South Island Primary Care Network Physician Leadership & Engagement Committee Minutes

September 23rd, 2019 | 5:30 – 7:30 PM

ACTION ITEMS:

Topic	Action Item	Owner	Status
Next meeting agenda	Add role of PCN committees and decision-making powers to the next agenda	**Co-Chairs**	
Next meeting agenda	Add change management discussion to next meeting agenda	**Co-Chairs**	
Next meeting agenda	Add ToR to next agenda	**Co-Chairs**	
Next meeting agenda	Review the most recent Governance document at the next meeting – include topics such as roles and responsibilities of each committee	**Co-Chairs**	

Attendees:

Name		Name		Name	
Alicia Power	Family Physician	Emma Isaac	Ministry of Health	Layton Engwer	Patient Partner
Anthony Nielsen	Family Physician	Erica Kjekstad	SIDFP	Lisa Holloway	Island Health
Brenda Hefford	DoBC	Ernie Chang	Family Physician	Margi Bhalla	SIDFP
Brendon Irvine	Island Health	Fiona Duncan	GPSC	Matthew Ward	Family Physician
Bridget Reidy	Family Physician	Ian Thompson	Family Physician	Robin Saunders	Family Physician
Caity Chilton	Family Physician	Jane McGregor	Family Physician	Samantha Stasiuk	Family Physician
Cal Shapiro	Family Physician	Jaron Easterbrook	Family Physician	Sari Cooper	Family Physician
Carole Williams	Family Physician	Jennifer Ross	Family Physician	Shawna Walker	Community Partner
Charlie Lamb	Family Physician	Jennifer Tranmer	Family Physician	Sienna Bourdon	Family Physician
Cheryl Cuddeford	Family Physician	Judy Jones	Family Physician	Steve Goodchild	Island Health
Chris Dowler	Family Physician	Kate Evans	Family Physician	Sylvie Tellier	Family Physician
Clay Barber	SIDFP	Kate Kuss	Family Physician	Ted Patterson	Ministry of Health
Cynthia Barco	Family Physician	Laura Asplin	Family Physician	Tom Bailey	Family Physician
Dan Horvat	Island Health – *Co-Chair*	Laura Birdsell	Family Physician	Valerie Nicol	SIDFP – *Co-Chair*
Elizabeth Rhoades	Family Physician	Laura Ritonja	Family Physician	Vanessa Young	Family Physician
Elizabeth Wiley	Family Physician				

MINUTES:

Agenda item	Discussion	Action
1. Welcome and Introductions		
	-Round table introductions -review Code of Conduct Housekeeping items: • Complete sign in sheets and check your address	
1. a) Conversation with MoH		
	Previous meetings Action Items: • Changing what had been the addendum to the LOI to a cover letter at the request of the Ministry of Health to not alter the format of the Letter of Intent template Guests from the Ministry of Health have attended tonight to speak to the issues raised to them in the cover letter and to give members a chance to ask further questions for clarification. • Patience and resiliency are appreciated for sticking it out as a Wave 1 community – everyone is tired and this has been a long process • With the work we are doing now, it isn't intended to solve all the problems of primary care but it is a start – this is the framing T. Patterson would like to use • We don't have to be perfect from the start, there are going to be problems o Some issues are linked to the PMA but some are issues that we can work through • It is tough introducing change on the scale we are working on Specific items from the cover letter submitted with the Letters of Intent: • Surprised to read about the physicians being recognizes for their expertise in primary care o It should go without saying that yes, of course primary care physicians are the bedrock, the foundation of the primary care system • The quadruple aim was not specifically spelled out in the LOI which was something the Division would have liked to have edited before submitting to the Ministry	

	○ In this province, DoBC and the Ministry of Canada, 15 years ago, approached IHI and asked if the triple aim could be used and incorporate the provider experience ○ The visual of the triple aim shows that without one of the three legs it just won't stand, it will wobble. If you don't pay attention to patient & provider experience, if you don't pay attention to sustainability in the system, or you don't pay attention to outcomes, you aren't going to be successful ○ This is a language issue that GPSC could look at, but historically the visual is one that has been liked and philosophically it was already included • Issue with the process being called collaborative, while many involved feel it has been anything but collaborative. How does Ministry see collaboration? ○ The Ministry has a role on behalf of the government for the province to set expectations for the health system so inevitably we do have to make decisions about the health system and the direction in which the health system goes ○ In order for us to move forward with transformational change, command and control just doesn't work in health care. ○ A lot of work has been done around this in the past 4-5 years but there is a struggle in moving the change forward. ○ In an environment when we all have an idea of how to move forward, we will disagree and when we do disagree and when we face challenges, we have to have a path through it. The right answer isn't and can't be going to war with the different parties involved; we actually have to work together. This doesn't mean we won't disagree or get into difficult situations from time to time but that is the best approach. When we do disagree, we've got to have a path through it; we've got to talk to each other about these things and move forward. ○ It was identified that there are working relationships amongst health authorities and Divisions across the province and some work better together than others. Fundamentally, for this system, it is important for the providers of primary care and the system in which they operate, they need to work together. It is important for the health authority and Division to work on their relationship together, the Ministry cannot do that work for you. ▪ Disagreement in the identification of a poor Division/Health Authority relationship; rather the room feels the poor relationship is with the	

	Ministry and the initiating of the urgent care centres rather than focusing on the primary care issue • How to move forward when conflict happens, for example, as front line care providers, we have great ideas that we feel should be implemented now and we feel like when we put these ideas forward, they are just shoved aside. We would like a mechanism for to determine how we negotiate this, how can we move this forward, how can we resolve this problem? There is no mechanism for this, such as a mediator or negotiator. o Request was made for examples as some ideas included compensation which it outside the scope of the PCN. • Compensation is an example. We have no way to negotiate in the PCN discussions like we did with the PMA when there is a conflict. o We have to work through disagreement but to be clear, the role of the Division is not to negotiate with the Ministry. o We work within constraints. If the Ministry agrees, for example, to an attachment fee for the South Island division, then essentially they are agreeing to that attachment fee for all physicians in the province. o There is a Medical Association that might be a more appropriate channel for that example. • It seems like when we have concerns, we get bounced off of others, from the health authority(HA) to the Ministry and from the Ministry to the HA – it's like one parent tells you to go to the other parent and then that parent sends you back to the first parent. We don't know how to collaborate with you, it is like having two difficult parents. o There are opportunities through GPSC to see how other communities have solved problems, for example the Wave 1 meetings, GPSC Summit in October, etc. where everyone can learn from others experiences o Regarding the bouncing – yes there have been some problems there and a better job of being clear could be done. As a Wave 1 community, things haven't always been clear and they have been slower which is recognized for the frustration that presents • Specific example: issues with overhead for having Allied Health in clinic – how do we move that discussion forward? o This has come up in many communities, and we are happy to talk any time	

	- A provincial rate of 15% was set for nurses in practice flexing up to 20% for some communities where that is necessary. Admittedly, there is a sense we need to have a dialogue going forward because some communities are trying to put together data, real evidence to support "you need to give us more" – we need to see that evidence as this is a Ministry area - Why would we sign up to have Allied Health in practice knowing it will cost the clinic/physician(s) to have them there but not being able to prove that until they are in practice and knowing the cost may not be recouped? Why would we take on that risk? This seems doomed to fail and none of us can afford to sign on. - As for collaborating, being told a meeting has been scheduled with the Ministry on Thursday afternoon at 2pm isn't helpful when the next three Thursdays in office are already booked – we need more notice and the primary responsibility to our patients needs to be respected. - The note about the meetings was pointed out at another time and that is why we are here tonight. - There have been a range of different experiences and different ways of doing it (allied health in practice) – I'm open to hearing alternatives, put it in black and white for me. There is a mixed bag, what I'm telling you is I'm open to hearing it A process can be developed to submit that easily. That can be discussed offline. - Capital costs – we are running small businesses. What does it look like having Government involved in a small enterprise? - Funds have been requested for the Western Communities and Saanich Peninsula – we are committed to talking about space but we want you, collectively, as partners to do the work. Tell us here's the space we need, why we need it, options we have to get that space and what it would cost. - There was some capital planning done by the Division but what the Ministry needs to see is the partners together on the same page. This is the space needed, here's the resources we're going to plug in, what it will look like. We are committed to having that conversation with you. - Capital timelines - It shouldn't take more than a few months to determine if proposals will be funded	

	o True capital dollars are stretched, but there are ways to structure arrangements where there are long-term projects and routine capital leasehold improvements • Is there an urgency to doing this or are we looking at over the next 5 years? o There is a desire to get going o Construction takes a few months, but in terms of approval, if it works we should be able to turn it around • Some things from our cover letter that we are looking for confirmation on: guarantee of being allowed to be flexible with the Allied Health practitioners within our budget envelope; flexible with capital within our budget envelope; and the new grad APP contract is being re-written? Just looking for confirmation on these things. o Wouldn't say the new grad contract is being re-written. There is a 5 physician member panel/committee recently convened who are consulting on the existing panel contracts. As a part of this process, the new grad contracts will be reviewed and hopefully made more attractive o For both the allied and capital questions – we are open to talking about changes and we do realize that plans change, capital may be subject to some details • Question was inaudible o Issue on governance flagged by the Ministry from reviewing the Governance chart specifically with the representation at the steering committee – it was corrected to the Ministry that the plan was developed months previously and that the steering committee does in fact have representation from local first nations and patient/family caregiver. • Ministry thanked for attending this sit down and dissemination of information directly. • Proposals have been made directly to the Ministry to be told that they need to go through the HA – when HA is approached they have stated that they have marching orders from the Ministry. Please consider that we have been working under these perceptions until now and this has been occurring for the last year to year and a half. These are important matters but we are feeling disengagement. o Ministry appreciates that and states that they have met with folks and made it clear that they await invitations and will gladly attend. This was balanced by saying that there is a sense of which there are some issues that have been	

	created by confusion. The relationship stuff is "you guys" but for our part we try to be straight and answer questions. • If the Ministry is drawing a line in the sand, it would be preferred to hear it directly rather than through the channels. • Nothing in this plan is going to attract physicians to come work in the South Island – there is a feeling that this has been gone about backwards. The bottom line is that we can create the environment but how do we attract the docs because they simply are not coming? Hoping the Ministry has heard this message loud and clear. • Biggest problems with the RNs – would love to have many of them in practice but there is a concern about the attachment targets – is there any flexibility? o Yes there is. Based on evidence we had seen and discussions had, targets were set but these are notional targets. We've adapted in terms of Wave 2 and may change targets in terms of certain context (i.e. patient population; geographic location – need for being in office and running the local ER). We are willing to be flexible and we are taking a learning approach. • Question inaudible – reluctant to sign LOI – feeling this won't work on the South Island o It's an LOI. We want to hear from you – it isn't not being acknowledged. It's in black and white in a letter to the Ministry. I hope it comes across that we are here for a reason – we want to listen to you. o Return question: If it's not going to work in the South Island, then what will work? Given the constraints on DoBC, Ministry and the systematic constraints? What will work? • Reasonable payment models, reasonable amount of overhead, realistic attachment targets and reasonable amounts for … *(remainder inaudible)* o $15 million allocated to South Island – that's something isn't it? As said previously, the attachment targets are notional and they will not be chasing anyone down on these. Ministry is aware of the payment issues, Mark Armitage is aware of the concerns. • We are the experts and we are teachers. There is a lot we could teach you about primary care. Rather than "testing the waters" or "learning as we go", why not take the feedback from the experts and teachers? o I'll say we have. The way that targets have been landed on is by talking to people.	

	• We don't feel our opinions have been heard or valued.
	  o They have been but the Ministry can't just say yes to everything that has been put forward.
	• What is very evident is the low morale and fatigue through this process. We are trained to be evidence-based so it is hard to just try something and see how it goes – it goes against our training and practice. There was a survey recently completed through SGP or DoBC regarding overhead which I'm sure we could get the results to you. We are feeing disrespected and not treated like the experts or that we are being listened to. With all due respect, it was said that the South Island has a problem with the health authority but actually, other communities may not be aware of what they have signed on to. They may not have asked the tough questions and some are surprised to hear now that there is an attachment target that comes with a nurse in practice. There is the perception that this will be pushed through and we will have been tricked in some way.
	  o Context is different in different communities and the responses have been different in different communities.
	• Governance – for some of us, we wonder if the patient shouldn't simply have a seat at the CSC or Steering Committee but should they represent a majority? Would like to confirm the Ministry's position on this given that we all serve patients.
	  o Can't disagree. We have set the minimum requirements and it's up to you to be creative with the rest.
	  o Personal opinion – broadening the discussion to be inclusive, is not a bad thing
	• 2 big barriers to nurse in practice – requiring clinics to pay for their overhead and not allowing the clinics any control over how they work with the nurses. Change management has been underestimated along with what will go into it. Rather than giving the funds and allowing clinics to use the nurse as they see fit, the position is very prescriptive and why do the nurses have to be attached to the health authority?
	  o The decision has been made to honor the collective agreements.
	  o There will be some flexibility in the selection and recruitment – there is a real desire to make this work.
	  o There should be change and practice resources available through DoBC and GPSC
	  o Discussions are happening now about how to support practices in bringing teams together.	

	1 thing often missing is a functional problem solving team. Physicians are the experts in Primary Care, but the system often works against us. That's why local partnerships are key. Without system change, this will continue to be a problem. • Does the Ministry have an overall plan for the UPCCs and PCNs? Is there an overall plan for Primary Care in BC? o Yes there is a plan. The key elements are Patient Medical Homes and Primary Care Networks as the core concepts. o Within communities, better coordination of PMH, community health centers (CHCs), UPCCs, HA services. Plan is to link them together and improve coordination in the PCNs. o A better job could probably be done to educate and communicate with the public. o The idea is to ramp up the PCN concept across the province • How successful has the UPCC been in providing long term primary care? o UPCC is not intended for that; co-located is a primary care center where the intention of this is to attach • Progress of the PCNs? o Behind, in terms of implementation, but Ministry is confident that it has been picking up and will continue to do so Ministry departed meeting.	
2. Committee Administration		
	PCN Process Updates LOI/FTA • The letters of intent were submitted to the Ministry 2 weeks ago along with the cover letter which contained the member concerns • Next steps are providing more information to the Ministry – once this is done, they can respond with a fund transfer agreement (FTA) o We are in the process of colleting this information to submit now SP PCN	

	• Prepping information for the Ministry – we will make ourselves available to clinics for an in-person meeting and for those who cannot accommodate an in-person meeting, there will be an online survey coming around shortly WC PCN • We have reached out to clinics on several occasions regarding what might fit into clinics – we will be looking to re-confirm this information and see if there have been any changes yet Governance changes • The oversight committee has been struck and consists of 3 Division, 3 Health Authority, 3 First Nation and 2 Patient representatives o This committee has requested to have feedback provided to them o It was questioned as to why there aren't at least 3 patient representatives to balance out the committee and also should others in the medical community be represented? o How is feedback to be provided and are there deadlines for this? ▪ Geographic committees will continue to meet and send any feedback to the oversight committee – in the process of determining exactly how to do this o Partners for Better Health has been the de facto committee for this up until now • Clarity was requested on what decision making powers lie where • Governance and the role of the PCN committees to be added to the next agenda for a more fulsome discussion Change Management • As we shift to implementation – what does change management mean? • There is a strong sense that physician engagement has sunk significantly, many of the reasons for this were already discussed tonight and fed to the Ministry • There is a lot that we don't have control over but those that are in our parameters – what can we do with the change management funds and what will need to be elevated to GPSC and Ministry due to hindrance of process • The group is critical especially while others are being worked out • This needs a more fulsome discussion and will be added to the next meeting agenda.	Add role of PCN committees and decision making powers to the next agenda. Add change management discussion to next meeting agenda.

	<u>Finalization of ToR</u>
	This has been tabled to the next meeting due to lack of time.
	
	<u>Appointment of Ongoing Co-Chairs</u>
	• Lengthy discussions have taken place at previous meetings and this topic is now being re-visited
	• A geographic representation is felt to be more relevant than a Division & Health Authority representation
	• A proposal was tabled for this group to reconsider having non-Island Health staff co-chair this meeting with a suggestion of using Margi & Valerie
	
	• Those present felt a need to have a better understanding of the purpose of this meeting and what discussion/decision-making might happen here
	  o It was noted that this **is not** a decision-making group but a working group
	• Clarity on the Governance structure with respect to names of committees, purpose of committees, roles and responsibilities along with where decision-making power lies was requested
	  o Members are feeling meeting fatigued and without a clear purpose, question the importance of meetings such as these
	  o A review of the most recent version of the Governance document will be added to the next meeting
	• This meeting is about wo-way communication with Division membership – is there a better way to do this? It is also an opportunity for the health authority to hear first-hand from the physicians
	• Physicians who have been expressing their opinions feel that no action is resulting from this – not sure that more committees are the answer
	• Representative groups already exist so why is this combined group meeting
	  o The local groups are more prescriptive in the invitees and this one is for all members to share their thoughts and opinions as well as a way to disseminate information to all
	• It was felt that a monthly meeting for this group was too frequent
	• Suggestion: if this group is used to collect input, more targeted agendas would be helpful, that way, physicians with experience or an interest in the topic being discussed
		Add ToR to next agenda.
		
		Review the most recent Governance document at the next meeting – include topics such as roles and responsibilities of each committee.

	can make sure they are in attendance (e.g. team-based care, waitlist management, etc.) • Decision making – when is something escalated to the PCN Oversight Steering Committee and what does this mean for decision-making at the local level? • It was suggested to reconsider the composition of the local steering committees/leadership committees (names to be finalized) as these groups have been meeting for quite some time and it might be worthwhile to take a look at who is at the table and who should be at the table	
3. New Business		
4. Adjourn		
	For the next meeting: • Discuss the best ways to engage physicians especially at the community level • Co-chairmanship of this committee • Change management It was requested that if members could please feed opinions and comments ahead of the next meeting, they can be consolidated for a more constructive conversation.	