Setting Priorities – Summary

Social Determinants of Health and Adverse Childhood Experiences: A Community Approach to Patient-Centred Care

On June 20th a small, dynamic group opened Day 2 of the GPSC Summit with a keynote entitled *Social Determinants of Health and Adverse Childhood Experiences: A Community Approach to Patient-Centred Care*. The session explored how embedding components of four big system moves – lived experience expertise, social determinants of health data, community partnerships and Adverse Childhood Experiences – are essential for system sustainability. There are practice and/or policy changes that – if valuable – could be implemented to support shifting the system. During the keynote, GPSC Summit attendees were asked to prioritize each suggested practice and/or policy change – below is a summary of the results (1 = low priority and 5 = high priority).

Topic	Suggested Practice and/or Policy Changes	Priority Average Score* (Score 1-5)
Patients as Partners Laurie Edmundson & Corey Reid	Any system design, policy or practice needs to be informed – from the beginning – by patient and/or family lived experience.	4.4
	Support a standard of care where physicians dialogue with their patients about: confidence in self-management, and how they would like to be greater involved in their own care.	4.2
	Health Authorities and physicians provide space for patients and families to make improvement suggestions.	3.8
	Patient Medical Homes/Primary Care Networks, Divisions of Family Practice and Health Authorities report back to patients and families about how their input and experiences have impacted practice and/or system changes.	3.7
Social Determinants of Health Trish Hunt & Dr Lee MacKay	Provide population health data for my community.	4.4
	Divisions of Family Practice and Doctors of BC work with government and others to agree on a set of social determinants indicators to measure and report on for Patient Medical Homes/Primary Care Networks in BC.	4.1
	New physician compensation models support PMH/PCN implementation by incorporating funds to address SDH, reflecting population health data.	3.8
	Cabinet decisions should require health impact assessments, prior to decision making.	3.6
	Physicians use poverty tool(s) in their practices, and record results in the EMR.	3.6
Community Partnerships Janet Austin & Dr Christine Loock	Patient Medical Homes have access to a 'Local Action Team' for high priority populations – such as mental health/substance use and seniors – to build linkages and trusted partnerships.	4.3
	The health system values and supports Health Authorities, GPs and Specialists working with NGOs to develop and maintain a system, including services and resources, that helps patients.	4.3
	Patient Medical Homes/Primary Care Networks, Divisions of Family Practice and Specialists will meet annually with their local government, including Indigenous partners, to identify priorities together.	3.9
	When public funding is used, require that information is shared with 811 (HealthLink BC) and bc211 so that physicians/MOAs and patients/families know local resources and services.	3.6
Adverse Childhood Experiences (ACEs) Dr Jeanette Boyd & Dr Linda Uyeda	Community partners work with GPs, Specialists and clinicians to build resilience in families and communities – building on the notion that the antidote for trauma is resilience.	4.4
	Trauma Informed Practice Training is valuable for physicians and clinicians, as it supports changing the conversation with patients from "What is wrong with you?" to "What have you experienced?"	4.4
	There is an urgent need for substantial investment in Cognitive Behavioural Therapy (CBT) and other evidence-based talking therapies in primary care.	4.2
	There is value in holding an Adverse Childhood Experiences Summit in BC for physicians, government and communities to set priorities and indicators.	3.9

*Please refer to Appendix A for the breakdown of scoring results.

1 = Low Priority 5 = High Priority

Appendix A – Breakdown of Scoring Results

Patients as Partners

Suggested Practice and/or Policy Change	Priority?					
	1 = Low	2	3	4	5 = High	Average Rating
Any system design, policy or practice needs to be informed – from the beginning – by patient and/or family lived experience.	2 (1.8%)	3 (2.7%)	6 (5.4%)	39 (35.1%)	61 (55.0%)	4.4
Support a standard of care where physicians dialogue with their patients about: confidence in self-management, and how they would like to be greater involved in their own care.	4 (3.6%)	8 (7.3%)	14 (12.7%)	22 (20.0%)	62 (56.4%)	4.2
Health Authorities and physicians provide space for patients and families to make improvement suggestions.	3 (2.8%)	15 (14.2%)	19 (17.9%)	34 (32.1%)	35 (33%)	3.8
Patient Medical Homes/Primary Care Networks, Divisions of Family Practice and Health Authorities report back to patients and families about how their input and experiences have impacted practice and/or system changes.	6 (5.5%)	16 (14.7%)	18 (16.5%)	33 (30.3%)	34 (31.2%)	3.7

Social Determinants of Health

Suggested Practice and/or Policy Change	Priority?					
	1 = Low	2	3	4	5 = High	Average Rating
Provide population health data for my community.	1 (0.9%)	2 (1.9%)	11 (10.2%)	28 (25.9%)	66 (61.1%)	4.4
Divisions of Family Practice and Doctors of BC work with government and others to agree on a set of social determinants indicators to measure and report on for Patient Medical Homes/Primary Care Networks in BC.	2 (2.0%)	6 (6.0%)	17 (16.8%)	34 (33.7%)	42 (41.6%)	4.1
New physician compensation models support PMH/PCN implementation by incorporating funds to address SDH, reflecting population health data.	9 (9.1%)	6 (6.1%)	20 (20.2%)	26 (26.3%)	37 (37.4%)	3.8
Cabinet decisions should require health impact assessments, prior to decision making.	11 (11.2%)	8 (8.2%)	22 (22.5%)	22 (22.5%)	35 (35.7%)	3.6
Physicians use poverty tool(s) in their practices, and record results in the EMR.	8 (8.3%)	14 (14.4%)	17 (17.5%)	27 (27.8%)	31 (32.0%)	3.6

1 = Low Priority 5 = High Priority

Community Partnerships

Suggested Practice and/or Policy Change	Priority?					
	1 = Low	2	3	4	5 = High	Average Rating
Patient Medical Homes have access to a 'Local Action Team' for high priority populations – such as mental health/substance use and seniors – to build linkages and trusted partnerships.	6 (6.1%)	3 (3.0%)	5 (5.1%)	23 (23.2%)	61 (61.6%)	4.3
The health system values and supports Health Authorities, GPs and Specialists working with NGOs to develop and maintain a system, including services and resources, that helps patients.	1 (1.0%)	3 (3.0%)	13 (12.9%)	28 (27.7%)	53 (52.5%)	4.3
Patient Medical Homes/Primary Care Networks, Divisions of Family Practice and Specialists will meet annually with their local government, including Indigenous partners, to identify priorities together.	6 (6.2%)	8 (8.3%)	13 (13.4%)	35 (36.1%)	34 (35.1%)	3.9
When public funding is used, require that information is shared with 811 (HealthLink BC) and bc211 so that physicians/MOAs and patients/families know local resources and services.	7 (7.4%)	17 (17.9%)	12 (12.6%)	25 (26.3%)	33 (34.7%)	3.6

Adverse Childhood Experiences

Suggested Practice and/or Policy Change	Priority?					
	1 = Low	2	3	4	5 = High	Average Rating
Community partners work with GPs, Specialists and clinicians to build resilience in families and communities – building on the notion that the antidote for trauma is resilience.	0 (0.0%)	5 (5.0%)	9 (9.0%)	27 (27.0%)	59 (59.0%)	4.4
Trauma Informed Practice Training is valuable for physicians and clinicians, as it supports changing the conversation with patients from "What is wrong with you?" to "What have you experienced?"	2 (1.9%)	7 (6.8%)	5 (4.9%)	25 (24.3%)	64 (62.1%)	4.4
There is an urgent need for substantial investment in Cognitive Behavioural Therapy (CBT) and other evidence-based talking therapies in primary care.	6 (6.1%)	4 (4.0%)	14 (14.1%)	19 (19.2%)	56 (56.6%)	4.2
There is value in holding an Adverse Childhood Experiences Summit in BC for physicians, government and communities to set priorities and indicators.	7 (7.0%)	11 (11.0%)	16 (16.0%)	22 (22.0%)	44 (44.0%)	3.9

1 = Low Priority 5 = High Priority