BC-PAN Meeting Minutes

September 30 & October 1, 2020

9:00 a.m. – 12:30 p.m. PDT | Zoom

The BC-PAN's first operational phase meeting was a two-day Zoom conference meeting on September 30 and October 1, 2020.

Meeting Purpose

Seek input from public advisors to guide health care regulation on virtual care as well as actions the colleges can take on anti-racism, cultural safety and health equity.

Key Learnings

- The public believes that virtual care should continue to be provided post the pandemic. It is important that virtual care platforms are safe, secure, confidential, and accessible.
- Expectations and standards that health care providers are qualified and culturally competent are the same for virtual care as in person.
- Cultural safety principles could benefit from being integrated into colleges' programs and processes such as quality assurance or accreditation programs.
- There is confusion surrounding the complaints process; the process is daunting and difficult to navigate. Improving accessibility and simplifying the process may reduce some barriers of filing a complaint.

September 30, 2020 – Virtual Care

Summary

Due to the COVID-19 pandemic, use of virtual methods to access care has increased. The college partners are interested in the advisors' experiences with virtual care during and prior to the pandemic, as well as the public's expectations moving forward. College partners would like to seek guidance on how colleges can support an effective public experience with virtual care.

Public advisors present

- Annie Danilko
- Dianne Johnson
- Elena Kanigan
- Emanuela Silvestri
- Helen Espiritu
- John Sherber
- Margaret Bricker
- Marty Lingg
- Rhianna Millman
- Shawna Bennet
- Terry Browne

College partners present

- Anita Wilks, CDSBC
- David Perry, CPBC
- Dianne Millette, CPTBC
- Elizabeth Bruce, BCCNP
- Eric Wrendenhagen, CMTBC
- Gillian Vrooman, COPBC
- Jonathan Ho, CTCMABC
- Kathy Corbett, COTBC
- Kelly Newton, CPSBC
- Michelle Da Roza, CCBC
- Susan Prins, CPSBC
- Victoria Spooner, COBC

Others present

- Susanna Haas Lyons, facilitator
- Praise Osifo, public engagement coordinator

Introductions

Anita Wilks, CDBC Director of Strategy and Engagement, opened the meeting with a welcome speech and land acknowledgement. She introduced Susanna and Praise as well as encouraged everyone to input in the chat the Indigenous territories they are located on. She provided information about the BC-PAN's pilot phase and her hopes moving forward. She closed with a quote from the Cayton Report, which includes recommendations on how health care regulators can improve:

> *"We need uniters not dividers, healers not hurters, communities not individuals. As part of the health system professional regulators need to work together, to take responsibility for their impact on the whole health economy, to reflect on their own attitudes to equalities and diversity, to think how they can reduce environmental impact and waste. To respond consciously and conscientiously to cultural safety, sexism, racism, health poverty and their consequences. A modern regulator will need to be agile, energetic, forward looking and open to society. A modern regulator will be a force for unity not division" – Harry Cayton*

Susanna briefly introduced herself and her background. She has worked on over 100 large and complex engagement projects with partners across North America – including the College of Dental Surgeons of BC and the U.S federal government under the Bush administration. She gave an overview of the day's agenda and emphasized the importance of the work of the BC-PAN.

Icebreaker

Susanna acknowledged that it has been a challenging time for everyone. The pandemic has impacted everyone in a range of ways. Public advisors participated in a reflection exercise. Using a marker and paper, they answered these questions by drawing a sketch, doodle, and/or using words:

- *Have you experienced any silver linings in the disruption?*
- *Have you had to get creative to make do? How?*

Advisors shared their drawings to the group as well as their name, where they live, and one important idea captured in the image.

College partners were asked to share their name, college and role, one outcome of last year's pilot that had an impact on their work or their outlook on achieving their college's mandate.

Context Presentation: Virtual Care

Susanna spoke to the group about the evolution of virtual care pre and post the COVID-19 pandemic.

- Prior to COVID-19, there was an average of 1,800 virtual care visits across BC per week. In June, the number of visits grew to more than 19,000 a week.
- Virtual health enables a patient to access clinical services such as:
    - Virtual health visits
    - Remote patient monitoring (monitoring patient health and sending information to their care team electronically)
    - Clinical digital messaging
    - Online treatment and resources
- This is an emerging field. The colleges want public advisors' guidance on how to support a positive public experience with virtual care.

Susanna gave suggestions for engaging in dialogue throughout the meeting:

- Step up and step back: Those who tend to let others speak are encouraged to bring their voice forward. Those who speak frequently are encouraged to create space for others.
- Speak personally: College partners are interested in the advisors' experiences as a member of the public. It is also important not to generalize individual experiences.
- Differentiate between intent and impact: Be self aware and empathetic of people's feelings rather than being defensive.
- Respect confidentiality: Some will disclose personal experiences or other's stories. Please do not share the content of what is discussed outside of the group.

Small Group Discussions: Experiences Accessing Virtual Care

Advisors were separated into break out rooms to discuss their personal experiences accessing virtual care. Susanna shared a collaborative Google document where college partners took notes of the discussion. Advisors were asked:

- *Have you ever used phone, email, virtual platform, text or video to access health services?*
    - *If yes:*
        - *What were the positive aspects of your experience?*
        - *What was challenging about the experience?*
    - *If no:*
        - *What would make you want to use virtual care?*
        - *What concerns might you have about the experience?*
    - *And:*
        - *Should health care providers continue to prominently offer virtual care once the pandemic is over? Why or why not?*

Advisor Feedback

- Most public advisors have utilized virtual health services because of the pandemic. The telephone was the most popular medium used.
- Seniors experience greater challenges in accessing virtual care. Some may have difficulties even handling a phone call due to mobility, hearing, or comprehensive issues.
- Privacy issues and ease of access are the greatest concerns.
    - There needs to be a balance. Platforms cannot be too restrictive so virtual care cannot be provided, but patient safety must be upheld.
- A record of the interaction to review what was said by the patient and the practitioner may be helpful.
- Face to face interaction makes some more comfortable to ask questions. Phone calls have a time constraint so people may feel less willing to ask questions.
- Healthcare providers should continue to offer virtual care.
    - Some healthcare visits still require face to face interaction.
    - Virtual visits can be used for following up appointments, filling prescriptions, etc.
    - Virtual care can be a substitute for a walk-in clinic or emergency care.

Criteria of Excellent Virtual Care

Susanna presented a list for advisors to review and rank individually. The results were:

1. Personal information is safe
2. Effective treatment
3. Technology is easy to use
4. Appropriate consent process
5. Culturally and patient responsive care
6. Continuity of care after the appointment
7. Options for in-person care when needed
8. Consistent across health care providers
9. Practitioner is known to me
10. Practitioner is competent with the technology
11. Avenues for advocacy and family/peer support
12. Clear communication about fees and billing

Small Group Discussions: Excellent Virtual Care at All Stages

Advisors were separated into break out rooms for small group discussions. Each group began with a different stage of virtual care but were asked to evaluate all three stages:

- Pre-appointment: Finding a practitioner, understanding the approach to virtual care, making a booking, testing technology, etc.
- Visit with your practitioner: Ease of technology, what information is recorded and in what ways, practitioner demeanor, etc.
- Follow up: Getting and filling prescriptions, filing a complaint, etc.

Advisors were asked:

- *What would enable a virtual care experience for patients that meets our top criteria?*
- *What potential challenges may need to be addressed?*
- *What expectations do you have about virtual care, in comparison to in-person care?*

Advisor Feedback

Pre-appointment

- People must trust that the system is safe, secure, and confidential.
- It is difficult to access care if an individual does not already have a practitioner that provides virtual services.
    - It would be helpful if regulators could provide a list of practitioners that offer virtual care.
- Would like to know that the practitioner is accepting patients, qualified, and culturally competent.
- There are stigmas and barriers related to a variety of health conditions. Some individuals need more assurance that their health information is secure.
- Knowing the practitioner or meeting them prior to virtual care would make most more comfortable to have a virtual consultation – having an initial face to face meeting is critical.

Visit with your practitioner

- A platform that the patient is comfortable with, visual component, security of personal information, ease of use, and competency of practitioner are all important aspects of a successful virtual care experience.
- Patients need to have the correct tools to access virtual care; infrastructure, speed of internet, etc.
- Virtual care provides the opportunity to balance the patient-practitioner power imbalance if done properly. Being on the phone helps to cerate a more neutral environment, but the practitioner's tonality may still be condescending.
- Colleges can create an environment where the patient understands key information and ensure that practitioners do not abuse the use of virtual care.
- Concerns about where information is being sent to – sensitive photos and examinations must be dealt with securely.
- The standard of virtual care and in person care should be the same within the limitations of technology.
- It is important to advocate for the aging and nonverbal population.

Follow up

- It would be helpful to schedule the follow up during the initial session as well as be notified of the information patients need to provide the practitioner in advance (blood pressure, temperature, etc.)
- Consistency between health care providers and accurate recordings of previous visits/questions asked.

- The practitioner needs to allocate ample time to the patient because some have several health concerns.
- Individuals may not have access to technology/internet. Remote communities are affected because of insufficient infrastructure.
- There must be confirmation that filing a complaint would be the same if the care is virtual.

Other comments

- How can nonverbal patients have equitable access to care?
    - Visuals are needed – telephone calls need a trusted facilitator.
    - There should be some capacity to be able to use augmentative communication tools such as the ToBI system.
- Virtual care has strengths but can also potentially enhance the inequities in our health care system if we become to dependent.
- Trust and accessibility: peer support can be beneficial so people can have assistance accessing and navigating the system.
    - The navigator must be a part of the system – not a volunteer.

Feedback on the BC-PAN Logo

Praise designed several logo options for the BC-PAN and presented them to the attendees. A discussion ensued addressing what advisors liked and disliked about the options.

- Open circle is good symbolism and shows equality.
- Missing association with health care regulators.
- Include a tag line.
- The logo should be clear that the BC-PAN is the union between the public and the regulators.
- Tree design with branches idea: the leaves of a tree can represent BC-PAN advisors.
- Re-evaluate colours.

Meeting Evaluation

College partners and public advisors were asked to fill out a meeting evaluation survey on Mentimeter.

What worked well about today's session?

- Breakout groups worked well; being with different people in each discussion was beneficial.
- Meeting was very engaging despite being virtual.
- Excellent facilitation and utilization of online tools.

What should we do differently at the next meeting?

- More large group discussions.
- Some more time to discuss topics would be helpful.
- It is distracting when the facilitator and engagement coordinator move around to different breakout rooms.

October 1, 2020 – Discrimination in Health Care

Summary

College partners would like to hear from the advisors on what colleges can do to promote cultural safety and equity within the health care system. Personal experiences, thoughts and feelings on this issue will be explored.

Public advisors present

- Annie Danilko
- Dianne Johnson
- Elena Kanigan
- Emanuela Silvestri (present for 2.5 hours)
- Helen Espiritu
- John Sherber
- Margaret Bricker
- Marty Lingg
- Rhianna Millman
- Shawna Bennet
- Terry Browne

College partners present

- Anita Wilks, CDSBC
- David Perry, CPBC
- Dianne Millette, CPTBC
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Welcome and Land Acknowledgement

David Perry, CPBC Director of Policy and External Relations, welcomed the group and opened with a land acknowledgement and a personal story about how he first began learning about his own white privilege as a young boy. He emphasized the importance of the day's work in the necessary steps needed to take to move towards racial equality.

All attendees inputted in the chat acknowledging the Indigenous lands they are located on.

Meeting Orientation

Susanna reviewed the prior day's meeting evaluation results. She explained the purpose of the day's meeting:

- To explore what the colleges can do to regulate through a lens of anti-racism, cultural safety, and health equity.

Susanna spoke about her personal white privilege and explored concepts of race, privilege, and intersectionality. She introduced the ideas of mirrors and windows:

- Mirrors: looking into ourselves and recognizing our own privileges.
- Windows: looking outside ourselves to understand the system that we live in.

Susanna made several points about the day's discussion:

- People will make mistakes; it is important to focus on the impact of those mistakes and not the intent. We must commit to acknowledging mistakes and learning.
- Attendees should feel free to take a break at any time.
- Some will have lived experience, there is no pressure to contribute more than what feels comfortable.
- This is an important but difficult conversation.

Orienting to a Discussion About Discrimination

Susanna initiated a poll to orient to a discussion about discrimination:

> *How familiar are you with discussions about identity and privilege?*

The results were:

- The words are fairly new to me: 10%
- I've done a bit of reading and/or training: 24%
- I'm working to integrate these concepts into my life: 29%
- I am highly committed to advancing this work: 38%

Susanna reviewed the results with the group. She mentioned that the day's discussion is focused on what the college partners can do. She invited participants to input in the chat the types of health care practitioners they use daily and emphasized the need to include the wide variety of health care professionals.

Presentation: Talking Together About Privilege and Discrimination

Susanna asked Susan Prins, CPSBC Director of Communications and Public Affairs, to clarify the mandate of colleges.

- Practice standards are expectations set by colleges that registrants must abide by and are held accountable to.
- Processes include processes for registering registrants, filing complaints, or administering quality assurance programs.

- Colleges provide oversight to ensure that registrants are competent and ethical through programs such as (in the case of CPSBC), peer practice enhancement programs and accreditation programs.

A brief group discussion followed:

- Confusion about the roles of health authorities and health care regulators.
- Regulatory mandates are sometimes in conflict with institutional policy and health authorities should be part of the conversation.
- College partners clarified that health authorities are accountable to the government through different means.
    - A health authority can bring concerns to a college if there are inquiries about individual health practitioners. Colleges are responsible for individual practitioners.

Susanna emphasized the urgency of the day's conversation. A few days prior, a 37-year-old Indigenous woman passed away in a hospital pleading for help and instead received racist, demeaning and condescending remarks from those who were supposed to provide her care. Advisors were visibly upset about the tragic incident and were moved to act towards addressing and deconstructing systemic oppression. Inspiring words followed:

> *"This is one of the too many stories about Indigenous peoples receiving inequitable care and avoiding care because of previous experiences. The need is great for our colleges to start to dismantle systemic oppression … We are going to make mistakes – we are all learning how to make powerful changes so let us be kind to each other and let us be brave."*

Context Presentation: BC's Health Regulators, Anti-racism, Cultural Safety and Health Equity

Gillian Vrooman, COPBC Director of Communications and Engagement, gave a presentation outlining the steps colleges have taken to address discrimination in health care.

Highlights

- Under the Health Professions Act, it is the duty of regulators to serve and protect the public as well as enforce professional ethics.
- BC Health Regulators pledged their commitment to making our health system more culturally safe for First Nations and Aboriginal Peoples in BC on March 1, 2017.
- BC Health Regulators, the First Nations Health Authority, and the Ministry of Health signed the Declaration of Commitment to Cultural Safety and Humility in Health Services in 2015.
- Following signing the declaration, different First Nations Health Authority events that bring together First Nation Peoples from across BC have created opportunities for regulators to listen, learn and begin to build trust.
- In 2018, BCHR identified a list of activities that health regulators agreed to continue to work on, such as reviewing complaints processes, policies, practices and programs with a lens of Cultural Safety and Humility.
- It is critical to acknowledge that there must be more done to address racism in health care. Mary Ellen Turpel-Lafond is leading an investigation into Indigenous-specific discrimination in B.C.'s health care following allegations of racist games played in some B.C. ERs.
    - BC Health Regulators fully support this investigation.

- The College of Pharmacists has established a Black Lives Matter Working Group within the College to focus on combatting the racism faced by Black people in B.C.

Patient Story

A public advisor shared their personal story about a time they faced discrimination based on their Indigenous identity. They described a procedure with a specialist where they experienced heightened levels of anxiety because of their already negative perceptions of health care providers. At the end of the procedure, the specialist discretely whispered to them, "no drinking for 24 hours".

The advisor closed with the following statement:

> *"I was so hurt and disappointed and upset as this was unbelievable to me … Unfortunately, this happens often … Why in 2020 do we still have to deal with this is beyond me. That is systemic racism and it seems to me that it will be around for my life span. Can I do enough to try and change things? Is there any hope? Right now, I'd say there is no hope for me."*

All attendees paused to ruminate on their story. A brief discussion followed:

- Attendees outpoured their support and gratitude to the public advisor for being so brave to share their story.
- Most were saddened and appalled to hear of their experience.
- Why did the advisor not file a complaint about the specialist?
    - The advisor feared retaliation and did not think that their word would be taken seriously.
- It would be helpful if there was a regulatory process to address these types of issues without going through the formal disciplinary process.

Draft Principles of Cultural Safety for Health Professionals Review

Kelly Newton, CPSBC Policy and Engagement Lead, briefly provided background on draft cultural principles for the public advisors to review. The College of Physicians and Surgeons of BC is working with the BC College of Nurses and Midwives and the First Nations Health Authority in developing the principles. The document is in the beginning drafting stages and colleges can individually determine its use. The college partners are seeking feedback from the advisors on what stands out and what is important to them.

Small Group Discussions: Feedback on Draft Principles of Cultural Safety

Advisors parted into break out rooms to evaluate the draft principles. Susanna shared a collaborative Google document where college partners took notes of the discussion.

Advisor Feedback

Which principles are likely to be most important for patients who might experience discrimination? Why?

- Acknowledgement of power and its effects – colonization is about power imbalance and decolonization requires its acknowledgement.
- Understand BC's colonial history as well as patients' past experiences, cultural values, beliefs and practices.

- Trauma informed approach involves understanding that trauma can occur and understanding why individuals are the way they are.

Are any ideas missing in these principles for health professionals?

- Integrate the concept of compassionate care into clinical practice. Touch and non-verbal behaviour can influence a patient's perception of cultural safety.
- Explain the purpose of interview questions and do not make assumptions about the individual.

What advice do you have for the college, or practitioners, about implementing these principles?

- Role play – provide opportunities for practitioners to experience being a patient.
- Require practitioners to undertake educational programs or professional development on residential care and provide certifications.
- Integrate cultural safety into quality assurance programs.
- Involve elders in the board of representatives to ensure that they have a voice.

Registering a Complaint of Discrimination

Susan Prins summarized colleges' complaints processes and takeaways from recent events.

- When a patient is concerned about the care they have received, they can file a complaint with the regulating college.
- Colleges are aware that not everyone feels comfortable filing a complaint. It is a complicated process that requires written correspondence, investigations, and a letter of the patient's experience.
- We know that there are problems in BC's health care system. Mary Ellen Turpel-Lafond is conducting an independent investigation into Indigenous-specific racism in B.C. health care.
    - Nearly 3000 Indigenous people have shared their stories in a survey for the investigation, yet colleges have heard very little in the form of a complaint.
    - In a search through CPSBC's complaint database over the past eight years using key words like discrimination, racism, and access to care, only 37 files were found.
- Colleges want to hear how they can support patients to come forward and file a complaint if they have had a negative experience. They want to tear down these barriers and improve internal processes.

Small Group Discussions: Registering a Complaint of Discrimination

Advisors were separated into breakout groups to discuss and brainstorm barriers in the complaint process and opportunities for the colleges to improve.

Advisor Feedback

What barriers might the discriminated person face in reporting the incident to a college or another person who can support them?

- Public awareness: most members of the public do not know that colleges exist to protect the public or that they can submit complaints to a college.
- Lack of accommodation: people may have language barriers or different preferences in communicating information.

- There is a power imbalance between the public and health care practitioners – some fear retaliation. People in remote areas only have access to few health care practitioners.
- Many people do not know the process or how to navigate the system. It is not clear who to contact to make a complaint or who has authority. Most would rather give up than attempting to understand the process.
- Having to retell a negative experience can be retraumatizing.

What can a college do before and after an incident of health care discrimination to empower the public to raise their concerns?

- Establish different levels of complaints and different mechanisms to address complaints.
- Provide the opportunity for the public to share concerns verbally; people should be able to speak to someone at the site of where the incident occurs.
- Have support available to guide the public during the complaint process.
- Ensure that the individual is not required to retell their story to the person who originally caused harm.
- An anonymous tip line for the public to address their concerns while protecting their privacy.
- For Indigenous people, issues are often brought forward through storytelling. It is important to make space for those stories to be told.
- Establish patient relations offices within communities and create an interface between those offices and colleges.
- It is beneficial to have visual material or easily accessible material in health care provider's offices about making a complaint; a bill of patient's rights or reinforce the charter of rights.
- Colleges should report on whatever action has been taken after the patient files a complaint.

Other comments

- The complaint system must be simplified through a mechanism such as an online portal.
- Words matter – colleges can make the process softer by avoiding harsh words such as "complaint" or "discipline".
- An independent third party who is a public advocate/navigator can support the public throughout the complaint process.
- Establish a post treatment process for patients to share their experiences through a questionnaire or kiosk approach that can be collected by colleges.

Meeting Evaluation

College partners and public advisors were asked to fill out a meeting evaluation survey on Mentimeter.

What worked well about today's session?

- The facilitator created an excellent environment for everyone to feel safe, be honest and share personal experiences.
- Group dialogue was open, and meeting was respectful.
- Breakout groups allowed college partners to hear from public advisors in greater detail.
- The technology is getting easier to use.

What should we do differently at the next meeting?

- More time allocated for discussions.
- Email all documents to be reviewed, PowerPoint presentations, and breakout questions ahead of time for public advisors to review and formulate answers.
- Bios of attendees would be helpful because of lack of informal opportunities to talk on breaks.
- There seems to be a misunderstanding of private health care. Focus the conversation on meaningful questions/topics that can be impacted by regulators.
- There is still a focus on physicians/medicine.