Achieving High-Performing Primary and Community Care: The Critical Role of Health Science Professions

FULL REPORT AND RECOMMENDATIONS FROM THE PRIMARY AND COMMUNITY CARE CONFERENCE

JULY 2018

HEALTH SCIENCES ASSOCIATION
The union delivering modern health care hsabc.org

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New Westminster, V3L0G7

HSASU

Achieving High-Performing Primary and Community Care:
The Critical Role of Health Science Professions

Full Report and Recommendations

Health Sciences Association of BC
July 2018

The Health Sciences Association of BC (HSA) is a democratic union that represents more than 18,000 health science and social service professionals in over 250 acute and community-based settings across BC including primary care, mental health and substance use centres, long-term residential care homes, child development centres, and community social service agencies.

HSA is committed to working with government and health system partners – including professional associations and community advocates – to strengthen our public health care system. HSA is a member organization of the BC Health Coalition – a coalition community representing over 800,000 people in BC that works to defend and strengthen public health care in the province.

This report and the executive summary are available for download at the Health Sciences Association website: www.hsabc.org.

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HSA would like to acknowledge that our office is located on the unceded homelands of the Qayqayt First Nation (pronounced keekite) on whose territories we live and thrive on. Our union works and has members in unceded territories across the province. Unceded means that Aboriginal title to this land has never been surrendered or relinquished.

HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

HSA

A Message from HSA President Val Avery

On behalf of the Health Science Association's 18,000 members, I am pleased to share the Final Report and Recommendations from our April 2018 Primary and Community Care Conference – *Achieving High-Performing Primary and Community Care: The Critical Role of Health Science Professions.*

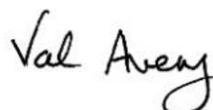
Too often in BC's public health care system there is a disconnect between frontline clinicians and decision-makers who are responsible for making policy decisions that affect patients and the health care workforce. With the Ministry of Health's vision to move towards an integrated system of team-based primary and community care, at HSA we felt it would be critical for decision-makers to hear directly from health science professionals about what's working and what's not.

Health science professionals are highly skilled, dedicated and caring professionals who are committed to strengthening our public health care system. The conference was the first of its kind to focus on the contributions of public-practice health science professionals and their commitment to team-based care. I encourage you to watch our short conference video where HSA members and the Honourable Judy Darcy, Minister of Mental Health and Addictions, describe the important contributions of health science professionals working together on the team to improve care for British Columbians.

Health science professionals are already on the frontlines of innovative programs that seek to fill gaps in the current system – but we know that our system can, and must, do better. But this will only be achieved by learning from clinicians about what facilitates and impedes interprofessional teamwork, implementing proven strategies based on the evidence from BC and internationally, and taking action on the urgent workforce challenges that create barriers to health care improvement.

Thank you to all the health science professionals who are working to improve care for British Columbians. I hope you find that your comments, concerns and recommendations are reflected in this report. As well, we were delighted to have such interest and participation from government, health authorities, researchers and patient and community advocacy organizations. Thank you to everyone for your thoughtful contributions to this important discussion. We hope that the conference contributes to ongoing dialogue that includes health and social care providers, policymakers, patients and the public.

Sincerely,



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Executive Summary

On April 13, 2018, over 70 Health Sciences Association (HSA) members, representatives from professional associations, Ministry policymakers, health authority decision-makers, researchers, family physicians and primary care advocates came together at BC's first-ever multidisciplinary primary and community care conference focused on the contributions of the health science professions[1] (see *Appendix D: Conference Program*).

In high-performing health systems internationally, there has been a greater focus on recognizing and optimizing the roles of public-practice health science professionals (hereafter, "HSPs") working in public in order to improve health services and population health outcomes. The HSA conference – *Achieving High-Performing Primary and Community Care: The Critical Role of Health Science Professions* – provided participants with an opportunity to better understand the different and critical roles of HSPs in primary and community care, as well as the barriers and opportunities for making interprofessional team-based care a reality for British Columbians in communities large and small, rural and urban.

The morning began with an opening welcome from Elder Roberta Price from the Snuneymuxw and Cowichan Nations, followed by opening remarks from HSA President Val Avery and the Honourable Judy Darcy, Minister of Mental Health and Addictions. Minister Darcy spoke about the critical role HSPs play in providing interprofessional team-based mental health and addictions care, including Foundry youth mental health and wellness centres that have opened across the province.

During the morning workshop (see Appendix A), HSA members discussed the unique roles of their disciplines in providing care to individuals with mental health and substance use issues and the frail elderly – two groups that require improved access to multidisciplinary team-based primary and community care, but too often end up in hospitals because comprehensive care and supports are not available.

Throughout the morning and afternoon panel discussions (see Appendix D and *Learning from the Canadian experience and high-performing systems internationally* section), conference participants learned about promising models of team-based care in which HSPs play integral roles. Social worker Elise Durante discussed the Vancouver Granville Foundry Centre and how staff work as an integrated team, with a focus on the social determinants of health, to meet the needs of youth with mental health and addictions issues. The Foundry is also designed to meet the primary care needs of youth who may otherwise not have access to a primary care provider or team.

Physiotherapist Chris Petrus highlighted how the Home Visits to Vancouver's Elders (Home ViVE) program provides 24-7 primary care to frail elders and reduces hospital visits. Health system consultant Cindy Roberts and Vancouver Coastal Health VP of Community Services Yasmin Jetha spoke about key ingredients to designing, implementing and sustaining unique and creative team-based programs, including the need for clinicians to take ownership over service redesign in order to sustain improvements.

[1] Health science professions are often referred to as, and part of the larger grouping of, "allied health professions".

Within the context of BC's ongoing overdose crisis, frontline clinicians from recreation therapy, family medicine, physiotherapy, occupational therapy, and social work identified challenges to, and opportunities for, strengthening team-based addictions care based on their experience working in innovative, low-barrier programs.

The day concluded with a panel discussion of lessons from BC and internationally on policy changes that can help BC overcome barriers to implementing interprofessional and multidisciplinary team-based primary care. Panelists discussed the importance of system-level changes, such as alternatives to fee-for-service physician compensation that facilitate team-based care; organizational structures to better support and engage frontline clinicians in implementing collaborative team models; and increasing community governance in primary health care, including the Ontario Community Health Centre model. Panelists included Professor Kimberlyn McGrail (UBC), Pam Mulroy (Northern Health), Adam Lynes-Ford (BC Health Coalition and Catherine White Holman Wellness Centre), and Marcy Cohen (Canadian Centre for Policy Alternatives).

Many participants remarked that the day was full of learning and stimulating discussions, and provided a unique opportunity to make new connections, especially between frontline practitioners and policymakers.

Based on a synthesis of conference workshops, panel discussions, participant feedback and a review of the relevant peer-reviewed and policy literatures, HSA identified the following key themes/lessons and policy recommendations.

Key Themes and Lessons

1. Health science professionals are critical members of primary and community care teams.

2. Health science professionals have important insight into what's working and what's not in primary and community care for frail seniors and individuals with mental health and addictions issues.

3. The lack of a province-wide approach to professional and interprofessional team development is a barrier to effective interprofessional teamwork.

4. The inability to work to full scope of practice is a concern and frustration expressed by many health science professionals across disciplines and public practice settings.

5. Public sector recruitment and retention challenges – contributing to shortages and heavy workloads for health science professionals – undermine effective teamwork and each profession's ability to work to full scope.

6. Health science professionals are committed to improving BC's integrated system of primary and community care – but they need to be recognized for their contributions and supported as leaders and improvement champions.

7. Promising and evidence-based practices and models of team-based care often suffer from the lack of a coordinated approach to scale up and spread innovations and improvements province-wide.

Recommendations

1. Learn from what is working and what is not on interprofessional primary and community care teams in BC and internationally. Apply those lessons in a coordinated, province-wide and ongoing manner by implementing a top-down and bottom-up approach to health system governance and improvement.

2. Establish a *Health Science Professions Policy Secretariat* in the BC Ministry of Health as a necessary step to recognize, support and develop the roles of health science professionals in BC's integrated system of interprofessional primary and community care.

3. Address urgent public sector shortages for health science professions.

4. Immediately expand training seats for health science professions, beginning with those identified as current priority professions by the Ministry of Health.

5. Develop a vision and strategy for public-practice health science professionals based on outreach and consultation with frontline health science professionals.

Thank you to all HSA members, conference attendees and speakers for your thoughtful contributions and ideas, which made the report and recommendations possible. Achieving an integrated system of high-performing primary and community care built around interprofessional teams is no small task. We hope that the conference and recommendations contribute to positive change and ongoing dialogue that includes health science professionals, decision-makers, patients and communities.

Conference Summary

On April 13, 2018, over 70 Health Sciences Association (HSA) members, representatives from professional associations, Ministry policymakers and health authority administrators, researchers, family physicians and primary care advocates came together at BC's first-ever multidisciplinary primary and community care conference focused on the contributions of the health sciences professions.

Achieving High-Performing Primary and Community Care: The Critical Role of Health Science Professions provided participants with an opportunity to better understand the different and critical roles of HSPs in primary and community care, as well as the barriers and opportunities for making interprofessional team-based care a reality for British Columbians in communities large and small, rural and urban.

The morning began with an opening welcome from Elder Roberta Price from the Snuneymuxw and Cowichan Nations. In her welcome, Elder Roberta Price spoke about the intergenerational trauma caused by the Indian residential school system, her personal struggle with mental health and journey to wellness, and the importance of cultural safety and humility in the health system.

HSA President Val Avery welcomed participants and introduced BC's first-ever Minister of Mental Health and Addictions Judy Darcy who spoke about the critical role HSPs play in providing interprofessional team-based mental health and addictions care, including at Foundry youth mental health and wellness centres that have opened in communities across the province. She also spoke about how mental health and addictions disproportionately affects Indigenous peoples and her government's commitment to the Truth and Reconciliation Commission's recommendations and the United Nations Declaration on the Rights of Indigenous Peoples.

Andrew Longhurst, HSA Researcher and Policy Analyst, provided the context for why HSA was convening the multidisciplinary conference and situated the day's discussions within the province's recent policy directions as well as key lessons from the international evidence for effective implementation of interprofessional team-based primary and community care (see *Background and Context: The Case for Policy Change*).

During the first morning workshop (see Appendix A), HSA members discussed the unique roles of their disciplines in providing care to the frail elderly and individuals with mental health and substance use issues – two groups that require improved access to multidisciplinary team-based primary and community care but often end up in hospital because comprehensive care and supports are not available. The disciplines included Respiratory Therapy, Physiotherapy, Occupational Therapy, Social Work, Mental Health/Substance Use Clinicians, Pharmacy, Dietetics, Music Therapy, Registered Psychiatric Nursing, Recreation Therapy, and Psychology (see Appendix A).

Throughout the morning and afternoon panel discussions (see Appendix B and *Learning from the Canadian experience and high-performing systems internationally* section), conference participants learned about promising models of team-based care in which HSPs play leading roles and the lessons from designing and implementing system improvements:

- Social worker Elise Durante discussed the Granville Foundry Centre and how staff work as an integrated team to meet the needs of youth with mental health and addictions issues.

- Social worker Cayce Laviolette talked about the importance of HSPs working with family physicians and other providers in the province's recently announced Patient Medical Homes and Primary Care Networks.

- Physiotherapist Chris Petrus highlighted how the Home Visits to Vancouver's Elders (Home ViVE) program provides 24-7 home-based primary care to frail elders and reduces hospital visits.

- Consultant and former health authority administrator Cindy Roberts and Vancouver Coastal Health VP of Community Services Yasmin Jetha spoke about key ingredients to designing, implementing and sustaining unique and creative team-based programs, including the need for clinicians to take ownership over service redesign in order to sustain improvements.

Within the context of BC's ongoing overdose crisis, frontline clinicians from recreation therapy (Sheri Steffen), family and addictions medicine (Dr. Rupinder Brar), physiotherapy (Sarah Buddingh Smith), occupational therapy (Tammam El-Khodor), and social work (Kaye Robinson) identified challenges to, and opportunities for, strengthening team-based addictions care based on their experience working in innovative, low-barrier programs.

The day concluded with a panel discussion of lessons from BC and internationally on policy changes that can help BC overcome barriers to multidisciplinary team-based primary care. Professor Kimberlyn McGrail (UBC), Pam Mulroy (Northern Health), Adam Lynes-Ford (BC Health Coalition), and Marcy Cohen (Canadian Centre for Policy Alternatives) discussed the history of primary care reform in BC and challenges to introducing and sustaining system-level changes, such as alternatives to fee-for-service physician compensation that facilitate team-based care; organizational structures to better support and engage frontline clinicians in implementing collaborative team-based models; and increasing the role of community governance in primary health care, including the Ontario Community Health Centre model.

Many participants remarked that the day was full of learning and stimulating discussions, and provided a unique opportunity to make new connections, especially between frontline practitioners and policymakers.

Why HSA Convened the Conference

Demographic shifts in the physician workforce and persistent challenges finding a family doctor, an aging population with more chronic diseases, growing demand for mental health and addictions services and the overdose crisis all put greater pressure on our public health care system, especially the acute care sector and workforce. Health science professionals are essential but underutilized members of interprofessional primary and community care teams who can help address BC's pressing health care challenges.

It is widely recognized that team-based primary and community care is the foundation of a high-performing health system that provides timely, effective, efficient, and patient-focused care. Both frontline HSPs and policymakers acknowledge much more work must be done to optimize the roles of the health care team, but to date, there have been few opportunities for frontline HSPs, researchers and patient advocates to come together and engage directly with decision-makers on existing barriers to team-based primary and community care, and how to overcome these challenges.

Too often in BC's public health care system there is a disconnect between frontline clinicians and decision-makers who are responsible for making policy decisions that affect patients and the health care workforce. With the Ministry of Health's vision to move towards an integrated system of team-based primary and community care, HSA felt it would be important for decision-makers to hear from frontline clinicians to inform provincial policy directions. It is also the first conference of its kind to focus specifically on the contributions of public-practice HSPs who are important partners in realizing the Ministry of Health's vision and goals for an improved system.

Background and Context: The Case for Policy Change

A large body of research evidence clearly demonstrates that primary care is the foundation of an effective, efficient and high-performing health care system.[2] *Primary health care* refers to a system-wide approach to designing health services based on primary care as the first point of contact in a system with a focus on addressing the social determinants of health and improving population health. Based on the World Health Organization, the ultimate goal of primary health care is better health for all, which includes five key elements: universal coverage to reduce exclusion and social disparities in health; organizing health services around people's needs and expectations; public policy that integrates health into all sectors of society; leadership that enhances collaborative models of policy dialogue; and, increased stakeholder participation.[3]

Primary care is the clinical level of primary health care, which should serve as the first point of contact with the health care system and where the majority of health problems are identified, treated and where other health and social care services can be mobilized and coordinated.[4] There are four key pillars of effective primary care: primary care is comprehensive, coordinated, continuous and the first point of contact in the health system.[5] Countries with a strong primary care orientation have better health outcomes, lower costs and greater equity in health. Put simply, jurisdictions with strong primary health care achieve superior outcomes at lower cost.[6]

Community care refers to a range of health care and social support services that some people require to remain in their homes and community. It can refer to facility-based care such as residential care or specialized community care programs. Many community care programs work to integrate and coordinate care across acute, community and home settings and between various providers.

Achieving a high-performing health system through interprofessional teamwork

High-performing health systems are defined as "those that have created effective frameworks and systems for improving care that are applicable in different settings and sustainable over time."[7] High-

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[2] Aggawal and Hutchison, 2012, p. 1. See also Cohen, 2014.
[3] World Health Organization, 2018.
[4] Cohen, 2014, p. 5.
[5] Starfield, 1998; 2011.
[6] Ibid.
[7] Baker et al., 2011, p. 13.

performing health systems, for example, create policy frameworks and strategies that involve frontline health care professionals as well as other stakeholders including patients and the public.

Interprofessional teams are widely recognized as the best way to achieve a high-performing primary care system (integrated with community care) based on the four key pillars of effective primary care.[8] In particular, there is growing evidence that collaborative interprofessional teams can "improve patient health and quality of life, especially for those with chronic conditions."[9] In BC, however, primary care remains predominantly medical care provided in a doctor's office by a physician in solo or group practice. Although various health care professionals may work in teams in hospitals and community care, British Columbia has very few examples of interprofessional and multidisciplinary primary care teams where health science professionals, nurses, physicians and other providers work collaboratively together.[10]

Based on what we know from high-performing health systems internationally (see next section), it is important and necessary to develop a more inclusive and expansive definition of primary care that recognizes the contributions of HSPs and acknowledges that for primary health care transformation to be successful, it must necessarily be multidisciplinary, interprofessional and better utilize the skills and contributions of health science professionals.

Defining interprofessional teamwork

The interprofessional team comprises various health care disciplines working together towards common goals to meet the needs of a patient population.[11] Team members divide the work based on the team members' education and experience, they share information to support one another's work, and they coordinate processes and interventions to provide a number of different services and programs to their patient/client population. Generally, there is an explicit underlying value of non-hierarchical decision-making.

The effectiveness of interprofessional teams has been demonstrated in systematic literature reviews, with the research identifying a number of key success factors, including physical co-location of the team; team members' knowledge of each other's roles and scopes of practice; mutual trust and respect amongst the team; commitment to building relationships; willingness to cooperate and collaborate; and the extent to which the team has organizational supports.[12] At the system level, policies and legislation, compensation models, workload and workforce planning, working arrangements and team characteristics such as leadership and shared purpose, influence how team members collaborate to achieve positive outcomes.[13]

It is very positive that the Ministries of Health and Mental Health and Addiction recognize the importance of shifting our public health care system to one that is built around interprofessional teams in order to improve quality of care and the experience of patients and providers.

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[8] Cohen, 2014.
[9] Aggawal and Hutchison, 2012, p. 23.
[10] Peckham et al., 2018, p. 6.
[11] Virani, 2012.
[12] Craven et al., 2006; Adams et al., 2007; Barret et al., 2007; Suter et al., 2010; Virani, 2012.
[13] Virani, 2012.

This policy direction is reflected in a number of provincial policy papers and reports, including the 2017 Select Standing Committee on Health's report *Looking Forward: Improving Rural Health Care, Primary Care and Addiction Recovery Programs*, the Ministry of Health's suite of 2015 policy papers and subsequent policy directives including *Primary and Community Care in BC: A Strategic Policy Framework*, November 2017 Select Standing Committee on Finance and Government Services' *Report on the Budget 2018 Consultation*, and the current Ministries of Health and Mental Health and Addictions Service Plans.

In Minister Darcy's address to conference participants, she discussed the Ministry of Mental Health and Addictions efforts to build a seamless and integrated system of care built around interprofessional teams where HSPs have important contributions to make.

In BC, *health science professionals* are a diverse group of many different professions and disciplines, and the second-largest group of health care professionals. Health science professionals provide health and social care services related to the prevention, identification, diagnosis, evaluation of diseases and disorders and the treatment and rehabilitation of patients. Health science professions in primary and community care include, but are not limited to, Occupational Therapy, Dietetics, Physiotherapy, Social Work, Recreation Therapy, Pharmacy, Art Therapy, Clinical Counselling, Music Therapy, Respiratory Therapy, and Psychology.[14]

British Columbians' lack of access to interprofessional and multidisciplinary primary and community care means that hospitals are often the point of entry into the health care system. Acute care services play a critical role in our public health care system, but the lack of strong prevention-focused, team-based integrated primary and community care leads to avoidable hospitalization, visits to emergency departments and a greater burden on the acute care workforce. Patients often end up in hospital as a result of chronic conditions that could be managed in primary care settings, but the lack of comprehensive, accessible and longitudinal primary care means that chronic conditions are more likely to require acute interventions because supports and preventative care were not in place. Seniors with complex chronic conditions and individuals with mental health and substance use issues are at greater risk for ending up in hospital.

In BC, health services utilization data tell us why it is important that we develop a more integrated system of primary and community care. One way to spot shortfalls in access to comprehensive primary and community care is to look at the pressure on the acute care system and workforce. Canadians are more likely to use emergency departments than people in other countries with evidence suggesting that hospitals may be the only available alternative when faced with challenges accessing timely primary care.[15] One in 5 emergency department visits are potentially avoidable where patients have low-acuity complaints that do not result in hospital admission.[16] For mental illness specifically, hospitalization rates and the length of hospitalizations are higher than the national average, and BC has the highest rates of repeat hospitalizations and readmission within 30 days due to mental illness.[17]

Primary care in BC (and much of Canada) remains physicians working in solo or uni-professional group practice as independent fee-for-service contractors without the system-level enablers, including

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[14] See Appendix B for health science professions on primary and community care teams. This is not intended to be an exhaustive list.
[15] Canadian Institute for Health Information, 2014, p. 6.
[16] Ibid.
[17] Canadian Mental Health Association BC Division, 2018, p. 4.

alternatives to fee-for-service compensation, that encourage interprofessional practice and teamwork. However, there is growing evidence that family physicians, especially recent graduates, would like alternatives to fee-for-service compensation that would facilitate the development of interprofessional teams.[18]

Interprofessional teams lend themselves well to the comprehensive, continuous and prevention-focused care required to support patients to manage chronic conditions in the community while also reducing burnout among providers. For seniors with frailty, we can look at patients who no longer require inpatient care but who continue to occupy a hospital bed because appropriate health care services in their home or community are not available. These patients are referred to as "Alternate Level of Care" or ALC patients and are derogatorily referred to as "bed blockers." The ALC issue is one of the biggest challenges to reducing health care wait times and improving health care access for everyone. In 2015/16, ALC use (measured as "ALC days") accounted for 13 per cent of total hospital use, and 84 per cent of ALC days involve seniors.[19] The majority of ALC use (53 per cent) is related to mental health issues, dementia, rehabilitation, convalescence or palliative care.

One common refrain is that increasing the supply of family physicians and offering financial incentives for doctors to practice "full-service" family medicine will solve many, if not all, of these challenges related to access to comprehensive primary care. Yet, despite a growing number of physicians practicing in BC and financial incentives to encourage physicians to provide comprehensive care with a focus on chronic disease management, research evidence from BC shows that it has not translated into better access, continuity and comprehensiveness of care.[20] A 2016 study published in the *Canadian Medical Association Journal* found that while "$250 million in incentives [in BC] improved the compensation of physicians doing the important work of caring for complex patients" it did not improve access or continuity in primary care or "constrain resource use elsewhere in the health system." The study authors concluded that "policymakers should consider other strategies to improve care for this patient population."[21]

In BC over the last decade and a half, provincial policies that have largely focused on increasing the supply of one provider group (physicians) by offering financial incentives have not delivered the desired results. The BC experience does not come as a surprise considering the growing evidence from Canada and internationally that primary care transformation requires system-level changes that facilitate the development of interprofessional teams where all providers work collaboratively at their full scope of practice.[22]

Importantly, the BC Ministries of Health and Mental Health and Addictions recognize the need for this policy shift and the need for system-level changes required to make interprofessional and multidisciplinary team-based primary care possible.[23]

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[18] Canadian Foundation for Healthcare Improvement, 2010; Brcic et al., 2012. The BC government's recently announced primary health care strategy, with a focus on interprofessional and multidisciplinary primary care delivery, will move the province in a very promising direction.
[19] BC Ministry of Health, Hospital Workload by Governance Authority, *HealthIdeas*, reported generated July 6, 2017.
[20] Lavergne et al., 2016; 2018; Hedden et al., 2017.
[21] Lavergne et al., 2016, p. 1.
[22] See Virani, 2012; Cohen, 2014; Conference Board of Canada, 2014.
[23] BC Ministry of Health, 2015; Office of the Premier, 2018.

Learning from the Canadian experience and high-performing systems internationally

High-performing health systems internationally are built around interprofessional team-based primary and community care teams with a diversity of health care disciplines. What is particularly important about these leading health systems is that they focus on chronic disease management for older adults with frailty and individuals with mental health and substance use issues. Team models depend on a diversity of disciplines beyond family medicine and nursing, and with a much higher ratio of non-physician providers to physicians than exist in Canadian jurisdictions. For example, primary care chronic disease management teams in the non-profit Kaiser Permanente system in the US generally have a ratio of *three or more* full-time equivalent non-physician clinical care providers for every physician on their teams.[24]

In Alaska, the Southcentral Foundation is a non-profit health system run by, and for, Alaska Natives that is internationally recognized for its leading work in the area of team-based primary care and chronic disease management built around interprofessional teams with a strong focus on the social determinants of health and the inclusion of behavioural health professionals on teams.[25] In BC, we have much to learn from systems that better integrate behavioural care professionals on primary and community care teams.

The Southcentral Foundation primary care team design also represents an important shift away from the traditional 'gatekeeper' model of primary care where all patients first see a physician and only then are referred onto other providers. Instead, patients may directly see other providers based on their needs. With shared electronic health records and regular team care planning meetings, the strength of this approach is a more patient-centred model where patients can more quickly access the more appropriate provider based on their needs. For the team, it more evenly spreads the workload and frees up physicians to be the medical specialist and focus on the most complex patients.[26]

There are also promising and successful models of care in BC and from other Canadian jurisdictions. Ontario's over 70 Community Health Centres (CHCs) operate as community-governed non-profit organizations (with elected boards that are responsive to the communities they serve) with interprofessional teams where medical and social care is integrated in order to address the social determinants of health (e.g., the team may include social worker, clinical counsellor, occupational therapist, family physician, nurse practitioner, income and housing support workers). Research has shown Ontario's CHCs to be the most effective primary care model in Ontario for serving high-needs clients with chronic conditions and reducing emergency department utilization.[27]

In BC, we have some very promising team-based models where HSPs have been critical to their success. At the conference, HSA members and conference speakers discussed innovative, evidence-based programs and teams including:

- Home Visits to Vancouver's Elders (Home ViVE) is an integrated home-based primary care program for homebound elders that has shown positive outcomes in its ability to stabilize emergency department visit and hospital admission rates. The Home ViVE team includes family

[24] Auditor General of Alberta, 2014, p. 23; Alberta Ministry of Health, 2016, p. 37.
[25] Collins and Berwick, 2015; Dale and Lee, 2016.
[26] Collins and Berwick, 2015, pp. 31-39.
[27] Institute for Clinical Evaluative Sciences, 2012.

physicians, nurse practitioners, HSPs, nurses and administrative staff. Services include "planned regular home visits, responsive daytime and after-hours care for emergencies, and nursing, physical and occupational rehab services as needed. The team holds regular meetings to discuss both individual patients and service quality more generally. In addition, there is capacity for allied health providers to communicate with physicians and nurse practitioners through a shared electronic medical record."[28]

- Long-term residential care provided by public health authorities, where seniors benefit from co-location with hospitals and having access to a broader team of HSPs than standalone seniors care homes, perform better based on a number of quality indicators including staffing levels and transfers to emergency. In a study of nursing home characteristics associated with resident transfers to emergency department, "results showed that higher total direct-care nursing hours per resident day, and presence of allied health staff – disproportionately present in publicly owned facilities – were associated with lower transfer rates."[29]

- Foundry centres are youth "one-stop-shop" centres for mental health and substance use services and primary care with a focus on improving timely access for youth through service integration. The integration of medical and social care with a social determinants of health orientation – a key innovation of Foundry centres – has been integral to the success of the Ontario CHCs.[30]

- The Osteoarthritis System Integration Service (OASIS) is a network of three clinics in Vancouver Coastal Health (Vancouver, Richmond and North Shore) for surgical and non-surgical osteoarthritis patients. The clinics provide central intake and triaging to support rapid access to appropriate care and supports for surgical patients while also adopting a primary care approach to support patients (and primary care physicians) with education and self-management supports. The clinics are staffed with physiotherapists, occupational therapists, dietitians, and administrative staff.[31] In fact, the Scottish NHS visited BC to take lessons from OASIS in order to inform their musculoskeletal services redesign work.[32] In most Scottish health authorities, patients can refer themselves directly to physiotherapists rather than GPs for certain musculoskeletal conditions.[33]

High-performing systems empower clinicians to drive system improvement

In the research literature evaluating the successes achieved by high-performing health systems, including the Scottish NHS and Kaiser Permanente, a large focus of quality improvement and systems transformation efforts have depended on improving workforce participation and changing organizational cultures to ensure that frontline clinicians are encouraged and supported to be leaders and system improvement champions. In the words of the Institute for Healthcare Improvement's Don

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[28] McGregor et al., 2018.
[29] McGregor et al., 2014.
[30] Institute for Clinical Evaluative Sciences, 2012.
[31] Longhurst et al., 2016, pp. 34-36.
[32] Personal communication, Cindy Roberts, former Director, Musculoskeletal Programs & Special Projects, Primary Care, VCH.
[33] Dayan and Edwards, 2017, p. 34.

Berwick, health systems must create the conditions that will support practitioners to do their best work based on "the intrinsic motivation of the healthcare workforce" and put more effort into "learning and less into managing carrots and sticks."[34]

In addition to considering the design of leading interprofessional primary and community care models, it is equally important to consider that the success of high-performing health systems depends on a movement away from hierarchical or "command-and-control" governance and management, and fostering learning organizations that support and encourage distributed leadership where frontline providers drive improvement.[35]

In this area, BC and other Canadian provinces have much to learn from high-performing systems internationally where there has been systematic, coordinated and ongoing quality improvement, and the culture and governance changes to facilitate this shift. In these cases, success has been achieved because it has been driven by frontline clinicians supported by quality improvement and workforce development infrastructure.[36]

In Scotland, for example, it became clear that health authority organizational cultures and top-down management styles needed to change in order to facilitate authentic and sustained health system change; hence, it was understood not as a "problem *for* management" but a "problem *of* management,"[37] and based on the evidence that an "engaged workforce is one that holds a positive attitude toward the organization and its values, and is foundational to creating high-performing organizations."[38]

[34] Berwick, 2016, p. 1329.
[35] Berwick, 2016; Dayan and Edwards, 2017; NHS Scotland and Institute for Healthcare Improvement, 2018.
[36] Healthcare Improvement Scotland, n.d.; NHS Scotland and Institute for Healthcare Improvement, 2018.
[37] Samuel, 2011; Bacon and Samuel, 2012.
[38] Perlo et al., 2017, p. 7.

Key Themes and Lessons

Based on a synthesis of conference workshops, panel discussions, participant feedback and a review of the relevant peer-reviewed and policy literatures, HSA identified the following themes and lessons.

1. **Health science professionals are critical members of primary and community care teams**.

   HSPs are necessary to achieve a high-performing system of primary and community care. Throughout the conference, we heard from clinicians, administrators, health system leaders, researchers and community health and patient advocates about the importance of multidisciplinary teams where health science disciplines contribute to effective interprofessional diagnosis, treatment, and rehab of seniors with frailty and complex care needs as well as individuals with mental health and addictions issues. Public practice HSPs working in the public system ensure that British Columbians, regardless of their socio-economic status, have access to necessary care and supports. HSPs also play important leadership roles in the development and delivery of primary and community care to frail elders and patients with mental health and substance use issues.

2. **Health science professionals have important insight into what's working and what's not in primary and community care for frail seniors and individuals with mental health and addictions issues.**

   At the conference, we heard about the leading roles that HSPs play on innovative teams, including OASIS, Home ViVE, the Rapid Access Addiction Clinic, the Complex Pain Clinic, and Foundry. HSPs have important insight into what's working and what's not working. The Ministry of Health and health authorities need to more purposefully and systematically ensure the participation of frontline clinicians in service implementation, redesign, and continuous improvement.

3. **The lack of a province-wide approach to professional and interprofessional team development is a barrier to effective interprofessional teamwork**.

   A common theme from HSPs was the lack of infrastructure and supports for professional and interprofessional team development. Management styles and organizational cultures pose significant barriers to improving how disciplines work together. From the conference, there was a notable desire for more meaningful and ongoing opportunities for interprofessional dialogue, networking and learning in order to facilitate greater trust and respect between disciplines.

4. **The inability to work to full scope of practice is a concern and frustration expressed by many health science professionals across disciplines and public practice settings.**

   Since team supports, education and structured approaches to improving trust, respect and understanding of each other's roles on the team are lacking, HSPs are not often working to their full scope of practice, thereby exacerbating recruitment and retention challenges in the public sector. The lack of health science disciplines represented in clinical management and leadership roles often means that the roles of HSPs are not well understood. As a result, HSPs are not supported to work to full scope. When health authority clinical leadership and management is dominated by nursing and

medicine, it can lead to role expansion and scope 'creep' among nursing and medicine, resulting in low morale and frustration among HSPs who do not see their disciplines represented, recognized or their scope of practice respected.

Heavy workloads – exacerbated by public sector shortages – make it more difficult for HSPs to work to full scope and provide optimal patient care. This was a key theme arising from HSA's recent member survey as well.[39]

5. **Public sector recruitment and retention challenges – contributing to shortages and heavy workloads for health science professionals – undermine effective teamwork and each discipline's ability to work to full scope.**

   The issue of vacancies for funded HSP positions is a significant challenge and means that public practice HSPs are expected to take on greater workloads, resulting in shorter visits with clients and a narrowing of scope. For example, due to the shortage of occupational therapists on the team, the role of an occupational therapist may be reduced to that of focusing exclusively on clients' equipment needs rather than having the time and being supported to work to full scope. As scopes narrow and practice becomes more repetitive, HSPs are more likely to exit public practice and new graduates may be less inclined to pursue public practice.

6. **Health science professionals are committed to improving BC's integrated system of primary and community care – but they need to be recognized for their contributions and supported as leaders and improvement champions.**

   HSPs comprise many diverse professions and disciplines committed to excellence in primary and community care. However, HSPs do not always feel recognized or supported by their health authority or the broader health care system for their contributions, expertise and leadership. This is often reflected in the culture and management of health authorities where health science professions are not often represented in clinical leadership roles. Recent health authority staff surveys validate this theme, showing that HSPs experience some of the lowest work satisfaction among provider groups.

7. **Promising and evidence-based practices and models of team-based care often suffer from the lack of a coordinated approach to scale-up and spread innovations and improvements province-wide.**

   Health system improvement depends on coordinated approaches to learn from promising and evidence-based practices and innovations by harnessing the knowledge and dedication of frontline practitioners.[40] At the conference, many HSA members stated that they appreciated the opportunity to engage and be heard by decision-makers – an opportunity that many believe should happen more often and lead to change. Conference participants indicated a desire for their frontline expertise and dedication to be better utilized and inform service design and improvement.

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[39] Health Sciences Association, 2018.
[40] Dayan and Edwards, 2017; NHS Scotland and Institute for Healthcare Improvement, 2018.

Recommendations

Based on a synthesis of conference workshops, panel discussions, participant feedback and a review of the relevant peer-reviewed and policy literatures, HSA makes the following policy recommendations.

1. **Learn from what is working and what is not on interprofessional primary and community care teams in BC and internationally. Apply those lessons in a coordinated, province-wide and ongoing manner by implementing a top-down and bottom-up approach to health system governance and improvement.**

   This will require provincially coordinated infrastructure that listens to, supports, and empowers, frontline clinicians in identifying what's working and what's not working on primary and community care teams, in order to apply those lessons in a systematic manner and inform decision-making at the health authority (organizational) and Ministry of Health (system) levels.

   This will require a hybrid approach to health system governance and improvement, often referred to as "top-down and bottom-up" in the research literature.[41] Health systems must create the conditions that will support practitioners to do their best work based on "the intrinsic motivation of the healthcare workforce" and put more effort into "learning and less into managing carrots and sticks."[42] We know from HSA members that these organizational factors are directly related to professional satisfaction, shortages and recruitment/retention.

   The Scottish NHS, supported by the Institute for Healthcare Improvement, has done leading work internationally within a single-payer health system context that is similar to BC:

   > *Scotland has a unique system of improving the quality of health care. It focuses on engaging the altruistic professional motivations of frontline staff to do better, and building their skills to improve. … It uses a consistent, coherent method where better ways of working are tested on a small scale, quickly changed, and then rolled out. Unlike the rest of the UK, this is overseen by a single organization that both monitors the quality of care and also helps staff to improve it.*[43]

   That single organization – Healthcare Improvement Scotland – embodies a top-down and bottom-up governance approach to public health system improvement by providing the critical infrastructure that supports health authorities, teams and clinicians to be drivers of improvement.[44]

   Scotland also implemented a "Staff Governance Standard" which includes specific requirements in which "[health authority] employers must demonstrate that they are striving to both achieve and maintain exemplary employer status [and are] expected to have systems in place to identify areas that require improvement and develop action plans that will describe how improvements will be made."[45]

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[41] See Bacon and Samuel, 2012; McDermott et al., 2015; NHS Scotland and Institute for Healthcare Improvement, 2018.
[42] Berwick, 2016, p. 1329.
[43] Dayan and Edwards, 2017, p. 3.
[44] Healthcare Improvement Scotland, n.d.; 2016; NHS Scotland and Institute for Healthcare Improvement, 2018.
[45] NHS Scotland, n.d. See also Bacon and Samuel, 2012.

2. **Establish a *Health Science Professions Policy Secretariat* in the BC Ministry of Health as a necessary step to recognize, support and develop the roles of health science professionals in BC's integrated system of interprofessional primary and community care.**

   HSA recommends the creation of a *Health Science Professions Policy Secretariat* to ensure that health science disciplines receive the necessary and ongoing recognition and policy attention required to address the critical workforce challenges that must be overcome in order to achieve a high-performing system of integrated, interprofessional primary and community care. Establishing a Health Science Professions Policy Secretariat, similar to the existing Nursing Policy Secretariat, would ensure focused and ongoing attention on significant policy and practice challenges that exist.[46]

   British Columbia is embarking on ambitious health system transformation. There is a growing body of evidence demonstrating that large-system transformation depends on *all* clinicians, including HSPs, to be engaged and take ownership of the change process.[47] This requires HSPs to be "at the core of the dialogue or debate on primary health care system reforms that affect them" in order for interprofessional teamwork to take hold.[48]

   The creation of a provincial-level Health Science Professions Policy Secretariat would align BC with Scotland, England and Australia, all of which have recognized the need for greater policy capacity and leadership to support the development of Health Science/Allied Health Professions in shifting to team-based primary and community care. In the Scottish NHS, the first Allied Health Professions Officer in the Scottish Government Health Department was established in 2002. This position was changed to Chief Health Professions Officer to reflect the 10 Allied Health Professions Groups and the 51 Healthcare Science Professions the position has policy responsibility for. The Chief Health Professions Officer provides advice to Ministers and the government on professional matters affecting all 61 disciplines including education, training, regulation and role/service development.[49] England followed Scotland's lead by establishing the Chief Allied Health Professions Officer in 2014 to drive the strategic work of advancing the allied health professional workforce and maximizing their contributions across health and social care. In 2013, the Australian Minister of Health established the first Chief Allied Health Officer "to further support allied health professionals and provide advice on how to best strengthen their role in the Australian health system."[50]

   Put simply, a Health Sciences Professions Policy Secretariat would provide voice at senior policy levels for HSPs, and ensure that the Ministry of Health, working collaboratively with partners, has the capacity to address urgent HSP workforce challenges that require focused attention and

[46] See Byres (2018) for an example for the kind of focused and consultative policy work that has been achieved through the Nursing Policy Secretariat.
[47] Best et al., 2012.
[48] Mable et al., 2012, p. 9. In a 2012 research report on the status of primary care reform across Canada, Key Findings Nos. 5-6 are still very much the case in BC: "Most informants commented often that teamwork to date is still too physician-centric and not in sync with patient-focused PHC objectives. Even though teams are a major component and more kinds of health providers are involved, the allied providers do not appear, form literature or informant input, to be at the core of the dialogue or debate on primary health care system reforms that affects them."
[49] Scottish Government, 2017.
[50] Australian Government Department of Health, 2013.

strategic action if we hope to achieve a high-performing health system where clinicians are champions of quality improvement and find joy in their work.[51]

3. **Address urgent public sector shortages for health science professions**.

   It is very positive to see the Ministry of Health engaged in health human resources planning and taking more leadership in this important area of health policy. Earlier this year, the Ministry of Health identified 13 (current) priority professions as having labour market challenges that require provincial attention and monitoring. The majority of disciplines identified as both current and future priorities are health science professions. The frontline perspectives articulated at the conference made it apparent that immediate action is necessary to address public sector shortages for health science professions. Consistent with conference discussion, immediate strategies should consider market (compensation) adjustments, student loan forgiveness, rural/remote practice incentives and medium and longer-term strategies including structured approaches to health authority culture change, workload, creating new leadership opportunities for HSPs, and addressing other practice and workplace concerns. Immediate and longer-term actions could be developed by the *Health Sciences Professions Policy Secretariat* and be the focus of a first-ever health science professions vision and strategy document (see Recommendation 5).

4. **Immediately expand training seats for health science professions, beginning with those identified as current priority professions by the Ministry of Health.**

   Building on Recommendation 3, the Ministries of Health, Mental Health and Addictions, and Advanced Education, Skills and Training should immediately expand the training seats for designated priority health science professions, and bring BC in line with the training seat capacity in other provinces.[52] BC currently lags behind other provinces, and the lack of in-province training capacity has contributed to the shortages we face today.

5. **Develop a vision and strategy for public-practice health science professionals based on outreach and consultation with frontline health science professionals.**

   Following the lead of high-performing systems, including Scotland's NHS, it would be important to develop a vision and strategy document for the health science professions. For example, NHS Scotland's first-ever strategic document laid out the vision and actions to develop and support the health science professions. As a model of how to begin this work in BC, the initial NHS Scotland vision and strategy made three important contributions and identified areas for future policy work based on consultation:

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[51] Perlo et al., 2017.

[52] These are physiotherapists, occupational therapists, perfusionists, and sonographers. We also recommend speech language pathologists and MRI technologists be added to the current priority health science professions based on the provincial government's recently announced surgical and diagnostic strategy (which requires increasing public MRI capacity) and the shortage of public-practice SLPs identified by employers, unions, families and disability advocates and affirmed in Recommendation 20 of the BC Legislature's Select Standing Committee on Finance and Government Services' *Report on the Budget 2018 Consultation*.

- It profiled the work of HSPs and highlighted their contribution to improving and maintaining patient health and wellbeing.
- Explained how [these] diverse groups of health professionals will be supported and developed.
- Set out the vision that will enable them to fully engage their expertise in improving health in Scotland, deliver excellence in health and social care, and support the development of best practice in multi-professional teams.[53]

Importantly, in developing the vision and strategy document, the Scottish NHS consulted widely with frontline practitioners and stakeholders, similar to what the BC Ministry of Health's Nursing Policy Secretariat has done in the January 2018 consultation report and priority recommendations.[54]

Thank you to all HSA members, conference attendees and speakers for your thoughtful contributions and ideas, which made the report and recommendations possible. Achieving an integrated system of high-performing primary and community care built around interprofessional teams is no small task. We hope that the conference and recommendations contribute to positive change and ongoing dialogue that includes health science professionals, decision-makers, patients and communities.

[53] NHS Scotland, 2002, p. 8.
[54] Byres, 2018.

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Appendix A: Workshop I – Understanding the critical role of each health sciences discipline in primary and community care

During this workshop, participants were grouped into discipline-specific tables with Ministry of Health and Health Authority decision-makers as an opportunity to share and learn about the role of each health science professional discipline. Discussion and learning was structured around the following questions:

- Describe the role of your profession in improving and maintaining the health of frail seniors in public practice settings. What practice interventions can help frail seniors improve and maintain their health?
- Describe the role of your profession in improving and maintaining the health of individuals with MHSU challenges in public practice settings. What practice interventions can help improve and maintain the health of individuals with MHSU challenges?

Recreation Therapy

Recreation Therapy (also Therapeutic Recreation) "is a profession which recognizes leisure, recreation and play as integral components of quality of life. Service is provided to individuals who have physical, mental, social or emotional limitations which impact their ability to engage in meaningful leisure experiences" and the profession "is directed toward functional interventions, leisure education and participation opportunities. These processes support the goal of assisting the individual to maximize the independence in leisure, optimal health and the highest possible quality of life."[55]

Recreation Therapists identified the following roles and contributions of their profession especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

- Bringing clinical treatment perspective

[55] Canadian Therapeutic Recreation Association, https://canadian-tr.org/about/.

- Addressing substance use that results from anxiety or isolation
- Care provided at client's home
- Therapeutic recreation vs talk therapy: therapeutic recreation is a low barrier form of treatment
- Explore alternative coping strategies
- Structure and routine, activity in community, meaningful activities, gym – all increase motivation of client
- Detecting pattern of substance use
- Therapeutic value of recreation
- Standardized assessments and outcome measuring tools – show progress and include patient in the process
- Connectedness to community resources/culture
- Program in all five domains of health: physical, social, emotional, spiritual, and cognitive
- Document therapy minutes
- Collaborate with patient to develop goals
- Patient owns their own success
- Work ourselves out of a job to implement client/resident independence in overall health and wellness
- We instill hope, empowerment and alleviate loneliness and boredom = life
- Patient/clients are champions in their plans
- Work on interdisciplinary teams to collaborate and problem solve
- Provide leisure education to explore alternative coping strategies
- Use leisure as medicine in order to decrease use of antipsychotic medications
- Increase activity levels to manage side affects of medications
- Assessment: provides baseline strengths and limitations; leads to measurable outcomes
- Planning, implementation, evaluation
- Interest-driven, evidence-based practice and goal driven
- Education: provided to clients to improve understanding and access to services

Occupational Therapy

Occupational Therapists are legally recognized professionals is "that help to solve the problems that interfere with a person's ability to do the things that are important to them – everyday things like self-care (getting dressed, eating, moving around the house), being productive (going to work or school, participating in the community), and leisure activities (sports, gardening, social activities)." Occupational Therapists are "trained to understand not only the medical and physical limitations of a disability or injury, but also the psychosocial factors that affect the functioning of the whole person – their health and their wellness."[56]

Occupational Therapists identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

- Focus on "occupation" – activities of daily living, things people need and want to do
- Look at environmental, cultural, functionality, cognitive impairment

[56] Canadian Association of Occupational Therapy, https://www.caot.ca/site/aboutot/whatisot?nav=sidebar.

- Adaptation to keep functionality and participation; work in context of individual's life: environmental modification; activity modification
- Definition of risk outside acute setting (advocate)
- Level of discourse to bring to team to keep individuals out of acute facilities
- Harm reduction approach (mental health and addiction)
- Focus on physical and psychological status
- Seniors at home
    - Preventative home visits
        - Stay independent in activities of daily living
        - Environmental modifications to decrease risk factors for falls
        - Build skills so people can keep independent in activities of daily living like cooking, toileting, managing meds
    - Support socialization, decrease isolation
    - Help live at home even with risk
- Seniors in residential care
    - Wheelchair prescriptions
    - Skin health maintenance for those in wheelchair
        - Decrease wounds
        - Surface prescription
    - Dysphagia assessment
    - Maintain participation in daily living
        - Toileting, dressing, enjoyable activities
- Mental health and substance use
    - Support transitions youth to adults
        - Build skills for independent living
            - Cooking, laundry, get and keep a job, live independently, productive and engaged in society, find purpose
- Saving lives and quality of life (e.g. recovering from brain injury due to substance use)
- Maintaining independence and housing
- Supporting a pathway for recovery
- Resources (funding) going into saving lives but not into rehab
- Clearer responsibility/links/integration between the different HSPs
- Challenges for OT
    - HHR – occupational therapy workforce is fragile
    - Only 27 per cent train in BC; only 48 seats in BC; reliant on in-migration
    - Misdistribution: most underserved are Northern and Fraser Health
    - Shortages: can't fill positions around BC

Physiotherapy

Physiotherapists are legally recognized professionals "with a significant role in health promotion and treatment of injury and disease" with the goal of "getting [patients] to a place where [they] can be at [their] best functional capacity, maintaining that and then helping [them] to prevent future injuries." Physiotherapy involves "hands-on treatment, including manual therapy to stretch stiff joints, therapeutic massage to loosen tight muscles[, and] [t]here may also be machines involved with …

treatment … [and prescribing] an individualized home exercise program … that may involve a combination of stretching and strengthening exercises."[57]

Physiotherapists identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

- Maintaining and improving the ability to move within home and community – in order for clients to remain connected to family and friends
- Strength, balance, falls prevention, ambulation
- Role of movement in maintaining cognition
- Rehabilitation assistants provide exercise and movement programs created and progressed by physiotherapists as seniors strengthen and have new goals
- Not optimized as primary care providers in public system; socioeconomic barriers to access private PTs (importance of public practice physio)
- Gap: mental health teams do not have physiotherapy
- Movement allows people to maintain connections with social supports, an important role in mood and mental health
- Non-opioid pain management strategies
- Address chronic pain challenges that often drive addictions: high benefit/low risk pain management
- Low income populations unable to access private PT – need to access low-barrier PT

Social Work

Social workers are legally recognized professionals "concerned with helping individuals, families, groups and communities to enhance their individual and collective well-being. It aims to help people develop their skills and their ability to use their own resources and those of the community to resolve problems."

In health and social care settings, "social workers are members of the treatment team. They provide a link between the family as well as with community resources … they contribute to the care, treatment and rehabilitation of the aged and of physically or mentally ill individuals, as well as the care of disabled persons." Furthermore, "social workers are involved in the provision of counselling to individuals or families and in providing services to seniors. Some work as community developers helping citizens to identify their needs and proposing ways of meeting those needs."[58]

Mental Health/Substance Use Clinicians

At the Social Work table, there was also representation from other mental health and substance use clinicians including from the VCH First Nations Mental Health Liaison Program. Other mental health professional disciplines include Clinical Counselling and Concurrent Disorder Clinicians, Child & Youth Mental Health Clinicians, and Community Mental Health Workers.

Social workers and mental health clinicians identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

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[57] Canadian Physiotherapy Association, http://physiocanhelp.ca/what-is-physiotherapy/what-physiotherapists-do/.
[58] Canadian Association of Social Work, https://www.casw-acts.ca/en/what-social-work.

- Adult guardianship – protection and autonomy
- Advocacy
- Individual, group, family counselling
- Holistic – biopsychosocial lens – person in environment
- Addressing social determinants of health
- Systems lens
- Assess and address gaps in resources and services
- Navigating systems
- Case management
- Knowledge of gatekeepers to services

Pharmacy

Pharmacists are legally recognized professionals who "are taking on expanded roles and are increasingly being recognized as the medication management experts of the health care team."[59] Pharmacists "listen to, understand, and respect the patient's story about experiences and expectations that will affect the use of medications[,] … provide proactive patient-centred care to develop a pharmacy care plan that reflects the patient's goals[,] … implement risk-reduction strategies to improve the safety of the medication-use system[,] … develop and assesses the pharmacy care plan in collaboration with other members of the health care team[, and] communicates the plan of care to the professionals who will assume responsibility for care of the patient at care transitions."[60]

Pharmacists identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

- Identify, prevent, and resolve drug therapy problems (wrong drug, dose, interaction)
- Assess goals of care and work together to meet goals – and follow up
- Facilitating care during transitions of care
- De-prescribing support
- Potential for more prescribing role in teams – done elsewhere more and can help fill gaps
- Assist with continuity – based on accessibility
- Help prevent and reduce the approx.. 25% of hospital admissions related to medication errors
- Lens of multiple therapy options for patients – help decrease barriers to medication access
- Clinical pharmacist role opportunity to expand health promotion, chronic disease management, patient education, de-prescribing etc.

Dietetics

Dietitians are "legally recognised as nutrition experts and are qualified to provide medical nutrition therapy for the prevention, delay and management of disease. Dietitians are uniquely trained to provide nutrition care along the entire continuum of health – from well, active individuals, of all ages, looking to

[59] Canadian Pharmacists Association, https://www.pharmacists.ca/pharmacy-in-canada/.
[60] Canadian Society of Hospital Pharmacists, https://www.cshp.ca/excellence.

improve their eating habits, to critically ill patients needing intensive medical nutrition therapy, and all stages in between."[61]

Dietitians identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

- Importance of food and its sensory input for seniors
- Importance of fostering community eating to combat isolation
- Addressing nutrition deficiencies
- Energy and mood
- Micronutrients/chemical imbalance
- Individual recommendations
- Common thread: often work with other HSPs, especially social worker
- Identify needs other professions can address and communicate
- Isolation and depression
- Role of family
- Eating well helps with prevention
- Medications have side effects (e.g. weight gain) and dietitians can help work with patients to address
- Help treat and support patients with eating disorders

Music Therapy

A Music Therapist "assesses the client(s) and creates a clinical plan for treatment in conjunction with team and client goals, which in turn determines the course of clinical sessions [within] within a client-centred, goal-directed framework. Music Therapy research and clinical practice have proven effective with people of all ages and abilities whether a person's challenges are physical, emotional, spiritual or psychological, music therapy can address a person's needs."

Music Therapists identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

- Using the innate ability of music to create social connection
- Patients/clients often can't or are unwilling to talk or engage in talk therapy and music provides connection, emotional release
- Non-threatening form of therapy
- Creates sense of community
- Increases engagement
- Important role working with seniors with dementia – e.g. "music and memory" program

Art Therapy

Art Therapy "combines visual art and psychotherapy in a creative process using the created image as a foundation for self-exploration and under-standing. Thoughts and feelings often reach expression in images rather than in words. Through the use of art therapy, feelings and inner conflicts can be

[61] College of Dietitians of British Columbia, http://collegeofdietitiansofbc.org/home/employers-the-public.

projected into visual form. In the creative act, conflict is re-experienced, resolved and integrated. Art therapy can be used with individuals, groups, or families as either a primary or adjunctive therapeutic mode in clinical, educational and rehabilitative settings. People of all ages can benefit from art therapy and previous art experience is unnecessary as the focus is on personal expression."[62]

Speech-Language Pathology and Audiology

Speech-Language Pathologists are legally recognized "professionals who have training and expertise in evaluating, diagnosing, and treating a wide range of speech, language, communication, and swallowing disorders. SLPs work with people of all ages, from newborns to seniors." Audiologists "work with individuals of all ages, from infants to seniors. Audiologists have training and expertise in evaluating, diagnosing, and treating a wide range of hearing and balance disorders."[63]

Registered Psychiatric Nursing

Registered Psychiatric Nurses (RPNs) legally recognized "nurses whose education and practice have a focus on psychosocial, mental or emotional health. They care for people of all ages experiencing issues related to mental health, substance use or behavioural addictions. RPNs have been an important part of BC's mental health care system since the early 1930s and form a majority of the nursing workforce in mental health and addictions."[64] HSA represents many RPNs in BC's public health care system who are integral members of interprofessional mental health and addictions teams in primary and community care settings.

Registered Psychiatric Nurses identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

- Psychosocial support
- Holistic approach to care
- Specialized training in mental health and communication
- RPNs increasing role in support to frail seniors (in all settings)
- RPNs facilitate communication with families (both in hospital and community)
- Recognize needs and make referrals
- Advocate for frail (vulnerable) individuals who feel they don't have a voice

Respiratory Therapy

Respiratory Therapists are "vital members of the health care team [and] provide a variety of therapeutic patient care, diagnostic, technical, education research, [and] administrative services. Respiratory Therapists are on the front lines in the fight against lung disease by assisting physicians in the diagnosis of lung disease through lung function testing, invasive and non-invasive cardio-pulmonary monitoring techniques, and bronchoscopic examination of the lungs by direct visualization, following up the care of patients in home and primary care settings, and promote wellness in several ways [including] patient

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[62] British Columbia Art Therapy Association, http://bcarttherapy.com/bcata/about-bcata/what-is-art-therapy/.
[63] Speech and Hearing BC, http://speechandhearingbc.ca/professional/careers/.
[64] College of Registered Psychiatric Nurses of BC, http://www.crpnbc.ca/wp-content/uploads/2011/02/CRPNBC_Brochure-web.pdf.

education programs, chronic obstructive pulmonary disease (COPD) rehabilitation programs and smoking cessation and prevention programs."[65]

Respiratory Therapists identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues as well as challenges facing their profession in public practice settings:

- Using knowledge of resources to empower and increase internal locus of control in improvement of quality of life (health promotion/prevention and education)
- Respond to clients when they are in crisis
- Therapeutic approach to relationship
- Challenges having sufficient time to build rapport with clients due to workload and staffing

Psychology

Psychologists are legally recognized professionals, educated at the PhD level, who "see people of all ages and may work with individuals, couples, families or groups. Many psychologists focus on psychological treatment; however others provide both treatment and assessment services."[66] Psychologists have specialized training and knowledge and may train and work in the following areas: clinical psychology; counselling psychology; neuropsychology; rehabilitation psychology; child psychology; geriatric psychology; and forensic psychology.

Psychologists identified the following roles and contributions of their discipline especially for seniors with frailty and patients with mental health and substance use issues:

- Providing leadership in MHSU services
- Providing training supervision
- Providing program development and evaluation
- Direct service: evidence based assessments – diagnosis and treatment
- For frail seniors
  - Assessment
  - Identifying and assessing emerging dementia
  - Anxiety and depression
- For substance use and mental health clients/patients
  - Evidence-based research design and program evaluation
  - Demonstrating outcomes with evidence on system-wide research initiatives

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[65] BC Society of Respiratory Therapists, http://bcsrt.com/education/the-rt-profession/.
[66] BC Psychological Association, https://www.psychologists.bc.ca/faq/what-do-registered-psychologists-do.

Appendix B: Workshop II – Barriers and enablers for health science professionals working on teams

The second workshop provided HSPs an opportunity share how they participate on multidisciplinary teams so that government and health authority decision-makers would have a better understanding of how HSPs participate on multidisciplinary teams, and the enablers and barriers to effective interprofessional teamwork.

In each table group, frontline practitioners were asked to share and discuss the following questions:

1. What program/team do you work on, and who are your patients/clients?
2. What are some of the enablers that make your team effective?
3. What were some of the challenges/barriers?
4. How can your role and the roles of other HSPs be enhanced to improve the effectiveness of the team? How will this benefit patients?

Based on the roundtable discussions, barriers and enablers to effective interprofessional teamwork were identified at the individual, team, organization, and system levels (see next page).

Bold words to indicate barriers/enablers that were raised multiple times by HSA members. The enablers/barriers are captured below as originally stated during the workshop in an effort to maintain the message/meaning as intended by participants.

	Barriers	Enablers
Individual level	▪ **Workload**; staffing levels to ensure continuity of care, quality of care and maintaining standards of practice ▪ **Unable to attend rounds** ▪ **Lack of standardized documentation** ▪ Individual team members only focussing on their area of accountability ▪ It's crisis rehab only ▪ No time, no energy ▪ Occupational health and safety: all health care professionals experience various trauma ▪ Professionals forget they are human (care for patients comes before themselves) ▪ Lack of physical space	▪ Mentoring ▪ Not feeling powerless ▪ Trust/respect ▪ **Work to full scope, optimize scope, respect of scope** ▪ **Role clarity** ▪ Building relationships ▪ Communication with client on establishing goals ▪ **Less paperwork**/administration (e.g. RAI, PARIS) – leads to more clinical time for patients ▪ Reduce duplication in charting ▪ Effective use of technology for remote settings ▪ Built trust with physicians to allow referrals from multiple sources, not only physician driven (primary care) ▪ Need to support staff: staff want to hold the connection to clients but also need support; spiritual care; team events (e.g. fancy Fridays); join associations; informal support groups; celebrate the victories ▪ Education in interprofessional work ▪ **Make work more enjoyable** ▪ Sense of purpose for staff to practice their specialty ▪ Compensation

	BARRIERS	ENABLERS
Team level	▪ **Lack of co-location of services/team members** ▪ Team members may be co-located but does not automatically mean effective teamwork – needs to be supported ▪ Lack of physical space ▪ **Workload**; staffing levels to ensure continuity of care, quality of care and maintaining standards of practice ▪ Communication/info sharing ▪ Concern regarding limited resources ▪ What is culturally safe care within multi-professional team ▪ Inefficient process within team (i.e. charting or paper work) ▪ Gaps in services within team ▪ Lack of standardized documentation ▪ **Lack of full knowledge of each others' scope (role clarity)** ▪ **Not working to full scope** (e.g. OT/PT relegated to equipment) ▪ How do we plan for our teams? Scope of practice discussion at the team level ▪ **Lack of regular team meetings (due to cost pressures)** ▪ 'Team' of one – not actually working as a team ▪ Case managers are not experts in speciality (e.g. geriatrics) ▪ Watering down the health care provider roles – too much cross training – creates tension between professions ▪ Focus on acute care services ▪ Connecting with other teams/programs, knowing who is who across the region, leaders for the different programs ▪ Language barriers for patients in group sessions ▪ Territorial divisions	▪ Mentoring ▪ Mentality of "how do we get this done" vs "we don't do that" ▪ Collaboration ▪ Breaking down hierarchy ▪ Trust/respect ▪ Frontline clinicians involved in authentic change ▪ Group accountability ▪ Importance of teams not being insular but forming strong partnerships/networks ▪ Involving community ▪ **Co-location** ▪ **Clear communication structures** ▪ **Regular in-person team care planning meetings** ▪ **Optimize scope of practice** ▪ **Role clarity on the team**: understand team approach, trust in each discipline; identify the commonality; clear on what each discipline brings ▪ **Support *how* to work as a team** ▪ Education in interprofessional work ▪ **Respect unique roles/contributions of each health care provider/discipline** ▪ Learning among disciplines ▪ Robust communication system between agencies, i.e. discharge/transition planning team (acute→community) ▪ Understanding purpose and composition of units/teams ▪ Client centred approach ▪ Employee recognition ▪ Building relationships ▪ Communication with client on establishing goals ▪ Care plan for the caregivers ▪ Need a competent leader that can provide professional safety and that we are valued ▪ Openness of leaders that professionals still (always) need to continue to learn; "safe to learn" ▪ Use of practicums to train as part of team ▪ Multi-disciplinarity – all disciplines on teams

		▪ Talk about successes and losses ▪ Time to assess programs ▪ Need time to do fun stuff (e.g. used to do lunches, birthdays, etc.) ▪ Addition of behavioural specialist to team for complex patients (e.g. psychologist, neuropsychologist) ▪ Reduce duplication in charting ▪ Built trust with physicians to allow referrals from multiple sources, not only physician driven (primary care) ▪ Frontline team involved in developing referral process ▪ Example of St. Paul's Hospital Complex Pain Clinic ▪ Responsive to individual needs ▪ Patient high users of health care system ▪ Pacing (to celebrate successes) ▪ Can't get into clinic unless they have exhausted all other support ▪ Old self vs new self: goal is to live functional life; patient education is critical; can't take away medicine and not replace it with some alternative ▪ One-stop shop/no wrong door ▪ Involvement of peer supporters are critical ▪ Helping patients with self-management resources ▪ Team rooted in social determinants of health ▪ Cultural fluency is a key attribute of team-based care

	BARRIERS	ENABLERS
Organization (health authority) level	▪ **Recruitment and retention** ▪ Lack of physical space ▪ Communication/info sharing ▪ Concern regarding limited resources ▪ Recruiting human resources to team specifically in rural areas/unavailable resources ▪ Working in silos, disconnect between agencies ▪ Lack of standardized documentation ▪ Need for better access to technology (PARIS) and ability to share care-related data ▪ Systems different within services and between health authorities ▪ Cost-benefit – no understanding of impact of preventive approach; budget constraints ▪ Staffing levels to ensure continuity of care, quality of care and maintaining standards of practice ▪ Barriers to accessing particular health science disciplines when referring clients to other service when outside of program scope, specifically OT, PT, counsellors, psychologists, dietitians ▪ Need to broaden the professions that are having the conversation re: role contribution to care model ▪ Spans of control do not enable support to assure health care provider is “safe” ▪ Watering down the health care provider roles – too much cross training – creates tension between professions ▪ It’s crisis rehab only ▪ Professionals forget they are human (care for patients comes before themselves) ▪ Resourcing appropriate levels (including leadership) and accessible leadership ▪ Health authority demands for data to justify money gets in the way of effective care ▪ Lack of integration and linkages: could make better connections between programs	▪ Collaboration ▪ Breaking down hierarchy ▪ Trust/respect ▪ Time away from frontline practice for team and relationship building ▪ Respect of each health care provider role/unique contribution ▪ Frontline clinicians involved in authentic change ▪ Importance of teams not being insular but forming strong partnerships/networks ▪ Identify the evolving needs of the community ▪ Robust communication system between agencies, i.e. discharge/transition planning team (acute→community) ▪ Robust feedback loop to staff and physicians ▪ Employee recognition ▪ **Need to support staff**: staff want to hold the connection to clients but also need support; spiritual care; team events (e.g. fancy Fridays); join associations; informal support groups; celebrate the victories ▪ Increase corporate wellness initiatives ▪ Building relationships ▪ Education of managers, directors of care, policymakers ▪ Education in interprofessional work ▪ Talk about successes and losses ▪ **Sharing success stories** helps promote multidisciplinary teams ▪ Openness of leaders that professionals still (always) need to continue to learn; “safe to learn” ▪ Investment in the program from all involved from governance level to staff level (top-down, bottom-up) ▪ Co-location of health and community social services ▪ Effective use of technology to expand reach to remote settings ▪ How to we attract and retain to public sector? **Scope of practice** a big issue

	▪ HSPs often too few and part-time	▪ **Clear and standardized clinical/care pathways with support for patient along journey**: Need to improve ability to refer to services – figuring out how to connect people to the service they need is too big of a part of the job – the path to services should not be so complex
		▪ Policy development and implementation of team-based primary care approaches needs to be based more on collaborative teams and frontline expertise
		▪ Improved service capacity planning: better understanding and managing demand for services. What is the capacity for transitions? Acute→community, youth→adult, adult→senior
		▪ Keep open mind to new/innovative programs
		▪ Increase funding for program evaluation
		▪ Lesson from Rapid Access Addiction Clinic (Providence Health Care)
		  ▪ Importance of self-referral
		  ▪ Links between programs are as important as the programs themselves
		  ▪ Upstream social determinants of health impact efficacy of health service: e.g. lack of stable housing impacting ability of patients to stay on medication (OAT)
		▪ One-stop shop/no wrong-door
		▪ Improved connection between programs serving similar patients (e.g. Rapid Access Addiction Clinic and pain management programs)
		▪ Publicly funded psychologist services
		▪ Increasing community services inpatient can refer to
		▪ Reduce territorial divisions

	BARRIERS	ENABLERS
System level	▪ **Recruitment and retention of HSPs** specifically in rural and remote ▪ Not a lot of **human resources planning** occurring ▪ HSPs often too few and part-time ▪ Not enough people being trained in the professions, and then retaining professionals ▪ Community can't always do it – lack of resources and not enough funding for prevention ▪ Working in silos, disconnect between agencies ▪ Fragmented communication/health record system; lack of standardized documentation; shared charting system (1 EMR) ▪ Systems different within services and between health authorities ▪ Cost-benefit – no understanding of impact of preventive approach; budget constraints ▪ Lack of access to/availability of services in public system (financial barriers to clients to access private care) ▪ Need to broaden the professions that are having the conversation re: role contribution to care model ▪ It's crisis rehab only ▪ Complexity of patients is increasing (aging population) ▪ Substance use care needs to be seen as part of primary care	▪ Identify the evolving needs of the community ▪ Employee recognition ▪ Education of managers, directors of care, policymakers ▪ Identifying better systems for data collection and that communicate between them for better access ▪ Respect of each health care provider role/unique contribution ▪ Importance of trust: between team members; in the system (e.g. is this another initiative); in the leadership (keep the momentum going) ▪ Education in interprofessional work ▪ Patient-centred: patients/clients have to feel they have a contribution to make and can be heard ▪ Effective use of technology for remote settings ▪ Need more interprofessional discussion/dialogue re solutions: how do we bring everyone together? Who convenes these voices? They all have a contribution to make: HSPs, nursing, physicians ▪ Consistent understanding of where we're going – supporting staff/leadership in the transformation ▪ Education/teaching for primary care providers so they know how to support patient self-management of condition ▪ Work with educational institutions ▪ Keep open mind to new/innovative programs ▪ Increase funding for program evaluation ▪ Increase communication across unions ▪ Look at funding to reduce so many pilots and move to permanent changes ▪ Respite care challenges: lack of respite for caregivers; lack of respite beds; cuts to home support for respite; caregivers may end up in hospital ill due to lack of resources

		▪ Integration of staff from different Ministries
		▪ Better support patients who are waiting for surgery
		▪ More integrative approach to planning
		    ▪ Funding to go to entity that is more accountable and multidisciplinary rather than just Divisions of Family Practice
		    ▪ Include providers, policymakers, administrators, researchers, communities

Appendix C: Conference Attendees

Name	Affiliation
Adam Lynes-Ford	Campaigner, BC Health Coalition
Amanda Murphy	Director of Regulations, BC Therapeutic Recreation Association
Andrew Longhurst	Researcher and Policy Analyst, Health Sciences Association of BC
Anne Davis	Director, Board of Directors, Island Health
Ben Ridout	Director, Patient and Public Engagement, BC Patient Safety and Quality Council
Buffy Bindley	Registered Psychiatric Nurse, Providence Health Care
Carol Riviere	Communications Officer, Health Sciences Association of BC
Cayce Laviolette	Social Worker; Patient Navigator/Project Manager, Sunshine Coast Division of Family Practice
Chiara Singh	Physiotherapist; Greater Vancouver/Sunshine Coast Director and Public Practice Liaison, Physiotherapy Association of BC
Chris Petrus	Physiotherapist; Home ViVE Program, Vancouver Coastal Health
Cindy Roberts	Consultant and former Health Authority Administrator; Co-Founder, OASIS Program and Richmond Hip and Knee Reconstruction Project, Vancouver Coastal Health
Debra Gillespie	Social Worker, Island Health
Dianne Heath	Executive Director, BC Association of Social Workers
Donna Wilson	VP of People, Performance & Lower Mainland Labs, Provincial Health Services Authority
Edward Staples	President, Support Our Health Care Society Princeton; Lead, BC Rural Health Network
Edith MacHattie	Occupational Therapist; Co-Chair, BC Health Coalition
Elise Durante	Social Worker, Granville Foundry, Providence Health Care
Evan Howatson	Director, Labour Relations, Ministry of Health
Gina McGowan	Director, Research Translation and Knowledge Mobilization, Ministry of Mental Health and Addictions
Giovanna Boniface	Occupational Therapist; Managing Director of Professional Affairs, CAOT-BC
Heather McAdie	Registered Psychiatric Nurse, Providence Health Care
James Benson	Recreation Therapist, Fraser Health Authority
Jared Hurdman	Social Worker, Vancouver Coastal Health Authority
Jay Slater	Family Physician; Medical Director, Home ViVE, Vancouver Coastal Health
Jennifer Gilchrist	Recreation Therapist, Vancouver Coastal Health Authority
Jim Sinclair	Board Chair, Fraser Health Authority

Joanna Richards	Director, Primary Health Care, Ministry of Health
Hon. Judy Darcy	Minister of Mental Health and Addictions
Kathy McLennan	Director of Operations and Strategic Priorities, Health Sciences Association of BC
Kaye Robinson	Social Worker, Rapid Access Addiction Clinic, Providence Health Care; Social Work Fellow, BC Centre on Substance Use
Kevin Lowe	Director, Strategic Policy, First Nations Health Authority
Kimberlyn McGrail	Associate Professor, UBC School of Population and Public Health; Faculty, UBC Centre for Health Services and Policy Research
Kiran Ahuja	Respiratory Therapist, Fraser Health Authority
Kirsten Duncan	Social Worker, Island Health
Kristina Brown	Regional Resource Neuro Rehab Physiotherapist, Island Health
Lorrie Cramb	Director, Education and Training, Ministry of Health
Louise Stevens	Manager, Professional Practice, Island Health
Lynn Pelletier	VP, Mental Health & Substance Use Services, Provincial Health Services Authority
Marcy Cohen	Research Associate, Canadian Centre for Policy Alternatives - BC Office
Margaret McGregor	Family Physician, Home ViVE; Clinical Associate Professor, Department of Family Medicine, UBC
Margi Blamey	Director, Board of Directors, Fraser Health Authority
Marilyn Chotem	President, BC Psychological Association
Martin Zakrzewski	Vice President, BC Psychological Association; Director of Psychology, BC Mental Health and Substance Use Services
Melanie Finley	Manager, Policy and Planning, Strategic Planning, Partnership and Research, Ministry of Mental Health and Addictions
Michael Marchbank	CEO, Fraser Health Authority
Miriam Sobrino	Director of Communications and Member Development, Health Sciences Association of BC
Nancy Chow	Clinical Nurse Leader, Rapid Access Addiction Centre (RAAC), Providence Health Care
Nienke Klaver	Secretary, Support Our Health Care Society Princeton
Pam Mulroy	Executive Lead, Primary and Community Care, Northern Health
Patricia-Jean Lynd	Physiotherapist, Providence Health Care
Perry Omeasoo	First Nations Mental Health Liasion, Vancouver Coastal Health
Rita McCracken	Family Physician; Primary Care Researcher; Associate Head, Dept. of Family Medicine, Providence Health Care
Rupinder Brar	Primary Care and Addictions Physician, PHS Community Services Society

Sarah Buddingh Smith	Physiotherapist, Complex Pain Clinic and Providence Residential Care, Providence Health Care
Shana Ooms	Executive Director, Primary Care, Ministry of Health
Shannon Nesbitt	Music Therapist, Fraser Health Authority
Shelley Tice	Project Director, Community Health and Care, Island Health
Sheri Steffen	Recreation Therapist, Fraser Health Authority
Sherry Hamilton	Chief Nursing & Liaison Officer, Provincial Health Services Authority
Stephanie Moccia-Bythell	Pharmacist, Fraser Health Authority
Sylvia Funk	Dietitian; Member Representative, Dietitians of Canada - BC Region
Tamar Koleba	President, Canadian Society of Hospital Pharmacists - BC Branch
Tammam El-Khodor	Occupational Therapist, Providence Health Care
Val Avery	Physiotherapist; President, Health Sciences Association of BC
Vickie Lau	Clinical Nurse Leader, Immunodeficiency Clinic, St. Paul's Hospital
Yasmin Jetha	VP, Community Services, Vancouver Coastal Health

Appendix D: Conference Program

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HSA is the union delivering mental health care in BC

A diverse range of health professionals represented by HSA provide multidisci-plinary mental health and addictions care in hospitals and team-based community health programs throughout BC.

PREVENTION

Outreach teams identi-fy individuals at risk in schools, in community, on streets and connect them with:

MENTAL HEALTH AND ADDICTIONS OUTREACH
based in the community

- Outreach Support Worker
- Counsellor
- Social Worker
- Pharmacist
- Case Manager
- Registered Psychiatric Nurse
- Dietitian
- Family Support Worker
- Child and Youth Clinician

TREATMENT

Emergency room or family doctors refer individuals in immedi-ate distress to:

ACUTE PSYCHIATRIC CARE
based in hospitals

- Registered Psychiatric Nurse
- Psychologist
- Social Worker
- Child and Youth Clinician
- Pharmacist
- Occupational Therapist
- Music Therapist

RECOVERY

Hospitals and doctors refer individuals needing support to:

COMMUNITY MENTAL HEALTH CARE TEAM
based in the community

- Mental Health Clinician
- Psychologist
- Social Worker
- Counsellor
- Dietitian
- Case Manager
- Recreation Therapist
- Art Therapist
- Occupational Therapist

hsabc.org

ACHIEVING HIGH-PERFORMING PRIMARY AND COMMUNITY CARE: THE CRITICAL ROLE OF HEALTH SCIENCE PROFESSIONS

April 13, 2018
Hyatt Regency
655 Burrard Street, Vancouver
Plaza AB Ballroom

CONFERENCE AGENDA

8:00 am	Registration and Continental Breakfast
8:30 am	Conference Opening and First Nations Welcome Elder Roberta Price Nicki Kahnamoui, Independent Consultant and Facilitator Val Avery, HSA President
9:00 am	Opening Remarks Honourable Judy Darcy, Minister of Mental Health and Addictions
9:20 am	Achieving a system of high-performing primary and community care in BC: the case for change Andrew Longhurst, HSA Researcher and Policy Analyst
9:45am	Workshop - Understanding the critical role of each discipline in primary and community care
10:30am	Break
10:45am	Multidisciplinary Care I Promising models of care: the role of health science professionals on primary and community care teams in BC Cayce Laviolette, Social Worker Cindy Roberts, Consultant and OASIS Co-Founder Chris Petrus, Physiotherapist, Home ViVE Elise Durante, Social Worker and Clinical Coordinator of Providence Health's Inner City Youth Program Yasmin Jetha, VP, Community Services, Vancouver Coastal Health Facilitator: Edith MacHattie, Occupational Therapist and BC Health Coalition Co-Chair

Cindy Roberts

Cindy Roberts is an innovative and strategic professional with extensive experience and significant leadership accomplishments in non-profit organizations. While at Vancouver Coastal Health, she implemented The Osteoarthritis Service Integration System (OASIS) program and co-lead the Richmond Hip & Knee Reconstruction Project.

The fostering of collaborative environments through engagement and partnership development facilitated the success of these programs. Cindy currently works as a consultant. An advocate for active living, she is on the Board of Directors for the Richmond Fitness and Wellness Association and is Race Director for a Trail Race Series on the North Shore. She completed her MA in Leadership at Royal Roads University, preceded by her Bachelors in Liberal and Business Studies at Simon Fraser University.

Kaye Robinson

Kaye Robinson is a registered social worker with Providence Health Care's Rapid Access Addiction Clinic (RAAC) based at St. Paul's Hospital in Vancouver. Kaye graduated in 2014 with a Master of Social Work from the University of British Columbia and has experience working on interdisciplinary health care teams across mental health, substance use, and acute care. She is looking forward to entering into the BC Centre for Substance Use Social Work Fellowship Program commencing in July 2018 to continue her growth in evidence-based social work practice with people who use substances.

Marcy Cohen

Marcy has been involved in social justice work as a professional and volunteer for most of her adult life. She has over 35 years of experience working as a health and social policy researcher and educator. Her research has focused primarily on community health restructuring, strategies for improving public health services, and workforce equity issues. Now retired, Marcy continues to support the work of the Canadian Centre for Policy Alternatives. Most recently, she led the Raising the Profile Project, which has been instrumental in raising the profile of the community-based senior services sector across BC.

Adam Lynes-Ford

Adam is the campaigner with the BC Health Coalition and has over a decade of experience as an organizer and strategist for an improved public health care system. He serves as co-chair of the Catherine White Holman Wellness Centre, a community-run centre that provides low-barrier services to trans and gender diverse people. He worked for several years as a support worker in emergency and supportive housing. Adam has served with many education, public health and environmental organizations including YouthCO AIDS Society and the Coalition to Build a Better BC.

Edith MacHattie

Edith sits on the steering committee of the BC Health Coalition as a representative for her union, HSA, and has been an elected co-chair of the BCHC since 2014. She is an occupational therapist who works at a child development centre in the Lower Mainland with school-aged children and their families. One of Edith's passions is creating safe and accessible spaces for people to feel a sense of belonging in their community. She is now on maternity leave with her son Theo.

11:40am	Workshop - Understanding the critical roles of health science professionals on teams
12:30-1:30	Lunch and networking
1:30pm	Multidisciplinary Care II Frontline stories on the overdose crisis and strengthening team-based addictions care Dr. Rupinder Brar, Primary Care and Addictions Medicine Physician, PHS Community Services Society Kaye Robinson, Social Worker, Rapid Access Addiction Clinic Sarah Buddingh Smith, Physiotherapist, Complex Pain Clinic Sheri Steffen, Recreation Therapist, Rehabilitation and Recovery Services Tammam El-Khodor, Occupational Therapist, Community Rehabilitation and Resource Team Facilitator: Nicki Kahnamoui, Independent Consultant and Facilitator
2:15pm	Break
2:30pm	Achieving team-based primary and community care in BC: overcoming health system barriers Adam Lynes-Ford, BC Health Coalition Dr. Margaret McGregor, UBC Department of Family Medicine Pam Mulroy, Northern Health Authority Kimberlyn McGrail, Associate Professor, UBC Facilitator: Marcy Cohen, Health Policy Analyst
4:00 pm	Concluding remarks Andrew Longhurst, HSA Researcher and Policy Analyst Val Avery, HSA President

ABOUT THE SESSIONS

Achieving a system of high-performing primary and community care in bc: the case for change

HSA researcher and policy analyst Andrew Longhurst will deliver a brief summary of the evidence supporting improved primary and community care to meet the needs of frail seniors and mental health and substance use clients. This session will discuss the role of health science professionals on interprofessional teams in achieving a high performing primary and community care system, and how the Ministry of Health policy directions seek to achieve this.

Understanding the critical role of each discipline in primary and community care

In this workshop, participants will develop an increased understanding of the unique role each health science profession has to offer seniors experiencing frailty and patients experiencing mental health and substance use challenges.

Multidisciplinary Care I
Promising models of care: the role of health science professionals on primary and community care teams in BC

In this panel discussion, participants will learn about existing and promising models of team-based primary and community care in BC, and the important roles of health science professionals on these teams.

Kimberlyn McGrail

Kimberlyn McGrail is an associate professor at UBC in the School of Population and Public Health and the Centre for Health Services and Policy Research. She is also scientific director of Population Data BC and data director for the new BC Academic Health Sciences Network. Her research interests are quantitative policy evaluation, aging and the use and cost of health care services, and the ethical and technical aspects of the development and operation of large linked data systems. Her research is conducted in partnership with clinicians, policymakers and the public. Kim is a founding member of the International Population Data Linkage Network and founding deputy editor of the International Journal of Population Data Science. She was the 2009-10 Commonwealth Fund Harkness Associate in Health Care Policy and Practice, a 2016 recipient of the Cortlandt JG Mackenzie Prize for Excellence in Teaching, and 2017 recipient of a UBC award for Excellence in Clinical or Applied Research.

Dr. Margaret McGregor

Dr. Margaret McGregor is a family physician who worked at Mid-Main Community Health Centre for 25 years. She currently works with a multidisciplinary home-based primary care service for seniors unable to access usual primary care due to advanced frailty (Home ViVE). She is the director of the UBC Department of Family Practice, Community Geriatrics, a research associate with the VCHRI’s Centre for Clinical Epidemiology & Evaluation and the UBC Centre for Health Services & Policy Research, and recently appointed to the Vancouver Coastal Health board.

Nicki Kahnamoui

Her tombstone will most likely read: “she made things happen.” It will also say something about her strong sense of integrity and contagious enthusiasm. With over two decades of experience in strategic and operational planning and implementation, Nicki Kahnamoui partners with mission-driven organizations in envisioning, realizing, and improving new and existing projects, programs, and processes. She is currently the director of strategic initiatives at Pain BC. Nicki has worked in the public, private, and not-for-profit sectors, in various industries and different countries. She has an MA in interdisciplinary studies, a Project Management Professional certificate as well as a certificate in Dialogue and Civic Engagement. She spends the rest of her time painting at her arts studio in East Vancouver. Nicki is facilitating the conference as an independent consultant and facilitator.

Yasmin Jetha

As vice-president, community services, Yasmin plays a pivotal role in the planning and transformative changes necessary to achieve Vancouver Coastal Health's vision for a new, integrated model of primary and community care. She oversees six regional program leadership teams - primary care, home health, end of life, mental health & substance use, residential care, and medicine. Yasmin brings a wealth of leadership experience in clinical operations and the implementation of complex system changes to the position. She joined the VCH senior executive team in September 2017. Most recently, she was the regional program director of palliative/end of life care and the director of home, community and palliative care within Vancouver Community. Yasmin holds a Master of Social Work and Health Administration degree from UBC.

Yasmin was nominated in 2015 for a BC Premier's Award for her work on a multi-system response to addressing the needs of individuals dealing with mental health and substance use issues.

Understanding the critical roles of health science professionals on teams

In this workshop, participants will discuss their roles on multi-disciplinary teams to gain a better understanding of how different professions work together.

Multidisciplinary Care II
Frontline stories on the overdose crisis and strengthening team-based addictions care

Frontline clinicians who provide addictions prevention, treatment, and recovery will share their knowledge and observations from the frontlines, and discuss opportunities to improve team-based addictions care, within the context of the overdose crisis. Panelists will also explore the silos that exist between physicians and health science professionals working together in addictions care.

Achieving team-based primary and community care in BC: overcoming health system barriers

Panelists will identify and discuss solutions to existing health system barriers to interprofessional team-based care. Through an interactive discussion format, panelists and attendees will explore concrete ideas for overcoming these barriers in a way that will ensure that current primary care transformation efforts build a strong and lasting foundation for quality improvement and system change.

OUR SPEAKERS

Hon. Judy Darcy

Judy Darcy was appointed British Columbia's first and Canada's only Minister of Mental Health and Addictions in July 2017. Minister Darcy has committed her career to building strong and vibrant communities, and has earned a reputation as an effective and compassionate leader. As a tireless advocate, she has spent much of her life working to improve health care, seniors' care, education and child care for British Columbians. She is committed to bringing people together to find innovative solutions to the issues that affect families to improve their lives.

As Minister of Mental Health and Addictions, she has taken urgent action to combat the devastating overdose crisis that is affecting families and communities across the province, including increasing the number of overdose prevention and supervised consumption sites and access to naloxone, and expanding treatment and recovery options. She is also forging ahead with her work to create a seamless and coordinated mental health and addictions system in British Columbia, so people can get the help they need, when they need it.

Minister Darcy has served in the B.C. Legislature since she was elected as a Member of the Legislative Assembly for New Westminster in May 2013. She served as the official opposition spokesperson for Health until her re-election in May 2017. During that time she championed many issues, including the initiative to establish a clinic for adult survivors of childhood cancer.

Minister Darcy also served as national president of the Canadian Union of Public Employees, Canada's largest union. She was the only woman to lead a national union for many years. Later, as secretary business manager for the Hospital Employees Union in B.C., Minister Darcy led negotiations that led to a historic settlement that established collective bargaining as Charter-protected rights for the first time for B.C. healthcare workers in 2008.

Dr. Rupinder Brar

Dr. Rupinder Brar, MD, CCFP, CSIAM, is a Canada Addiction Medicine Research Fellow with the BC Centre on Substance Use and a primary care and addictions medicine physician with the PHS Community Services Society in the Downtown Eastside. She also works as an Addictions Consultant at St. Paul's Hospital and Surrey Memorial Hospital and as a Clinical Instructor with the Department of Family Practice at the University of British Columbia.

Sheri Steffen

Sheri received her masters from UBC in 2015 and has worked in the field of therapeutic recreation (TR) for 28 years. The last 19 years she has worked in the area of mental health and substance use services within the Fraser Health Authority. She has worked in both adult and youth and young adult services and has experience with a continuum of services from acute psychiatry, tertiary, day treatment programs, and community outreach services. Currently, Sheri works as an outreach recreation therapist assisting young adults to develop the skills necessary to achieve their full potential through a positive leisure lifestyle and community integration. She is a member of the BC Therapeutic Recreation Association Board of Directors where professional development, education and research are her passions. She is a member of the Standards of Practice committee for the Canadian Therapeutic Recreation Association. She believes that it is important to have evidence-based research to support and advance the TR profession. She has published a research studying on clinical decisionmaking and has presented education sessions on a national level.

Tammam El-Khodor

Tammam holds a Bachelor of Science in Social Sciences, a Bachelor of Science in Occupational Therapy, and master's degree in rehabilitation science. He has been practicing as an occupational therapist for 18 years. He worked in diverse clinical settings including acute care, ICU, outpatient, and homecare, and has advanced training and expertise in neurological rehabilitation. He was a faculty lecturer for the School of Physical and Occupational Therapy at McGill University. His leadership roles included establishing occupational therapy service on the neurological surgery team and collaborating on developing an interdisciplinary protocol for spinal cord and brain injured patients at the Jewish General Hospital in Montreal. Presently, he works on the VCH Community Rehab and Resource Team, providing community-based neurological rehabilitation and consultation to community home service and supportive housing regarding complex patients and their transition to more independent living environments.

Sarah Buddingh Smith

As a physiotherapist at the St. Paul's Hospital Complex Pain Clinic, Sarah uses movement and mindfulness to help people living with chronic pain reconnect to meaningful activities and relationships. She holds a master's degree in physical therapy, as well as a Bachelor of Science in Molecular Biology. With Providence Health Care, she works at St. Vincent's Langara Residential Care, the Alder Tertiary Neuropsychiatry Program and the St. Paul's Inpatient Mental Health Program. Sarah believes that building client self-efficacy requires the expertise of diverse professionals working as a team. As clinical faculty with the UBC Department of Physical Therapy, she regularly takes students for placements, serves on the Indigenous Advocacy Committee and is a member of the Fred Bryan's Master Teacher Program. With Pain BC, she serves on the Self-Management Working Group and is collaborating with Live Plan Be to develop resources for people living with chronic pain.

Elder Roberta Price

Coast Salish, Snuneymuxw (pronounced Sna-Neigh-Mu) and Cowichan Nations

Roberta is the mother of four children and grandmother to eight beloved grandchildren. She has worked for many years as an Elder for the Richmond, Delta & Burnaby school districts, where she has facilitated cultural teaching circles in schools for 32 years. She is also frequently called to support adult learners at the UBC Learning Exchange in Vancouver's Downtown Eastside.

Roberta works closely with the Aboriginal Wellness Program at Vancouver Coastal Health where she is the elder-in-residence and works with the Aboriginal Patient Navigators Program to support patients in many Vancouver Coastal Health hospitals and health care centres. She also provides traditional services and healing services for the Elder Visiting Program at BC Women's and Children's Hospital and at St. Paul's Hospital.

Roberta has worked with the UBC School of Nursing as an adviser/research partner and elder for over 10 years, providing Indigenous leadership and support on research projects about women's intimate partner violence, mental health, and equity. She is currently a co-principal investigator on a large CIHR-funded study to improve care for Indigenous people in emergency units. She is the elder for Critical Research in Health and Health Care Inequities (CRiHHI) School of Nursing at UBC and also sits as an elder on the National Indigenous Council on Diabetes. Roberta has accepted the position as Indigenous co-Lead elder at UBC School of Family Medicine and is recognized as a part-time adjunct clinical professor for UBC School of Family Medicine as of July 1, 2017.

Pam Mulroy

Pam Mulroy is the Executive Lead, Primary and Community Care with Northern Health. In her work, Pam provides strategic support to the implementation and development of an integrated system of primary and community care services across the Northern Health region. Northern Health started implementing a team based system of services in three prototype communities in 2012 and has since launched similar models of service across the Northern Health region. Pam calls Prince George, B.C. home and enjoys all that the north has to offer.

Val Avery

Val Avery has been president of HSA since September 2013. A union member for 35 years, she served as union's vice president since May 2009. Avery has been the chair the Health Science Professionals Bargaining Association, which negotiates on behalf of 18,000 health science professionals working in BC's public acute and community health care facilities. Avery is a physiotherapist at Royal Jubilee Hospital in Victoria, most recently working in the outpatient orthopaedic clinic. She is a strong advocate for health science professionals and the public health care system, and is committed to speaking up for quality and accessible health care and community services, and respect for the people who deliver these services.

Cayce Laviolette

Cayce is a social worker with over 15 years experience in community and acute mental health and urgent care. Starting out in emergency shelters and outreach teams in Vancouver's Downtown Eastside, Cayce soon moved to a street HIV clinic with Vancouver Coastal Health. His work led to the creation of STOP teams and new standards of practice for social workers in the field of HIV. Around the same time, Cayce partnered with UBC, the Vancouver Area Network of Drug Users, and the Safer Crack Use Coalition to pilot the distribution of safer crack kits in Vancouver. He worked with active users to develop a rapid education project that promoted harm reduction and engagement in health services.

Over the last 3 years Cayce has been working with the Division of Family Practice on the Sunshine Coast, supporting physicians and their patients address the social determinants of health. He is currently involved in the development of an emergency homeless shelter in Gibsons, BC, after playing a key role in getting one open 7 nights a week in Sechelt two years ago.

Elise Durante

Elise Durante is a registered social worker who works as the clinical coordinator of Providence Health Care's Inner City Youth Program, site of Foundry Vancouver Granville. Elise graduated with a master of arts in social work from the University of Chicago in 2006 and has over 10 years' experience working as a social worker in interdisciplinary teams – both in primary care and mental health & substance use services. Elise's clinical training and practice have centered on providing evidence and trauma-informed care for individuals and families with concerns related to mental health and substance use.

Andrew Longhurst

Andrew Longhurst, MA, is a researcher and policy analyst with HSA and a research associate with the BC Health Coalition and Canadian Centre for Policy Alternatives—BC Office. His research interests include health and social policy, poverty and inequality, and labour market change. His past publications include "Privatization and Declining Access to BC Seniors' Care"(2017) and "Reducing Surgical Wait Times: The Case for Public Innovation and Provincial Leadership" (with Marcy Cohen and Dr. Margaret McGregor, 2016), published by the CCPA–BC.

Chris Petrus

Chris graduated from the UBC Master of Physical Therapy program in 2006. He has worked across many areas of public health, from hospital, transitional care units, residential care, orthopaedic outpatient, and community care. He has been part of VCH's Home ViVE (Visiting Vancouver's Elders) program since 2011. Chris has worked in private physiotherapy clinics in the Lower Mainland as well as working in private community care with adults and seniors in home, gym and pool settings. He also had the opportunity to work in the geriatric inpatient/outpatient unit of Australia's largest private hospital in Brisbane.