Patients as Partners
The Patient and Health Care Provider Experience
Three years ago Patients as Partners formalized the relationship between patients and health care providers to focus on patient-centered care as a way of improving B.C.’s health care system. Patients as Partners continues to evolve and engage health care providers, patients, families, and caregivers in health care at three levels: i) individual care; ii) bringing in the community; and iii) system redesign. The number of patient and provider partners who are participating has increased and it is exciting to see the growing number of opportunities for patient engagement in the province.

Of note, there is an increasing demand by health care providers and organizations to have the patient, family and caregiver voices represented as decision-makers at various committees. This report reflects the continued movement towards integrating Patients as Partners in care and the impact engaging the patient voice has had on patients, health care providers, and the health care system overall.

The collaboration and effort from both patients and providers is garnering attention. British Columbia’s commitment and work on Patients as Partners and patient-centered care is being recognized as a promising practice nationally and internationally. In 2011-2012, Patients as Partners presented our work at numerous local, provincial, and national venues as a method to increase understanding of all our partners’ collaborative efforts towards health care improvement. To meet numerous requests in 2012, we have published this 2012-2013 annual report that summarizes our philosophy, guiding principles, some key activities, and our vision for the future. Our hope is that this report can inspire those individuals, both patient and provider, who are currently not involved, to get involved and, for those who are already involved, to celebrate our achievements.

There is still more work to be done. The Provincial Patients as Partners Committee is committed to continuously building on existing work in self-management support, patient and provider engagement, and quality improvement. We understand that to achieve real system change, both patients and health care providers need support, a voice at the table, and encouragement to keep collaborating. The innovative work reflected in the following report shows that quality changes are being made to the health care system through patient and provider collaboration.

We would like to acknowledge and thank all who are involved in this exciting work and look forward to continued success in patient and health care provider engagement and improved health care delivery in B.C.

Caryl Harper, co-chair  
Provincial Patients as Partners Committee  

Connie Davis, co-chair  
Provincial Patients as Partners Committee
“Getting public participation right is essential, including striking the right balance amongst competing priorities of government; being clear to the public about what can and what cannot be accomplished in the short term.”¹

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“Collaboration with Patients as Partners has been an enormous benefit for physicians. Patients as Partners remind us on a daily basis that patients’ welfare is the focus of our collaborative efforts to transform our health care system in B.C.”

-Dr. Dan MacCarthy, B.C. Medical Association
Patients as Partners is a recognized strategy of the B.C. Ministry of Health, in both policy and philosophy, as first outlined in the 2007 Primary Health Care Charter. Leadership for Patients as Partners is provided jointly by both the ministry and health authorities through Integrated Primary and Community Care. The membership comprises areas of primary health care, mental health and substance use, and home and community integrated care.

The work is guided by a Provincial Patients as Partners Committee. Committee membership and Patients as Partners work is carried out through health authorities, health care organizations, health care providers, not-for-profit agencies, and patients, families and caregivers in the community.
What we do

The principle driving Patients as Partners is “nothing about me without me.” This principle embodies the belief that patients are partners in their own health care—in system change discussions and when speaking with their health care providers. Patients, families, and caregivers are partners in health care when they are supported and encouraged to participate: in their own health care, in decision making about that care (at the level they choose), and in quality improvement and health care redesign in ongoing and sustainable ways.

Quality Improvement

Quality improvement provides a framework to set goals, define why the work needs to be done, and identify measures to ensure changes are leading to improvements. Patients as Partners uses the principles of continuous quality improvement, or the combined and continuous efforts of everyone (health care professionals, patients, families and caregivers, researchers, educators, and other partners), to test small cycles of change that will lead to better patient and provider experience and better system performance, at a cost we can afford—the Triple Aim.3,4

**How will we know changes are an improvement?**

- Healthy People
- We can afford it
- Improvement in population health
- Lower per capita costs
- Improved patient and provider experience
- Happy People
Collaboration is key

The voices and experiences of the patient, family, and caregiver needs to be heard in health care decision-making. Without a patient and public engagement process and collaborative mechanisms, it is often required that patients take an advocacy role, which results in a focus on defending decisions rather than involving and collaborating to solve problems and make improvements.

The most effective outcomes are determined by supporting collaboration between patients, health care providers, administrators, and between different health care organizations. The health care system is complex and everyone needs to be working together to identify gaps in care, duplications and opportunities for improvement.

Allowing providers and patients to collaborate at all stages of system redesign reinforces the understanding that building improvement together through respectful, trusting interactions will ultimately build a better system.

In June 2012, Dr. Robert Varnum, from the United Kingdom National Health Service Institute for Healthcare Improvement, was the keynote speaker at the Integrated Primary and Community Care Forum in British Columbia. In his report he states:

“Among the impressive features of British Columbia’s approach are their commitment to working in partnerships with patients from the outset, the recognition that general practitioners must be at the heart of integrated solutions and their avoidance of the structuralist trap... ‘Patients as Partners’ has been the watchword of the integration movement in British Columbia, and it shows.

Patients and community leaders outnumbered doctors in the 300 strong audience at the Learning Forum—many of whom have been at the forefront not only of campaigning but leading and managing improvements to health and social care services. A number of localities gave inspiring accounts of transformational change programmes which have been initiated and led by local communities themselves...

There was certainly much to celebrate about the progress made thus far towards delivering more integrated care to patients in British Columbia. There is also much we could learn in the NHS from the values and approaches they have adopted.”

Patient and Public Engagement

Patient and public engagement is about having conversations, building understanding and relationships, and using collective wisdom and deliberative dialogue to make durable decisions. This process can create understanding of opportunities and challenges, create shared ownership of decisions, and save time and money.

Patients as Partners embraces patient and public engagement as the core to health care system improvements. In part, Patients as Partners was created in response to the Office of the Auditor General of British Columbia’s findings and recommendations regarding the importance of public participation in any type of system change.
“As a young Patient Voices Network volunteer, I get to be involved in the development of strategies or programs that will bring positive outcomes to our health care, while focusing on my areas of interest. So let us begin by making the first step; getting involved!”

-Aisha, patient partner

Patients and their non-clinical support network, including their families, friends and caregivers, have a unique perspective on the health care system that is different from that of the provider, health care worker or administrator. Therefore, the patient voice adds value in understanding challenges and creating solutions.

Patients who are more engaged in their own health care have better health outcomes, are safer, and have an improved experience of care. Providers report an improved experience in care-delivery when they work with patients at the centre of care, and the system itself saves money when people are healthier and safer.

Providers and frontline health care staff also experience a positive impact, including: improved attitude towards engagement and health care users; acceptance of patients as full partners in care; and enriched teamwork and morale.

Patients as Partners focuses on the area of Integrated Primary and Community Care—a province wide effort to establish a community-based health care system where teams of health care providers work together to support patients, families and caregivers as full partners in health care.
What Guides Us?

Patients as Partners is guided by three quality improvement charters that were developed collaboratively by patients and healthcare stakeholder organizations: individual care, bringing in community, and system redesign. Employed concurrently, these charters provide the overall vision and direction for our work. The Patients as Partners charters are:

**Individual Care**
The patient is activated, involved in their own health through self-management and has an engaged role in health care decision-making. The health care system is patient centred—responsive, respectful, and collaborative.

**Bringing in Community**
Patients, families, communities, and strategic partners are engaged in policy development or strategic planning. There may be representation from patient, families, communities, and strategic partners in local governance.

**System Redesign**
Patients, families, community organizations, strategic partners are engaged in design, delivery and evaluation of health care programs and services at a strategic and/or system level.

The charters highlight how patients and the health care system can benefit from having Patients as Partners in system change. The three charters, while independent, can overlap one another. Specifically, though a Patients as Partners project may focus on one of the charters, there are usually portions that involve the other two charters. As such, Patients as Partners work encompasses aspects of each of the three charters.

Setting Priorities

The Provincial Patients as Partners Committee sets priorities through the provision of leadership to five overarching committees and one council that are composed of dedicated members from the provincial committee’s organizations. These members work collaboratively to reach consensus in decision making. Each committee tailors its actions to support the continuing Patients as Partners work, while focusing on strategic direction and identified priorities for the year.
The Patients as Partners decision making processes are largely driven by Key Result Area #3 (‘Integrated & Targeted Primary & Community Health Care’) in the Ministry of Health’s Detailed 2010-2013 Health System Strategy Map. Specifically, Key Results Area #3 states:

“Implement an integrated model of primary and community care to more effectively meet the needs of British Columbians, especially frail seniors and patients with chronic and mental health and substance use conditions.”

A Provincial Patients as Partners Committee representative is a member of the Implementation Leadership Committee to ensure alignment with Key Result Area #3 and provide support to other Key Result Area #3 strategies.

“British Columbians are truly fortunate to be able to participate in self-management to acquire the knowledge, skills and confidence needed to experience optimal quality of life. Delivered by health professionals and peer leaders, self-management facilitates a powerful and dynamic experience which attests to the altruism and resiliency of activated communities”

-Patrick McGowan, PhD, University of Victoria

Summary of actions taken in 2011-2012 for goals outlined in the Patients as Partners First Annual Report:

The First Annual Report outlined five goals for 2011-2012 to enable the advancement of the three Patients as Partners Charters. The goals and their resulting outcomes were:

1. Create a clear vision for Patients as Partners work in redesigning integrated primary and community care in B.C. that is accompanied by expectations, timelines, measures, support
and guidance. We will do this through work plans with clear responsibilities and goals. The outcome in 2012 was to develop quality improvement goals and outcome measures to support the charters for each of the committees.

2. Raise awareness about Patients as Partners philosophy throughout British Columbia. We will do this through developing and sharing an annual report to celebrate our successes and what we’ve learned and by leading the hosting of an International Patients as Partners Workshop here in British Columbia. Voices in Action workshops were held in 2011 and 2012, an Integrated Primary and Community Care Provincial Forum and a Reducing Avoidable Readmissions by Improving Transitions in Care workshop in 2013 highlighted the activities of Patients as Partners. Therefore, the goal of publishing an annual report was reconsidered. A decision was subsequently made to publish the next annual report for 2012-2013.

3. Build capacity in organizations and citizens to be engaged in primary care in British Columbia. We will do this through supporting the development of the skills among providers and administrators needed for patient engagement and supporting patients to enhance their self-management or advisory skills. This goal was accomplished primarily through the development of Patient and Public Engagement training materials and training support. In 2011 and 2012, this included organizing sessions to provide the International Association for Public Participation certification course, the creation of patient and public engagement training materials, and the development and provision of patient and public engagement sessions for health care executives and decision-makers. As well, the ministry has continued to provide funding for self-management supports for patients, as described later in this report.

4. Create a consistent, sustainable measurement strategy and tools. We will do this ensuring that patient experience and patient confidence is at the centre of what we measure and work towards. The Patients as Partners measurement catalogue was completed and launched in 2012 as one mechanism to achieve this goal. The catalogue is a searchable online database of improvement measurement tools currently being used by health care partners who measure change to support improvement in British Columbia.

5. Enhance the options for patients, families, and caregivers to be proactive partners in care through the delivery of evidence informed self-management programs and services. Ministry funding was provided to a number of non-governmental agencies to provide self-management programs and services in both 2011 and 2012, some of which are described in detail in this report. Programs and services that would better enable and support self-management were also provided by Patients as Partner organizations. Some of these activities are also listed in this report and include: Brief Action Planning, health literacy educational materials, Your Voice Counts, and Talking with Your Doctor and Other Health Care Providers.
Patient and Provider Experience in 2012-2013

It is important to recognize that patient and public engagement requires participation of key stakeholders. The diversity of the integration of the patient voice and the culture-shift to Patients as Partners by all health care stakeholders demonstrates the importance and the value each place on this interaction with each other. In the past three years, we have seen more health care providers and organizations expecting to have patient representatives at the table to provide the patient voice in decision-making.

In the third year of Patients as Partners, the impact of patient involvement is highlighted, not only in the patient experience, but in that of the provider in the larger context of health care system redesign. Within this context, in June 2012, the Provincial Patients as Partners Committee identified three priorities for 2012-2013:

1. Increase communication and awareness of Patients as Partners.
2. Review the Patient Voices Network orientation using continuous quality improvements for both the content and process.
3. Focus on patient and public engagement for the mental health and substance use populations.

The following pages detail a sampling of the many innovative patient and provider experiences that occurred this past year to meet these goals.

“I am participating in the extreme sport of being a senior! In managing my health and dealing with chronic disease, there have been times where I felt my voice has been stilled. The network is an invitation to share your experiences, be heard, and know your contribution can make a difference.”

-Dulcie, patient partner
“I have been involved with the centre on Aging for many years and 2011 was a period of great change. The Centre is such a wonderful resource for seniors in our community. I am very active with Victoria Hospice and I am grateful for my association with the centre.”

- John Tomczak, community member

Individual Health Care Charter Accomplishments

Self-Management Support

Health Care Professional Self-Management Support (SMS)
An electronic survey of 709 health professionals and peer leaders was undertaken by partner organizations to better understand SMS training experiences and use of SMS skills. In summary, 94 per cent of respondents understood they were expected to use SMS skills in their practice, and 39 per cent did not have time to assist clients or patients with problem-solving and follow-up. Those who had not received the training expressed a deep interest in being trained.

Self-Management Support Three Year Strategy
Based on the health care professional self-management support survey results and the recommendations of the Health Council of Canada Report, the Self-Management Support Committee identified the need for starting work on a three-year strategic plan to achieve the desired outcome of a more supportive self-management health care system. In 2013-2014, a review of gaps in care for the use of self-management support by health care providers will be undertaken to support the development of a three-year strategy.

Patient Activation Measure (PAM®)
Some partner organizations have started to implement PAM® as a gauge for patient activation in their self-management programs. Patient activation measurement was recommended in Self-Management Support: A Health Care Intervention. PAM® categorizes responders into four progressively higher levels of patient activation. Research shows this to be a useful predictor of health outcomes. Preliminary results of pre and post score changes are showing positive results. Analysis of results will be undertaken in 2013-2014.
“Brief Action Planning has captured the attention of many health care professionals because is pragmatic and immediately useful. The uptake across B.C. is encouraging and individuals as well as health care organizations are eager to build additional skills and embed self-management support into their systems.”

-Connie Davis,
Centre for Comprehensive Motivational Intervention

Brief Action Planning

Brief Action Planning is an evidence-based, structured communication tool to support patient self-management and behavior change. In 2012-2013, Patients as Partners provided funding and support for Brief Action Planning to be tested as a learning prototype to develop self-management support skills in health care providers and coaches. Brief Action Planning presents a relatively low cost option for increasing this valuable skill set in the health system. Training was provided by the Centre for Collaboration Motivation & Innovation and ImpactBC. Eight teams and more than 100 trainees from across the province participated. Fifty trainees are now certified.

The responses from an evaluation completed at the end of March 2013, were positive:

- 88 per cent of respondents rated their confidence in using Brief Action Planning as 7 out of 10 or above, indicating they are likely to be successful in their use of Brief Action Planning.

- 67 per cent agreed or strongly agreed that taking self-management support skills training has positively impacted their job satisfaction.

Based on the evaluation, decisions on continuing training and goal setting will be determined early in the fiscal year.
Individual Health Care Programs

Bounce Back: Reclaim Your Health

Bounce Back is an evidence-based, supported self-management program led by the Canadian Mental Health Association B.C. Division and funded by the Ministry of Health. Bounce Back provides adults experiencing symptoms of mild to moderate depression, low mood, or stress, with two forms of self-help: 1) a DVD in English, Mandarin, or Cantonese; and, 2) workbooks with telephone coaching in English or Cantonese.

Bounce Back Participant Advisory Committee, composed of past participants of the program, assists in the review of new materials, evaluation tools and program promotion. This year, the Canadian Mental Health Association created an engagement facilitator position for a person with “lived experience” of mental illness to work with branches and programs, enhance the role of participants/patients in the services provided, educate workplaces about ways to meaningfully involve our participants, and to collaborate with the Patients as Partners - Patient Voices Network to expand the understanding of ways to include the voice of patients with mental health challenges in Patients as Partners work.

Bounce Back is integrated into the Adult Mental Health Practice Support program. It has been a successful year, with 4,315 referrals made and 19,427 DVDs distributed.

Further information is available at:
www.cmha.bc.ca/how-we-can-help/adults/bounceback

“I believe Brief Action Planning is a very valuable tool for health care providers in supporting First Nations clients to make healthy changes in their lives. It is important for health care providers to have knowledge about using this tool due to the high incidence of chronic disease in First Nations.”

-Bernice Johansen, RN, BSN, MN, clinical nurse specialist, First Nations Health Council
**First Link®**

FirstLink® offers services and support to those recently diagnosed with dementia and their families. FirstLink® is provided by the Alzheimer Society of B.C., with funding by the Ministry of Health.

Individuals and families can self-refer or receive a referral to First Link® from a health professional. Services may include a phone call from the Alzheimer Society, information packages, connection to the society’s education programs and support groups, or referrals to other community and health care services. The society is enhancing partnerships and linkages with health care providers, health authorities and other community services to raise awareness of FirstLink®. As a result, referrals are steadily increasing. This fiscal year there were 1,284 referrals accepted, and a total of 3,458 individuals referred to date.

More information on FirstLink® is available at: www.alzheimerbc.org/We-Can-Help/First-Link.aspx

“I really appreciated being able to work at my own pace. I have been able to identify areas I need to work on quite quickly and separate out those areas that I have mastered. It is great to have source material available that is practical to use repeatedly until the patterns become habitual and triggers are immediately noticed.”

-Bounce Back participant
**interCultural Online Health Network (iCON), University of British Columbia Faculty of Medicine eHealth Strategy Office**

The joint goal of Patients as Partners and iCON is to help optimize chronic disease prevention and management using culturally relevant, linguistically appropriate, and trusted health information and workshops on chronic disease management to B.C.’s multicultural communities patients, and caregivers. iCON is a community-driven health promotion project funded by the Ministry of Health and provided by the UBC Faculty of Medicine eHealth Strategy office. An example of the work was a skill building workshop in Cantonese for 30 participants focusing on eHealth literacy, nutrition and healthy eating, exercise, and stress management.

A highlight of this year’s activities includes the development and launch of a mobile-enabled web platform to provide accurate, easy-to-read, culture-oriented health facts and knowledge to multicultural members to help them better manage their health conditions and more effectively communicate with health professionals. Another notable highlight included over 800 attendees at the Punjabi Health Forum: Living Well with Diabetes and Cardiovascular Disease.

More information is available at:  www.iconproject.org/dnn_icon/
**Chronic Disease Self-Management Programs**

The Patients as Partners Chronic Disease Self-Management programs are evidence-based, peer-led, interactive programs that bring together small groups of participants, once a week for a seven week period, to learn new ways to manage their symptoms and daily life. Programs are provided by the University of Victoria Self-Management B.C. and funded by the Ministry of Health. Programs include:

- Chronic Disease Self-Management;
- On-line Chronic Disease Self-Management;
- Arthritis / Fibromyalgia Self-Management;
- Chronic Pain Self-Management;
- Diabetes Self-Management; and
- Active Choices.

Research has found the benefits of these chronic disease self-management programs include: fewer hospital visits, better management of symptoms, better problem solving skills, better communication with their health care providers, better eating and exercise habits, better goal setting skills, better coping techniques with difficult emotions such as anger and frustration, as well as greater self confidence in managing their health.

“For chronic disease, overall, patients attending the seven week Chronic Disease Self-Management program had fewer hospitalizations over a six month period than controls, resulting in a six month net savings of $750 per patient.”

Participants may self-refer or be referred by health care providers. During 2012, University of Victoria program staff trained 564 new program leaders, who then delivered 301 programs to 3,791 persons in 58 communities throughout B.C., exceeding expected targets, based on past participation levels.

Further information can be found at:  [www.selfmanagementbc.ca](http://www.selfmanagementbc.ca)

**System Change Charter Accomplishments**

**How’s Your Health BC? (www.howsyourhealthbc.ca)**

Patients as Partners is supporting the General Practice Services Committee prototyping of the Dartmouth Medical School’s How’s Your Health? quality project in British Columbia. Planning began in 2011 for the 2012-2013 prototype.

How’s Your Health BC? provides a range of tools and resources, including an anonymous online survey, to involve patients more actively as partners in their own health care, as well as providing an opportunity for physicians and patients to communicate and collaborate.

How’s Your Health BC? supports the Triple Aim through: the patient experience to guide improvements and prioritize efforts; supporting a satisfying medical practice by strengthening patient-physician communications; and, helping patients maintain health and control disease as more active partners in their health care using self-management tools and resources.
Patient Voices Network

The Patients as Partners Patient Voices Network is administered by ImpactBC and is funded by the Ministry of Health. Patient Voices Network is a community of B.C. patients, families, caregivers, and others who use their experiences to make positive change in the health care system. Patients represent a variety of backgrounds, cultures, and age groups, and all share a commitment to working collaboratively within the system toward positive change. Patient Voices Network currently has more than 1,400 volunteers from communities throughout the province.

Patient Voices Network uses an orientation skill-building model with patient volunteers, which allows patients to interact and effectively collaborate with each other and health care providers. Patient Voices Network effectively balances the supply of patients, both through recruitment of new patients and ongoing support and skill building, with the increasing demands for patient involvement. A summary of 2012-2013 Patient Voices Network highlights include:

- 186 new patient partners joined Patient Voices Network and 105 volunteers became activated after attending orientation.
- 406 patient partners were placed in 114 unique patient engagement opportunities including: focus groups, information sessions, surveys and polls, testimonials, working groups, advisory committees, workshops, research panels, forums, and conferences. To date there have been over 900 patient engagement opportunities for patient partners.
- 13 skill building webinars were hosted on a variety of topics including: public speaking skills, cultural competency and addressing common misunderstandings.
- Patient Voices Network/patient engagement presentations were made to 57 organizations.

Further information on Patient Voices Network is available at: www.patientvoices.ca

Community Engagement Advisory Network

The Community Engagement Advisory Network is a group of members from the public who support patient and public involvement in health service planning and decision-making at Vancouver Coastal Health. In one of the many engagements this year, members, in collaboration with the Patient Voices Network, provided input into the creation of a medication safety pamphlet which is now being used by health care providers and patients to discuss medication management and safety.

Patients as Partners Measurement Catalogue

The Patients as Partners Measurement Committee implemented a comprehensive measurement catalogue to enable searching and sharing of Patients as Partners measurement tools. The catalogue is a resource for B.C. health care practitioners and providers tasked with measuring change to support improvement projects. The searchable database of improvement measurement tools is currently being used by health care partners within the B.C. health system.

Further information can be found at: http://measures.ImpactBC.ca
Bringing in the Community Charter Accomplishments

Patient and Public Engagement

Patient and Public Engagement Training
The Patient and Public Engagement Committee spearheaded training activities to further integrate patient and public engagement knowledge into the health care system. It developed, implemented and tested a B.C. specific training curriculum for patient and public engagement in health.

International Association of Public Participation Training
Twenty health authority and Ministry of Health leaders were certified in International Association of Public Participation through an intensive five-day training program provided by Delaney & Associates. Training modules included planning for effective public participation, effective communications and techniques for patient and public engagement. In addition, half-day health care leaders sessions outlining the benefits and appropriate uses of patient and public engagement were presented to ministry and health authority leaders by Delaney & Associates.
As part of the overall patient and public engagement training, Interior Health and Patients as Partners provided the opportunity for leaders from the integration team to participate in the training. The four-hour workshop provided the opportunity for those involved to understand:

- The structure and process of decision-making;
- What public participation/community engagement is, why it is important, and when it needs to be used;
- The various levels/spectrum of engagement, examples of tools for each level and how the spectrum of engagement relates to decision-making; and
- A sample of succinct summary statements (elevator speech) for patient and public engagement, which were based on the discussions from the workshop.

**Online Patient and Public Engagement Resource**

A collaborative Patient and Public Engagement Committee developed a foundational online resource to provide patient and provider partners’ with instructive information about patient and public engagement. Once finalized, this will be a resource for health authorities, joint clinical committees, Divisions of Family Practice, Ministry of Health and other partners who will be participants in patient and public engagement work.

**Patients as Partners: Patient and Public Engagement Mental Health Substance Use Framework**

The ministry and health authority staff, along with other partners, are working together with Delaney & Associates to develop an analytical Patients as Partners patient and public engagement mental health and substance use framework. The framework is being tailored to meet the unique needs of the mental health and substance use health care community (patients/clients, providers, family members, and decision makers). It is building upon existing successes within the mental health and substance use experience and practice within B.C. and current literature. The framework will be used to understand how to better connect and utilize engagement techniques specific to the mental health and substance use target community.

There are three phases in the development of the framework that will be implemented over the next few years. The framework is intended to be a step-by-step approach to planning and managing patient and public engagement within the mental health and substance use stakeholder community. The framework will:

- Provide quick access to guidance and planning tools;
- Incorporate best practice for this health care community;
- Incorporate legal and policy requirements;
- Ensure consistency in planning and implementation; and
- Create mechanisms for continuous improvement.

A draft framework for consultation was developed in 2012-2013. Consultation and completion of the framework will be undertaken in the next fiscal year.
**Diversity**

Patient and public engagement requires participation of key stakeholders. Within the patient voice, diversity of experience, culture and other factors are important considerations. Integrating a diverse patient voice that is reflective of the provincial demographic will ensure system change reflects the needs of the population accessing the health care system. In 2012, Patients as Partners established a group to consider increasing diversity in Patients as Partners projects. We will continue to focus efforts on embedding the culture of collaboration and seeking the input of all partners.

**Health Literacy**

Increasing health literacy skills of all users of the health system is an ongoing area of work of Patients as Partners. Health literacy is about the ability to make informed decisions and take actions to promote and protect health. It is the degree to which individuals are able to access, understand, evaluate, and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course.\(^{17}\)

One Patients as Partners health literacy project highlight this past year was a collaboration with Vancouver Coastal Health, the B.C. College of Family Physicians, as well as other partners, to create Health Literacy Basics for Health Care Professionals—a short video outlining how health care professionals can use health literacy to help patients access, understand, evaluate and communicate health information. The video is available at: https://www.youtube.com/watch?v=FXf1qyfn3iE

**Your Voice Counts**

Your Voice Counts began in 2010 as a collaborative effort of the Ministry of Health, Fraser Health, iCON and ImpactBC. It was funded by the Canadian Health Services Research Foundation, now the Canadian Foundation for Health Improvement, and with in-kind contributions from the partner organizations.

Your Voice Counts was carried out over two years and included workshops and webinars. It was built on the principle of mutual learning, whereby patients, health professionals, and health administrators learned directly with patients about opportunities and effective ways to foster patient participation. In both the face-to-face workshop forums and online webinars, patients were provided with an overview of the Canadian health care system, an introduction to patient and public engagement and how to become involved, and were provided with effective communication skills for engagement. Workshops were facilitated in English and, with the assistance of cultural advisory committees, were adapted and translated into Chinese and Punjabi. Patients were included in all stages of this project to ensure relevance when working with different cultures. From the success of this project and learnings from the initial face-to-face and online educational sessions, it is anticipated that the materials will be further revised and expanded to other health authorities in British Columbia.
“It has been my privilege to serve as chair of the advisory Board. I have been continually impressed with the dedication of the faculty, research affiliates and staff in maintaining the excellence with which the centre has become known. Progress has been made in the work of the four subcommittees (Knowledge Mobilization, Internal Communications, Education and Fundraising), and the centre has continued to foster and enhance the relationships with its community partners.”

-Geri Hinton, chair, Centre on Aging Advisory Board
Talking with Your Doctor and Other Health Care Providers

Talking with Your Doctor and Other Health Care Providers was a Patients as Partners collaborative prototype in 2011-2013. Partners included the University of British Columbia Division of Health Care Communications, the Ministry of Health, and ImpactBC. The two-hour workshop for patients, aimed at improving communication with their health care provider, were well-received by both facilitators and participants. Evaluations showed an average satisfaction score of four out of five for participants, and 8.8 out of 10 for facilitators. Nineteen workshops were held throughout the province, reaching 268 participants. From these findings, a business case will be developed to inform decisions on continuing this program or offering other options to provide this information to patients.

Shared Care Committee—Transitions in Care and Partners in Care

The Shared Care Committee, a joint clinical committee of the B.C. Medical Association and the Ministry of Health, is working to improve health outcomes, the patient journey, and address co-ordination of patient care and best use of health care resources. The Shared Care Transitions in Care project aims to improve the delivery of comprehensive, streamlined patient care during transitions into and out of acute care. The project supports work in selected B.C. communities and is focused on finding local solutions to local problems. Shared Care Partners in Care is about streamlining referral and consult processes, shared care planning diagnostic standards and communications, telephone advice protocols, and more.

To date, there have been 56 patient partners engaged in over 100 engagements in 27 Shared Care Committee projects throughout all B.C. health authorities.

Further information about Shared Care Committee is available at: www.bcma.org/partners-patients

Family Caregivers’ Network

The Family Caregivers’ Network not-for-profit society was established in 1989. Their mission is to inform, support, and educate on issues of concern to family caregivers through the promotion of the significance of the family caregiver’s role and contribution in the health care system.

Their work focuses on advancing education and improving access to information for family caregivers and health care practitioners, as well as being an ongoing voice to include the family/friend caregiver as a partner in care. Some highlights of collaborations with Patients as Partners include:

- Developing and facilitating a webinar during Family Caregiver Week in B.C. with Patients as Partners, Patient Voices Network—Our Health System’s Invisible Backbone: Family Caregivers;
- Offering the Talking with Your Doctor and Other Health Care Providers webinar targeting family caregivers, in partnership with Patient Voices Network; and
- Collaborating with iCON and the Ministry of Health to print and share information for family caregivers at iCON health forums, and facilitating connections for a Vancouver-based forum for the Chinese community.

More information is available at: www.fcns-caregiving.org/
Integrated Primary and Community Care Acceleration Projects:

Beginning this year, up to $50 million per year for the next three years will be provided to regional health authorities to launch or expand targeted primary and community care initiatives to meet local demand to support chronic and complex conditions, reduce the need for avoidable hospital and emergency department visits, and reduce or delay the need for admission to a residential care facility. Further details are available in the announcement at: www.newsroom.gov.bc.ca/2013/03/bc-continues-to-expand-primary-and-community-care.html

The regional health authorities are undertaking a variety of community projects. Some highlights include:

- Home First and Home is Best to support clients with complex health care needs in the community and to avoid unnecessary residential and acute care admissions.
- Northern Health Care enhanced Home Health Services Strategy to enable intensive management and co-ordination for the frail elderly, people with mental health and substance use challenges and for people with chronic disease, with the goal of keeping patients healthy at home.
- Early Supported Discharge to support patients diagnosed with heart failure, chronic obstructive pulmonary disease, or a new stroke through an early discharge from acute care. The interdisciplinary community team working in collaborative partnerships with general practitioners provides short term rehabilitation from acute care.
- BreatheWELL at Home to support chronic obstructive pulmonary disease patients and improve their quality of life.
- End of Life Care project to support patients who wish to die at home.
- Improved assessment and treatment of patients with mental health and substance use challenges. One program targeted to people with treatment resistant psychosis, aims to reduce their visits to hospital and improve their quality of life. Other programs support assertive community treatment outreach teams and provide co-ordinated medical team support for patients physical and mental health care.

All programs are being evaluated. Although they are in the early stages of implementation, some programs are already showing reductions in emergency room admissions, hospital admissions and reduced length of stays in hospital. Patients as Partners are engaged by health authorities in setting the direction needed to drive integration by participating on Integrated Primary and Community Care committees to determine expansion of these improvement ideas. The corporate community engagement teams in health authorities also seek patient partners to participate in their integration work.

Patients as Partners Communications Planning

The Patients as Partners Communications Committee initiated the development of a draft communications plan. The committee will be drafting a three-year communications strategy in the next fiscal year (2013-2014), with implementation to follow. The Provincial Patients as Partners Committee and partner organizations are engaged in the process of developing this plan and play a significant role to ensuring a collaborative inclusive approach is incorporated.
Other highlights include:

**B.C. Mental Health & Addiction Services**
Seven client discussion groups (60 patient partners in total) from across Provincial Health Services Authority agencies discussed transformative practices embracing mental well-being.

**Integrated Primary and Community Care Healthier Community Partnerships**
Fraser Health developed an age-friendly, two-day forum that addressed housing and mobility and the opportunity to build social enterprise options for transportation in Fraser East communities, in collaboration with the Fraser Valley Regional District, and the cities of Hope, Harrison, Agassiz, Abbotsford, Chilliwack, and Mission. Participants discussed what was working well in the community, what could be improved and provided, and discussed suggestions for solutions on how to make improvements.

**Chronic Pain Management Strategy**
Twelve Interior Health patients provided their unique perspectives on chronic pain management through focus groups, a teleconference or online surveys.

**Maternity Clinic at Victoria General Hospital**
Vancouver Island Health Authority conducted initial patient journey sessions with a medical at-risk patient group and a socially at-risk patient group, followed by an online survey to low-risk women.

**B.C. Cancer Agency Focus Groups**
Patients and their families were engaged in improvement projects including media campaigns for screening programs, and patient questionnaires for advance care planning.

**Partners in Care Focus Groups**
Eighteen patients were involved over three separate engagements to learn what patients’ perceptions, opinions and experiences have been when being referred to a specialist for care.

**Divisions of Family Practice**
Seven Divisions of Family Practice (Chilliwack, Kootenay Boundary, Nanaimo, North Okanagan, Oceanside, Ridge Meadows, and South Island) involved 26 patients in their respective communities as part of advisory committees or working groups.

**Strongest Families B.C. Program**
A parent who had completed the Canadian Mental Health Association’s Strongest Families B.C. program presented her experiences of living with a child with disruptive behavior, the family’s experience with the mental health system, and the help the family had found with Strongest Families B.C. at a meeting with the ministers of Health and Children and Family Development.

**Community Partnerships**
Primary health care teams in Northern Health have developed partnerships with community organizations in a number of communities. For example, a recreation center in Quesnel provides free passes for women in need, and trained professionals provide diabetes related health care services.
**Practice Support Program Child and Youth Mental Health Module**

Teams in six Northern Health communities are developing partnerships with school districts, the Ministry of Child and Family Development, and Aboriginal liaisons.

**Patient Advisory Council**

Fraser Health developed an internal asset inventory that defined the current state of patient and public engagement in all programs that are led by community health specialist.

**Mental Health and Substance Use Primary Care Projects**

Patient input was gathered to inform the development of primary care projects in nine identified Interior Health communities, adapted from the Kamloops’ King Street model, to ensure primary and support services are meeting the needs of the mental health and substance use population.

**Continuing Health Services**

Vancouver Island Health Authority formed a Patient Advisory Committee to engage patients in program planning and engagement.

**Prenatal Services B.C.**

Providence Health gathered public feedback for use in primary maternity care planning and for public reporting of the prenatal indicators plan.

**Aboriginal Health DVD (iCON, in partnership with Vancouver Coastal Health)**

A DVD video was created featuring First Nations and Aboriginal Traditional Healers to provide Vancouver Coastal Health professionals with information on cultural healing practices and how to facilitate patient access to traditional healers.

**Breathe Well Steering Committee**

Fraser Health’s Breathe Well Steering Committee members received International Association for Public Participation Patient and Public Orientation/Training. A draft engagement strategy has been developed and submitted to the committee for review.
Patient and Provider Learning

Large scale change

Health care system redesign in B.C. is about large scale change. To this end, Patients as Partners leadership incorporates shared or distributed leadership practices. In other words, by combining our efforts and expertise across the system locally and provincially, we strive to ensure that the collective result is significantly greater than the outcomes of individual leadership actions. Patients as Partners is driven from the bottom up (from the patients and community) and supported from the top down through a collaborative approach. We believe that by co-creating and working together on a shared purpose based on the Triple Aim (improving population health, good experience for the patient and provider, and at a cost we can afford) we will achieve large scale health care system redesign. In order for us to achieve our goals we depend on our collective leadership to:

- Act together around a shared purpose;
- Build a combined and shared base of knowledge and expertise;
- Build relationships, trust and commitment with each other, and hold each other accountable to ensure the Triple Aim is achieved; and
- Design mechanisms and enablers, at every level of the system, that are aligned with a collaborative approach in order to support large scale change within health care redesign in British Columbia.

The ministry supports a distributed leadership approach to strengthen the Patients as Partners, Integrated Primary and Community Care projects. “Everyone benefits as a result of the Patients as Partners work. Improving patient and provider experience is one leg of the Triple Aim. Therefore, we must continue moving Patients as Partners forward to ensure the transformation of our health care system.” (Kelly McQuillen, executive director, Integrated Primary and Community Care Branch, Ministry of Health).

This approach is supported by literature on large scale change. As Thomas J. Sergiovanni, author of The Principalship: A Reflective Practice Perspective, states:

“Leadership of health and healthcare into the future should be ‘more managerially loose and culturally tight’. If we want more control, we have to give up some control in a traditional management sense. We are talking about as much, or more, delivery discipline in the change process and holding to account for the outcomes of large scale change. However, we do so on the basis of commitment in relationships to one another, seeking a shared purpose, rather than solely relying on the performance management mechanisms of a compliance regime.”
Culture shift

Patients as Partners is about a shift in culture. At the core of Patients as Partners is change, and change is hard. Providers do not always know when or how to ask for the patient voice and patients may not know how to participate or comprehend the value of their perspective. Some health care providers question why are we engaging patients in system redesign. Patients as Partners motto, “all teach, all learn”, provides the foundation to work together for system change. Through our many partners, Patients as Partners provides skills training, enhances linkages, and fosters the environment for collaboration.

Change requires continuous learning and flexibility

The ultimate goal of Patients as Partners is to build a better and more sustainable health care system. Continuous learning encompasses learning new skills and best practices such as health literacy, patient and public engagement, and communications. However, equally important is learning about each others’ experiences in the health system, thinking creatively, making changes for improvement, measuring progress frequently, and making adjustments to plans based on the results. Flexibility encompasses making changes over time, as well as considering the unique needs within each environment.
Looking Forward

As the patient, family and caregiver voice becomes a larger part of system change, flexibility to make change, measure, adjust, and adapt to new environments will require a commitment from everyone involved.

The Provincial Patients as Partners Committee is reflecting on the successes of the past three years and will be conducting planning early in the next fiscal year. At that time, new one, three, and five-year accountability targets will be set for Patients as Partners.

As a made in B.C. partnership for working together to improve health care, the Provincial Patients as Partners Committee is looking forward to the expansion and further integration of the Patients as Partners philosophy in all areas of health care.

The continued focus on engaging patients and providers to work in partnership towards a better health care system will continue to present challenges and opportunities that we look forward to conquering together. As we look forward to this year, our commitment to quality improvement for large-scale system change remains.

Vision for the future:

A health care system that actively reflects the needs and interests of the people it serves...

The patients.
Many organizations are contributing to the advancement of the Patient as Partners philosophy and agenda and include the following:

- The Arthritis Society, BC and Yukon – www.arthritis.ca
- The Lung Association of BC – www.bclung.ca
- B.C. Medical Association – www.bcma.org
- Bounce Back (Canadian Mental Health Association BC Division) – www.cmha.bc.ca/how-we-can-help/adults/bounceback
- Canadian Diabetes Association, B.C. Division – www.diabetes.ca
- Centre for Collaboration Motivation & Innovation – http://www.centrecmi.ca/Centre_for_CMI/Home.html
- University of Victoria Self-Management programs – www.selfmanagementbc.ca
- Divisions of Family Practice – www.divisionsbc.ca/provincial/home
- Family Caregivers’ Network Society – www.fcns-caregiving.org
- Fraser Health Authority – www.fraserhealth.ca
- General Practice Services Committee – www.gpsc.bc.ca
- Heart and Stroke Foundation of BC and Yukon – www.heartandstroke.com
- iCON UBC eHealth Strategy – www.iconproject.org
- ImpactBC – www.impactbc.ca
- Interior Health Authority – www.interiorhealth.ca
- Northern Health Authority – www.northernhealth.ca
- Pain BC – www.painbc.ca
- Patient Voices Network – www.patientvoices.ca
- GPSC Practice Support Program – www.gpsc.ca/psp/practice-support-program
- Provincial Health Services Authority – www.phsa.ca
- Shared Care Committee – www.bcma.org/partners-patients
- Specialist Services Committee – www.sscbc.ca
- Vancouver Coastal Health Authority – www.vch.ca
- Vancouver Island Health Authority – www.viha.ca
Notes


18 Beven, H. 2011. *Part 2 Leading large scale change: the postscript. Why do leaders of health and healthcare need these principles of large scale change right now?* NHS Institute for Innovation and Improvement.

19 Ibid

Notes: