South Island MSA

SOUTH ISLAND MEDICAL STAFF ASSOCIATION

Minutes
General Meeting – May 9, 2022
Virtual (Zoom)
Meeting 6:00-7:30pm

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1. **Call to Order at 6:01 pm** - Welcome by MSA Co-President Dr. Catherine Jenkins
    a. Welcome to special guests:
        - Annebeth Leurs – Engagement Partner, Doctors of BC
        - Alanna Black – Regional Advocate and Advisor, Doctors of BC
        - Dr. Ian Bekker
        - Dr. Ben Williams, Vice President of Medicine and Quality, and Chief Medical Officer
        - Kristine Votova – Director, Medical Staff Quality, Analytics and Clinical Improvement

    b. Approval and adoption of agenda and minutes

    c. Dr. Suresh Tulsiani has joined the SIMSA Executive team as Treasurer – welcome!

2. **Making your Island Health email work better for you** – Dr. Ian Bekker
    - Island Health email wasn't designed for physicians but had a lot of potential; secure, confidential, access to email address list to help find people, useful for care conferences, fax replacement

    - Five things we can do – Physician Email Enhancement & Management Portal https://apps.viha.ca/PEEMP/home
        - Email filter
        - Notification of emails to other email address
        - MOA shared email
        - Mobile access to email (Boxer – iPhones only currently)
        - Out office with alternate contacts

    - Questions:
        - With the firewalls and security the only way to get to email on Android phone is through Gateway, any plan for Boxer for Android?
            - Not as secure as Apple so no plan to include Android currently

        - Any suggestions re: merging Google & Island Health calendars?
            - Ian Bekker will look into it and can help you get set up

        - A lot of emails from Island Heath, are there opportunities to have "subscription feeds" with specific communication needs?
            - Emails that come through MSAs and Divisions are tailored to specific audiences

3. **Clinical Governance Improvement Initiative (CGII)** – Dr. Ben Williams
    - Recognizing how stretched the system is and the fundamental shift in the type of work
    - It takes time to make changes in large organizations, pandemic showed we can come together, be nimble to adapt and change quickly
    - CGII is about strengthening our organizational foundation for culturally-safe high-quality care, transparent and accountable decision making
    - Over 400 responses to CGII surveys; 47% of responses were from Medical Staff
    - What we've heard needs improvement:
        - Diversity patient/client perspectives
        - Proactive planning for person's experience
        - Shared improvement priorities
        - Sustainment of improvement initiatives
        - Clear CG roles and responsibilities
        - Perceived power imbalances professionally and geographically
        - Simple and transparent decision pathways including escalation and feedback loops
        - Support for QI and sustain improvement
        - Application of right data, at the right time
        - Rigorous auditing and reporting
        - Appropriate use of evidence and data sources

    - Current CG structures perceived as unclear, complex, hierarchical top down, and lack efficiency, accountability, transparency, and partner voice in health service planning
    - 48% of respondents indicate that when they've brought safety and quality concerns forward in the past, concerns were not addressed, or ideas didn't result in action
    - 46% of respondents do not believe their professional discipline has a voice in CG decisions
    - Perceived lack of standardization and/or alignment across programs, policies and GEOs
    - Worked to validate feedback with Deloitte; have robust Steering Committee including Medical Staff
    - Also heard there are good relationships in organization, connections within teams
    - Looked at leading practice organizations around the world using international standards
    - Organizations who do Clinical Governance well support continuous quality improvement and these leading practice themes
        - Patient/family voice at multiple levels of CG
        - Shared organization wide vision and plan for care with clear metrics of success
        - Streamlined/coordinated CG tables promote clear accountabilities/integration across system
        - Transparent, evidence informed decision making and proactive collaboration
        - Organization wide KPI with system wide reporting enables consistency, regularly prioritized
        - Appropriate and frequent communications and feedback with support
        - Non-punitive feedback and celebration towards goals
        - Inter-professional cross-continuum clinical planning
        - Leaders know what they are responsible for and who makes decisions

    - Aim by September 2022 - looking ahead to what the Leading Practices could look like at Island health
        - Identify top 5 improvement opportunities based on review of current state, local expertise, and leading international practice
        - Systems perspective that include all the clinical service setting and populations of focus
        - Focus on program planning, clinical policy, practice standards development and implementation

    - More focus groups to follow and repeat survey to be clear; can also give feedback to Ben directly via email

Questions from Medical Staff – Prepared and from Zoom chat:

- What is different about this redesign than other cyclical reorganizations?
    - Not changing organization structure; reorganizing how we make clinical decisions
    - Making things better than they are today, help people to hear back
    - Want to make it clear things like who approves order sets; help know who needs to be involved

- Are difference between Department and Division organization in scope?
    - Not in scope of this project; asked consulting firm when they get feedback on medical leadership structure to still capture it but adjusting medical leadership structure is a different undertaking

- Do we need fewer Medical Leaders who are better supported?
    - Yes, future project work

- Why choose this project first instead of bed occupancy crisis and capacity issues?
    - Capacity varies but is up everywhere, all hospitals are full
    - ER visits up across the board, admission rates from ER stable; LOS ebbs and flows
    - Provincial and National problem; this is a significant issue
    - Staffing (nurses, physios, physicians) – hard to find people, need to make it a good place to work; there is significant HR work being done and more training being done
    - This is a crisis, but focusing in on discharging patients is time limited, need to improve the system, decide what we offer and where, how we are setting up care pathways – need to have a way to make these decisions and have structures in place to make decisions more nimbly

- We are very middle management heavy, taking time away for meeting times, including operational leadership. Resources could be better spent on patient care and front line needs.
    - Important to use resources wisely
    - Not always clear on roles and responsibilities; some roles require a lot of meetings, need to have accountability structures without meetings
    - Want to use people as effectively as we can

- Implementation is limited traditionally by proper engagement and understanding local culture and human factors. What strategies does MAA plan to use to overcome these potential barriers for successful implementation?
    - Implementation has its own domain of science
    - Anything we do will involve change; defining ahead of time what will change by local context and how we need to engage
    - Need good pathways for decisions to get made or informal approvals continue
    - Patient Partners are heavily involved in steering committee and other work
    - Patient Partner on HAMAC asked why we involve them at the end just for approval, it is not engagement. Trying for further than partners but having their involvement in design

- Witnessed things move nimbly and effectively at the beginning on the pandemic, beside MoH mandate what allowed this quick movement and decision making?
    - Necessity – things changed quickly because we had to, there was no choice
    - Crisis part of it, money was part of it too but the message was “do what needs to be done”

  - Needed to change overnight; EOC structure met daily, someone from each department in the room. Decisions were being made quickly with a structured decision making template, allowed incredible speed in decisions
  - Don't know what the end Clinical Governance structure will look like, but taking all we learned into account. Speed and nimbleness, transparency, people knew where to go, wasn't the same structures you had to wait for, people were together and it led to more simplicity

- When it comes to planning clinical initiatives, seems Allied Health and nursing resources are planned in a separate way as Medical Staff resources. Is there a role for CGII to play in improving planning clinical programing in a cohesive way, where physicians are considered part of team?
  - Team based planning – some areas do planning for how we work together well
  - Don't have clinical service plan on what we are offering now, where we are going and how we will incorporate what we need
  - Getting better but starts with a plan, CGII will be start to plan
  - See what is feasible and where resources will come from and what can't be used

- Wondering if any thought given to approaching opioid crisis in similar way as pandemic, feel pandemic benefited from focus as the most important thing. Giving it focused time and needs. What role do we play in opioid crisis? Affecting all aspects of care, but not listed as priority topic in palliative even though it is an important priority. Was hopeful when medical leader meetings shifted from pandemic they would have shifted to opioids instead but they didn't.
  - It is a toxic drug crisis, somehow we need to work across domains to move beyond addictions medicine doctors who can't solve it alone, takes societal change
  - Real focus of government in addition to HA, numbers are going the wrong way, losing more lives
  - Have to get out of mindset that it is someone else's problem

- Would mortality data be effective to cross reference in order to highlight gaps in access to care/short staffing/reduction in suffering? Forensic pathology is seeing more advanced diseases causing death; diseases not previously diagnosed in patients without family docs - diseases you would not expect to cause death in BC in 2022 such as appendicitis, overwhelming sepsis, extensively metastatic cancers etc. even heart disease in younger (40s aged) people who had been to ER or walk in clinics with 'chest pain' but had no family doctor for follow up.
  - Not Clinical Governance but it is part of the Primary Care conversations
  - Primary care is in crisis; acuity has gone up a bit but non-acute has gone up significantly
  - Physicians are seeing things they are not used to seeing
  - Have enough CCFP, but don't have enough attachment with patients; have high population of family doctors with patients not attached
  - Never seen province come together on an issue like Primary Care crisis, number one issue out there; won't be quick or easy but will start addressing barriers for FP to do longitudinal care
  - Work Island Health is doing is helpful; working with clinics for service contracts, amazing work happening at Downtown UPCC
  - This is a complex area, continued attention on it will drive change

- What does CGII cost?
  - Don't know offhand the contract costs for consulting firm but it is a contained contract, Health System Redesign funding paying for physician time, CGII also has project manager
  - We have a big problem, need to invest to solve it, was worth investing in physician time to have them at the table

- Need to improve the system to move forward, timeline was initially by June, but now is September; wanted more engagement, did second round of focus groups

Comments:

- We all end up working with our own small group cultures; have very little sense of the needs and major changes of other departments and regions
- We need to decide what metrics we use as a community to guide us to measure quality
- Many meetings spent with operations/medical leadership in isolation, sometimes coming out with opposing directives for staffs which is challenging to navigate. (E.g. MDs are being directed one way, nurses in another).
- Deciding what areas to focus on; KPIs, data and output tends to favour through-put and procedures, things easy to measure and count. Patients need more of is Care Coordination and reduction of suffering
- The lack of family doctor follow up becomes a barrier to discharge from specialized mental health services and contributes to growing wait lists
- Tough but necessary work; Island Health doesn't have a structured way to make clinical decisions
- Organizations need guidelines on how to make clinical decisions – encouraging working towards a structure
- Need to revamp entire health care system for patients of today; data we previously collected doesn't work any more, need to evolve with the needs
- CGII is good because it is based on world leaders and will have defined 5 things for improvement
- If we can work together to understand who is benefiting from cost decisions we make and who is not benefitting, the understanding will put us in a better spot
- All for efficiency and simplification

4. Other Business:

- Events - to register, please contact info@southislandmsa.ca
  - Schwartz Rounds - Tues, May 10, 12.00 – 13.00 @ VGH
  - Narrative and Cultural Humility Workshop - Mon, May 16, 18.30 – 20.00, Virtual
  - Psychological Safety Webinar – Bullying in Healthcare - Tues, May 31, 17.30 – 18.30, Virtual
  - Virtual Doctors' Lounge with Special Guest Dr. Ian Thompson - Weds, June 1, 17.00 – 18.00, Virtual
  - Island Health Medical Staff Town hall - Weds, June 1, 07.30 – 08.45, Virtual
  - Welcome and Thank You Evening - Thurs, June 9, 19.00 – 22.00 @ Ocean Pointe Resort.
  - Choosing Courage over Comfort: How to be an Effective Ally - Weds, June 15, 19.00 – 20.30, In person @ RJH and Virtual
  - South Island MSA Meeting - Mon, Sept 19, 18.00 – 19.30, Location TBC

Adjourned at 19:28