physicians came together in the process of building a Community of Practice (CoP) in order to work together to improve access and outcomes for children, youth and families with mental health and/or substance use challenges. From that day-long session, three areas of focused attention emerged:

(1) fostering relationships with government;
(2) implementing Adverse Childhood Experiences (ACEs); and,
(3) building networks of physicians.

April 6th, 2018 was the second provincial gathering for the Physician Community of Practice for CYMHSU. This time, 45 physicians (22 Family Physicians, 7 Pediatricians, and 16 Psychiatrists) came together with 15 individuals from Government, Health Authority and Doctors of BC. Physicians came from all parts of the province: Fraser (12), Interior (8), Island (8), Northern (3), Vancouver Coastal (6), PHSA (8).

The purpose of the session was to provide physicians with opportunities to:

- build and foster connections – locally, regionally and provincially – with other physicians working with the CYMHSU population
- have meaningful dialogue on considerations and priorities for an integrated system of care for CYMHSU through:
    - continuing to build relationships with government partners
    - sharing information and experience, physician-to-physician, community-to-community
    - identifying connections with the work of the Primary Care Networks (PCN)
- identify next steps of action and engagement, including the value of a Community of Practice

The following is a capture of how the day unfolded.

UNDERSTANDING OUR CURRENT CONTEXT:

First: WHAT WE HAVE DONE SINCE WE MET LAST?

The day began with a summary of the progress and activity underway in each of working groups that had emerged from the last Community of Practice day.

- ACES
- Network of Physicians
- Relationships with Ministry of Health

The details are found in Appendix A.

Second: WHAT IS IMPORTANT TO THOSE WHO HAVE GATHERED TODAY?

All participants were asked to weigh in on what was valuable for them to be in discussion about over the day. Attendees were prompted to think about what brought them to the meeting – at the micro, meso and macro levels – and share the issues that mattered to them related to CYMHSU.

From that conversation, the following eight core themes emerged:

1. How do we really support the system to be more proactive and preventative?

2. Quality and “choosing wisely”
3. How do we support networking and spread?
4. How do we really work as a team?
5. Learning together: how and what and where?
6. Helping people to really access care
7. How to build resilience with patients
8. How do we create collective impact for change?

The more detailed ideas that came forward from the conversations are captured in Appendix 2.

The information that was generated during this discussion became the areas of discussion that we focused on later in the day.

CONTEXT: WHAT IS HAPPENING IN THE SYSTEM RIGHT NOW THAT WE SHOULD BE AWARE OF?

These rapid fire table presentations were intended to support physicians and guests in understanding key activity that was happening in the system related to CYMHSU and how it may impact them and the work of the Community of Practice. These presentations included:

- Ministry of Children & Family Development
- Ministry of Mental Health & Addictions
- Primary Care Networks Ministry of Health/GPSC

- Foundry
- Psychiatry Outreach BC Children's Hospital
- Adverse Childhood Experiences
- Cross-Ministry Child and Youth Mental Health and Substance Use Plan
- Child and Youth Mental Health Service Framework

CRITICAL SMALL GROUP DISCUSSION:

Participants were now asked to choose one of the eight themes that were previously identified and to discuss these further in small groups. Each table was asked to follow the following arc of inquiry:

- **What** has been identified (through the activities) as part of this topic area… is there anything critical that we feel we need to add to this?
- **So What** does this topic area – and its corresponding parts - "MEAN" to us, to our colleagues, to the system"? **So What** is important for us to pay attention to at this point – and why?
- **Now what** do we need to do next – what is going to be most helpful for physicians in practice, and as we try and support children, youth and their families?

Once complete, scribes summarized the key points for the whole group. However, it was recognized that the three priorities established for the CoP at the inaugural meeting in 2017 describe interdependent components instead of three parallel streams of work, and as such each table was asked to "locate" its recommended next steps on the Venn diagram of priorities as part of their report out process (see Figure 1).

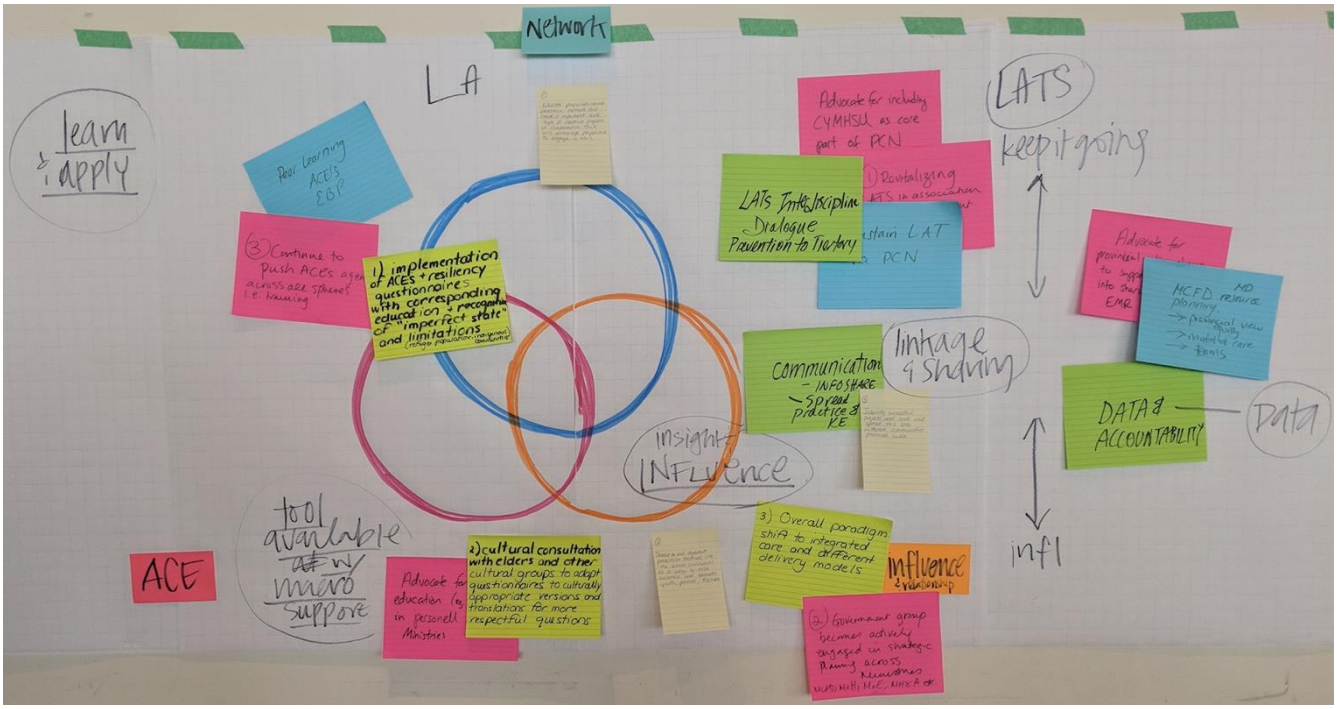

Figure 1. The three interlocking priorities for the CoP established in 2017 – the red circle represents ACEs; the orange circle represents issues that require Influencing Senior Decision Makers; and, blue circle represents Strengthening the Network – and post-it notes from the April 6th, 2018 discussion are mapped to represent the intersecting ways the issues need to be addressed.

With the exception of a small group of child psychiatrists who realized there was work to be done outside the CoP to better connect the child psychiatry community, the remainder of the work proposed for the broader CoP

could be mapped to the three priority areas: (1) fostering relationships with government; (2) implementing Adverse Childhood Experiences (ACEs); and, (3) building networks of physicians.

Below are the themes capturing the activity/directions forward for the CoP and the notes are provided in Appendix 2.

LATS – keep them going

- The Local Area Teams provided a strong foundation for the critical interdisciplinary, cross sectoral approaches that need to be taken to address the challenges that are faced in CYMHSU. We need to find a way to keep them going.

Linking and sharing

- Individuals and organizations are creating tools and resources to fill gaps… but without a way to tell others about them, we duplicate work, or never benefit from these gems. It is incumbent upon us to ensure that we are identifying and developing ways to share our resources, and reach-out to each others across our existing silos and distance.

Data

- We need better data to make decisions. How can we improve the quality of our data that is informing decisions elsewhere. How do we access data – or generate data – to full picture of what we are experiencing as we provide care to children/ youth.

Insight and influence

- How do we better USE what we are seeing individually, and bring those insights together to identify trends - in service of informing and influencing for the changes that need to happen in the system.

Tools Available

- We need tools available for the (family) physicians that create capacity to support the children and youth in our practices and in our communities. We need to strengthen the tool of "relationship" between pediatricians, psychiatrists, and family physicians.

Learn and Apply

- Once we learn new skills – and however we learn new skills – we need to apply them so that we build that strength in our community.

The day wrapped up with a discussion about the significance of the Community of Practice, addressing specifically the physicians' motivation to join the CoP and its value proposition to the system. Overwhelmingly there was a sense that the CYMHSU CoP is a valuable convening space for physicians to build relationships with other physicians and learn from each other's experience, develop a collective voice around CYMHSU priorities and advocate for system improvements using their frontline experience. Some specific examples of participants' responses include:

- Thinking and doing what is best for the future of our children in Canada
- Because we need each other to learn together and to advocate/influence more effectively
- Opportunity to share, energize, learn together, grow together
- Creates relationships and foster passion among physicians for CYMHSU
- Creates a collective voice for physicians regarding CYMHSU to influence policy and improve the system of care
- It does make me not feel alone… and become powerful
- Support best practice and practitioners providing that care and to inform government policy development from a bio-psycho-social clinical perspective.

What became evident was that the CoP has three key functions

- Bringing physicians together who want to champion change in the area of CYMHSU – and supporting the connections and relationships that will develop valuable clinical linkages
- ensuring that physicians at the local level are equipped to provide the best possible care to CY with MHSU
- and leveraging on-the-ground experiences of physicians to advocate to - and work with - government on collective priorities, to strengthen the system for children, youth and families living with MH/SU issues.

Where to from here

The future action of the Community of Practice will be driven by, and responsive to, member needs.

Achieving timely access to integrated care for children, youth and families – this includes enabling information sharing between providers, supporting infrastructure for Local Action Teams

Embedding an ACEs/trauma-informed approach, into practice and policy

Appendix 1. Raw Notes from the Prompt "What is important to discuss?"

How do we really support the system to be more proactive and preventative?

- Cross ministry communication… and with communication with community physicians
- Upstream investment in indicators: ACES/TIP
- Informed communication and information sharing
- Building relationships
- Focus upstream
- Reduce silos; build consistency and stop doing things Ad Hoc.
- Ongoing funding for the LATs
- Implementation of effective prevention programs

Quality and "choosing wisely"

- Early indicators: how do we know how we are doing?
- Education and supports for MDs to increase their confidence
- Ensuring family physicians are well supported to bridge the gaps
- Consistency: province-wide guidelines

How do we support networking and spread?

- Transfer of passion
- Physician engagement

How do we really work as a team?

- Algorithm to support/ navigation between care providers i.e. CYMH teams, pediatricians, GPs, psychiatry
- PMH: integrate psychiatry and social counselling and treat holistically
- Longitudinal care (follow up)
- Lack of Continuity of Care
- Team based care
- Multi-disciplinary team-based care
- Wraparound care: connections to each other/ between providers
- How do you make integrated, wrap around care really happen?

Learning together

- Shared education opportunities
- Education/ schools nearly childhood, families. Skills building, caregivers
- Education/ training (knowledge transfer)
- Better connection between health and mental health practitioners (practitioner-to-practitioner AND integration of treating the whole person)
- Accessing data. Using data to learn.
- Learning about team-based care

Helping people to really access care

- Access to various services
- MH and SU need to be more integrated in practice provision
- Figure out role of GP in triage

- Better navigation and access
- LATS need to be sustained: they support access
- EQUITABLE access
- Equity across geography
- Culturally safe/appropriate supports throughout the system
- Transitional age supports
- Access to specialists: local or virtual

How to build resilience with patients?

- Meeting kids where they are
- Culturally sensitive care
- Holistic approach – physician and mental
- Universal trauma informed care

How do we collectively create collective impact for change?

- Leverage MMHA
- Need to leverage school system supports
- Need more shared care
- Community partnerships
- Communication across sectors
- "Go where the fire is lit"
- No more band aid solutions
- Evolving medical practices BUT stagnant system
- Change management
- System fragmentation
- Long term plans
- Funding
- Alignment of services between tiers and matching resources and funding… someone has to have an overall picture from above.

Appendix 2. Small Group Discussion Report Out

- Peer learning: ACE's EBP
- Continue to push ACEs agenda across all spheres i.e. training
- Implementation of ACES and resiliency questionnaires with corresponding education and recognition of "imperfect state" and limitations (refugee populations, indigenous communities)
- Data and accountability
- MCFD MD resource planning – provincial view, equity, model of care, teams
- Advocate for provincial attention to ACEs
- Advocate for including CYMHSU as core part of PCN
- LATs at interdisciplinary dialogue prevention to tertiary
- Communication – info share, spread practice and knowledge exchange
- Overall paradigm shift to integrated care and different delivery models
- Identify successful projects and practices and spread this into different communities province wide
- Develop prevention methods in the school curriculum as a way to raise awareness and support youth, parents and teachers
- Cultural consultation with elders and other cultural groups to adapt questionnaires to culturally appropriate versions and translations for more respectful questions

Appendix 3. Attendees

Doctors of BC/BC Government Staff

Augustine, Mary
Bartel, Martin
Begg, Jennifer
Blemings, Roxanne
Davis, Sue
Glynn, Keva
Grewal, Ray
Harrhy, Dave
Hefford, Brenda
Hill, Katie
Hoag, Gordon
Lampard, Robert
MacMillan, Joanne
Sinclair, Sonja
Stevenson, Stephanie
Watt, Robin

Family Physicians

Ali, Tahmeena
Barlow, Sandra
Broker, Hayley
Chang, Ernie
Crow, Richard
Dawkin, Danette
Dosanjh, Ramneek
Ehasoo, Valerie
Fedor, Glenn
Fujiwara, Joan
Hii, James
Ketch, James
Keyter, Herman
Larsen Soles, Trina
Lehman, Robert
Ross, Shelley
Somani, Aly
Sze, Shirley
Uyeda, Linda
van Wyk, Andre
Webb, Charles
Wladichuk, Adrian

Pediatricians

Arruda, Wilma
Davey, Allyson
Luu, Kelly
Poynter, Aven
Sotindjo, Tatiana
Warshawski, Tom
Whitehouse, Sandy

Psychiatrists

Agbahovbe, Onome
Burkey, Matthew
Chow, Matthew
Davidson, Jana
Esmaili, Haydeh
Friedlander, Robin
Hosenbocus, Sheik
Kane, Barbara
Mathias, Steve
Rosenauer, Helen
Saari, Carol-Ann
Saran, Kelly
Slater, Jennifer
Smith, David
Stratton, Julia
Vogt, Lori

Appendix 4. Updates from Working Group activity

Since the three priority areas were identified in September 2017, three working groups formed to move forward the work of the CYMHSU Community of Practice. In the months that followed, each working group thoughtfully drafted action plans outlining objectives to focus its priorities and expedite its endeavours.

Government & Physicians Working Group

The Government & Physicians Working Group has focused on key system priorities for the community of practice to advance to government. The working group aims to leverage the work of the Local Action Teams (LATs) and has identified the following long-term objectives:

1. How to include physicians at the leadership table, and
2. How to open the communication lines between all agencies providing CYMHSU care.

Regularly scheduled cross-Ministries meetings were also recently established to sustain communication between the community of practice and government. Over the next months, short-term goals will be actioned to pursue these overall objectives.

ACEs Working Group

The ACEs Working Group is focusing on building awareness, sharing information, shifting practices and policies, and creating a repertoire of trauma-informed resources for referral. Opportunities identified include:

1. Embedding the ACEs questionnaire into electronic medical records (EMRs) and patient intake processes,
2. Embedding the ACEs questionnaire into antenatal screening and ensuring parenting supports are in place for parents and their newborn and other children,
3. Developing ACEs learning packages for physicians (e.g. through Small Group Learning Sessions),
4. Developing provincial guidelines on ACEs (i.e. GPAC), and
5. Outreach ACEs presentations to communities and organizations.
6. Advocate for Early Childhood supports and interventions on a provincial level

This working group's mandates consist of 3 focus areas:

1. Raising awareness of ACEs with providers and communities,
2. Supporting practice implementations (embedding ACEs 'history taking' in practice), and
3. Influencing policy.

The importance of tying the ACEs questionnaire to population health outcomes and customizing for specific target populations (e.g. pregnant women, refugees, and indigenous population groups) has been highlighted, in addition to the overall resistances and barriers associated with using the ACEs questionnaire in practice that physicians face. The ACEs working group recognizes the challenges around influencing larger policies and aims to encourage practices to start small with new patients and equip physicians with practical ideas for implementation. Further, there was consensus from the group to support an ACEs Summit in the following year to continue to increase awareness of ACEs and its implementation into practice.

Networks Working Group

Since September 2017, the Networks Working Group has been engaging in the following areas of work:

1. Setting its key purpose statement and coming up with ideas for supporting internal and external networks,
2. Developing the concept of the online communication platform and its purpose, and
3. Supporting the launch of the monthly newsletter.

The purpose statement outlines the following 3 key functions of this working group:

1. Communicating between physicians and other providers, across settings and geographies, to improve CYMHSU care,
2. Communicating within physician communities on clinical care and system issues, and
3. Exploring strategies for networking and advocating effectively as a group.

The overall priority of the Networks Working Group is to enable communication between physicians to share ideas, solve problems, and build clinical capacity, with the goal of improving the system of care for children, youth, and families dealing with CYMHSU issues. Moving forward, this group aims to highlight success stories and build opportunities for coaching, with the long-term objective of enabling the community of practice to concurrently influence Primary Care Networks (PCNs) in the province.