Event Report

Surrey-North Delta 2025: Integrated Primary and Community Care for Diabetes and Mental Health

Surrey-North Delta
Division of Family Practice
A GPSC initiative

fraserhealth

Executive Summary

Coming Together

April 14th saw over 90 stakeholders from across Surrey and North Delta gather to discuss improving primary and community care for diabetes and mental health. Patient partners, local community organizations, Fraser Health partners, Nurse Practitioners and Family Physicians came together early on a Sunday morning for an opportunity to dialogue and to collaborate with each other.

A large group mind-mapping activity was an exciting opportunity for participants to share their observations, and identify trends influencing mental health and diabetes. Over the day, participants agreed that these two separate health conditions are intertwined; there are many cultural trends that are impacting the delivery of care and the high incidence of these two health conditions in our community, and mental health and diabetes need to be considered in tandem as we develop best models of care.

As the focus of the day shifted from the present to the future, each of the fourteen table groups wowed the room with their presentations of desired future scenarios. Highlights from the presentations included poems, musical renditions, dramatic scenes, an imaginary visit from BC's Future Cabinet Ministers, and media reporters showcasing patient- and care provider-centered family practices and health systems in 2025. Participants identified theme areas from these future scenarios, and in the final activity of the day worked in breakout sessions on the theme area they felt strongly about in order to identify next steps.

Key themes that emerged from the day's activities and dialogue are:

- **Collaboration and Team-Based Care** - To address complex health care needs, family physicians, Fraser Health, community organizations and patients will achieve greater outcomes through collaboration. There is an appetite to address current gaps by deploying allied health services within or close to family practices and investing in team-based care.
- **Prevention and Public Education** - Patient education and awareness are integral to the success of any health care system. There is a need to shift our focus from "treating the illness" to "preventing the illness".
- **Health Education in Schools** - Health promotion and education about diabetes and mental health for school-aged children and youth is an integral part of implementing a best model of care.
- **Compassion and Trauma-Informed** - Advocate for, identify with, understand and work toward: empathy, compassion and kindness, embodied in all levels of connection. From cultural empathy to the practices and treatments provided, the goal is patient wellness.
- **Physician Wellness** – Health care providers are able to provide excellent, quality health care when there is also a focus on their own wellness.

- **Easy Access** – Prioritize timely access to mental health services, as well as an ongoing dialogue with primary care providers and community partners involved with mental health care and wellness.
- **Electronic Medical Records** – Interoperability between care providers' medical records will support an integrated primary and community care system.
- **Funding** - Health care treatments and disease prevention services must be financed to incentivize coordinated care with acceptable access.

Impact of the Event

Participants appreciated the discussions and collaboration with a large group of diverse community stakeholders, and the opportunity to share their thoughts and experiences. Even at five hours, the time seemed too short for the topic and the tremendous energy in the room. Participants indicated they would like more of these collaborative meetings and want to follow-up on the generated ideas, to move towards concrete actions for integrating primary and community care.

Our Next Steps Together

The themes that emerged will be matched to see where they might inform work that is currently going on in Surrey-North Delta; and themes that do not currently have a focus will be referred for prioritization by the Primary Care Network Working Group, a collaborative group of family physicians and Fraser Health employees working in Surrey-North Delta, who are currently meeting biweekly to discuss and move forward the integration of primary and community care.

At the same time, neighbourhood-focused groups of family physicians and partners will be convened to begin meeting regularly to discuss their more immediate and local needs, and to identify the supports they would like to see to achieve a more integrated system.

Join Us!

What do you see from your vantage point?
What is one commitment you are making?
Who can you connect with?

Feel free to share with our Division staff your thinking on the above, and reach out if you would like more information about integrated community care, need assistance connecting with one of the participants at the event, or would like to become more involved with a theme area or neighborhood group.

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Introduction

April 14th saw over 90 stakeholders from across Surrey and North Delta gathering to discuss improving primary and community care for diabetes and mental health. Patient partners, local community organizations, Fraser Health partners, Nurse Practitioners and Family Physicians came together early on a Sunday morning for an opportunity to dialogue and collaborate with each other.

The purpose of the event was to increase shared understanding, create a common vision for the future and identify strategies and models of integrated primary and community care for the areas of mental health and diabetes in Surrey and North Delta. People collectively engaged and collaborated across interactive activities, and table-level and whole-room conversation to understand:

> *where we are, what we want, and how we get there.*

The event was initiated by the Surrey-North Delta Division of Family Practice, and the result of efforts by a Planning Group formed by patients, community organizations, Fraser Health, family physicians and the Division.

This event report gives a summary of the event and the work of participants, and captures the ideas generated and answers to the above questions, to support action in primary and community care for mental health and diabetes.

Focus on the Past: Appreciative Interviews

The event started with an activity for participants to appreciate their collective history and build on key strengths. Participants conducted appreciative interviews in pairs around the invitation:

> *Think of a time when you worked on a challenge in the area of mental health or diabetes with others and you are proud of what you accomplished. What were you doing? What made that moment great?*

Those stories were then shared in mixed table groups of 6-8 as each person took turns introducing their partner and their partner's story at their table. The room buzzed with energy as people connected with each other, and to the stories of success and collaboration, setting the tone for the rest of the event.

Focus on the Present: Current Trends

Large Group Mind Map

The next step in the event focused on the present by having participants consider the forces affecting mental health and diabetes. Participants were invited to come to the front of the room, around a large piece of paper fixed on to the wall, to build a mind map of trends in society that currently affect mental health and diabetes. The goal was to include all perceptions, get everyone talking about the same world, and create the broadest possible context for dialogue and decision-making. Trends could be social, economic, environmental, technical, political, etc.; anything having an impact on us now.

What trends do you need to consider as you plan?

The large group mind mapping activity was an exciting opportunity for participants to share their observations, and identify trends influencing mental health and diabetes. Participants called out trends and gave examples while two facilitators mapped out the trends. Over forty-five minutes, participants explored diabetes, mental health and areas of overlap. Participants' experience of the completed mind map ranged from "chaos" to "hope".

Table 1 lists the themes from the trends identified by participants. Few participants thought diabetes and mental health are two separate topics; however, the majority of them believed both health conditions need to be viewed together while developing best models of care, as both are intertwined. It is interesting to note that the majority of trends identified by the participants influence both mental health and diabetes.

Stakeholder Group Mind Map

Participants reorganized into stakeholder groups and worked with the trends of highest concern to their respective groups. The purpose was to discover how key trends are connected and what people are doing now and want to do in the future in relation to those trends. Groups were asked to identify three to five key trends that are of greatest concern and draw their own mind map showing how they are related. These were shared with the greater room, along with answers to the questions:

- *What are you (alone or together) doing right now to anticipate or respond to these trends?*
- *What new actions do you want to take in the future?*
- *What are others doing elsewhere that really excites you?*

Table 2 is a compilation of the reports shared by each stakeholder group.

The mind mapping activities gave everyone in the room a larger perspective of mental health and diabetes than any one person had coming in, including a better understanding of where we are, how key trends are connected, and what people are doing now and want to do in the future in relation to those trends.

No.	Trends Impacting Both Mental Health & Diabetes
1.	***Chronic Pain & Complexity*** a) Increasing co-existence of chronic pain b) Reduced access to timely care for pain c) Increase in complexity of both health conditions
2.	***Health Care System*** a) Increasing dependence on health care system b) Reduced human interaction in health care c) More focus on treatment and less focus on prevention d) Increasing delays in referrals e) Increase in number of diagnosis due to changing diagnostic thresholds f) Reduced accountability within health care system
3.	***Access to Information, media and patient expectations*** a) More access to information for patients, more access to health care resources b) Increase in patient expectations from healthcare providers c) More mistrust on the system & increase in spread of misinformation d) Increase in GP charting at home & increasing workload of healthcare providers e) Increasing gap between patient expectation of what GPs can do and what they can't do f) Increase mistrust of patients in healthcare providers, increase spread of misinformation g) Increase in mistrust of care providers in health system h) Increase in biases/ attitudes towards medical conditions i) Increased need to mobilize Canadian Chinese population online
4.	***Patient Demographics*** a) Increasing number of immigrants b) Decrease in cultural understanding & health literacy c) Increase in cultural disparity d) Increasing need for local, culturally tailored health information e) Decreasing education and income, more disparity in wealth f) Aging population, increase in homelessness & poverty
5.	***Lifestyle*** a) Decrease in physical activity & lack of healthy food choices at school b) Increase in sedentary lifestyle & screen time c) Increase time pressure, busy lifestyle, & lack of sleep

Table 1: *Salient themes from trends identified by participants, currently affecting mental health and diabetes (continued on next page).*

No.	Trends Impacting Diabetes
6.	***Collaboration for Comprehensive Care*** a) Increase in need for collaboration between organizations, community patients and health care providers b) Increased need for comprehensive services required by diabetics c) Increased need for pooling of resources funding from governments d) Increased need to expand work currently being done by SAHI
7.	***Food Choices*** a) Decrease in healthy diet b) Increase in use of processed food c) Increase in cost of living & food
8.	***Patient awareness*** a) Increase in use of technology by patients for self-monitoring b) Increased need for self-management, patient education and patient-centered care
9.	***Pharmacare*** a) Increase in drug costs b) Increasing difficulty in coverage for required drugs c) Decreasing access to drugs for immigrants
No.	**Trends Impacting Mental Health**
10.	***Increase in culture of independence and social isolation***
11.	***Decrease in access to timely care for mild to moderate mental health conditions***
12.	***Increasing gap in accessing the optimal standard of care***
13.	***Increase in poisoned drug supply***
14.	***Youth Specific Trends*** a) Increase in substance use b) Increase in anxiety and depression c) Loss of interest in school

Table 1: *Summary of trends identified in whole-group mind-map (continued from previous page).*


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Stakeholder Group	Trends of Greatest Concern
Community Partners and Patient Partners	**Key Trends** 1. Lack of accountability 2. Difficulty accessing and navigating the healthcare system 3. Less human (face to face, in-person) contact 4. Inadequate resources/resource allocation for population 5. Insufficient local/cultural/ethnic sensitive healthcare system 6. Need more solutions (and less focus on negative) • 1, 4 and 6 linked; and 2, 3 and 5 linked
Community Partners DIVERSEcity	• **Stress** – community clinics, education • **Poor food choices** – community kitchens, youth cooking programs, education • **Economic limitations** – low/no cost supports • **Language limitations** – increase advocacy, education • **Revolving door** medical system – define the problem, collaborate with other services, education

Fraser Health
Diabetes Clinic
	JPOCSC Diabetes Clinic
	• ↑ demand and expectations on services (double booking, class-based care, ↑ follow-up clinics)
	• ↑ complexity
	  ○ ↑ social issues (substance use)
	  ○ ↑ new Canadians, medical complexity and culturally sensitive (all requires resources)
	  ○ ↑ unattached patients who are referred
	  ○ No show appointments
	  ○ Collaborating with SAHI
	• Lack of understanding of the scope of the clinic

Fraser Health Mental Health	**Trends** 1. Demand for services 2. Opioid crisis 3. Culturally matched/safer services **What we are doing** • Adding resources • Adding capacity • Streamlining services • Team based care **Exciting work being done elsewhere** Nuka Health, Alaska

Table 2: *Trends of greatest concern and mitigating actions identified by separate stakeholder groups (continued on next page).*

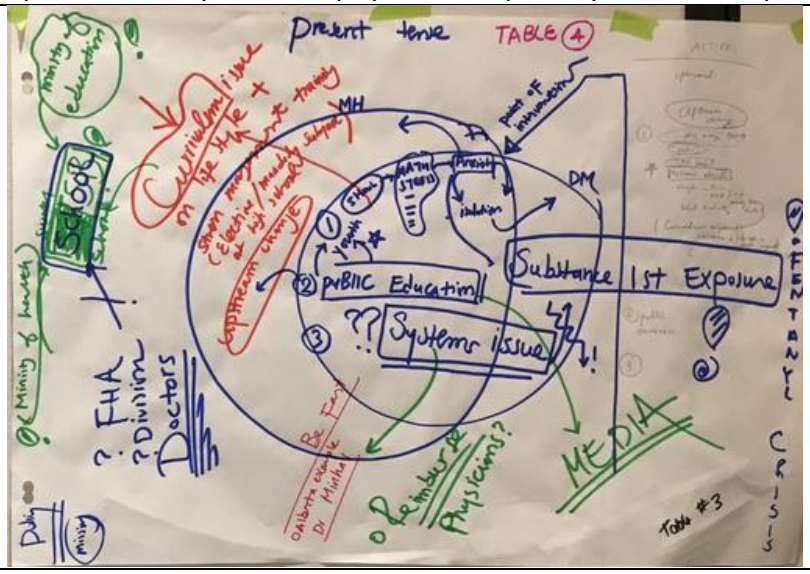
Stakeholder Group	Trends of Greatest Concern
Fraser Health Home Health	• ↑ **expectation to care providers and patients to work differently** <u>Doing now</u> 1. Home Health Redesign 2. Educating patients 3. Collaborating with different stakeholders <u>Future</u> 1. Need to educate ourselves about available resources 2. Need to reach out to tell people what we do • **Social Isolation** • ↓ **flexible enough to deal with complexity of system** (e.g. not ready for change, some under stretched, some unaware of limits, time constraints)
Family Physicians Cloverdale, Fleetwood, Panorama and East Newton	**Mental Health** • ↑ child mental health > ↑ substance use > ↑ training (naloxone/methadone) • ↓ counselling services > ↓ counselling patients by physicians <> ↑ declining of referrals by psychiatrists > ↓ follow up for "complex" patient **Diabetes** • ↓ communication with specialty clinic (JPOCSC) for patients • ↓ access to medications > changes to pharmacare **Combined** • ↑ language barriers • ↑ expectations of providers/physicians especially for social aspects
Family Physicians North Surrey	

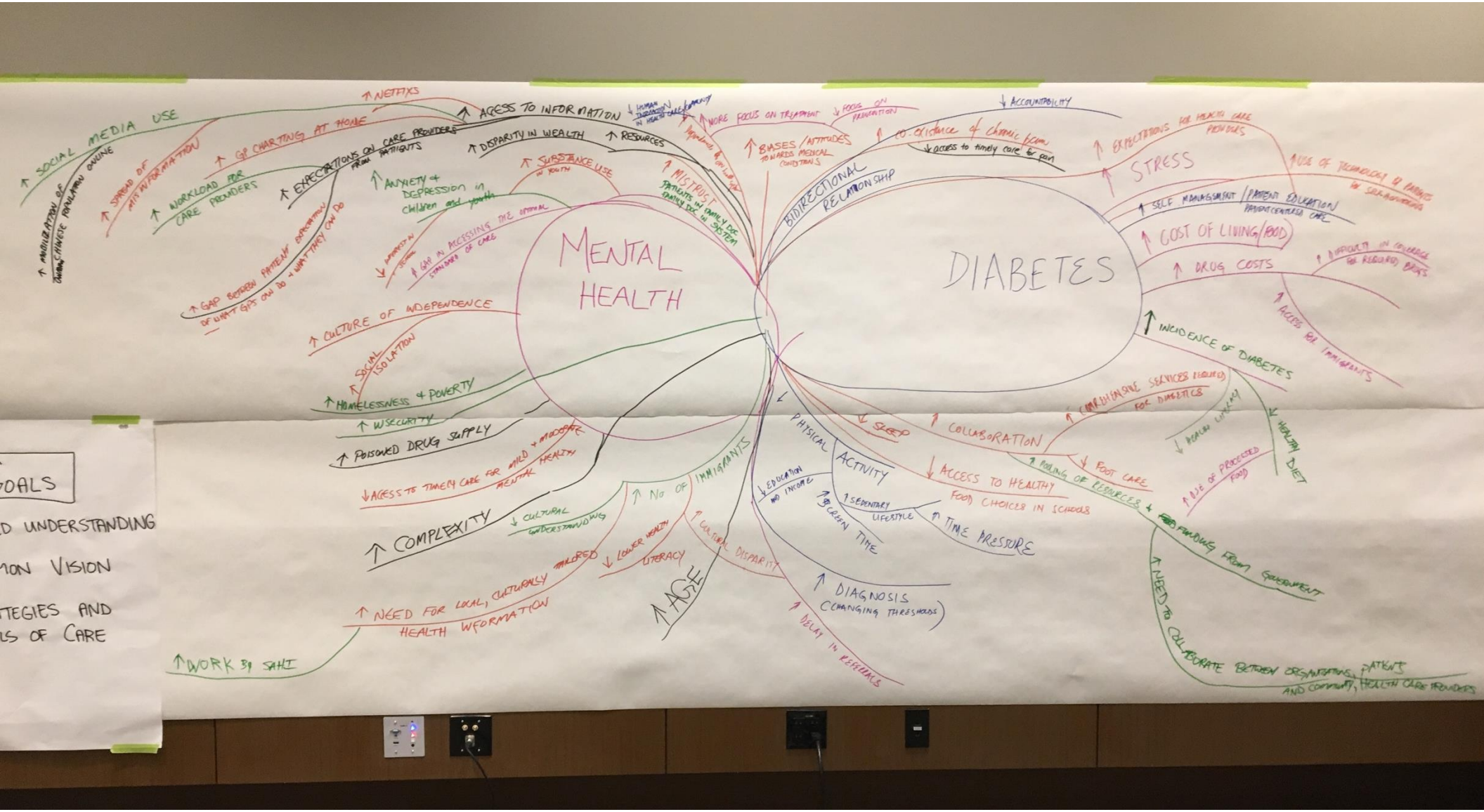
Table 2: *Trends of greatest concern and mitigating actions identified by separate stakeholder groups (continued from previous page and on next page).*

Stakeholder Group	Trends of Greatest Concern
Family Physicians Guildford	**Increasing history of stress** • History of trauma (Indigenous + immigrant) • ACE's • Physician stress and increasing responsibilities (connecting with other doctors) • Resources: using DIVERSEcity, diabetes clinic, home health **Increasing complexity of our population** • Age • Multiple comorbidities • Poor diet/exercise choices • Over reliance on medical system/drugs **Education** • Getting support from colleagues for challenging cases • Handouts, JPOCSC diabetes clinic • Group visits, presentations in the office
Family Physicians North Delta, West Newton	**↓ access and ↑ gap in access to care** • Early intervention for mild to moderate mental health • Team-based care • Use online resources • Hire more allied health (i.e. counsellor, diabetic nurse, dietician, etc.) **↑ social isolation (use of electronics)** • Fitness pass • ↑ access, make it low barrier **↑ cost of treatment** • Free counselling • Change to pharmacare (i.e. drug coverage; have family doctors as part of decision making)
Diabetes Physician Advisory Group	• Cost and drug coverage • Technological tools to help choose healthier and more affordable food choices (e.g. Flipp app) • Early education regarding lifestyle choices and physical activity • Allied health care professional within medical clinics to provide education • Building a structure or model of care to provide team-based care (difficult in fee-for-service model)

Table 2: *Trends of greatest concern and mitigating actions identified by separate stakeholder groups (continued from previous page and on next page).*

Stakeholder Group	Trends of Greatest Concern
Hospitalists, and Partners from Neighboring Communities	**Education** • ↑ self-care for provider • ↑ awareness of provider's mental health **Expectations - More collaboration** • ↑ onus on patient/patient accountability • Accept the wins • Honest with patients **Accountability** • Patient's role (goals and timelines) • Provider's role (goals and timelines) • Accepting challenges **Technology - recognize and try to overcome:** • ↓ activity • ↑ isolation
Residents and Young Grads	Lack of resources for mild/moderate cases → Difficulty with cultural norms and their relationship with illness → Over diagnosis of non-pathological diagnosis of anti-depressants → Lack of coverage of new medications and hurdles in coverage → Failure to follow patients once they transition from pediatrics to adult → Empowering patients (self-management) **Actions** • Using allied healthcare professionals • Change in pharmacare coverage • Physical exercise prescriptions (clear, easy to follow) • Education is one piece, change in patient belief
Surrey-North Delta Division of Family Practice	**What is something the division can identify and change?** • Increased trend in teamwork + collaboration (through doctors, specialists and service providers): Team Based Approach • Primary Care is a good model of overarching medical care, huge potential if managed well to provide effective patient acre • ACES prevention and social determinants of health are important care factors • Using technology to move towards more pro-active patient care, the team is more included • Risk to primary care homes from new virtual health trends

Table 2: *Trends of greatest concern and mitigating actions identified by separate stakeholder groups (continued from previous page).*


MENTAL HEALTH
DIABETES
BIDIRECTIONAL RELATIONSHIP
SOCIAL MEDIA USE
NETFIXS
ACCESS TO INFORMATION
SPREAD OF MIS INFORMATION
GP CHARTING AT HOME
WORKLOAD FOR CARE PROVIDERS
EXPECTATIONS ON CARE PROVIDERS FROM PATIENTS
DISPARITY IN WEALTH
RESOURCES
ANXIETY & DEPRESSION IN CHILDREN AND YOUTH
SUBSTANCE USE IN YOUTH
MISTRUST
GAP IN ACCESSING THE APPROPRIATE STANDARD OF CARE
GAP BETWEEN PATIENTS EXPECTATION OF WHAT GPS CAN DO + WHAT THEY CAN DO
CULTURE OF INDEPENDENCE
SOCIAL ISOLATION
HOMELESSNESS & POVERTY
INSECURITY
POISONED DRUG SUPPLY
ACCESS TO TIMELY CARE FOR MILD + MODERATE MENTAL HEALTH
COMPLEXITY
CULTURAL UNDERSTANDINGS
NEED FOR LOCAL, CULTURALLY TAILORED HEALTH INFORMATION
LOWER HEALTH LITERACY
WORK BY SAHI
NO OF IMMIGRANTS
CULTURAL DISPARITY
DELAY IN REFERRALS
AGE
DIAGNOSIS (CHANGING THRESHOLDS)
PHYSICAL ACTIVITY
EDUCATION AND INCOME
SEDENTARY LIFESTYLE
GREEN TIME
TIME PRESSURE
SLEEP
ACCESS TO HEALTHY FOOD CHOICES IN SCHOOLS
ROLLING OF RESOURCES
FOOT CARE
COLLABORATION
COMPREHENSIVE SERVICES REQUIRED FOR DIABETICS
HEALTH LITERACY
HEALTHY DIET
USE OF PROCESSED FOOD
FINDINGS FROM GOVERNMENT
NEEDS TO COLLABORATE BETWEEN ORGANISATIONS, PATIENTS AND COMMUNITY HEALTH CARE PROVIDERS
ACCOUNTABILITY
CO-EXISTENCE of CHRONIC ILLNESS
ACCESS TO TIMELY CARE BY GPS
MORE FOCUS ON TREATMENT
FOCUS ON PREVENTION
BIASES / ATTITUDES TOWARDS MEDICAL CONDITIONS
EXPECTATIONS FOR HEALTH CARE PROVIDERS
STRESS
USE OF TECHNOLOGY TO ENABLE SELF-MANAGEMENT
SELF MANAGEMENT / PATIENT EDUCATION
PATIENT-CENTERED CARE
COST OF LIVING / FOOD
DRUG COSTS
DIFFICULTY IN ACCESS TO REQUIRED DRUGS
INCIDENCE OF DIABETES
ACCESS FOR IMMIGRANTS
GOALS
D UNDERSTANDING
ION VISION
TEGIES AND
LS OF CARE

Focus on the Future

Future Scenarios

Having spent the morning focusing on the present to better understand where we are, how key trends are connected, and what people are doing now and want to do in the future in relation to those trends; the room's focus shifted to the future.

Participants were organized in their original assigned mixed table groups. Their task was to:

> *Put yourself 6 years into the future. Today is April 14, 2025. You have brought your dreams to life. Visualize primary and community care for diabetes and/or mental health now.*
>
> *Describe what's happening:*
> - *Systems, programs, policies, models of care, and governance you have created since 2019 that support diabetes and/or mental health*
> - *How stakeholders relate to one another*
> - *How primary and community care are integrated*
> - *Your impact on society*
> - *The impact on your own well-being*
>
> *List the main roadblock you had to remove back in 2019 to get to where you are now, and how you did it.*
>
> *Choose a creative way to present your desired future as if it is happening right now (drama, story, poem, music, art, TV show, or whatever you decide).*

Fourteen table groups delighted and wowed the room with their presentations of desired future scenarios. Highlights from the presentations included:

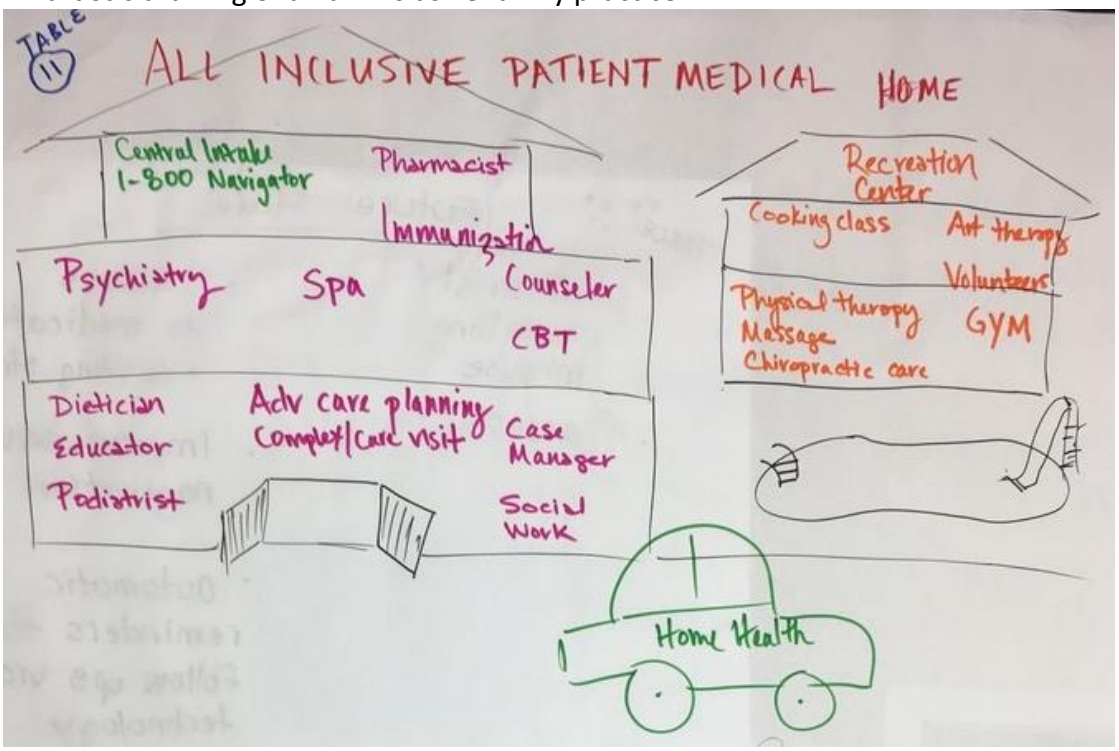
- A dramatic scene in which a patient visits their family physician. The family physician recognizes the patient's need to talk with a counsellor, introduces the patient to the counsellor during the visit, and arranges a quick referral to a psychiatrist for further assessment. The physician also notes that medication costs are covered by insurance.

- A TV program featuring futuristic diabetic care in a group family practice. The program highlights that the family practice is connected to the hospital's medical records and is well informed of the patient's medical status. A collaborative health care team includes a podiatrist who does diabetic foot checks; and there is funding for the team that encourages following best practice guidelines, including exercise programs and chronic disease education. In addition, diabetes medications for the patient are covered by

insurance and text messages reminders are used to help patients track appointments and testing.

- A never-heard before musical performance includes lyrics about a future with integrated electronic medical records, subsidies for schools / gyms / walking groups / accessible aids available for people in need; a focus on children and family when delivering health care, case management services that can support patients with multiple care needs, system navigators that empower patients in the health care journey and home visits for patients, leveraging volunteers.

- An artistic drawing of an all-inclusive family practice:



- A Brady-Bunch-inspired montage of the different team members within a family practice home to provide modern, patient-centred, culturally sensitive care for people needing diabetes support. A key component of the team includes a patient navigator to assist with accessing appropriate services in a timely manner.

- A sneak peak of a news reporter visiting a family practice on assignment to learn more about the innovative approach to family practice. The physician's patients are doing so well due to the collaborative, holistic care provided that the physician has time to show the reporter around. The team-based care approach is apparent right down to the regular team potlucks. The reporter ends up asking for a job at the clinic.

- A presentation of a Mental Health accessible menu of services for patients, including personal health monitoring through smartphone applications and ensuring patients are

involved and empowered in their care. Features of this future scenario includes team-based care, medication costs covered by insurance, and an integrated medical record.

- An official introduction to our 2025 BC Government's Cabinet Ministers. Each Minister describes their role in facilitating better health care: the Minister of Technology is facilitating interoperability of medical records, the Minister of Health is enacting a provincial pharmaceutical plan to cover medication costs, the Minister of Education is ensuring health education is a core component of curriculum, and the Minster of Mental Health and Substance Use is announcing new funding that facilitates quality care to be accessible for patients with mild to moderate mental health concerns. Importantly, Family Physicians are listened to and are networked to provide collaborative care side by side with their colleagues and other allied health care professionals.

Major roadblocks that were identified by the teams included:

- Structural Roadblocks
  - Space Restrictions
  - Documentation requirements and current limitations
  - Privacy regulations
  - Economic barriers to accessing care (transportation, parking, etc.)
  - A need for funding *(3 teams identified this as a roadblock)*
  - A need for compensation or other incentives working together *(2 teams identified this as a roadblock)*

- Relational Roadblocks
  - A need for clarity of roles of health care providers
  - A need for improved communication between stakeholders
  - A current lack of patient involvement and empowerment in care
  - Lack of / need for education among health care providers, especially as it relates to trauma informed care and cultural safety

Resonant Themes

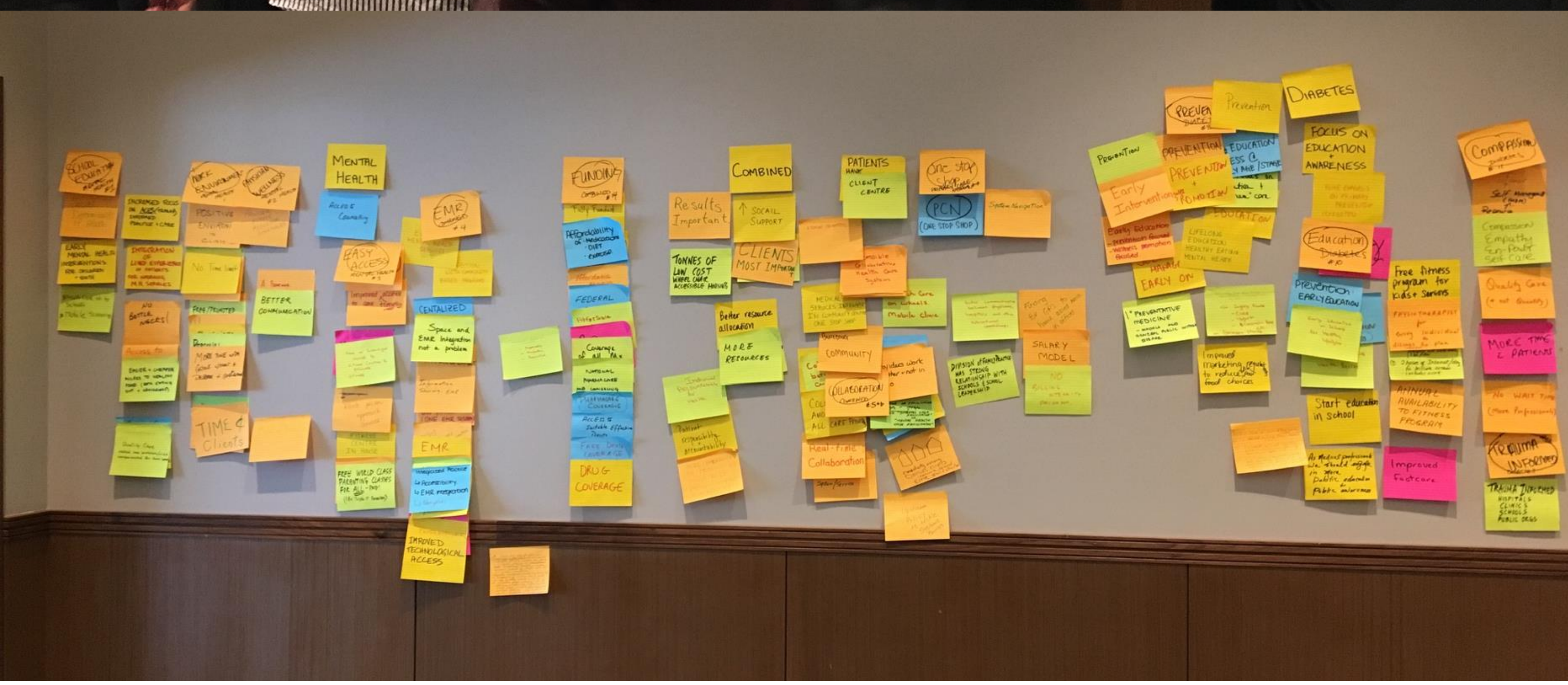
Following the presentations of future scenarios, people debriefed with their mixed table groups. They shared with each other what they heard, what excited them, and what they would have wished for. They captured their ideas on large post it notes and posted them up on a wall. A group made up of representatives from each table then arranged the factors into groupings, and identified several key themes:

- Collaboration
- One-Stop Shop
- Prevention
- School Education

- Diabetes Education
- Compassion
- Trauma Informed
- Physician Wellness
- Easy Access
- Electronic Medical Records
- Funding

These themes are indicative of what participants want for mental health and diabetes, and are described further in the following section, *Action Planning: Breakout Sessions*.


AWARENESS
PREVENTION
DIABETES
Prevention/ Education
Health Care on wheels. Mobile clinic
MORE EMPHASIS ON PRIMARY PREVENTION (DIABETES)
Free fitness program for kids + Seniors
NO BOTTLE NECKS!
COMBINED
CLIENTS MOST IMPORTANT
TIME & Clients
Collaboration between PT + Care Provider
Results Important
MENTAL HEALTH
PATIENTS HAVE OPTIM
MORE TIME
EARLY EDUCATION


MENTAL HEALTH
COMBINED
DIABETES
Prevention
FOCUS ON EDUCATION + AWARENESS
Results Important
CLIENTS MOST IMPORTANT
TIME & Clients
FUNDING
EMR
DRUG COVERAGE
Free fitness program for kids + Seniors
Start education in school
MORE TIME & PATIENTS
Improved Fastcare
CENTRALIZED
Space and EMR Integration not a problem
SALARY MODEL
COMMUNITY
Real-Time Collaboration
IMPROVED TECHNOLOGICAL ACCESS
PCN (ONE STOP SHOP)
BETTER COMMUNICATION

Action Planning: Breakout Sessions

The final part of the event built on the momentum created from the presentations of future scenarios and the identification of resonant themes for the future into making that future more likely. Breakout groups were formed for each of the resonant themes, and space was opened to participants to attend a session(s) of their choosing. Each group was asked to:

1. *Draft a statement of your theme area that describes the guidelines you will follow in planning for the future.*

2. *Identify what's needed to help move us towards our desired future. What specific actions or changes will bring your theme area and statement to life?*

Each group reported their future statements and actions back to the whole room. **Table 3** is a compilation of the reports shared by participants. The future statements and actions point to what we want and begin to identify how we get there as it relates to integrated primary and community care for diabetes and mental health in Surrey and North Delta. The key themes from the breakout sessions are:

- **Collaboration and Team-Based Care** - To address complex health care needs, family physicians, Fraser Health, community organizations and patients will achieve greater outcomes through collaboration. There is an appetite to address current gaps by deploying allied health services within or close to family practices and investing in team-based care.
- **Prevention and Public Education** - Patient education and awareness are integral to the success of any health care system. There is a need to shift our focus from "treating the illness" to "preventing the illness".
- **Health Education in Schools** - Health promotion and education about diabetes and mental health for school-aged children and youth is an integral part of implementing a best model of care.
- **Compassion and Trauma-Informed** - Advocate for, identify with, understand and work toward: empathy, compassion and kindness, embodied in all levels of connection. From cultural empathy to the practices and treatments provided, the goal is patient wellness.
- **Physician Wellness** – Health care providers are able to provide excellent, quality health care when there is also a focus on their own wellness.
- **Easy Access** – Prioritize timely access to mental health services, as well as an ongoing dialogue with primary care providers and community partners involved with mental health care and wellness.
- **Electronic Medical Records** – Interoperability between care providers' medical records will support an integrated primary and community care system.
- **Funding** - Health care treatments and disease prevention services must be financed to incentivize coordinated care with acceptable access.

Theme Area	Future Statement	Actions Required
Collaboration	We are committed to collaborating with stakeholders to develop a plan of increased opportunities for better health	**Themes** • Prevention, education • Increased access to services/address gaps • Patient/community engagement, • EMR • Identifying barriers • Inclusivity (cultural safety) • Collaborate with municipal, provincial and federal partners **Key Action:** Establish an inter-sectoral partnership committee
One-Stop Shop	We will develop and collaborate an array of services that support patient-centered care needs	**Actions** (specific for diabetes management and mental health): • Identify primary care physicians willing to join into primary care networks • Identify patient population/needs that require support • Proposal for allied support needed, based on patient population needs (diabetes / mental health) • Proposal approved - Allocate resources required and implement in clinic(s)
Prevention	Preventing diabetes by creating healthier communities, implementing culturally sensitive lifestyle habits at an early age and identify the best route to educate each population group	• **Education** at elementary schools regularly • **Policies** in place to promote healthier eating • **Education committee of physicians** in schools

Table 3: *Participants' recommended guidelines and actions around future theme areas (continued on next page).*

Theme Area	Future Statement	Actions Required
School Education	We are committed to contributing to the development and allocation of services and interventions that align with our goal to improve physical, mental and social health of children through school	**<u>Changing the curriculum</u>** 1. **Emotional Regulation:** coping skills – DBT, add to core curriculum 2. **Educating Teachers:** DBT, ACES, Trauma, Resilience 3. **Parent Education:** increasing involvement in physical, mental, social and spiritual health 4. **Socialization:** increased among peers, weekly/monthly lunches 5. **Increased Physical Activity:** allocated time 3-4 pm 6. **ACE screening** at school 7. **Health Authority involvement** for healthy lunches 8. **Invite HCP/nutritionist** to talk to children before June 2019
Diabetes Education		• **Awareness of Resources and Knowledge**: Public education (public forum, Diabetes Canada, workshops), Self-referral, General healthy eating • **Access** to resources • **Government**: Marketing, screening, healthy eating awareness • **Survey**: effectiveness – education; cost-effective preventive education (free forums once a month / 3 months)
Compassion	Dedicated programs (Diabetes Centre at JPOCSC and SAHI) with decreased wait times and increased quality time to understand background and issues	**Key Action:** • Recruit more allied health professionals for counselling, nutrition, education, diet and exercises • Technology – virtual appointment, text reminder • More funding to support professionals

Table 3: *Participants' recommended guidelines and actions around future theme areas (continued from previous page and on next page).*

Theme Area	Future Statement	Actions Required
Trauma Informed	We advocate for, identify with, understand and work towards empathy, compassion and kindness being embodied in all levels of connection through our practice and the treatments we provide, with the end goal of Patient Wellness	**Key Action:** Increase education and awareness on how to be trauma-sensitive
Physician Wellness (continued on next page)		**Physician Wellness** • Free gym pass with accountability program (ministry-funded) • Ensure family doctors have a family doctor • Meal service, healthy food, dietician delivered to office • Culture work around self-care → start in medical school **Life Balance and Family** • Vacation coverage tax credit • EMR sign-out • Childcare easily available – nanny finding service • Eldercare **Medical Doctor – Patient Relationship - Equal Partners** • Public advocacy – we are humans first • Translator • Patient awareness of constraints experienced by a GP **Professional Development - Communication Skills** • Facilitate communication of updates for ICBC, WCB etc. • Emotional intelligence training • Trauma-informed practice

Table 3: *Participants' recommended guidelines and actions around future theme areas (continued from previous page and on next page).*

Theme Area	Future Statement	Actions Required
Physician Wellness (continued from previous page)		**Delegation Skills – Clinic/Practice Management** • Advocate for private fees • One MOA for every GP (MOAs' training must improve) • Nurse three times a week **Healthy Patient Load - Clinical Complexity** • Use case-mix-based load • Meaningful metrics → ministries that are truthful **EMR** • Automated recall software (texts, emails) • Self/online booking **Interprofessional Relationship** • Physician lounge for community • Do not hold GPs accountable for things they cannot control
Easy Access	We recognize the need for prioritizing timely access to mental health services, and ongoing dialogue with primary care providers and other community partners	**Communication** 1. Central intake for all mental health referrals 2. Feedback – i.e. received referral, etc. 3. Communication back and forth communication between MH and GPs 4. Clients to connect with mental health **Triage** • Should happen quickly • More clinicians required for intake **Accessibility** Education, language, counselling, psychiatry, cultural brokers

Table 3: *Participants' recommended guidelines and actions around future theme areas (continued from previous page and on next page).*

Theme Area	Future Statement	Actions Required
Electronic Medical Records	We are committed to the development and coordination of one unified provincial electronic health record system	**We need:** • Secure network for all providers • Full funding • Access and implementation in all areas by a deadline • Training provided • Access to all previous info from past 25 years • Needs assessment for all providers' charting requirements • Ability to link in labs, pictures, x-rays, joint care planning • Fully funded provincial support team • Assessment of other provincial unified electronic records to see which ideas we can copy • Access to scheduling and referrals
Funding	Health care treatment and disease prevention services are "nationally" financed in a system that provides coordinated care with acceptable access	• Fully funded • Affordability of medications, diet, exercise • Federal leadership of pharmacare • Foot care / podiatry etc. ought to be funded • Funding of pharmacare program • Comprehensive services that contribute to managing illness and disease prevention (e.g. podiatry, foot care) • Increase accountability on spent dollars, what it is accomplishing, and in consideration of alternatives (i.e. goods and services)

Table 3: *Participants' recommended guidelines and actions around future theme areas (continued from previous page).*

Conclusion – What's Next?

The event was a display of collaboration and dialogue of over 90 stakeholders from across Surrey and North Delta. Outlined in this report are the themes that emerged from their collective effort to understand where we are, what we want, and how we get there.

Where we are - Mental health and diabetes are affected by multiple trends, with the majority of trends identified by participants influencing both mental health and diabetes. Indeed, few participants thought diabetes and mental health are two separate topics, with the majority of them believing both health conditions need to be viewed together while developing best models of care, as both are intertwined.

What we want and how we get there - Key themes that emerged from the day's activities and dialogue are:

- **Collaboration and Team-Based Care** - To address complex health care needs, family physicians, Fraser Health, community organizations and patients will achieve greater outcomes through collaboration. There is an appetite to address current gaps by deploying allied health services within or close to family practices and investing in team-based care.
- **Prevention and Public Education** - Patient education and awareness are integral to the success of any health care system. There is a need to shift our focus from "treating the illness" to "preventing the illness".
- **Health Education in Schools** - Health promotion and education about diabetes and mental health for school-aged children and youth is an integral part of implementing a best model of care.
- **Compassion and Trauma-Informed** - Advocate for, identify with, understand and work toward empathy, compassion and kindness, embodied in all levels of connection. From cultural empathy to the practices and treatments provided, the goal is patient wellness.
- **Physician Wellness** – Health care providers are able to provide excellent, quality health care when there is also a focus on their own wellness.
- **Easy Access** – Prioritize timely access to mental health services, as well as an ongoing dialogue with primary care providers and community partners involved with mental health care and wellness.
- **Electronic Medical Records** – Interoperability between care providers' medical records will support an integrated primary and community care system.
- **Funding** - Health care treatments and disease prevention services must be financed to incentivize coordinated care with acceptable access.

With these themes, the process of identifying strategies and models of integrated primary and community care for the areas of mental health and diabetes has begun.

What's Next

Based on feedback from participants, people enjoyed the discussions and collaboration with a large group of diverse stakeholders, and having their voices heard. They acknowledged the need for more dialogue on what are two large topics/areas, and the inherent challenge of moving the large number of ideas brought up to concrete actions and change. People are keen to continue with more of these collaborative meetings, and want to follow-up on ideas, outcomes and next steps.

The themes that emerged will be matched to see where they might inform work that is currently going on in Surrey-North Delta; and themes that do not currently have a focus will be referred for prioritization by the Primary Care Network Working Group, a collaborative group of family physicians and Fraser Health employees working in Surrey-North Delta, who are currently meeting biweekly to discuss and move forward the integration of primary and community care.

At the same time, neighbourhood-focused groups of family physicians and partners will be convened to begin meeting regularly to discuss their more immediate and local needs, and to identify the supports they would like to see to achieve a more integrated system.

Join Us!

What do you see from your vantage point?
What is one commitment you are making?
Who can you connect with?

Feel free to share with our Division staff your thinking on the above, and reach out if you would like more information about integrated community care, need assistance connecting with one of the participants at the event, or would like to become more involved with a theme area or neighborhood group.

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