***EmbedSDH***

***Meeting of Wave I Communities***

*June 27, 2019, 7:30-8:30 a.m.*

*Draft Minutes*

**Participants:**

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| Georgia Bekiou, ED, Burnaby Division | Terry Brock, Regional Liaison, Fraser | Paula Carr, Manager, GPSC Liaisons |
| Diana Daghofer, Consultant, Wellspring Strategies | Andrew Earnshaw, ED Kootenay Boundary Division | Olive Goodwin, ED Prince George Division |
| Nicole Halbauer, ED Pacific Northwest Division | Cheryl Hogg, COO, Vancouver Division | Dr. Charlene Lui, Chair Burnaby Division |
| Marina McBride, Regional Liaison, Vancouver Coastal | Lucas Parker, Regional Liaison, Vancouver Island | Denise Ralph, ED Richmond Division |
| Jillian Wong, Community Liaison, Interior | Kathryn Wozny, Community Liaison, Vancouver Coastal |  |

**Chair:** Dr. Fiona Duncan

1. **Minutes/agenda** – No additions were made to the agenda. Terry noted that the current time, while it does not meet everyone’s needs, was the most convenient for most members, according to the recent Doodle poll. Olive has a conflict, so will find another person to represent Prince George in the fall. Minutes from May were accepted as presented.
2. **Terms of Reference** – The ToR were accepted, including the concept of a rotating chair.
3. **Focus Presentation:** Patient Attachment – How can attending to the SDH within PCN increase patient attachment, access and longitudinal relationships? Highlights of the conversation are outlined below:

*Olive*: PG has focused on the most vulnerable people in our community., We have bolstered a native health storefront clinic and started an innovative outreach service to unattached people that brings primary care to them, where they are. In this way, we can connect them with a longitudinal chart, including any other health services they use (hospital, specialty services, etc.).

*Andrew:* KB started by cleaning up our patient panel. By isolating these higher-needs patients, we hope to see the most improvement in capacity of physician time. As such, we see SW as a key resource to free up physician time and therefore, increase opportunities for attachment.

*Olive* – The goals in our Service Plans related to supporting patients and supporting practitioners to work to their scope of practice. High-needs patients often don’t fit into the ‘fee for service’ model, so the more emphasis that is put onto attaching patients, the less ‘return on investment’ will come from addressing SDH needs.

*Denise* – In our area, you can’t get too far on SDH until we look at cultural competency. How do practitioners deal with that in terms of role development and design? There is also the issue of residency.

*Georgia* – Services are organized by community and if people reside outside of the community where they physician is, they will be referred to their own communities.

*Andrew* – We are only putting AHP in a portion of our clinics. Where is the equity in that approach? We need messaging to explain to patients who do not qualify within the PCN region that the service may available at another time in this location, but not available now.

*Georgia*– We haven’t been calling it SDH, but heard very clearly from physicians that they need help with the ‘lower-to-middle triangle’. such as: (1) lifestyle management group– (all underpinned by SDH); (2) mild to moderate mental health; (3) chronic pain; (4) low income/economic pain (need social work support). Our service plan is largely designed around these four streams. We traded positions so we could buy more AHP spaces, aiming at a holistic attachment target rather than tying attachment to specific resources. Community partners are on our steering table. We have begun with process with mental health, but are finding it a challenge to integrate community services.

*Georgia* – We have positioned PCN as an integral component of the wellness strategy of the City of Burnaby, which is already a multi-agency table to support wellness.

*Nicole* (PNW) – We are focused on working with community partners. SDH is interwoven into all our work, including with the Friendship Centre, poverty reduction, housing, Indigenous partners (majority of unattached patients). SDH does not form a specific target, but is part of the overall work.

*Andrew* – Feel we are in a dance, aiming at an attachment target to which we have to tailor SDH. We don’t feel we can meet attachment targets without more resources, and we won’t get more resources until we land the attachment target.

*Georgia* –We are working with our HA to set parameters for who qualifies for the services, and feel we will reach our targets, but it cannot be done by focusing on one-to-one attachments. We believe we will hit our target by paying attention to a composite of things that are important to patients.

1. **Summary of issues raised**:

* *Challenge: how to address SDH and still meet attachment targets?* How can the funding formula, based on attaching patients, be used to address patients with complex needs? One strategy: engage physicians in developing the plans.
* *Using SDH language* – Divisions frequently talk about addressing SDH without naming them as such. There may be a benefit to explicitly naming SDH work in communications to the Ministry, to make a better case for funding for these services. If we could find a way to articulate this piece and the role of community, perhaps future proposals could be more successful.

1. **Wrap-up/Future Agenda**:

Suggestion that there be a stream on SDH at the fall GPSC Divisions Event. Paula noted that SDH did not come up in the focus group, but she could put that suggestion forward.

**The next meeting will take place on Thursday, September 26 at 7:30-8:30am PDT.** Chair and focus topic to be determined.