



## 2013 Shared Care Committee showcase: *Discovering our Collective Impact*

Summary report of the event held October 24-25, 2013



**TABLE OF CONTENTS**

---

*Executive summary*..... 3

*Introduction*..... 4

*Breakout learning sessions*..... 6

    PDSA: Trials, Tribulations, and Learnings.....7

    Practical Tools for Patient Engagement.....8

    Collaborative Learning – The Benefits of Working Together.....10

    Addressing Polypharmacy: Innovative Solutions to a Growing Challenge .....12

    Gathering Evidence – Measuring Impact.....13

    Creative Solutions: Finding New Paths to Improvement.....14

    Rapid Access to Psychiatry: Exploring an Alternate Model of Care .....15

    The Challenges and Benefits of Addressing Co-morbidity .....16

    RACE: Talk to Me – Telephone Advice in BC.....17

    Imagine the Future! – Ideas for Effective Knowledge-sharing .....18

    All Voices Heard – The Value of Comprehensive Stakeholder Engagement.....19

    Building on Lessons Learned – Sharing Transition Tools Across Initiatives .....20

*Closing plenaries*..... 21

    Day one ..... 21

    Day two ..... 22

## EXECUTIVE SUMMARY

On October 24 to 25, 2013, the Shared Care Committee held its second event to showcase the accomplishments, lessons learned, and future plans of its various initiatives focused on improving health outcomes and the patient journey through the health care system. Titled **Discovering our Collective Impact**, the showcase brought together family and specialist physicians, representatives from the BC Medical Association (BCMA), the Ministry of Health (MoH), health authorities, the Shared Care Committee, General Practice Services Committee (GPSC), Specialist Services Committee, and patient partners.

The event included 12 breakout learning sessions bookended by plenary presentations that featured remarks from a number of representatives, including Dr William Cunningham, President of the BCMA, and Lindsay Kislock, an Assistant Deputy Minister (ADM), Health Sector IM/IT at the MoH.

The more than 200 showcase attendees participated in various breakout learning sessions that highlighted the following key components of the collaborative work that is funded and supported by the Shared Care Committee:

- Physician engagement
- Patient engagement
- Health authority engagement
- Plan-Do-Study-Act cycles
- Evaluation
- Innovative design
- System enablers

During intervals between plenary presentations, composer and pianist Michael Jones played music that infused the large convention centre space with a sense of intimacy, and Avril Orloff graphically recorded presentations and breakout sessions. Some of Orloff's imagery is included in this report.



At the conclusion of the first day, attendees also had the opportunity to view poster presentations that highlighted various Shared Care projects, before gathering for dinner.

Attendees were given the opportunity to provide feedback at various points throughout the event and by submitting their thoughts in writing. An assessment of this feedback suggests there is a continued need to:

- Spread the word about Shared Care projects among all stakeholders.
- Support partners to take what they learned at the showcase and act on it.
- Support and encourage partners involved in Shared Care quality improvement projects to raise awareness of the work underway.

This report provides an overview of the plenary presentations and 12 breakout learning sessions featured at the showcase.

## INTRODUCTION

---

The Shared Care Committee is a joint committee of the BC Medical Association (BCMA) and the Ministry of Health (MoH) that is working to improve health outcomes and the patient journey through the health care system.

The committee was formed in 2006, as part of the Physician Master Agreement between the MoH and the BCMA, to address the growing need for coordination of patient care and best use of health care resources.

Each year the Shared Care Committee showcases the accomplishments, lessons learned, and future plans of its various initiatives.

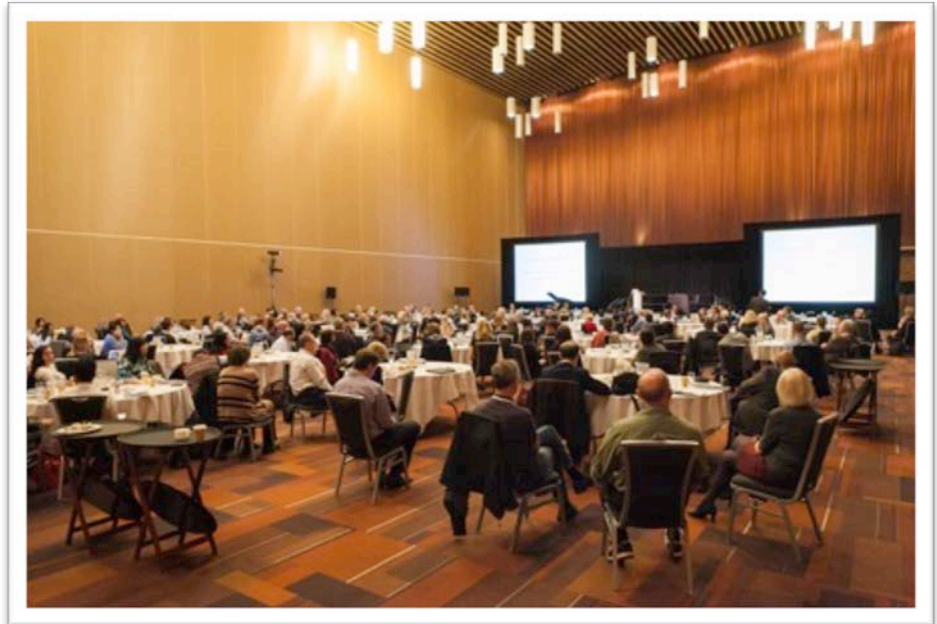


PHOTO 1: OPENING PLENARY

This year, family and specialist physicians, representatives from the BCMA, the MoH, health authorities, the Shared Care Committee, General Practice Services Committee (GPSC), Specialist Services Committee, and patients all gathered at the Vancouver Convention Centre for a two-day event called **Discovering our Collective Impact**.

---

### PLENARY: PURPOSE, INTENTIONS, AND WELCOME

---

The showcase began with a traditional coastal First Nations welcome from Janis Campbell, an Aboriginal Senior Ambassador of Squamish and Musqueam descent.

Charles Holmes, the showcase facilitator, explained that the event was designed to highlight the value and impact of the partnerships fostered through Shared Care initiatives and how these initiatives are enabling family and specialist physicians to work together to provide coordinated, continuous, and comprehensive patient care.

Five intentions for the showcase were established at the outset:

1. To optimize opportunity for dialogue and conversation.
2. To learn with and from each other about where and how to achieve collective impact.
3. To explore questions that matter.
4. To showcase examples of shared care in action.
5. To identify opportunities for building new – and expanding existing – Shared Care initiatives.

Dr William Cunningham, President of the BCMA, and Lindsay Kislock, an Assistant Deputy Minister (ADM), Health Sector IM/IT at the MoH, each welcomed participants with a plenary speech.

Dr Cunningham identified the Shared Care showcase as an opportunity for face-to-face engagement, and a chance for those familiar with and those new to Shared Care work to meet. He acknowledged that the work of the Shared Care Committee is ever-expanding and now includes more than 80 funded projects across the province.

He reflected that many physicians and their health care partners are learning from the work of their colleagues elsewhere in the province, and as the number of Shared Care projects increases, Dr Cunningham sees more physicians getting involved.



*PHOTO 2: LINDSAY KISLOCK, ASSISTANT DEPUTY MINISTER OF HEALTH*



*PHOTO 3: DR WILLIAM CUNNINGHAM, BCMA PRESIDENT*

Kislock, who spoke on behalf of Stephen Brown, the Deputy Minister of Health, expressed her passion for change and her interest in supporting better integration between programs and policy. Kislock said she wants to renew accountability and work collaboratively with health authorities.

Attendees also heard from Caryl Harper, Director, Patients as Partners, MoH, and Bev Bakka from ImpactBC, who spoke about Patients as Partners growing within three years from 15 to over 15,000 patients engaged. They emphasized that the central principle of the initiative and its work is “nothing about me without me,” which reflects the belief that patients are partners in their own health care—in system change discussions or speaking with their health care providers. Bakka also spoke about one of the first patient partners, the late Val Demont, saying he set the tone for patient engagement in BC and paved the way for a variety of patient initiatives around the province.

Holmes instructed table groups to explore two questions: What are you curious about? And, what is a question that you would like to explore during this showcase? Following small group discussions, a few curiosities and questions were explored during the plenary session.

One group wondered if those involved in Shared Care are asking the right questions to guide health care along the right path. Another group asked what could be done to enhance the manner in which scarce resources are expended. Further to that, one group questioned how serious stakeholders are about committing funding to Shared Care initiatives.

One commenter suggested the work of the committee and the various initiatives is difficult to learn about and wondered if the creation of an online, searchable repository of work would be a potential solution.

Holmes encouraged the group to explore their questions over the course of the showcase and in the 12 breakout learning sessions delivered that afternoon and the next morning.

## BREAKOUT LEARNING SESSIONS

Attendees of the 2013 showcase participated in 12 breakout learning sessions that highlighted the following key components of the collaborative work that is funded and supported by the Shared Care Committee:

- Physician engagement
- Patient engagement
- Health authority engagement
- Plan-Do-Study-Act cycles
- Evaluation
- Innovative design
- System enablers



*PHOTO 4: BREAKOUT TABLE DISCUSSION*



*PHOTO 5: DR KEN BURNS, FAMILY PHYSICIAN; DR SHELLEY ROSS, GENERAL PRACTICE SERVICES COMMITTEE CO-CHAIR; DR NIGEL WALTON, BCMA BOARD MEMBER*



*PHOTO 6: DR GAREY MAZOWITA, FAMILY PHYSICIAN, SHARED CARE COMMITTEE MEMBER; DR BRENDA HEFFORD, WHITE ROCK-SOUTH SURREY DIVISION OF FAMILY PRACTICE CHAIR*



*PHOTO 7: "GATHERING EVIDENCE" BREAKOUT PRESENTATION*

## PDSA: TRIALS, TRIBULATIONS, AND LEARNINGS

PRESENTED BY LESLIE ROGERS, DR KATHLEEN ROSS, AND VICKI THOMPSON

The Plan-Do-Study-Act (PDSA) cycle is a quality improvement tool for testing a change in a real work setting by planning it, trying it, observing the results, and acting on what is learned.

All Shared Care projects use the PDSA approach, which enables team members to adjust, refine, and even discard components of improvement activities, based on what is learned along the way.

Shared Care Project Lead Leslie Rogers and Dr Kathleen Ross, Medical Lead discussed using the PDSA approach to address communication breakdowns in the Fraser Northwest region. Through the Partners in Care and Transitions in Care initiatives, physicians prioritized the rebuilding of those communications channels in the earliest stages of patient treatment.

Project steps included:

1. Designing/planning project (June 2012).
2. Consulting with GPs and hospitalists (July - Sept. 2012).
3. Consolidating input (Oct 2012).
4. Combining focus groups (early November).
5. Consulting additional stakeholders (November-December).
6. Initiating PDSA cycle for pilot projects (early January 2013).

Ross and Rogers advised others to spend time up front on detailed planning, but to be willing to respond and adapt as things change.

Vicki Thompson is the director of resident care at Mount St. Mary Hospital in Victoria, where she has initiated a Polypharmacy initiative project to develop an enhanced medication review process. Her team used PDSA cycles to achieve this end.

The planning stage was detailed and involved interdisciplinary teams, reviewing existing processes, identifying gaps, and developing a medication review form that went through eight revisions before the team would accept it.

The “do” stage started with education of the various teams on how to use the forms. Thompson said they then implemented the plan and collected data and made observations along the way.

During the “study” stage, they learned of a significant quality improvement, including a reduction in medications and improved outcomes.

For the “act” stage they made alterations to their plan based on data and analysis, collaborated with the team to look for continuous improvements, and began planning for the next PDSA cycle.



**PRACTICAL TOOLS FOR PATIENT ENGAGEMENT**

PRESENTED BY CHERYL RIVARD, MONA MATTEI, BETHINA ABRAHAMS, AND MOE BALOO

The Shared Care Transitions in Care initiative aims to address the various challenges of patient transition into, through, and out of acute care.

The Practical Tools for Patient Engagement breakout session focused on **patient engagement in health care redesign** and highlighted how different patient engagement methodologies are being used in Transitions in Care projects.

For Cheryl Rivard, Patients as Partners Coordinator for Vancouver Coastal Health, the phrase, “nothing about me, without me,” encapsulates the patient engagement ethos. Rivard outlined a framework doctors can follow to incorporate patient-centric thinking into their work: Inform→Consult→Involve→Collaborate→Empower.

One practical tool for patient engagement is the **patient journey map**, a process that brings patients and health care providers together to consider the journey patients take through the system and to identify opportunities to improve patient flow.

There are three approaches to patient journey mapping: large group, focus group and one-on-one sessions.

The large group format has been used in maternity and psychiatry by physicians in the Kootenay Boundary region and involves bringing as many as 20 patients together with family doctors and specialists. The format has been used to identify key tension points in the medical system.

Mona Mattei, Shared Care Project Manager in the Kootenay Boundary region, said this kind of session requires a high level of planning, months of preparation, and overcoming logistical challenges like scheduling patients and their care providers. Mattei said relying on doctors to recruit patients and conducting pre-session meetings to allay concerns or anxiety about participating in group discussions are helpful tactics.

With this format, patients are exposed to multiple perspectives of other patients, and, despite the eight-hour session length, doctor time is used efficiently.

Alternatively, the **focus group format**, which has been used in cardiac care in the Kootenay Boundary region, brings six patients together to discuss their journeys. In the same way market researchers collect focus group material, patient input is anonymous. Patients indicated they felt supported in this setting, and Mattei said the sessions are easier to organize.

**One-on-one sessions** have been conducted as part of the





Shared Care work underway through the North Shore Division of Family Practice.

Bethina Abrahams, Transitions in Care Assistant Project Director, said patients in these sessions seemed comfortable enough to voice their concerns and many were frank and forthright with their opinions on the medical system. Prevalent themes were then identified in the various sessions (e.g., wait times) and forwarded to physicians to help them understand how inefficiencies and gaps are affecting patients.

Another practical tool for patient engagement is the **bedside patient interview**.

Moe Baloo from Providence Health Care in Vancouver has been interviewing patients at the General Medicine Ward of St. Paul's Hospital in downtown Vancouver, with a view to improving patient outcomes. He said this kind of patient involvement in health care redesign could improve patient experience and outcomes and decrease per capita costs.

So far, Baloo has conducted five comprehensive 45-minute interviews in which he asks each patient 10 key questions derived from Institute for Healthcare Improvement studies. For example, he asks patients if they have a GP who can do a follow up examination, if they understand the instructions they were given, and if there is anything that might improve their hospital experience.

He said this kind of interview requires a great deal of patience; many patients are too sick to be interviewed, and the interviewer must be conscious of the time they are taking up.

Baloo thinks this kind of in-depth interviewing technique can help reduce patient re-admission rates, which cost taxpayers \$1.8 billion annually.

Lastly, **patient participation in committees** is another engagement tool that gives patients an equal voice in the planning process. However, many patients involved in committees have expressed difficulty following some of the more technical discussions.

## COLLABORATIVE LEARNING – THE BENEFITS OF WORKING TOGETHER

PRESENTED BY CHARLES SCOTT, DR DAN HORVAT, AND SUSAN BROWN

The Shared Care Partners in Care initiative comprises numerous joint efforts by family and specialist physicians to streamline referral and consult processes, shared care planning and re-referral criteria, diagnostic standards and communications, telephone advice protocols, and more.

Partners in Care projects are necessarily collaborative and while working together has benefits, it also poses challenges. For Charles Scott, Project Lead with the Northern Partners in Care initiative, overlapping interests and competition are major **collaborative learning challenges**.

Identifying the right decision-makers to involve in planning processes, and striking a balance between innovation and control are two other challenges Scott has identified.

On the other hand, Scott has learned several important lessons on collaborative learning in a Shared Care setting. Defining the common ground at the beginning of a process is helpful, and spending the time up front to define shared goals ensures everyone involved has a stake in the outcomes and their interests are reflected in the plan. Scott suggested writing down shared goals and definitions of success so that stakeholders can ensure they are making decisions with the right goal in mind, that they are on-track, in-scope, and are not missing anything vital.

Furthermore, Scott said he has learned communication is important, but must be done strategically. With so many organizational layers, there is a huge amount of information that must be communicated, but if it's overdone, audiences can burn out and lose interest. With some projects lasting two to three years, communication should be timely, but not overwhelming.

The last of Scott's top three lessons learned focused on relationships. Relationships are vital for getting through tough issues. This means involving the right people at the right time and collaboratively deciding next steps.

One challenge faced by physicians working in a collaborative learning environment is time management, according to Dr Dan Horvat, Physician Lead, Northern Partners in Care, who also suggested that working collaboratively with health authorities requires considerable time and effort.



Dr Horvat said a strong team, engagement from all levels of management and with the community, and strategic planning are crucial elements of successful Shared Care projects.

The learning session incorporated input from Susan Brown, an administrator with Interior Health regarding her top challenges and lessons learned from a health authority perspective. (Brown did not attend the session.) Brown's top **challenge** is determining if ideas fit with the organizational strategic plan. A health authority operates within a strategic framework, and even the greatest idea that is well supported by evidence may not fit within that framework.

Likewise, new projects compete for limited funds and time. Brown, like many others at the showcase, identified the time limitations of physicians as a major challenge, and while health administrators approach time allocation from a different perspective than physicians, the end result is very similar – there is more work than time.

Brown's top **lesson learned** is that engagement is reciprocal. When Shared Care initiatives and local divisions of family practice began developing, she heard a lot about physician engagement. But early on it was clear that health authority engagement by physicians was equally important to the quality improvement process.

Brown also learned that persistence pays off, and that learning is an iterative process.



*PHOTO 8: "COLLABORATIVE LEARNING" BREAKOUT*



## GATHERING EVIDENCE – MEASURING IMPACT

PRESENTED BY DR ANNETTE MCCALL AND DEWEY EVANS

The Shared Care Youth Transitions initiative aims to improve the transition from pediatric to adult care for youth and young adults (age 10 to 24) with chronic health conditions and/or disabilities. Youth can access pediatric care services until their eighteenth birthday, when they must transfer, with little preparation, to adult care services provided by regional health authorities.

Dr Annette McCall, a family practitioner in North Vancouver, and Dr Dewey Evans, who has worked with youth for over 20 years, shared how they are evaluating their work in an effort to improve care for youth with chronic health conditions as they transition to adult care.

They posed two questions to guide their presentation:

- How do we know if our quality improvement efforts are having the desired impact?
- How can we ensure that even our missteps keep us on the path toward the Triple Aim?

To measure the effectiveness of their efforts, Dr McCall and Evans have evaluated two transition tools: medical transfer summaries, which are based on the Royal College of Physicians Most Responsible Physician criteria, and transition clinical pathways, which are summaries of information provided when patients are transferred. They picked six transition cases, featuring patients who suffered from inflammatory bowel disease, neuromuscular, and biochemical disorders, to review, and learned the following:

- Due to privacy issues, provincial systems prevent the collection of youth contact information.
- Anticipatory guidance for patients needs to be clear and concise.
- Doctors must be clearer on who is going to do what.
- Referral networks must be optimized.
- Indications and contraindications for medications are necessary.
- Information about psychosocial, sexual health, and school functioning are important and help family practitioners connect with youth during consults.



**CREATIVE SOLUTIONS: FINDING NEW PATHS TO IMPROVEMENT**

PRESENTED BY CLAY BARBER, DR KEN BURNS, DR JOHN PAWLOVICH, AND DR MARIE-PIERRE DALLAIRE

The Creative Solutions: Finding New Paths to Improvement breakout session illustrated the successes and challenges of the Teledermatology initiative.

This initiative is working to integrate digital technology and aspects of the Internet to improve access to dermatological consults for family physicians in urban, remote, and isolated communities in BC.

More than 400 BC physicians are using a process known as “store and forward” to eliminate the prolonged wait times for dermatologists that patients in rural, remote, and even urban areas of BC usually endure.



Dr Ken Burns, a family physician and chair of the Ridge Meadows Division of Family Practice, discussed his use of [bc.consultderm.com](http://bc.consultderm.com), a secure web site and database that facilitates electronic clinical communication between family and specialist physicians, enabling remote dermatological consults. Burns explained how he uses his smartphone to snap photos of a patient’s dermatological lesions and submits them, along with notes and relevant information from the patient’s medical record, to the web site where they are viewed and assessed by a specialist. Once the dermatologist has completed the assessment, the system notifies Dr Burns by e-mail.

The web site and consult process build on the ConsultDerm system that is used by family physicians from Alberta and the Northwest Territories.

There are a number of Teledermatology prototype sites in BC, including Salt Spring Island, where 86% of patients surveyed were satisfied with the store and forward consult process, and 86% preferred this consult process to having to travel for in-person specialist consultation.

Four dermatologists currently participate in the Shared Care Teledermatology initiative, but initiative leads are looking for more specialists to join.

Expanding on the idea of finding creative solutions to improve patient care, two doctors joined the presentation via a satellite video feed. Drs John Pawlovich and Marie-Pierre Dallaire, who specialize in rural care, outlined some of the techniques they use to assess patients remotely. For example, a nurse in a remote community can use a special throat camera to upload a video to Dr Pawlovich for his assessment. Rather than going to that community to assess the patient, he can save time and health care system funds by doing it from his desk.

The doctors agreed that patients under their care are receiving treatment levels equal to people living in major cities.

**RAPID ACCESS TO PSYCHIATRY: EXPLORING AN ALTERNATE MODEL OF CARE**

PRESENTED BY DR RON REMICK

The Shared Care Rapid Access to Psychiatry initiative is increasing capacity, using existing resources, for psychiatric patient care in BC. Psychiatrists engaged in the initiative are using an alternate model of care that includes group medical visits (GMVs) and/or physician-patient e-mail communication for treatment of patients with mood disorders.

This session, led by Dr Ron Remick, Medical Director at the Mood Disorder Association of BC (MDABC), included a mock GMV for the audience to observe. Participants were struck by the efficiency with which one doctor can provide information to so many patients.

Dr Remick said 80% of GMV patients are referred by family doctors for treatment of mood disorders. This referral process ensures the right patients are attending GMVs.

The key tenets of Dr Remick's MDABC model are:

- Encourage patients to become informed consumers.
- Use GMVs in lieu of individual visits.
- Use e-mail communication to increase patient access and in lieu of individual visits.
- House the program in a milieu that offers support and advocacy and lessens stigma.

A majority of patients indicated in a survey that they prefer GMVs or have no preference between GMVs and individual care. Less than a third of patients surveyed said they prefer individual care to GMVs.

One doctor from a small BC community wondered if there would be anonymity concerns with GMVs in a town with a small population. Dr Remick said it is surprising how much personal information patients are willing to volunteer in a group setting, and in situations where something is extremely personal, private visits can be arranged.

Dr Remick shared a few techniques for conducting effective GMVs. He said if he has an idea of who is in the group, he addresses upbeat, articulate patients first and last and addresses the low-spirited more distressed patients in the middle of the session. And if someone presents an extreme problem, Dr Remick meets with the patient privately right at the end of a session to ask more direct questions.

Dr Remick presented information to make a case for ongoing financial support of the MDABC program:

- The program is six times more efficient than traditional psychiatric care (per number of patients assessed and able to receive follow-up treatment per year).
- Wait times for assessment and treatment are one-quarter to one-sixth the norm.
- It costs one-third to one-fifth the amount of money traditional care requires.
- Patient satisfaction is high.
- Physician satisfaction is high.



## THE CHALLENGES AND BENEFITS OF ADDRESSING CO-MORBIDITY

PRESENTED BY DR SEAN VIRANI

Cardiologist Dr Sean Virani discussed the development and aim of the System of Shared Care for Patients with Chronic Obstructive Pulmonary Disease (COPD)/Heart Failure learning module, a Practice Support Program (PSP) offering that supports effective coordination of care for patients with these comorbid conditions. The PSP provides training and support for physicians and their medical office assistants designed to improve clinical and practice management and to support enhanced delivery of patient care.

COPD and congestive heart failure are the two most common causes of hospital admission in Canada, and in 25% of COPD cases admitted, there is co-existing heart failure.

While there is increasing recognition that chronic diseases co-exist, there are few guidelines to support optimal care of patients with co-morbidity, Virani noted. Collaboration then is integral to effective shared care of patients with two or more concurrent chronic conditions, who are at increased risk of morbidity/mortality, hospitalization, and health care utilization.

Dr Virani and respirologist Dr Mark FitzGerald developed the module with the funding support and under the governance of the Shared Care Committee. The module provides much-needed guidance for treatment of two diseases that commonly co-exist, but are often

indistinguishable and for which inappropriate diagnosis and treatment and suboptimal or incorrect delivery of therapies are common. Additionally, exacerbation of one disease state often impacts the outcome of the other.

By facilitating opportunities for synergy between treatment-specific care pathways, such as rehab or smoking cessation, the module exemplifies the value of training physicians to diagnose, treat, and coordinate care for co-morbid patients.

Virani identified the following as necessary for an effective system of shared care for patients with comorbid conditions:

- Specialists, primary care providers, and allied health professionals working together.
- Providing education, care pathways, and clinical decision support tools.
- Building systems of care.
- Patient-focused rather than disease-focused treatment.
- Care providers maintaining communication throughout the patient journey through the health care system.
- Leveraging established infrastructure for both disease states and identifying synergies.





**RACE: TALK TO ME – TELEPHONE ADVICE IN BC**

PRESENTED BY MARGOT WILSON

Margot Wilson from Providence Health Care discussed the Rapid Access to Consultative Expertise (RACE) program, a telephone hotline that provides family physicians in the Vancouver Coastal Health (VCH) region with access to specialist advice.

RACE is part of the Shared Care Committee’s Partners in Care initiative and serves as a model for similar systems being developed at a number of sites around the province.

Family physicians in the VCH region can phone one number to speak to specialists in eighteen different fields.

Wilson assessed 30% of the 8,000 calls received at St. Paul’s so far and found the following:

- 80% of calls were answered within 10 minutes.
- 90% were less than 15 minutes in length.
- 60% avoided face-to-face consults.
- 32% avoided ED visits.
- GPs found that this service helped with their clinical judgment, furthering their ongoing knowledge development.

Wilson outlined some of the key lessons learned since the implementation of the RACE program. She said a system that works in one region or city might not work elsewhere, and it’s important to consider existing lines of communication that may be valuable. Establishing criteria for response times, knowledge transfer, and collegial interaction are important.

RACE used a focus group to incorporate the viewpoints of patients into the plan. RACE program leads learned to keep the system simple, and that, as is the case with any new service, marketing is important.



**IMAGINE THE FUTURE! – IDEAS FOR EFFECTIVE KNOWLEDGE-SHARING**

*DISCUSSION LED BY BOHDAN ZAJCEW AND ANTHONY FAST FROM SIENA CONSULTING*

This breakout session served more as a focus group than a showcase of an initiative. Participants were asked for their input on the development of a **knowledge-sharing network or system** that would increase communication across initiatives, projects, and regions.

Dave Harry, the Transitions in Care Initiative Lead, referred to an existing knowledge-sharing web site created by the BCMA that allows for cross-initiative sharing of ideas. This web site can host documents and supports forums for dialogue, but the site is virtually unused.

However, 94% of respondents to a recent survey said they would use a similar system if it were more relevant and kept up to date. In light of this, participants at the Imagine the Future – Ideas for Effective Knowledge-sharing session were asked to imagine a system or network that offers family and specialist physicians, patients, allied health professionals, and others engaged in improving shared care in BC easy, intuitive, and instant access to information and best practices.

Participants were asked the following three questions and provided the subsequent feedback:

1. What would an effective knowledge sharing network/system look like?
  - Easily accessible, searchable, and intuitive.
  - Allows for dialogue between users.
  - “Push notifies” users of relevant updates.
  - Includes a “blue sky space” where doctors can “dream” new initiatives and where they can “inspire, be inspired, and dream.”
  
2. What are the gateways or opportunities and what are the obstacles?

<b>Opportunities</b>	<b>Obstacles</b>
<ul style="list-style-type: none"> <li>• Mobile devices.</li> <li>• Capacity to share information between all – including patients.</li> <li>• Integration with other initiatives.</li> <li>• Potential for a site of “expert resources.”</li> <li>• Capacity for “speed, ubiquity, interoperability.”</li> <li>• Necessary technology exists.</li> </ul>	<ul style="list-style-type: none"> <li>• Time required.</li> <li>• Extra work.</li> <li>• Cost.</li> <li>• Privacy and confidentiality.</li> <li>• The question of who controls the content.</li> <li>• Whether or not the system is publicly accessible (e.g., is it accessible by patients?).</li> </ul>

3. If we build this system/network, how do we ensure people use it?
  - Use existing portals.
  - Maintain clarity of purpose.
  - Send out the system for feedback and use an iterative rollout process.
  - Ensure that the goal is to connect people behind networks (creation of the tool is not the goal).

## ALL VOICES HEARD – THE VALUE OF COMPREHENSIVE STAKEHOLDER ENGAGEMENT

PRESENTED BY CHRISTINA SOUTHEY, DR SHEIK HOSENBOCUS, RAE SAMSON, AND DR ALLYSON DAVEY

Children and families experiencing mental health and/or substance use issues face a complex and challenging journey as they transition between school and community programs, acute and community care, tertiary and secondary services, and from youth to adult programs.

The Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative aims to increase the number of children, youth, and their families receiving timely access to integrated mental health and substance use services and supports in the Interior Health region.

This breakout session illustrated how highly effective engagement practices are enabling stakeholders to guide this process.

Dr Sheik Hosenbocus, a child psychiatrist who has spent the last 20 years working in Kamloops, BC, stressed the importance of shared care in psychiatry. When looking at the mental health of children, he said doctors must understand the trajectory of the disorder and devise long-term programs.

He identified some key components of effective collaborative care:

- Anticipatory care:
  - When moving children to another agency, anticipate what problems they may have as they move through the system and keep track of who is keeping an eye on these patients to understand difficulties (particularly when it comes to the transition to adulthood).
- Comprehensive care:
  - There must be a structured routine, and treatment must be consistent.
  - Care must involve parents, who oftentimes are facing their own challenges.
  - Case management is essential.

Dr Hosenbocus' collaborative team includes mental health care representatives, Child and Family Services, First Nations groups, and schools. Today it is called K4C, and it is one of eight Local Action Teams involved in the CYMHSU Collaborative.

Rae Samson, one of the on-the-ground service providers within K4C, discussed the beginnings of the concept. Samson said it started with a general agreement to improve outcomes for children and youth with mental health and substance use disorders in Kamloops and the surrounding area by creating a seamless and coordinated continuum of care.

Dr Allyson Davey, who is a pediatrician but lacks training in psychiatry, said she realized early in her practice that she had to rely on the broader network around.

Dr Davey highlighted some barriers she has faced along the way:

- Physician resources:
  - 25,000 people in Kamloops do not have a family doctor. People near the poverty line and Aboriginal people are overrepresented in this category.
- Timely access to services.
- Communication gaps between caregivers.
- Gaps in transitions between services.



## BUILDING ON LESSONS LEARNED – SHARING TRANSITION TOOLS ACROSS INITIATIVES

PRESENTED BY DR SANDY WHITEHOUSE AND ERIN MCFEE

This breakout session featured developments from the CYMHSU Collaborative and the Shared Care Youth Transitions initiative.

The CYMHSU Collaborative aims to increase the number of children, youth, and their families receiving timely access to integrated mental health and substance use services and supports in the Interior Health region.

The Shared Care Youth Transitions initiative aims to improve the transition from pediatric to adult care for youth and young adults (age 10 to 24) with chronic health conditions and/or disabilities. Youth can access pediatric care services until their eighteenth birthday, when they must transfer, with little preparation, to adult care services provided by regional health authorities. The initiative is one component of a broader project called ON TRAC developed at BC Children's Hospital to improve continuity of care for this vulnerable patient group.

Dr Sandy Whitehouse from BC Children's Hospital, a pediatrician and the medical lead of the team, and Erin McFee, a clinical nurse at BCCH, discussed PDSA cycles as applied to tools for improving the transition of patients between care settings.

Dr Whitehouse and McFee explained that the tools used in ON TRAC were developed in the hospital, then taken to the community, and then brought back in again. They are entering a sixth PDSA cycle.

Based on suggestions from the participants, Dr Whitehouse and McFee tailored their presentation to the following topics:

**The three Rs of stakeholder engagement: respect, remuneration, and response:** Doctors and nurses work as health care providers, but they also work for youth and their families, whose time and ideas must be respected. To this end, Whitehouse and McFee recommended providing stakeholders food and reimbursement for travel. They also noted the importance of timely responses to suggestions and guidance and maintaining a feedback channel.

**The elephant in the room: funding:** At BCCH, care is multidisciplinary. But replicating that for adults isn't feasible because it's costly and there are issues around cross-jurisdictional care and funding. Additionally, patients with rare and complex conditions require additional time from physicians, which adds to the cost.

**Youth engagement:** Whitehouse and McFee pointed out that this is the *Youth* Transitions initiative, so youth should play a major role in it. They stressed that youth should be encouraged to be active participants.

**One size doesn't fit all:** Past materials on transition have either been disease-specific or general, which doesn't address complexity on a case-by-case basis. Mitigating factors in individual cases may make a simple disease a complex case to treat in the adult system, or vice-versa. Additionally, some diseases become more complex in adulthood.

McFee and Whitehouse outlined some factors that affect the complexity of a transition:

- Patient's cognitive level.
- Whether or not the patient is ambulatory.
- Level of family support.
- Medications taken.
- Number of specialists needed.
- Financial concerns.
- Number of subspecialists needed.
- Access to care, urban vs. rural.

CLOSING PLENARIES

DAY ONE



Following the first day’s breakout sessions, attendees regrouped for a plenary discussion with Barb Walman, Assistant Deputy Minister, Medical Beneficiary and Pharmaceutical Services; Kimberly Strain, a patient partner with Patients as Partners; and Allan Seckel, CEO of the BCMA.

Barb Walman expressed the importance of relationship building – the foundation of shared care – and communication. She said it is apparent to her that the work of the Shared Care Committee and its initiatives is going unrecognized. Walman said even she is realizing how much she does not know.

Allan Seckel also stressed the importance of working together and used the phrase “we are all better if we work together.” He said doctors, like other professionals, are taught a lot about personal accountability and that it can be difficult to shift from “me” to “we.” Seckel said he was impressed with the subculture of change present at the showcase, but wondered if the “revolution” would ever expand. He encouraged people to take what they learned at the showcase and tell their families, colleagues, and patients.

Speaking from a patient partner perspective, Kimberly Strain said she was surprised to learn so many physicians share her frustration with the system. But she saw sparks and seeds of change in the breakout sessions and the Shared Care initiatives they explored.

DAY TWO



The closing plenary session began with some group reflections on connections made, knowledge gained from the learning sessions, and actions attendees might take after the showcase. Both enthusiasm for and the continuing need to spread the word about Shared Care work were made clear by comments that included:

- Shared Care initiatives provide helpful leverage for system change.
- The showcase enabled valuable connections and conversations to occur.
- There are a lot of opportunities for people outside the medical community to get involved in addressing challenges to effective shared care, but there is a significant lack of awareness about them.

One attendee indicated that he planned to present a relevant Shared Care project to each of the departments at his hospital to showcase the opportunities that exist, while others said they planned to go home and educate and engage others on Shared Care projects.

Shared Care Committee co-chairs Kelly McQuillen, Executive Director, MoH , and Dr Gordon Hoag, from the BCMA, along with Darren Lauscher, a patient partner, also reflected on the showcase and delivered the final closing remarks.

Dr Hoag thanked all the attendees and participants in Shared Care initiatives, and McQuillen reiterated the importance of collaboration, co-design, and shared leadership when trying to make system-wide changes. To finish, McQuillen highlighted the MoH’s principles of collaboration: effective management, calculated risks, enabling innovation, creating new/shared culture, challenging the status quo, and focusing on patients.

Lauscher reflected on “pearls of wisdom” shared and collected over the showcase and suggested attendees “steal shamelessly” from the presentations to spread the word beyond the confines of the showcase.