Engagement Journey

Kootenay Boundary

Division of Family Practice

A GPSC initiative

KOOTENAY BOUNDARY

Small in numbers, but fierce on change.

With a population of 80,000, spread throughout 13 distinct communities and rural environs, the Kootenay Boundary is small but mighty. The division has proactively taken on a role of change leader, and has reached out to divisions around the province to build relationships, and share their concepts regarding complex system change.

The Kootenay Boundary's engagement journey began when the Ministry of Health released the policy papers on Rural Care and Primary Care in the spring of 2015.

"We had a growing understanding of what kinds of solutions were going to work to solve sustainability issues in healthcare and we recognized the opportunity in the policy papers," says Andrew Earnshaw, Executive Director of the Kootenay Boundary Division of Family Practice.

The opportunity was to be at the forefront of a movement to radically restructure how healthcare is provided in British Columbia. The division saw this as an invitation to be part of a transformational change provincially instead of deploying small initiatives in different communities.

"In a perfect world, once the Patient Medical Home (PMH) exists most of our current project work becomes a continuing professional development module, because you actually have the structure in place to deliver integrated care," Andrew explains.

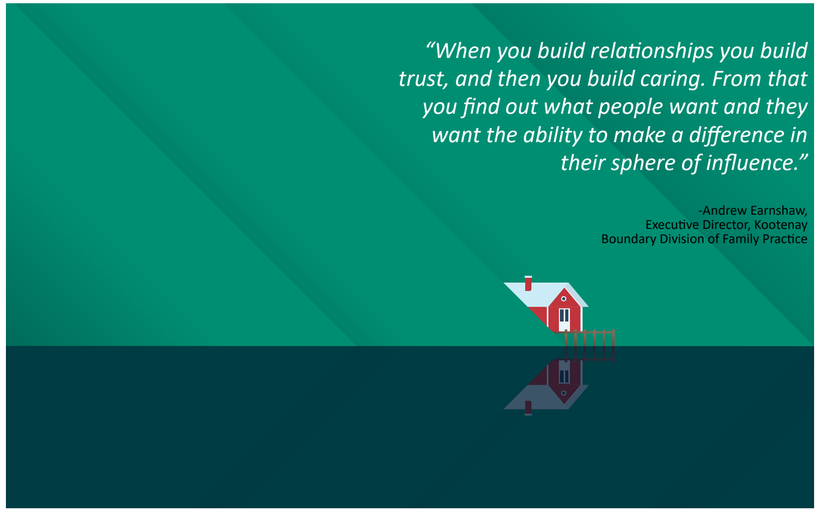
Shortly after the policy papers were released in 2015, the division began engaging their members and talking about what a PMH would look like in the region's unique communities. Their first step was to summarize the 90-page policy papers into a five-page document highlighting the important points and concepts behind the new model of care.

The following September, the Kootenay Boundary Collaborative Services Committee (CSC) agreed the PMH and Primary Care Network (PCN) were going to be the main focus of work for the foreseeable future, and they made a firm leadership commitment to advancing it.

"This decision was sparked by a real experience. We had a small community where a clinic collapsed and we discussed a primary care model as a fix. It was an anecdote that spurred us on," Andrew recalls.

At the October 2015 Annual General Meeting (AGM), the division invited the Northern Health Authority (NHA) to be keynote speakers. The NHA team from Prince George has a reputation among divisions as leading the province in their progress toward PMH/PCN, and they are highly collaborative.

Surrounding their participation in the AGM, the NHA contingent accompanied division staff on what was dubbed the 'Roadshow'. They toured four communities, speaking to physicians, community leaders and Interior Health Authority (IHA) staff about the work they were doing around primary care in the North.



That winter the division released a discussion paper on quality improvement (QI).

"The QI paper was critically important for both its content and for its use in broader engagement. We pitched it to anyone who would listen, which positioned us as thinkers and leaders on this topic," says Andrew.

At the February 2016 CSC retreat, the partners considered the local, regional, and provincial stakeholders they needed to engage to advance the PMH/PCN model. The partners developed a set of questions for each stakeholder, and then used the responses to design a specific engagement plan for each group.

"You can imagine how an exercise like this built cohesion, trust, and a sense of common cause at our local CSC," says Andrew.

In the spring of 2016, the division held their third round of formal engagement events with over 15 presentations to leaders and managers in the primary health care system, community leaders, and members. The presentations described the partner's philosophy that transformation must be a locally driven exercise. A detailed diagram helped convey that PMH concepts will look similar across the region, but will be tailored to local need.

"We tell our members that the engagement team is there if they're interested. Physicians know their local reality and need to come up with a model that works for them. If they choose to do that we will give them the vehicle to get there and continue to support them," explains Andrew.

The spring 2016 meetings lead to the division receiving IHA funding to get implementation underway in the Boundary sub-region of Kootenay Boundary. The CSC facilitated a collaborative, consensus-based planning process with their Boundary-based physician members, IHA staff, and CSC leaders to reach an agreement on how to allocate the funds.

Andrew mentions that, "The CSC used three 'Success Technologies' that really permeated everything we did in engagement. The first is change management and the first key element of that is creating a shared need. Without it, nothing proceeds."

One of the tools used to create a shared need was the Blue Matrix infographic with information from the Ministry of Health's database of system costs based on illness burden, and population growth. Another tool was an infographic outlining healthcare as a percentage of government revenues from 2000 forward. The division spent quite a bit of time reviewing both of these concepts with their members at a variety of different tables and it resonated with all parties.

The second success technology is the 'Kootenay Boundary Engagement Diagram'. The image uses the division's mantra of the 'Three C's': communicate, consult, and collaborate. The diagram encourages clarity with your audience as to why you're engaging, what you control, and what they can influence.

The third and final success technology the division deployed was building relationships.

"When you build relationships you build trust, and then you build caring. From that you find out what people want and they want the ability to make a difference in their sphere of influence," Andrew states.

Andrew notes a successful approach to presentations was building PowerPoint slides for each audience that addressed the risks and pitfalls the division could see as to why the PMH model may be problematic. By addressing the risks immediately, they were able to save the energy in any given room by cutting down the conversation time talking about possible negative outcomes.

"We also tell members the really good news, which is that this is not a new concept. The Primary Care Home model is something that has been used in the western world for decades. There is evidence of great success with this model," Andrew simplifies honestly.

The final illustration of significance is the 'Kootenay Boundary Primary Care Home Weather Forecast'. This diagram was constructed to assist members in dealing with the emotional stress of change. Each of the 'Weather Makers' in the diagram (players in the healthcare system) is linked to a Greek God symbol and a body of weather (the prominent areas of each group's work).

"The point of this slide is to manage expectations in a complex system that nobody can really control. There are many players who don't all get along. An action by one of them can throw the other totally off track. But notwithstanding all that uncertainty, it's clear there's going to be weather. It's going to rain, and our job is to build the barrel, and water the garden," Andrew elaborates.

The division continues to approach their members with honesty and transparency about the system change. As Andrew explains, it's unsettling and unnerving for members to hear inconclusive information upfront, but it's far better than surprising physicians with predetermined drastic change in the future.

Active change is now underway in the Kootenay Boundary division. Physicians are moving to bigger clinics to accommodate teams. The division's engagement strategies have created significant physician interest, and there is some concern from the division about being able to meet the demand.

"People are passionate about being involved in health system transformation," Andrew concludes.

Moving forward the division will release two additional white papers on 1) self-management in practice, and 2) the social determinants of health. They also remain committed to acting as change leaders within the division's network.