HOW TO
USE THIS STORYBOARD
AND RAPID-FIRE GUIDE

This brochure has been designed as a convenient guide for JCC ‘The Power of Togetherness’ participants to learn more about the work being featured at this event.

With over 40 rapid fire presentations, and 20 storyboards on display, the guide provides you with the opportunity to preselect storyboards you most want to visit during the day, and to learn more about the work presented that you may not have seen.

Spreading Success & Keeping in Contact

In the interest of spreading success and innovation, and to help inform your own quality improvement projects, a contact name and email accompanies each abstract to help you connect with colleagues before, during and after the event.
<table>
<thead>
<tr>
<th></th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A Community Vision for Primary Health Care in the Thompson Region</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>A New Way of Caring for People with Alcohol Use Disorder (AUD)</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>A Quality Improvement Project to Develop a Facilitator Training Program for CBT</td>
<td>11</td>
</tr>
<tr>
<td>4</td>
<td>BC Guidelines: Supporting Primary Care Practice in BC</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>The Beliefs and Understanding of Advanced Care Planning Among the Chinese Community</td>
<td>13</td>
</tr>
<tr>
<td>6</td>
<td>Beyond Burnout and Resilience: A Journey toward a Health Promoting Work Environment</td>
<td>14</td>
</tr>
<tr>
<td>7</td>
<td>Bringing Communities Together: Sharing Success Strengthens BC's Maternity Network</td>
<td>15</td>
</tr>
<tr>
<td>8</td>
<td>CHANGE BC Kids Camps: Building a GP Led “Bolt On” Model to Embrace Healthy Lifestyles</td>
<td>16</td>
</tr>
<tr>
<td>9</td>
<td>Compass is a province-wide service to support evidenced based care to all BC children</td>
<td>17</td>
</tr>
<tr>
<td>10</td>
<td>Delta's Health Hub: Enhanced connections of Assisted Living/Independent Living seniors to health services</td>
<td>18</td>
</tr>
<tr>
<td>11</td>
<td>Early Detection of Delirium at Delta Hospital</td>
<td>19</td>
</tr>
<tr>
<td>12</td>
<td>The First North American Hip Surveillance Program for Children with Cerebral Palsy</td>
<td>20</td>
</tr>
<tr>
<td>13</td>
<td>Fostering Family Practice Networks through Collaboration</td>
<td>21</td>
</tr>
<tr>
<td>14</td>
<td>Initiation of Opioid Agonist therapy in the ER: Fentanyl crisis ER response</td>
<td>22</td>
</tr>
<tr>
<td>15</td>
<td>Integrating New Psychiatric Collaborative Pit Appointments in British Columbia</td>
<td>23</td>
</tr>
<tr>
<td>16</td>
<td>Locally Grown: Making Connections with our Allied Health Neighbours</td>
<td>24</td>
</tr>
<tr>
<td>17</td>
<td>Optimizing Anemia Prior to Major Oncology Abdominal Surgery within ERAS Pathway</td>
<td>25</td>
</tr>
<tr>
<td>18</td>
<td>Optimizing Patients Prior to Major Oncological Abdominal Surgery</td>
<td>26</td>
</tr>
<tr>
<td>19</td>
<td>Polypharmacy Risk Reduction: Practical Opportunities</td>
<td>27</td>
</tr>
<tr>
<td>20</td>
<td>Smoking Cessation in Crohn's Disease</td>
<td>28</td>
</tr>
<tr>
<td>21</td>
<td>Telehealth &amp; Teleradiology Services at a Tertiary Care Centre</td>
<td>29</td>
</tr>
<tr>
<td>22</td>
<td>Toward a Sustainable Model of Physician Care for Long Term Care Residents</td>
<td>30</td>
</tr>
<tr>
<td>23</td>
<td>Working Together: Division and Facility Engagement Partners</td>
<td>31</td>
</tr>
</tbody>
</table>
CONTENTS

RAPID-FIRE BREAKOUT SESSION ABSTRACTS

A1 PARTNERSHIPS FOR IMPROVED MENTAL HEALTH SERVICE DELIVERY
Attending to the Needs of Post Secondary Students with ADHD ................................................................. 33
Sustaining and Spreading CBT Skills Group Medical Visits .......................................................................... 34
BOOM! When Collaboration Works Out: Creating a Youth Services Hub ................................................... 35

A2 PARTNERSHIPS FOR IMPROVED CARE OF OLDER ADULTS
Delta’s Health Hub: Connecting Seniors in Assisted Living to Health Services .............................................. 36
Leaning into New Conversations: Palliative Care & Assisted Dying ............................................................. 37
How One Nurse Changed a System ............................................................................................................... 38

A3 PARTNERSHIPS THAT ENGAGE & EMPOWER
Shared Care’s Chronic Pain Network ............................................................................................................ 39
Partner to Empower: The Story of the Powell River Hospice Society ......................................................... 40
Physician Engagement in Cancer Care: Developing a BC Medical Staff Engagement Society .................. 41

A4 INNOVATIONS FOR MATERNITY CARE
Bringing Maternity Care Back to the Community .......................................................................................... 42
MoM Models: Tripartite Care Planning for Primary Care Networks .............................................................. 43
Rural Surgical Obstetrical Networks: System Accountability Through CQI & Evaluation ............................ 44

A5 SURGICAL OPTIMIZATION
Surgical Patient Optimization ......................................................................................................................... 45
Surgical Optimization Prehabilitation Program at VCH ................................................................................ 46

B1 THE POWER OF COMMUNITY FOR MENTAL HEALTH SYSTEM IMPROVEMENTS
Northern Shared Care Psychiatry Collaboration .............................................................................................. 47
Working Together: Ten Years of Innovative & Inclusive Care at the Anderson Creek Primary Care Clinic ...... 48
It’s Not Your Problem, it’s OUR Problem: Cowichan’s Efforts in the Opioid Crisis ...................................... 49

B2 HIGH IMPACT TEAMS CARING FOR OLDER ADULTS
Pender Harbour Health Centre Model ........................................................................................................... 50
Coyote’s Food Medicines: Addressing Polypharmacy in First Nations Communities through Storytelling .... 51

B3 IMPLEMENTING CARE TEAMS FOR SYSTEM CHANGE
Supporting Chronic Pain through a Specialist Referral Pilot ......................................................................... 52
Improving Chronic Pain Care in a Rural Community .................................................................................... 53
A Collaborative Approach to Improving Quality of Long Term Care in Interior Health ............................... 54
B4 NEW APPROACHES TO MATERNITY CARE
Filling Perinatal Mental Health Gaps for Moms ................................................................. 55
Supporting Rural Maternity Sites: A Collaborative Exercise in Service Planning ................................................................. 56
Bringing Communities Together: Sharing Success Strengthens BC’s Maternity Network ................................................................. 57

B5 MATCHING CARE INNOVATIONS TO COMMUNITY NEEDS
Collaboration to Support Transformation: Team Mapping & Patient Centred Circles of Care ................................................................. 58
Harnessing the Winds of CHANGE BC: Rural GP Perspectives on Innovation ................................................................. 59
Transgender Patient & Provider Pathways for Abbotsford and the Fraser East ................................................................. 60

C1 LEVERAGING TECHNOLOGY FOR IMPROVED MENTAL HEALTH & SUBSTANCE USE OUTCOMES
Standardization of Early Psychosis Assessment ................................................................. 61
Evolving Doors with E-Mentor: Using Virtual Mobile Number Technology to Support Peer-to-Peer Networks ................................................................. 62

C2 INNOVATIVE TECHNOLOGY IN THE CARE OF COMPLEX OLDER ADULTS
Shared Care in Action: The Development of a Regional Cardiology Referral Process ................................................................. 63
Pre-Habilitation for Enhanced Recovery After Surgery: Creating Tools & Relationships ................................................................. 64

C3 INNOVATION IN SYSTEM IMPROVEMENTS
Goals of Care Conversations with Patients of Chinese Ethnic Background ................................................................. 65
Social Worker in Family Practice ................................................................. 66
A Multi-Disciplinary Approach for a Sustainable OR Program ................................................................. 67

C4 PARTNERSHIPS FOR SYSTEM IMPROVEMENTS
A Community Vision for Primary Health Care in the Thompson Region ................................................................. 68
Heart Health for Mothers in Rural BC: The Prince Rupert Post Partum Clinic Experience ................................................................. 69
Family Practice: Psychiatry Partnership ................................................................. 70

C5 SYSTEM CHANGE AND TECHNOLOGY
Real Time Virtual Health Support in Emergency: Opportunities, Issues, & the Path Forward ................................................................. 71
Finding a Better Way: Improving the Referral Process with an Electronic Platform ................................................................. 72
The QI League! Building a Culture of CQI at Royal Columbian Hospital ................................................................. 73
THE POWER of togetherness

STORYBOARD
ABSTRACTS
A Community Vision for Primary Health Care in the Thompson Region

Contact: Rhonda Eden
Thompson Region Division of Family Practice
reden@divisionsbc.ca

The intent of this project was to work collaboratively with a diverse subset of stakeholders in the region, including Indigenous people, to understand challenges and opportunities associated with the patient-health provider experience, and garner feedback to develop a region-wide shared vision for primary health care. The GPSC PMH Practice Characteristics Matrix was used as a guide to inspire stakeholder feedback. A multi-faceted approach to engagement was taken, including an online survey, patient interviews, public events, and targeted stakeholder focus groups and / or workshops. A webpage was also developed for stakeholders to find out information on the project and take the survey. Communities involved included Logan Lake, Kamloops, Barriere, Sun Peaks, Chase and Scotch Creek and between the survey and in-person events the engagement efforts reached over 700 people. The benefits of this project include, a greater awareness of the primary health care system, the need for individuals to play a more active role in their health outcomes, the need for communities to play a more active role in supporting delivery of comprehensive primary care, and an opportunity to create new community partnerships. This project supported a more collaborative effort to enhance health care and a move toward a more team-based approach to primary health care. The information gathered has the potential to help inform primary care networks and / or community health services planning, as well as guide future Division work and public education.
A New Way of Caring for People with Alcohol Use Disorder (AUD)

Contact: Jeff Harries
Interior Health Authority
jeffharries@gmail.com

There is a new way of caring for people suffering with Alcohol Use Disorder that is dramatically better than what we have done previously. Pharmacotherapies that are inexpensive, used for a limited time, have been shown to dramatically improve patient outcomes.

Our project involves raising awareness of this New AUD Treatment Protocol and to support its community wide adoption.

This project and has no affiliation with any commercial interests. The project is currently expanding across IHA and in other Health Authorities in B.C.
A Quality Improvement Project to Develop a Facilitator Training Program for CBT

Contact: Julie Lawrence
UBC Psychiatry
jul.lawrence@gmail.com

CONTEXT AND RELEVANCE:
The CBT Skills Group Program is an 8 week program recently designed by a group of psychiatrists and family physicians in Victoria, B.C., which is being spread to other communities. The pilot was funded by the Victoria Division of Family Practice and the Shared Care Committee, and aims to offer accessible self-management skills for primary care patients with mild-moderate mental health problems, delivered within group medical visits. Family physicians train to become facilitators, but come to the process with diverse backgrounds and skill sets. We sought to improve on an existing physician training model so it could be integrated into a standardized training program for spread. The existing model included family physicians progressively co-facilitating groups and debriefing with a psychiatrist, guided by an electronic Facilitator’s Guide.

INTERVENTION:
Using plan-do-study-act cycles, we collected feedback from users, redesigned and field tested a new version of the Facilitator’s Guide and honed the co-facilitation process. We also crafted observable competencies to aid in assessment of facilitator knowledge and skills.

OUTCOMES:
Through qualitative feedback surveys and repeated measures of a needs assessment tool, trainers and trainees reported they were overall very satisfied with the training program. Trainees reported increasing competence and confidence facilitating the CBT Skills program over the course of the training process. A series of three rounds of observing/co-facilitating the CBT Skills program was deemed the minimum to attain competency.

LESSONS LEARNED:
Trainees highlighted features of the training model and tools that were of significant utility, and provided suggestions for ongoing support as they transition to independent facilitation. Key components to include in a standardized spreadable program are being identified.
BC Guidelines: Supporting Primary Care Practice in BC

Contact: Sandra Lee
Guidelines and Protocols Advisory Committee
sandra.lee@mac.com

BC Guidelines are concise, evidence-based, clinical practice guidelines tailored to support primary care practice in BC, available at www.BCGuidelines.ca. BC Guidelines are produced by the Guidelines and Protocols Advisory Committee (GPAC), an advisory committee of the Medical Services Commission and a joint collaboration between Doctors of BC and the Ministry of Health. GPAC supports effective utilization of medical services and high quality, appropriate patient care through the development of BC Guidelines. In order to be relevant and accessible in the busy primary care context, BC Guidelines are concise and user-friendly and are tailored to practice in BC through providing local content and resources for practitioners and patients.

Over the past 20 years, GPAC has developed more than 60 BC Guidelines on a wide range of topics such as diabetes, asthma, heart disease and opioid use disorder. Our storyboard will highlight how BC Guidelines are developed, how GPAC collaborates with stakeholders across the BC health care system, and how stakeholders and practitioners can contribute to guideline development. We will also report on guideline implementation and evaluation strategies (e.g., monitoring changes in lab test ordering and web analytics). We will provide insight on how we have overcome challenges in expanding our reach by building strategic partnerships with other health sector organizations and improving our promotion among BC practitioners. We will highlight recently released guidelines and new guidelines that are under development including Testosterone Testing, Thyroid Function Tests, Adverse Childhood Experiences, Alcohol Use Disorder and Chronic Pain.
The Beliefs and Understanding of Advanced Care Planning Among the Chinese Community

Contact: Amrish Joshi
Richmond Integrated Hospice Palliative Care Program
jamrishaj@gmail.com

CONTEXT:

Discussions on Advanced Care Planning (ACP) with patients—understanding their goals of care in advance of serious illness—reaps benefits for patients and family: improved quality of life and a reduction in aggressive interventions when the patient is no longer able to direct care. Presenting tools and approaches to these discussions incorporates the Western concept of autonomy—the patient’s ‘right to know’ versus the Eastern concepts of a family’s right to know.

OBJECTIVES:

Exploring the appropriateness of language and terminology used when presenting the Serious Illness Conversation Guide (SICG) to English speaking Canadians of Chinese ethnic origin. Design A qualitative approach recorded the experiences from focus groups—individuals from a Chinese ethnic background who are able to communicate in English. A role-play of the SICG was conducted for the groups to critique the process and the language used. Theoretical Constructs, Themes, and Sub-themes were conceived from the study. Participants Four organisations, representing members from the Chinese community, participated in the study; they were based within Richmond and Vancouver, British Columbia. A total of 27 participants were interviewed.

RESULTS:

Three Theoretical Constructs, nine Themes, and twenty-seven Sub-themes were identified. The Theoretical Constructs formulated: Advanced Care Planning (ACP)/Advanced Care Directives (ACD); Factors Facilitating or Hindering Communication; Words and Phrases Used in the SICG. The Themes formulated: Awareness of ACP/ACD; Key Individuals; Timing of Discussions; The Façade; Religion; Relationship Building; The Perception of Palliative Care Services; Perceived Futility of the Questions; The Power of Words—Negative and Positive. Conclusion The study corroborates the influence of the Western concept of autonomy in the SICG, while acknowledging the Eastern concepts of a more passive role of the individual in decision-making; the family’s role, importance, and involvement may at times supersede the individual.
Beyond Burnout and Resilience: A Journey toward a Health Promoting Work Environment

Contact: Dr. Anne Pousette  
Prince George Medical Staff Association  
drannepousette@gmail.com

The prevalence of clinician burnout and poor health has been widely reported on in recent literature, and the impact of this on patients, health outcomes, and cost to the system similarly documented. In June 2017 a project funded through the Facility Engagement program at University Hospital of Northern BC (UHNBC) began to explore how the health and well-being of physicians and hospital staff might be improved. This physician lead initiative involves 5 physicians, 6 senior leadership and staff from Northern Health, Doctors of BC Regional Advocate, and learners. We will present work to date which includes evaluation of models and frameworks for health in the workplace, a literature review to increase our understanding of physicians and hospital staff perspectives on what contributes to their health, mapping of factors that influence health to the 13 Psychological Health and Safety Framework (Canada’s national standard for the workplace), results of a physician survey on relevance and awareness of resources, the communication plan including a newly designed website tool with linked resources, and our road map for continued work on this journey. Early findings demonstrate key enablers as well as areas for action and knowledge mobilization as we seek to improve the health and well-being of hospital based physicians and staff at UHNBC.
Bringing Communities Together: Sharing Success Strengthens BC’s Maternity Network

Contact: Lee Yeates
Shared Care Committee
lyeates.rm@gmail.com

We come to know collaboration in the fullest sense, by experiencing it. Enhancing an interprofessional collaborative approach to the local planning and delivery of maternity services underpins Shared Care’s new Maternity Network. The Network’s emerging success exemplifies the power of togetherness. In collaboration and alignment with the Rural Coordination Centre of BC, the GPSC Maternity Working Group, and Perinatal Services BC, the Shared Care Committee is evolving a provincial process and community of practice for enhancing interprofessional collaboration, that also facilitates the spread and sustainability of local innovation, increased access to care, and improved care quality. At the coalface of this initiative, in 21 communities across British Columbia, maternity teams co-led by family physicians, obstetricians, and registered midwives are engaging in supported, needs-based projects that enable the sharing of knowledge, ideas, and resources so that improved relationships across health disciplines, and between providers, practice groups, community partners, and families may emerge. Teams are strengthening their collaborative muscles as they come together to tackle tough local issues like developing maternity pathways and standardizing care, improving access for vulnerable populations and with Indigenous peoples, sustaining rural maternity services, and building interdisciplinary team-based practice groups. By capturing and evaluating the incredible successes realized in early project communities such as Comox, we have created a roadmap and toolkit for enhancing collaboration that includes key process steps and resources. As a potential model for the patient medical home, this Shared Care initiative also aims to capture and describe the successes and challenges of developing integrated, team-based approaches to care.

AUTHORS:
1) Lee Yeates, RM, MHM, CHE
2) Jeanette Boyd, MD, CCFP
3) Nancy Falconer, MSc, PMP; Liaison – Shared Care Committee
8

CHANGE BC Kids Camps: Building a GP Led “Bolt On” Model to Embrace Healthy Lifestyles

Contact: Brenda Huff
huffbrendaag@gmail.com

BACKGROUND:

With the development of the patient medical home and primary care networks in British Columbia, Family Physicians are looking at innovative healthy lifestyle models to improve health. In seeing a significant number of children with obesity in family practice, and recognizing that 18.6% of BC children are overweight or obese (Statistics Canada 2013), Family Physicians in the Pacific Northwest Division of Family Practice expressed an interest in developing a kid friendly, cost effective outreach model to engage with children attending summer camps.

METHODS:

A comprehensive literature review of national and international literature was undertaken on pediatric primary care lifestyle models. Family Physicians from the communities of Haida Gwaii, Terrace, and Houston worked together with University of British Columbia School of Kinesiology students to develop an innovative CHANGE BC Kids Camp, a pilot program designed to bolt early physical literacy and healthy nutrition into existing community summer camps.

RESULTS:

Qualitative analysis of results (n=42) from pediatric camp participants ages 6 – 12 (July – August 2018) showed positive results in terms of perceptions of adding early physical literacy and healthy nutrition activities to existing camps. The camps also were noted to be cost effective due to opportunities to co-design modules with existing community camps, rather than building separate infrastructure.

CONCLUSION:

Family Physicians and Kinesiology students leading the development of CHANGE BC Kids Camps have developed a demonstration pilot that was well received by children in the communities of Haida Gwaii, Terrace, and Houston. This “bolt on” model of primary care prevention is scalable as a potential cornerstone model within primary care networks and will be further expanded and evaluated in the summer of 2019.
Compass is a province-wide service to support evidenced based care to all BC children

Contact: Jennifer Russel
BC Children’s Hospital
jennifer.russel@me.com

WHAT IS COMPASS?

Compass Program Overview

Compass is a province-wide service to support evidenced based care to all BC children and youth living with mental health and substance use concerns. This is done by supporting community care providers with the information, advice, and resources they need to deliver appropriate and timely care to children & youth close to home.

The multidisciplinary team includes child and youth psychiatrists, mental health and substance use clinicians (social workers, nurses, psychologist, etc.) and a care coordinator.

WHO CAN USE THIS SERVICE?

The service is available to various community care providers working with children and youth with mental health & substance use issues, such as primary care providers, specialist physicians, child & youth mental health team clinicians, Foundry clinicians, and concurrent disorders/substance use clinicians.

WHAT CAN YOU EXPECT FROM THE SERVICE?

When you call for a consultation, you’ll have access to a multi-disciplinary team who can offer:

• Telephone advice and support
• Identification and help with connection to local & online resources
• Telehealth consultation to you and your patient, when needed
• Tailored training and education

The Compass team can help with diagnostic clarification, medication recommendations, treatment planning, consultation around cognitive behavioural therapy, dialectical behaviour therapy, substance counselling, behavioral issues, family issues, trauma treatment, etc., and general support when things aren’t going well. You will receive a written record of all consultation recommendations for your patient’s chart.
Delta’s Health Hub: Enhanced connections of Assisted Living/Independent Living seniors to health services

Contact: Tomas Reyes
Delta Division of Family Practice
treyes@synergyimpact.ca

BACKGROUND:
Seniors in assisted or independent living residences have limited access to primary care supports. The high prevalence of multiple chronic conditions within this population results in residents often being sent to hospital emergency departments (ED) when they require care. Many of these seniors cannot be discharged because of the lack of appropriate supports. They stay in hospitals for longer periods of time or inappropriately moved to residential care homes, both of which incur a high cost on the health care system.

PROJECT:
The Delta Division of Family Practice, with funding from the Shared Care committee and in partnership with Fraser Health (FH), implemented a “Health Hub” at Augustine House in Delta, BC. The Hub offers a centralized service that connects residents to their family physicians (GPs) and manages referrals to geriatricians, pharmacists, and Fraser Health’s Home and Community Services. The Hub also hosts education sessions that empower residents to self-manage their own health.

METHODS:
FH and project documentation will be reviewed to assess the Hub’s operations and implementation, and progress made towards the intended outcomes. Questionnaires will collect qualitative and quantitative data from clients and families regarding their experience with the Hub. Key informant interviews with stakeholders will gather information on the project’s development, engagement, and outcomes.

OUTCOMES:
The Hub’s primary intended outcomes are decreases in the number of ED transfers from Augustine House and length of stay in hospitals. Secondary outcomes include the number of residents identified as frail, number of services to which seniors are referred to and their outcomes, number of residents reporting increased knowledge of targeted medical issues, and perception of support by residents and families, GPs, and Augustine House staff. After four months, the Hub has served 40 residents. More results will be available when the project ends in March.
Early Detection of Delirium at Delta Hospital

Contact: Jane Van Den Biggelaar
janecvdb@gmail.com

AIM:
Increase the percent of patients with Delirium that have a documented diagnosis within 24 hours of presentation to the Delta Hospital Emergency Dept to 80% by June 2018.

BACKGROUND:
Delirium is poorly recognized and inadequately treated in medical settings. Delta Hospital is a 75 bed hospital in the Fraser Health Authority of British Columbia, Canada, where delirium has become more prevalent due to aging demographics. Literature reviews on delirium in the emergency department have shown that many elderly patients are often sent home or admitted with unrecognized delirium. The emergency room is the first contact with elderly patients who often have relatives/friends with them for collateral history. Although delirium is often multifactorial, the goal of early detection is early treatment of reversible causes. Delayed detection of delirium can lead to increase length of stay and morbidities.

CHANGES:
Introduction of a ER Delirium Screening Tool – INCLUSION Criteria (age>75 and/or dementia)) EDUCATION sessions on CAM and bCAM Establish an effective COMMUNICATION system between RNs and MDs regarding CAM – verbal/note “Delirium Protocol” order which includes PPOs and green flagging chart

CONCLUSIONS/FUTURE PLANS:
Since Nov 2017, 59% of patients presenting to the ER with delirium have been diagnosed within 24 hours (taken from I chart), the goal being 80% ER delirium screening. CAM education and communication likely contributed to improvement. ER delirium screening has been added to the regional emergency assessment record since June 2018 and we continue to collect data on early detection.
The First North American Hip Surveillance Program for Children with Cerebral Palsy

Contact: Stacey Miller
BC Children’s Hospital
smiller4@cw.bc.ca

The Child Health BC Hip Surveillance Program for Children with Cerebral Palsy is the first province/state wide hip surveillance program in North America. The aim of the program is to ensure that all children with cerebral palsy (CP) in British Columbia (BC) receive screening to allow for early and appropriate management of hip displacement. One in three children with CP will have displacement.

A provincial implementation plan was developed collaboratively with over 60 multisector stakeholders, including parents, from across BC. Surveillance occurs in the child’s local community. A program coordinator and medical lead at BC Children’s Hospital (BCCH) work with the child’s local health care team, primarily the child’s physiotherapist. Prior to implementation, pediatric physiotherapy (PT) and occupational therapy services in BC were mapped to determine service providers and to identify gaps in services. Targeted education and enrollment information were provided to therapists through emails and the development of online resources. Staged implementation began in September 2015 at BCCH and at two test sites in February 2016 before full provincial roll out in August 2016.

A total of 781 children have been enrolled in the program. This represents 46% of the estimated population of children with CP in BC born between 2000 and 2016. Enrollment between the province’s 5 health authorities varies from 19% (Interior) to 53% (North) of expected suggesting regional differences in ability to identify and enroll children with CP in the program. PT’s have reported barriers to enrolling children including a lack of a CP diagnosis and a lack of support for enrollment from the family physician/pediatrician or family. This has necessitated additional targeted knowledge translation strategies for families, physicians, and therapists. Regional differences in ability to enroll children in surveillance are now being considered and will necessitate customized strategies.
Fostering Family Practice Networks through Collaboration

Contact: Shelley Breen
Thompson Region Division of Family Practice
sbreen@divisionsbc.ca

In a true Patient Medical Home (PMH), family practices are an essential part of clinical networks partnering to meet the access and comprehensive care needs of patients in a community. Reciprocally, the design, function and operationalization of these networks are typically dependent on the needs of those stakeholders.

In a recent case study, the development of family-practice-to-family-practice (FP-FP) networks in Thompson Region was explored to exhibit key findings. The study involved a literature review, interviews with local family providers, Practice Support Program (PSP), Division of Family Practice (DFP) and provincial stakeholders, and a survey to local FPs.

The outcome demonstrates that the growth of the FP-FP network is dependent on collaboration between PSP and DFP. This intentional teamwork builds both relationships and trust across stakeholders, enabling the expansion of FP-FP networks to include other PMH resources such as allied health and specialized nursing.

Recommendations for other collaborative structures developing local FP-FP networks include:

- Establish partnerships between local PSP, DFP and FPs as the foundation to support network development.
- Identify approaches to integrate familiar, trusted and valued resources into networks, including relationships and processes. This streamlines the progression of the work.
- Prioritize communicating early successes from other FP-FP networks as they are identified.
- Develop resources and tools that can be used to support FP-FP networking.
- Identify methods to compensate physicians for their investment in networking activities and ensure that their involvement is limited to their areas of expertise.
- Continually evaluate the value of these networking activities to improve, sustain and generate economies of scale.

Close working relationships between PSP, DFP and FP, along with structural, operational, and relational enablers will foster the development of FP-FP Networks for years to come.
Initiation of Opioid Agonist therapy in the ER: Fentanyl crisis ER response

Contact: Jason Wale
Island Health
jasonwale99@gmail.com

The ongoing fentanyl overdose epidemic is the worst health care crisis in British Columbia, claiming more than 1,400 lives in 2017. It is the leading cause of death in youth to age 45, killing 1 person every 6 hours in BC. Most who died had prior medical encounters leading up to their death, with the majority being in the ER. Previously emergency Departments only treated the complications of opioid use such as overdose, infectious, social and mental health complications. In July 2016 the BCCPS authorized all physicians to use the opioid substitution medication Suboxone (buprenorphine and naloxone in a sublingual tablet), giving ER physicians a new opportunity to proactively help these most vulnerable patients by offering and encouraging opioid substitution therapy initiation in the ER with bupropion. This partial agonist is a safer treatment for withdrawal and has the best evidence behind it to help opioid use disorder patients recover from their disease. We aim to provide 100% of opioid use disorder patients presenting to Island Health emergency departments the option of initiating Suboxone and rapid access to addictions treatment. Piloted at RJH and VGH in Victoria in 2017 we now have similar protocols initiated in multiple Island Health Emergency Departments and are actively learning from each other. Lessons learned from the more than 150 patients referred in Victoria include the necessity of streamlining ER initiation and referral by beginning nurse protocols at triage, the power of peer support in-reach to gain patient trust and engagement and the need for ER observation units to hold patients for up to 23 hours for buprenorphine initiation. The ER visit can be a sentinel moment in a patient’s life. For patients with opioid addiction we are attempting to capitalize on this to change the trajectory of their addiction illness and save lives.
Integrating New Psychiatric Collaborative Pit Appointments in British Columbia

Contact: Marilyn Thorpe
drmarilynthorpe@gmail.com

Mental health is an area of concern for governments, clinicians and patients. Waiting lists for psychiatric consultations in B.C. are long. As previously presented at the Quality Forum, the Specialist Service Committee (SSC) sponsored clinicians at the University of Victoria Health Services to evolve and curate a new collaborative 30 minute psychiatric assessment (i.e., Pit Appointment) which takes place with a family doctor, patient and psychiatrist in the family practice clinic. Wait times dropped from 43 days to 11 days for a Pit Appointment and 19 days for a full psychiatric consultation. This innovative model is ready to be celebrated and spread to other communities. Supported by SSC for one year (2018), our team aims to identify spread sites in B.C., and to teach both how to integrate Pit Appointments in current clinic work and how to best evaluate the impact on clinic wait times, patient and provider satisfaction. Success is measured by actual and impending implementation. The recently published paper, mock pit assessment video, website, and Pit Appointment manual will be used to disseminate this information. Presentations to B.C. health administrators, family physicians and psychiatrists are underway, gleaning interest and learning of barriers in clinics from attendees. At the midpoint of our spread initiative, the greatest challenge is finding suitable spread sites in an ever-changing health care context. Activating psychiatrists to try a new collaborative method and activating individual sites where physicians are already busy and overwhelmed are also barriers. Balancing the desire for communities to be innovators instead of adopters of innovation is also challenging. Consequently, our messaging and focus are evolving. We will present our results, describe what we learn from various sites we target, and illustrate how our messaging and focus evolves. Plans to continue implementation, including evaluation, will be described.
Locally Grown: Making Connections with our Allied Health Neighbours

Contact: Chelsea Brookes
Thompson Region Division of Family Practice
cbrookes@divisionsbc.ca

In 2017 the Thompson Region Division of Family Practice hosted a networking event bringing together division members and allied health professionals. The primary focus of the evening was to provide an opportunity for providers to meet and develop connections to support a move toward team-based, integrated care within the Thompson Region. The turnout was overwhelming with over 85 allied health, family physicians, medical residents, and nurse practitioners in attendance.

Attendees engaged in several interactive activities related to the importance of team-based care, current barriers to collaboration, and opportunities to work together. We heard that there is widespread interest in moving toward a collaborative and integrated system of health care in our community and that allied health involvement is an important part of that equation. This event was the first step in building relationships to start talking about patient medical homes and networks.

Since then, the project team met with 8 groups of allied health to continue the conversation and discuss networking. This has been ground-breaking for our community; providers are used to working in silos and communication remains an ongoing challenge. We heard that the main barriers to collaboration centre around a lack of time, inadequate communication, and information sharing issues. While solutions to these barriers varied, many individuals indicated the value of opportunities to interact professionally through more social and educational events with colleagues. We are planning educational events; for example, the orthopedic surgeons will host a CME event for primary care providers, physiotherapists, and massage therapists. We intend to do the same with mental health.

Ultimately, we are seeking a community approach to network planning to ensure it is more sustainable. The goal is to formulate a coordinated system of care between providers in the Thompson Region that focuses on the needs of the patient.
17

Optimizing Anemia Prior to Major Oncology Abdominal Surgery within ERAS Pathway

Contact: Kelly Mayson
Vancouver Coastal Health
kelly.mayson@vch.ca

Our VGH NSQIP database has demonstrated that 40.8% patients with bladder cancer presenting for radical cystectomy (RC) present with anemia, and even higher for gynecological oncology (GO) patients at 43.2%. Transfusion rates in the first 72 hours after commencing surgery were 26.6% (RC) and 14.23% (GO) respectively. Our Perioperative Blood Management Team had recommended to surgeons that all patients undergoing RC, regardless of sex, should be screened for iron deficiency anemia if their hemoglobin was less than 135 g/L. GO female patients should be referred with Hg < 110. Despite this recommendation a prior audit found that only 43% of RC patients meeting that criteria were referred to the PBMP and received either oral or IV prior to surgery.

INTERVENTION:
A multidisciplinary group of family physicians, surgeons, anesthesiologists a transfusion medicine specialist, endocrinologist and nursing staff was created in September 2017, and had bimonthly meetings to process map the patients’ journey from their initial consultation with the surgeon to their admission to hospital. Education around the PBMP referral criteria, the timeline for treatment (minimum 3 weeks), and average transfusion rates was provided.

RESULTS:
76 consecutive elective RC cases, and 297 GO were followed from Oct 1 2017-July 30, 2018, and compared to historical NSQIP data. There has been a significant decrease in anemia for GO, 42.3% to 30.3% (p< 0.05) and a trend to a decreased transfusion rate, 14.7% to 10.1%. The incidence of anemia for RC is trending downwards from 40.3 % to 32.9%, however percentage of cases requiring a transfusion has not yet decreased (26.6% vs 30.3%), but the number of units transfused per patient is decreasing. As well the % of appropriate referral to PMBP has significantly increased.

LESSONS LEARNED:
Greater education regarding anemia to physicians and improving referral to PBMP resulted in a decrease in the incidence of anemia preoperatively.
18

Optimizing Patients Prior to Major Oncological Abdominal Surgery

Contact: Kelly Mayson
Vancouver Coastal Health
kelly.mayson@vch.ca

ERAS protocols improve care and decrease complications. Preoperative risk factors such as frailty, malnutrition and hyperglycemia are associated with increased morbidity, mortality and length of stay. Our aim was to delineate the incidence of these risk factors & ensure that high risk patients were identified & optimized while on the surgical waitlist. Our prevalence of diabetes was approximately 15% in this surgical population, and ~50% of non-diabetic patients have been documented to have glucometers >9.0 in the postoperative period, hence the need for optimizing glycemic control preoperatively.
Polypharmacy Risk Reduction: Practical Opportunities

Contact: Dr. Chris Rauscher
Shared Care Committee
rauscherchris50@gmail.com

This storyboard will highlight the work of the Shared Care Polypharmacy Risk Reduction Initiative to develop, test and implement practical approaches for generating patient-centred interdisciplinary medication plans, spanning acute care, residential care and the community. This work has been carried out over the last 6 years in local communities, in partnership with the Divisions of Family Practice and acute care physicians, as well as pharmacists and other health care providers in those care environments. Key approaches and the associated resources and tools will be profiled, as well as polypharmacy resources on the Shared Care Committee’s website which contains the ‘legacy’ of the Polypharmacy Risk Reduction Initiative. This information, with the legacy of the website, will support interested individuals who may wish to establish or carry on this work in their specific communities.
Smoking Cessation in Crohn’s Disease

Contact: Ben Cox
ben.cox@alumni.ubc.ca

Crohn’s disease is a debilitating disorder that effects many areas of the body, predominantly the gastrointestinal system. Symptoms include abdominal pain, diarrhea, and weight loss. The causes of Crohn’s disease are not fully understood, but it is known to be influenced by genetic and environmental factors. One of the most significant environmental factors is smoking, which increases the risk of developing Crohn’s disease and the severity of disease flares, yet smoking cessation is often overlooked in the management of Crohn’s. My research aims to determine if having a specific Smoking and Crohn’s Disease information package in the offices of gastroenterologists and a dedicated smoking section in the charts of Crohn’s patients leads to an increase in the rate at which gastroenterologists discuss smoking cessation with their patients.

A Smoking and Crohn’s Disease information package was created which outlines the risks of smoking with Crohn’s disease as well as cessation options, and was made available in the offices of two gastroenterologists. These gastroenterologists were asked to dedicate a section of patient charts to smoking. A chart review was performed for 250 Crohn’s patients from these gastroenterologists as well as ten other gastroenterologists who did not have the information package. The rates at which smoking history and cessation was discussed with patients was obtained. In the offices with Smoking and Crohn’s Disease information packages, smoking history was documented for 95% of patients compared with 56%. In patients who were smokers, a cessation plan was discussed 92% of the time in the offices with the information package vs. 15% in those without. Smoking has a profoundly negative impact on the disease course of Crohn’s. Having a specialized Smoking and Crohn’s Disease information package and a dedicated smoking section in patient charts leads to an increased rate of smoking documentation and cessation planning.
Telehealth & Teleradiology Services at a Tertiary Care Centre

Contact: Eva Habib
BC Children’s Hospital
eva.habib@cw.bc.ca

Telehealth is a growing area of focus in the Canadian health sector. Federal and provincial funding has been provided to use communication technologies aimed at improving access to health care for all Canadians and understanding whether clinicians can provide patients with an equal or higher standard of care without an in-person examination.

Teleradiology is the transmission of radiological images, such as x-rays, CTs and MRIs, from one location to another for the purposes of sharing patient information with other physicians. We reviewed 80 patients (F=66, M=14) that received teleradiology orthopaedic consultations at a tertiary care pediatric centre since 2015. This involves health care service for a patient initially seen at our institution but arranged to have follow-up radiologic imaging in their community, followed by a telephone consultation with the orthopaedic team to review results. Of these patients, 62 patients had been diagnosed with developmental dysplasia of the hip, 7 with cerebral palsy, 5 with osteogenesis imperfecta, 3 with other hip disorders, and 2 traumatic injuries. The mean age was 3.5 years [95%CI 2.5-4.4] at the time of x-ray. The average distance from each community facility to our institution was 1,167km [95%CI 920-1,414], a measure of the total travel distance saved in travel for each patient in a single direction.

The travel distance saved is considerable, especially for patients that no longer require extensive intervention in their care. Teleradiology services give families the opportunity for continued care without the need for extensive, costly travel, which may negatively affect a child’s quality of life if they have specific limitations due to their condition. If more teleradiology services are implemented, we can improve access to care for patients without diminishing the quality of care received, more patients and families can remain in their home communities and we can decrease clinic wait lists to see specialists.
22

Toward a Sustainable Model of Physician Care for Long Term Care Residents

Contact: Jennifer Begin
jlb088@mail.usask.ca

Physicians in the South Okanagan Similkameen (SOS) are reimagining how they deliver Long Term Care. Instead of following patients into numerous care homes and having difficulty getting in to see them regularly, local GPs are starting to identify as house physicians at the care homes of their choice. As house physicians they are willing to take residents without a GP, and are rewarded for carrying 5-15 residents at 1-2 facilities, and committed to working toward best practices in collaboration with the care home staff.

In 2017, one care home had a number of residents without a dedicated physician for several weeks. It was not until a GP came to the local Residential Care Initiative (RCI) Physician Champions group with a strategy, that things improved. He had worked through how to navigate this facility to provide quality proactive care, but was overcapacity. His idea: approach colleagues open to doing residential care, with an invitation to meet over lunch at the facility to orient them, as well as discuss new physician incentives in the works with the Division of Family Practice to better support long term care. RCI working groups throughout the region were co-developing two new physician incentives: an RCI ‘New Patient Incentive’ to address the loss of the 14074 GPSC Billing Code for taking on complex care patients; and a ‘House Physician Improvement Incentive’ to support physicians to intentionally improve their practice. By identifying whether clustering (creating a critical mass of patients at one facility), prearranged rounds, or polypharmacy risk reduction were their focus, the care home and RCI staff could support individual physicians and their house physician teams to achieve these aims.

All 13 care homes in the area have since developed a significant roster of house physicians, each with an identified improvement focus, and no resident is without a GP.
Working Together: Division and Facility Engagement Partners

Contact: Chelsea Brookes
Thompson Region Division of Family Practice
cbrookes@divisionsbc.ca

The facility engagement groups in Kamloops (the Royal Inland Hospital Physicians Association and Medical Staff Association) and the Thompson Region Division of Family Practice work collaboratively on shared initiatives to foster engagement between providers in our community.

A recent success is the publication of a medical staff yearbook that includes more than 350 pictures of facility-based physicians, specialists, community family physicians, nurse practitioners, and midwives. It has photos of many hospital departments, and Interior Health and community clinics. The yearbook is intended as an orientation tool for new physicians and also allows people to put faces to names. It has been widely distributed and well received.

Another shared initiative is specialist/primary care provider engagement events including “Meet your Cardiology and Internal Medicine Department” events. These evenings were designed to share successes in recruitment and allow primary care providers to provide input into what services should be offered by outpatient clinics. The Cardiology event discussed the creation of an outpatient clinic which was developed and operationalized. The Internal Medicine event gathered feedback on the recently launched a new Rapid Access to Internal Medicine Clinic. There is a strong desire to support continued ongoing dialogue.

Over 100 TRDFP and RIHPA members registered for a joint winter engagement event focused on teamwork and teambuilding. A combination continuing medical education and engagement event will also be hosted in February 2019. Feedback on our engagement activities has been overwhelmingly positive and physicians are looking for other opportunities to connect.

RIHPA and the TRDFP also coexist at an operational level. The organizations share a physical office space. Executive members from both groups sit on high level working groups and the local Shared Care Steering Committee links both organizations.
THE POWER of togetherness

RAPID-FIRE PRESENTATIONS
Attending to the Needs of Post-Secondary Students with ADHD

Contact: Elisabeth Baerg Hall, MD, CCFP, FRCPC | Medical Manager
Hope Centre
eball@icloud.com

Post-secondary students with adult attention deficit hyperactivity disorder (ADHD) have lower grade point averages in the first year of college and a higher likelihood of being placed on academic probation. They are more likely to have poor time management and organizational skills compared with their peers. In a busy student health service, these students are difficult to treat because of ADHD-related difficulties with attending appointments in a timely manner and non-compliance with treatment plan.

Langara Student Health initiated the use of group medical visits scheduled at a consistent time and place to aid students challenged with ADHD. Students complete a prescreening protocol developed by our team of family doctors and psychiatrists, using evidence-based assessment tools and questionnaires tailored to the student population. They first attend at least two assessment visits with the clinic nurse and one visit with the family doctor to start medication. Once those are complete, the clinic family doctor(s) and psychiatrist facility the 11 session GMV.

The clinic psychiatrist and one family doctor facilitate the 11-session GMV. Group sessions include individual check-in, group discussion, and ADHD-related self-management topics, including developing time management, using planners, setting priorities, and dealing with impulsive emotions. Medication side effects are discussed, and doses are adjusted and renewed as required. Participants may have their vitals checked as required during the sessions. All other stable psychiatric medications can be renewed during group sessions.

After the successful implementation of this program at Langara College, student health staff from the University of BC and Simon Fraser University were recruited and trained to deliver the program at those institutions. A manual was developed and is available through Doctors of BC. Two years after project completion all three institutions continue to deliver this program each semester.
RAPID-FIRE PRESENTATIONS

THE POWER OF TOGETHERNESS BREAKOUT SESSION A, 9:00 – 10:30AM

A1
PARTNERSHIPS FOR IMPROVED MENTAL HEALTH SERVICE DELIVERY

Sustaining and Spreading CBT Skills Group Medical Visits

Contact: Christine Tomori | Project Lead, CBT Skills Groups Spread
Vancouver Island Health
ctomori@divisionsbc.ca

The new Cognitive Behavioural Therapy (CBT) Skills Group Medical Visits, funded by the medical services plan, provide timely and accessible mental health care to patients with mild to moderate mental health conditions within primary care. Family physicians in Victoria had identified access to non-pharmaceutical mental health treatments as their top priority. The CBT Skills Group program was designed to address this need through self-management skills training for groups of 15 patients. The program is delivered as an 8-week series of 90-minute group psycho-education and skills training sessions. Psychiatrists train family physicians to lead the groups through co-facilitation and mentorship while providing the service to patients.

BENEFITS:
The program has been a “win-win-win” for patients, providers, and local mental health services. In Victoria, 12 providers serve South Vancouver Island, offering 25 daytime and evening groups through a centralized referral centre, meeting patient demand with minimal wait lists. To date, over 5100 patients have been referred from over 500 physicians, and 63% of those enrolled in the program complete it (i.e., attend at least six of eight sessions). Completers report 94% satisfaction, and 93% report confidence in their ability to manage their mental health symptoms. Quantitative measurements of symptom severity have demonstrated statistically and clinically significant improvements in anxiety and depression symptoms, with large to very large effect sizes. Referring family physicians ranked the value of the program at 4.7/5. The group providers, both psychiatrists and family physicians, report high levels of satisfaction and acceptability. The training and delivery model has been tested and spread to other communities (e.g., Vancouver, Nanaimo, Salt Spring Island). In Vancouver, over 400 patients have been referred from 140 physicians. Results from the first 13 Vancouver groups yielded the same patient outcome and satisfaction scores as in Victoria. Lessons learned while sustaining and spreading this model to new communities will be explored (i.e., training, patient selection, educating referring GPs).
A1
PARTNERSHIPS FOR IMPROVED MENTAL HEALTH SERVICE DELIVERY

BOOM! When Collaboration Works Out: Creating a Youth Services Hub

Contact: Nerine Kleinhans | Physician
Creston Valley Hospital
nerineobie@yahoo.com

In October 2017, the principal of Prince Charles Secondary School school called a meeting with the Superintendent of School District 8 (Kootenay Lake), teachers, physicians, public health, counsellors, Ministry of Children and Family Development representatives, Kxunata Kinbasket Child and Family Services, College of the Rockies, RCMP, East Kootenay Addictions Services, and Divisions of Family Medicine. The principal had the following message: "Our youth are in trouble and our teachers feel completely unsupported."

Four months later, a new working space for multidisciplinary providers in the school, called “the Hub” was up and running. The Youth Services Hub has proven to be a successful a collaboration between the Ministries of Health and Education, School District 8, Valley Community Services, East Kootenay Division of Family Practice, and the local business community in Creston.

Tailored to meet the health and wellness needs of students in the Creston area, the student clinic opened on February 15, 2018 staffed by two family physicians, a public health nurse, two clinical counsellors, two school counsellors, and three outreach workers.

The first semester of the Youth Hub was well received by both students and staff. Within the first 4 months it became clear that youth generally seek medical care when in crisis. Of those youth that attended Hub, 68% have family physicians, but many don’t know who their physicians are. As well, making an appointment with their family physician is a hurdle for them due to different schedules. The Hub ensures that youth don’t miss school during these appointments. 38% are seeking mental health support.

There was concern that the Hub would be seen as a mental health clinic and those involved have worked hard to avoid this stigma. Other support areas include musculoskeletal, contraception, insomnia, urinary tract infections, and eating disorders. With a student’s permission, a note is sent to the family doctor to close the circle for wraparound care.

The aim of the project is to a sustainable model. This project is still young, but so far feedback has been very positive.

Everyone involved believes this is a lasting, spreadable model that is the future of youth wellness.
A2
PARTNERSHIPS FOR IMPROVED CARE OF OLDER ADULTS

Delta’s Health Hub: Connecting Seniors in Assisted Living to Health Services

**Contact:** Tomas Reyes | Health Hub Project Lead
Delta Division of Family Practice
treyes@synergyimpact.ca

**BACKGROUND:**
Seniors in assisted or independent living residences have limited access to primary care supports. The high prevalence of multiple chronic conditions within this population results in residents often being sent to hospital emergency departments (ED) when they require care. Many of these seniors cannot be discharged because of the lack of appropriate supports. They stay in hospitals for longer periods of time or inappropriately moved to residential care homes, both of which incur a high cost on the health care system.

**PROJECT:**
The Delta Division of Family Practice, with funding from the Shared Care committee and in partnership with Fraser Health (FH), implemented a “Health Hub” at Augustine House in Delta, BC. The Hub offers a centralized service that connects residents to their family physicians (GPs) and manages referrals to geriatricians, pharmacists, and Fraser Health’s Home and Community Services. The Hub also hosts education sessions that empower residents to self-manage their own health.

**METHODS:**
FH and project documentation will be reviewed to assess the Hub’s operations and implementation, and progress made towards the intended outcomes. Questionnaires will collect qualitative and quantitative data from clients and families regarding their experience with the Hub. Key informant interviews with stakeholders will gather information on the project’s development, engagement, and outcomes.

**OUTCOMES:**
The Hub’s primary intended outcomes are decreases in the number of ED transfers from Augustine House and length of stay in hospitals. Secondary outcomes include the number of residents identified as frail, number of services to which seniors are referred to and their outcomes, number of residents reporting increased knowledge of targeted medical issues, and perception of support by residents and families, GPs, and Augustine House staff. After four months, the Hub has served 40 residents. More results will be available when the project ends in March 2019.
**A2**

**PARTNERSHIPS FOR IMPROVED CARE OF OLDER ADULTS**

**Leaning into New Conversations: Palliative Care & Assisted Dying**

**Contact:** Rosanne Beuthin, (PhD, RN) CNS MAiD  
Vancouver Island Health  
rosanne.beuthin@viha.ca

**ISSUE AND CONTEXT:**

Canadian legislation now allows eligible persons to end their suffering with an assisted death. This represents a major shift in practice for physicians providing the death and those practicing in palliative care (PC), and tensions have been expressed nationally. Given the high numbers of assisted deaths on Vancouver Island, there have been many interactions and sharing of patients between these two groups of physicians. All this occurring in a health authority that emphasizes PC and assisted dying as compatible at end of life. During the first 2 years as MAiD became established, the health authority did not formally foster developing relationships between the two groups, yet as we entered the 3rd year we heard mutual desires for a gathering. To that end, our leadership team envisioned an event.

**AIM:**

To support physicians to come together in rich dialogue; to share their experiences and knowledge about MAiD and PC. We believed that conversations could build understanding of others role, foster local connections, enhance collaborations, and lead to further innovations that support dying persons.

**ACTIONS:**

We held two 4 hour events, one for south island and one for center. In total, 31 physicians attended (mileage and a sessional fee offered). The event started with an ice breaker exercise, followed by a brief overview of PC on the island as well as MAiD. Thereafter, facilitated discussion ensued about any topics attendees wished to explore. The group shared what was working well and areas for improvement.

**OUTCOMES:**

An evaluation reflected that the event had value and will help foster increased collaboration between PC and MAiD physicians. We heard some early pre-conceived dichotomies fall away, and a shared desire for quality care at end of life. Attendees were surprised by the common ground, the general agreement between all MAiD providers as to the necessity of good palliative care, the misconceptions about palliative sedation, a story about how seeing MAiD today reminded one physician of their original experience with palliative care 30 years ago, and “how committed to patients my colleagues across the board are.”
A nurse can make a difference. In fact, one nurse can change a system. At a time when the population is aging and home care needs are increasing beyond the ability of the health care system to manage them, we needed to make a change in how we work together between our GP providers and the HA specialized services.

The Fraser Northwest Division of Family Practice began a revolution by hiring one nurse. Her name was Debbie. She, in partnership with the family practitioners, selected the most frail and at risk seniors to have proactive home visits to find out how they were functioning in the community and if there were any proactive supports needed. This extended the reach of the family physician to give a lens into the happenings and needs in the home and gave the patient one point of contact if there were concerns that they had. This nurse provided both case management and clinical supports to this group of over 500 patients.

While all of this was ongoing the health authority specialized team had just completed a review of the home health service to determine what was not working, and the list was long. Working with the FNW Division on how to improve the system, they took a closer look at the Nurse Debbie clients to determine if there was an effect on system utilization. The results were astounding. Over 500 ED visits averted and over 17000 patient days saved in the same cohort of clients within a 1 year period of introduction to this change.

This started the redesign of the HH system for our region. Three years later, we are now at a stage where positions have been changed to create an additional 27 Primary Care Nurses (Nurse Debbies) and 2 social workers, working alongside GPs in community. It is important to note that new dollars were not required for this change but a willingness to look at the system from a different perspective was. There will be many more steps along the way, but over the course of three years, our system has changed for the better.
More than 1 in 5 people in BC suffer from various complexities related to chronic pain. Untreated or poorly managed chronic pain restricts activities of daily living, increases the likelihood of developing complex conditions with associated co-morbidities, and patients are four times as likely to experience anxiety and depression and more than twice as likely to report substance use disorder or commit suicide.

Shared Care has initiated a physician lead spread network to improve care for patients with chronic pain, and to support communities in the spread of successful work across BC. We are working with partners such as the Ministry of Health and Pain BC, to better coordinate initiatives to address chronic pain across the province, integrate with the work of the patient medical home and primary care networks and develop common indicators to measure improvements.

We have engaged 15 communities and the momentum continues to build. Physicians are collaborating to:

- Enhance access to chronic pain care through new models of interdisciplinary care;
- Link patients, families and providers with patient self-management resources and support;
- Enhance skills and capacity for local physicians to provide chronic pain care and
- Address the prevention and treatment of opioid use disorder.
A3
PARTNERSHIPS THAT ENGAGE & EMPOWER

Partner to Empower: The Story of Powell River Hospice Society

Contact: Guy Chartier  |  Executive Director
Powell River Division of Family Practice
gchartier@divisionsbc.ca

This session will explore how a partnership between a Division of Family Practice and a non-profit society contributed to providing accessible and appropriate hospice care for residents of their community. In only 2 years, the Powell River Hospice Society went from an ad hoc group of dedicated people meeting in the Division office to an organization being involved in 25% of deaths in the community. The presentation will involve insights into partnership, highlights of evaluation findings and sharing of human stories.
**Physician Engagement in Cancer Care: Developing a BC Medical Staff Engagement Society**

**Contact:** Dr Dan Le  |  Managing Director  
BC Cancer Medical Staff Engagement Society  
dan.le@bccancer.bc.ca

Physician engagement is an important issue in cancer care with implications on quality of care, patient safety, and physician burnout. In 2014, a memorandum of understanding between the BC Ministry of Health, BC Health Authorities, and Doctors of BC led to dedicated funding provided to facility-based physician organizations to improve physician engagement and dialogue with health care leadership. With this funding, BC Cancer medical staff developed an independent organization to address physician engagement issues.

A governance structure and working group were created to represent all BC Cancer medical staff. The broad range of cancer care specialties and regional cancer centres were included. Regional engagement consultations were held across the province, and a strategic plan was established. A biannual call for engagement initiatives was implemented for all BC Cancer medical staff and annual general meetings (AGMs) were held in 2017 and 2018.

Through this work, the BC Cancer Medical Staff Engagement Society representing 530 BC Cancer medical staff members was incorporated on 4 November 2016. From January 2016 to December 2018:

- A working group composed of 23 BC Cancer medical staff across the province and health authority senior executives met monthly.
- Five regional engagement consultations were held across BC.
- Four physician engagement strategic priorities were established.
- Three rounds of priority-driven call for engagement initiatives were implemented, which led to the funding of 45 physician-led/leadership-sponsored initiatives involving 71 medical staff and 24 health care leadership sponsors.
- Nine peer recognition awards were given across four disciplines and six regional centres at the 2018 AGM.

The creation of this medical staff engagement society has led to meaningful physician engagement within a provincial cancer organization. This society has implemented the foundational elements necessary to encourage ongoing physician engagement for years to come.
INNOVATIONS FOR MATERNITY CARE

Bringing Maternity Care Back to the Community

Contact: Shona Brown
Mission Division of Family Practice
sbrown@divisionsbc.ca

The growing population of Mission had a large gap in maternity care. Patients would have to commute to Abbotsford for all appointments, therefore creating a large barrier for patients faced with transportation issues.

The initiative aimed to provide accessible, sustainable and well-coordinated maternity care by increasing family physician capacity to provide prenatal care through 3 strategies:

1. Establish a maternity clinic within the existing Mission Primary Care Clinic
2. Increase the capacity of family physicians to deliver maternity care, especially to provide prenatal care to their patients until 20 weeks, through training, mentorship, and development of a maternity resident program
3. Strengthen referral linkages of maternity related services for improved coordination of maternal care

Evaluation findings indicate that the opening of the maternity clinic positively impacted patients. Interview data suggests that the most significant impact of the initiative has been improving the “availability of prenatal care in Mission near patients’ homes”. Due to the implementation of this clinic, many patients have accessed maternity care locally who previously may not have received any care or would have traveled to Abbotsford for care. As noted by four interviewees, there are several barriers to patients accessing care in Abbotsford including, transportation, low income, time constraints, and physical or mobility issues, as many patients’ main mode of transportation is public transit.
Traditional patient care planning often involves a linear model of health care access and delivery. A particular patient with a clinical concern accesses a primary care provider (PCP, such as a GP, midwife, or nurse practitioner) who acts as a gatekeeper to direct the patient to a specialist with appropriate expertise. The patient then sees the specialist who provides an initial opinion to the patient, and then a formal opinion to the PCP. The PCP often recalls the patient to discuss the specialist's opinion and develop a care plan, and may need to contact the specialist again if there are further questions or a change in the patient's clinical status.

The Mobile Maternity (MOM) project is changing that traditional linear model to foster a tripartite model that provides for much greater efficiency and more comprehensive care planning. The project uses mobile devices (e.g., tablets and phones) to host telehealth consultations in any location, including a patient's home, to discuss the clinical problem with practitioners and patient. This reduces the time to relay the specialist's opinion, and allows the PCP and patient to inform the specialist of particular challenges to the provision of care related to geography or local health resources.

The MOM project demonstrates how their concepts can be adapted to suit the needs of communities and geographies, health authority processes and policies, variations in physician practice, and different technologies. This tripartite telehealth model enhances education for both providers and patients, removes geography as a barrier to timely access, and supports the stability of primary care networks. Challenges to the telehealth tripartite model involve provider and patient scheduling and communication technology fidelity. This pilot can become the standard model of care in integrating specialist care into rural and remote primary care networks.
RAPID-FIRE PRESENTATIONS

THE POWER OF TOGETHERNESS BREAKOUT SESSION A, 9:00 – 10:30AM

A4
INNOVATIONS FOR MATERNITY CARE

Rural Surgical Obstetrical Networks: System Accountability through CQI and Evaluation

Contact: Jude Kornelsen | Associate Professor/Co-Director
Centre for Rural Health Research, Department of Family Practice, UBC
jude.kornelsen@familymed.ubc.ca

The attrition of rural surgical services across BC and Canada has been well documented and has precipitated a loss in local access to care, most noticeable through the closure of rural maternity services. A recent system intervention, Rural Surgical and Obstetrical Networks (RSON), has been funded by the Joint Standing Committee on Rural Issues to quell the tide of closures by supporting increased scope and volume of services, clinical coaching between rural sites and referral centres, continuous quality improvement at a community level, technology to bridge geographic distances, and a thorough and rigorous evaluation of health outcomes, costs, and the efficacy of the network itself. Addressing the recent evidence on surgical evaluation that emphasizes the importance of process measures in addition to outcome and structure indicators, the RSON approach integrates “ground up” (local quality improvement) data with “top down” (administrative) data to provide a rigorous analysis of effectiveness.

Based on information gathered from key stakeholder engagement and community consultation, a standard approach to surgical evaluation has been reframed to include a focus on:

• System and team process measures.
• Effective dimensions of network efficacy starting with strength of relationships between sites and level of shared values and vision.
• Stratified population health outcomes based on population catchments surrounding the RSON-supported facilities to augment facilities-based outcomes.

This approach has been developed and will be implemented within a shared measures development framework.

Through applying key-stakeholder input in the design of the RSON evaluation and integrating evaluation and CQI initiatives, a robust framework has been created to ensure system accountability for rural surgical programs.
Surgical Patient Optimization

Contact: Geoff Shierback | SSC Liaison
Doctors of BC
gshierback@doctorsofbc.ca

“Surgical patient optimization is a multi-disciplinary, structured, personalized pre-habilitation program designed to help patients prepare for, recover faster, and have better outcomes from major surgery.”

Preparing for surgery can be compared to training for a marathon. Just as an athlete must prepare mind and body, training vigorously in a multitude of ways in order to improve their race outcome, a patient must also prepare for the challenge of surgery, as literature has shown that both physical and mental preparation can lead to better outcomes. As care providers, we can use the preoperative waiting period as an opportunity to better prepare patients both physically and mentally for surgery as well as to empower ourselves and our patients to improve surgical outcomes.

The Joint Collaborative Committees of Doctors of BC and the BC Ministry of Health are committed to supporting care providers to improve the surgical outcomes for patients. As part of a provincial collaborative, we will achieve the following objectives:

- Improve patient outcomes for elective surgeries across the province.
- Support care providers to implement changes in processes to improve patient readiness for surgery.
- Use the patient’s preoperative surgical wait time to create multidisciplinary, structured, personalized programs to support improved outcomes after surgery.

How will these goals help patients? The draft change package is available to be used by teams to identify the priorities of optimizing patients as well as for ideas on improving patient outcomes.
SURGICAL OPTIMIZATION

Surgical Optimization Prehabilitation Program at VCH

Contact: Dr Kelly Mayson | Clinical Professor, Director
Quality Assurance & Patient Safety, Department of Anesthesia and Perioperative Care, VGH & UBC Hospitals
kelly.mayson@vch.ca

ERAS protocols improve care and decrease complications. Preoperative risk factors such as anemia, smoking, malnutrition and hyperglycemia are associated with increased morbidity, mortality and length of stay. The preoperative period is an optimal time to identify and intervene upon these modifiable risk factors. Our aim was to delineate the incidence of these risk factors and to ensure that high risk patients were identified and optimized while on the surgical waitlist.
The goal of the Northern Shared Care Psychiatry Collaboration is to improve the coordination of care for people requiring mental health and substance use services, especially where primary care and specialist services are called on to work together in service of the patient. The collaboration has brought together psychiatrists, family physicians, health authority specialized services, and primary and community interprofessional teams from across the North to design a new Service Model for Mental Health and Substance Use for Northern residents. The project built on the work of the Northern Geriatric Services model and is aligned with the Northern Health Idealized System of Services. It has been shared across the North and is thought to be a model that will work for any patient no matter how remote or complex. It is also thought to be transferable to any population or disease group in the system. The project engaged unprecedented numbers of physicians, divisions, mental health clinicians and community agencies. It completed extensive process modelling and designed a new service model that could be transformational in the way we think about integration and shared care. The service model was rigorously tested by running a number of patient scenarios, and implementation is now underway.
RAPID-FIRE PRESENTATIONS

THE POWER OF TOGETHERNESS BREAKOUT SESSION B, 11:00 – 12:30PM

B1
THE POWER OF COMMUNITY FOR MENTAL HEALTH SYSTEM IMPROVEMENTS

Working Together: 10 Years of Innovative & Inclusive Care at the Anderson Creek Primary Care Clinic

Contact: Dr Josh Greggain | Site Medical Director
Anderson Creek Health Centre / Fraser Canyon Hospital
joshua.greggain@fraserhealth.ca

“Together” does not start with “I,” yet “I” starts inclusion, innovation, and impact

Anderson Creek First Nations is located 63 kilometers north of Hope, a rural location isolated from many services. People living there face challenges to accessing primary care and specialized services, and both the local Indigenous and non-Indigenous people struggle to get the care that they need.

In 2009, Chief Delores O’Donahue of the Anderson Creek band committed to building a primary care clinic so that people in the region, both Indigenous and non-Indigenous, could access primary services on First Nations land. This inclusion, which starts with “I,” of Chief Delores set a precedent of togetherness that carries on in the clinic and community today.

Over the last 10 years, the Anderson Creek band, along with Fraser Health, First Nations Health Authority, local family physicians and nurse practitioners, and several community services organizations, have worked together to provide and expand care. The innovation, which starts with “I” of the individual providers, and which now includes primary care and mental health services, employment counselling, detox services, and community paramedics, is offered every Wednesday of the year. In 2018, telehealth began to be used as a way to provide innovative care to those services that are not available locally.

The impact, which starts with each of “I” for those who continue to travel each Wednesday, now reaches four communities: Boston Bar, Anderson Creek, Spuzzum, and Boothroyd. Annually, the service reaches over 1000 people, both Indigenous and non-Indigenous in the clinics and in their homes. This initiative has become the source of primary care and specialized services in Anderson Creek and the Fraser Canyon.

All of it, which started with “I,” has led us together.
RAPID-FIRE PRESENTATIONS

THE POWER OF TOGETHERNESS BREAKOUT SESSION B, 11:00 – 12:30PM

B1
THE POWER OF COMMUNITY FOR MENTAL HEALTH SYSTEM IMPROVEMENTS

It's not your problem, it's OUR problem: Cowichan's efforts in the opioid crisis

Contact: Cindy Lise | Regional Facilitator
Our Cowichan Communities Health Network
cindylisecchn@shaw.ca

The opioid crisis, the impacts of substance use and keeping people alive are challenges that are far greater than any organization, including our health system, can tackle alone. As the crisis grows, the parameters keep changing as one response requires another and another and another. The Cowichan approach is an example of how methods of collective impact can bring together people with diverse levels of knowledge and experience to resolve complex challenges. This includes working with partners who are not responsible for the issue but who can take on a piece as a part of one organized response.

Under the leadership of Our Cowichan Communities Health Network and the Community Action Team, we have had incredible success in the building of diverse relationships and connections which result in inroads that are having profound impacts that would not be possible otherwise. The process includes finding ways to support how to make it happen, keeping folks at the table and growing the response when things get really challenging. How? By asking the questions, understanding the questions and then working together collectively to find answers. The road is not always successful or easy as we challenge each other in difficult situations, but the will of the Cowichan team responds out of a deep compassion for community and the support of the partners travelling on the same path.

This work was achieved as a direct result of building relationships and trust and is aligned with local government, the Ministry of Health, and health authority strategic priorities and policies.

We encourage you to come and learn about the Cowichan model and what may possible for other communities who face the opioid crisis, the impacts of substance use and keeping people alive.
B2
HIGH IMPACT TEAMS CARING FOR OLDER ADULTS

Pender Harbour Health Centre Model

Contact: Susan Papadionissiou | Executive Director
Sunshine Coast Division of Family Practice
spapadionissiou@divisionsbc.ca

The primary care system includes Community Health Centres (CHCs) in many communities. On the Sunshine Coast, the Division of Family Practice, the Pender Harbour Health Centre (PHHC) and Vancouver Coastal Health are currently working out logistics related to how Patient Medical Homes, CHCs and Health Authority services fit together to create systems of care for the patients they serve. This includes shared strategic planning around a seniors strategy for the community using a team-based care approach.
Coyote’s Food Medicines: Addressing Polypharmacy in First Nations Communities through Storytelling

Contact: Gina Gaspard | Clinical Nurse Specialist
First Nations Health Authority
gina.gaspard@fnha.ca

One of the most important and yet often overlooked barriers to wellness is overuse of medications. There is a point where using multiple medications (polypharmacy) can actually make a person sicker. Lack of regular access to a consistent health care team (prescriber, pharmacist, and nurse) is the most common barrier to appropriate medication management. Many people do not understand the importance of knowing what medications they are taking or why. Some First Nations people worry it is rude or disrespectful to question what medications they are taking. As a result, many people take more medications than are clinically warranted. Approximately 6000 BC First Nations people take more than 20 medications. Surprisingly, the largest BC Indigenous demographic for polypharmacy is middle-aged adults, not the very old as one might expect.

The Shared Care Polypharmacy Risk Reduction Initiative, working in partnership with the First Nations Health Authority, wished to create a way to communicate this concern to BC First Nations in a culturally appropriate and meaningful way. There is no doubt that the best way to engage a community is from within, rather than from the outside.

Secwepemc’ulcw Elders worked with doctors and nurses to create a story to teach people about the dangers of polypharmacy. Storytelling is a traditional Indigenous way to share knowledge, wisdom, and humour. Indigenous stories often include a mix of natural and spiritual beings including animal figures. Many Indigenous stories include a transformer or trickster character who can be both humorous and heroic. Through the character’s misadventures, a multilayered story emerges with lessons for people of all ages. In BC, the transformer takes on many forms, including Coyote.

The hope is that this well-crafted storybook publication will spark conversations among Indigenous families, their caregivers, and health care professionals on the topic of optimal medication management.
Supporting Chronic Pain through a Specialist Referral Pilot

Contact: Lori Graham | Project Lead
Ridge Meadows Division of Family Practice
lgraham@divisionsbc.ca

The long wait lists—up to 18 months—for patients to be assessed via regional pain clinics prompted local Ridge Meadows family physicians to suggest the value in having local pain specialists to refer patients to. Reasons given were:

• To improve team-based care and physician-patient relations (between specialist, physician, and patient).
• To increase family physician and patient confidence and knowledge.
• To provide an opportunity to reinforce and confirm patient knowledge about the importance of self-management practices, opioid tapering, etc.
• To decrease wait times.

Fortunately, Ridge Meadows had access to two pain specialists who were keen to participate in the pilot. Space for the appointments was provided by a local family practice. The booking of patient appointments, transcribing of reports, and delivery of care plans were managed by MOAs who worked in the practice that provided the space.

The following non-cancer chronic pain patients were eligible for referral:

• Those experiencing chronic pain for longer than 3 months
• Those attached to a primary care provider
• Those struggling with continuing to work or returning to work
• Those feeling “stuck” or that nothing is working
• Those engaged in or motivated to participate in self-management programs
• Those who would benefit from a second opinion.

The intent of this pilot project was to:

• Test the value of having a local pain specialist who family physicians could refer challenging pain patients to for assessment, plan/medication reviews, and advice.
• Determine the feasibility of the project from the specialists’ perspective.
• Inform the needs of the Chronic Pain Physician Network as part of the primary care network.
• Understand next steps for the community, including operational costs.

Over a 2-month period, 23 patients were referred by 13 family physicians. Overall, the family physicians, specialists, and patients involved said there was value in the pilot project, and if the referral opportunity opened again, family physicians would continue referring patients to the specialists.
Implementing Care Teams for System Change

Improving Chronic Pain Care in a Rural Community

Contact: Christien Kaaji | Senior Project Manager
Powell River Division of Family Practice
ckaaij@divisionsbc.ca

Powell River, population 20,000 people, is somewhat remote, being accessible only by plane, boat, or car with two ferry connections. Consequently, referrals to pain specialists are challenging, so treating patients with chronic pain care has been a concern for local physicians since 2011.

In May 2017, Shared Care approved a project aiming to increase the self-management capacity of chronic pain patients and to:

- Enhance patient and provider experience.
- Lower per capita cost of care.
- Improve population health by increasing patient’s functionality.

The project runs till March 2019 and involves several interventions:

- Patient education through articles and public workshops.
- Physician and allied health care provider education.
- Tools, including Self-Management Roadmap and Functionality Scale.
- New local services, such as a local multidisciplinary pain team.
- Coordination of services with existing resources.
- Improved access to tertiary centres (in progress).

The project is overseen by a steering committee and guided by a patient advisory committee.

Most results will be available from the Joint Collaborative Committees. To date, there are two results of note:

- 100% of workshop respondents would recommend the workshop to a friend, and 97% felt more hopeful they can live with their chronic pain.
- 97% of education-day physician attendees reported having increased awareness of chronic pain resources and non-pharmacological treatments, and being better equipped to support self-management.

The lesson learned from this project include:

- Collaboration requires a lot of time and flexibility.
- Tools will be used if they save physicians time and support their practice.
B3
IMPLEMENTING CARE TEAMS FOR SYSTEM CHANGE

A Collaborative Approach to Improving Quality of Long-Term Care in Interior Health

Contact: Dr Douglas Smith | Executive Medical Director
Interior Health, Long-term Care, Palliative and End of Life Care, Medical Assistance in Dying
douglas.smith@interiorhealth.ca

The Interior Health Palliative Approach in Long-term Care (PALm) initiative is about shifting our approach in order to help people with complex chronic medical conditions live as well as they can for the remainder of their life.

This approach applies the principles of palliative care early in a person’s disease trajectory, integrating the principles of palliative care and chronic disease management. The approach is person and family-focused including conversations about serious illness, personal preferences, values, and goals of care. It anticipates illness progression while recognizing the uncertain prognosis of life-limiting conditions. Our goal is to improve the quality of life for the person and their families through early identification and treatment of pain and symptoms, medication management, addressing psychosocial needs, and other problems.

We know that 75% of our long-term care (LTC) residents have moderate to severe cognitive impairment; 90% are frail with increasingly complex chronic conditions, and on average are in their last 18 months of life. Key outcome indicators show that consistently using a palliative approach will give us the biggest impact on improving the quality of care for individuals and their families.

A steering committee has been established for this project that includes representation from medical and LTC services leadership, IH organizational development, quality improvement, health system planning, and Patient Voices Network. Working Groups are focused on collaboration with the key stakeholders (physicians, staff, and patient/family representatives.) Five phase one sites have been selected by the LTC leadership team to participate in the PALm project.
Using a multi-disciplinary approach, the Kootenay Boundary region revamped services supporting new moms in their perinatal mental health. In 2015, psychiatrists identified low referral and intake levels for moms with mental health challenges, while GPs were often at a loss for ways to assist moms they knew were struggling. Starting with patient journey mapping and TRIZ processes, the Kootenay Boundary Regional Perinatal Committee undertook a two-year project to affect change. With patient advocates guiding their work, the regional committee, including family services, Interior Health MHSU, physicians, midwives and public health, addressed different aspects of patient and provider education, prevention, screening and diagnosis, treatment options, virtual access and coping networks. Building resources and tools for providers and patients, education for multi-disciplinary teams, and new services for moms and families has set the stage for developing a solid overarching regional program. The pilot of facilitated peer-support groups, Motherwise, became a flagship for the project with 71% of moms showing a statistically significant improvement in their mental health. MHSU has seen an increase in referrals to their services and the psychiatrist noted increased numbers of patients being seen. Sustainability of system change, especially the introduction of a new program with budget implications, has been the key challenge. More work is needed to build a robust program, funding for continued groups operations, and dissemination of the program to physicians, midwives, and patients should be ongoing. Key to the success of this project was the collaboration across different service teams and the resulting connection between providers. From community organizations to mental health and substance use clinicians to patients and maternity providers, the project was guided by all voices at the table.
**B4**

**NEW APPROACHES TO MATERNITY CARE**

**Supporting Rural Maternity Sites: A Collaborative Exercise in Service Planning**

**Contact:** Jude Kornelsen  |  Associate Professor/Co-Director
Centre for Rural Health Research, Department of Family Practice, UBC
jude.kornelsen@familymed.ubc.ca

Rural maternity services in BC have been subjected to a wave of closures and service reduction, and those that remain open face significant challenges to sustainability. In BC, five communities continue to offer local deliveries without local access to caesarean section, but four of them struggle to remain viable.

The Building Blocks to Sustainable Rural Maternity Care project was funded by the Joint Standing Committee on Rural Issues to determine, “from the ground up,” the building blocks required for sustainable care across BC. As with all system change initiatives, the importance of integrated and collaborative work with local, regional, and provincial key stakeholders lead by the JSC underscored this project.

A five-pronged feasibility analysis was conducted including:

- Engagement with community members (including Indigenous health centres).
- Iterative development of provider-driven building blocks to sustainable care.
- Outreach to other 1A sites to validate findings.
- Deliberative dialogue through provincial symposiums.
- A comprehensive data-derived and costed plan of system supports needed.

Comprehensive consultation with community members, care providers (locally and in regional centres), administrators, and other key stakeholders were undertaken within a collaborative and integrated approach through intentional collaboration.

Significant system-level obstacles to providing local access to rural maternity care were identified. There was a two-year process of consensus-building needed to achieve buy-in from key stakeholders to stabilize local services, starting at a community level with regional health authority and provincial implications.

When taken together, the step-wise deliberative dialogue on rural maternity care created a clear framework for how to sustain rural maternity care in BC. Bringing together community priorities and a system response within an evidence-based framework was an effective mechanism for setting priorities.
We come to know collaboration in the fullest sense, by experiencing it. Enhancing an interprofessional collaborative approach to the local planning and delivery of maternity services underpins Shared Care’s new Maternity Network. The Network’s emerging success exemplifies the power of togetherness. In collaboration and alignment with the Rural Coordination Centre of BC, the GPSC Maternity Working Group, and Perinatal Services BC, the Shared Care Committee is evolving a provincial process and community of practice for enhancing interprofessional collaboration, that also facilitates the spread and sustainability of local innovation, increased access to care, and improved care quality. At the coalface of this initiative, in 21 communities across British Columbia, maternity teams co-led by family physicians, obstetricians, and registered midwives are engaging in supported, needs-based projects that enable the sharing of knowledge, ideas, and resources so that improved relationships across health disciplines, and between providers, practice groups, community partners, and families may emerge. Teams are strengthening their collaborative muscles as they come together to tackle tough local issues like developing maternity pathways and standardizing care, improving access for vulnerable populations and with Indigenous peoples, sustaining rural maternity services, and building interdisciplinary team-based practice groups. By capturing and evaluating the incredible successes realized in early project communities such as Comox, we have created a roadmap and toolkit for enhancing collaboration that includes key process steps and resources. As a potential model for the patient medical home, this Shared Care initiative also aims to capture and describe the successes and challenges of developing integrated, team-based approaches to care.
Collaboration to Support Transformation: Team Mapping & Patient Centred Circles of Care

Contact: Sarah Fletcher | Manager
Innovation Support Unit, Dept of Family Practice
sarah.fletcher@ubc.ca

Communities across British Columbia are currently developing service plans to support the transformation of primary and community care through by implementing patient medical homes and primary care networks.

The Innovation Support Unit at UBC has developed a team mapping process that engages service providers (GPs, Specialists, Allied Care provider), patients, and other stakeholders in a facilitated a patient-centred mapping activity. The team mapping process presents participants with patient personas, tailored to encourage focus on community and practice-relevant care challenges and opportunities. It also encourages discussion and supports participants to consider aspects of team function, team communication, and team composition, while also allowing for reflection and knowledge sharing related to key roles, discussion of scope of practice, and identification of opportunities for collaboration and innovation.

From June through August 2018, the Innovation Support Unit worked with the South Island Division of Family Practice to engage 63 participants in four mapping sessions. The results of these discussions and the recommendations report from the team mapping process informed the South Island Division of Family Practice Team-Based Care planning.
Harnessing the Winds of CHANGE BC: Rural GP Perspectives on Innovation

Contact: Dr Brenda Huff | CHANGE BC Lead, Board President, and Family Physician
Pacific Northwest Division of Family Practice
cennis@divisionsbc.ca

Family physicians from Haida Gwaii, Terrace, Smithers, and Houston are leading family practice–based health system redesign by developing Canadian Health Advanced by Nutrition and Graded Exercise British Columbia (CHANGE BC) to address metabolic syndrome with positive outcomes for patients while creating health system efficiencies and savings.

In this demonstration model, adult patients with metabolic syndrome were supported though four diverse family practices to receive a personalized nutrition and exercise program. The participants were followed for 12 months with the help of an innovative grant provided by Metabolic Syndrome Canada. In addition, a CHANGE BC community-based pediatric nutrition and early physical literacy program was designed and implemented by family physicians in partnership with the University of British Columbia School of Kinesiology.

Family physicians are uniquely positioned to inform the development of family practice–based health system redesign initiatives such as CHANGE BC. Results from both the adult and pediatric CHANGE BC initiatives have shown promising results that have been well received by adults and children in the communities of Haida Gwaii, Terrace, Smithers, and Houston. These scalable initiatives that also demonstrate cost savings and efficiencies for the health system are positioned to be cornerstone models within patient medical homes situated in primary care networks currently under development in BC.
Transgender people comprise approximately 0.5% of the population and face significant barriers to accessing health care and navigating available services due to the fear of stigmatization and difficulties in identifying health care providers who are knowledgeable of gender-affirming care. For many years there has not been a clear, consistent care pathway for Abbotsford and Fraser East residents seeking gender-affirming care. This absence has created challenges for patients seeking access to timely and appropriate care, and the lack of an effective referral process has posed challenges for physicians.

In 2016, the Abbotsford Division of Family Practice collaboratively developed clear pathways for gender-affirming care in Fraser East (Abbotsford, Mission, Langley, Chilliwack, Agassiz, Hope) through a Shared Care project. The pathways encompass local, regional, and provincial services. Materials were developed collaboratively by Divisions of Family Practice Physicians and staff, specialists, nurse practitioners, allied health providers, Fraser Health, Vancouver Coastal Health, Trans Care BC, BC Children’s Hospital, local and regional organizations, and patients and their loved ones.

The project, under the guidance of the physician lead, Dr James Liu and Steering Committee members, supported providers, patients and families, to connect to resources and developed a community of practice of multiple provider types and organizations. The pathways have been welcomed by providers who appreciate the clarity provided. Input from both interested community organizations and those on the transgender journey, is that the roadmap is a needed and informative document.
**Standardization of Early Psychosis Assessment**

**Contact:** Dr Daniel Boston  |  Psychiatrist  
Island Health  
daniel.boston@viha.ca

**BACKGROUND:**
Psychosis affects 3% of people in their lifetime with antipsychotics being the main pharmacological treatment. Antipsychotic polypharmacy is commonplace, yet not evidence-based and increases the risk for side effects including metabolic abnormalities and weight gain. Antipsychotic use requires physical health monitoring that is inconsistently performed. These factors are partially attributable to people with severe mental illness having a 2–3 times higher mortality rate and a life expectancy 10–20 years less than the general population.

**AIM:**
This project focused on admitted patients with first episode psychosis, 17 to 35 years of age, at the Royal Jubilee Hospital. Our aim was to achieve a(n): decrease in antipsychotic polypharmacy by 30%, increase baseline monitoring of glucose and lipids to 100% and to increase baseline and discharge weights to 100% and to decrease length of stay by 5% by September 30, 2018.

**METHODS AND PDSAS:**
Starting September 1, 2017, we developed an evidence-based clinical order set (COS) for use on admission. Several PDSA cycles were performed and the COS is trialed from July 1st to March 31st, 2019.

**PRELIMINARY FINDINGS:**
Our clinical order set was used during, on average 64% of admissions. Regular and total polypharmacy were relatively unchanged but PRN polypharmacy decreased by 28.6%. Baseline lipids increased from 2.3% to 42.6% of admissions and similarly baseline glucose changed from 38.2 to 75.8%. Baseline weights measured changed from 2.4% to 57.3% of admissions and weights measured decreased from 64.3% to 57.7%. Length of stay was decreased from 19.7 days to 16.2 days and if this trend continues would represent a savings of 203 bed days.

**DISCUSSION:**
While our findings preliminary it looks like we will be successful in changing some prescribing, can focus on improving metabolic and weight factors and decrease length of stay. The biggest challenge has been changing physician practice changes and this remains elusive.
RAPID-FIRE PRESENTATIONS

THE POWER OF TOGETHERNESS BREAKOUT SESSION C, 2:15 – 3:45PM

C1
LEVERAGING TECHNOLOGY FOR IMPROVED MHSU OUTCOMES

Evolving Doors with eMentor: Using Virtual Mobile Number Technology to Support Peer-to-Peer Networks

Contact: Beccy Robson | Project Manager
Nanaimo Division of Family Practice
brobson@divisionsbc.ca

The concepts of communities of practice and clinical networks are becoming the gold standard for providing continuity of care in diverse and expansive geographical regions. Despite the recognition of the value of peer support and knowledge sharing, tangible mechanisms to create and sustain networks are challenging to understand and implement.

One solution is eMENTOR, a text-based platform using a virtual mobile number (VMN) that is simple to use, affordable, and sustainable. These characteristics offer potential for regional networking and application in many disciplines.

Evolving Doors is a new Division of Family Practice project funded by the Shared Care Committee. It uses the existing messaging capabilities of eMentor and harnesses additional functionality available through the provider to support the creation of a peer-to-peer network of opioid agonist treatment (OAT) prescribers in Central and North Vancouver Island.

Using the Messagebird online platform, a text hotline was developed to allow primary care physicians easy access to advice and support from addictions subspecialty colleagues. Physicians could speak with an addictions mentor within 2 to 4 hours (often sooner) of sending a request for information. The benefits of using eMentor compared to other initiatives were identified as providing swift, informal, and economical access to local expertise. As well, physicians were able to connect to colleagues for guidance on topics that may not require addiction specialist level consultation.

However, eMentor, while successful in its application, has encountered challenges in uptake, reflecting those seen in similar provincial models.
**C2**

**INNOVATIVE TECHNOLOGY IN THE CARE OF COMPLEX OLDER ADULTS**

**Shared Care in Action: The Development of a Regional Cardiology Referral Process**

**Contact:** Margot Wilson | Director, Shared Care & Virtual Health
Providence Health Care
mwilson@providencehealth.bc.ca

The Vancouver Division of Family Practice and the UBC Division of Cardiology decided to work together to improve access to care. Challenges with the referral process were identified related to diagnostic testing, clinic locations, forms, wait times for an appointment, and acknowledgment of referrals. A survey of 50 Vancouver family physicians revealed that 69% did not know which cardiology clinic or specialist to refer to, and 85% did not know if the clinic or specialist had received the referral.

Through consultation and engagement, a group of cardiologists, family physicians, patients, clinic assistants, and administrators developed a regional cardiology referral process to improve patient care and access. The result is a single form that replaces dozens of existing forms, allowing family physicians to refer directly to cardiology offices or to any of the 30 cardiology specialty clinics located across Vancouver Coastal Health. Concise specialty clinic descriptions are provided and an acknowledgment of referral component is included.

The form was trialed over a 3-month period, with 72 referrals being made between 40 family physicians and 20 cardiologists. Seventy-five percent of the referrals were acknowledged and the average time to acknowledgment was 5 days. Of these, 42% were acknowledged within the target time of 72 hours. Eighty-two percent of referrals were directed to specific cardiologists and 18% were directed to hospital-based specialty clinics. All surveyed family physicians reported increased knowledge of cardiology services when using the new form, and 38% of cardiologists said the referrals contained more relevant information compared to 6% when using other forms. As well, 67% of family physicians and 62% of cardiologists said the referral process had improved with the new form.

For ease of use, digital versions have been integrated into EMRs and can be viewed by more than 1000 community physicians. This project is being seen as a successful model of Shared Care that can be spread to other specialties.
C2
INNOVATIVE TECHNOLOGY IN THE CARE OF COMPLEX OLDER ADULTS

Pre-Habilitation for Enhanced Recovery after Surgery: Creating Tools and Relationships

Contact: Christine Colbert | Executive Director
Campbell River and District Division of Family Practice
c Colbert@divisionsbc.ca

ISSUE:
There is a body of evidence that patients who are optimized for surgery have better outcomes. Many of the factors for surgical optimization (pre-habilitation) are ones that family physicians are well poised to address with their patients. However, we had no consistent guide to aide in pre-habilitation and there was a lack of communication between specialists, primary care providers, allied health care providers and patients regarding pre-habilitation.

SOLUTION:
We held a "world café" with GPs, surgeons, anesthesiologists, and MOAs as well as a patient voice and discussed research in the 4 areas of pre-habilitation; anemia, nutrition, exercise and smoking cessation. At that event the patient journey was explored and the concept of a patient passport to guide patients and their health care providers through pre-habilitation activities was developed.

ACTIONS:
The resulting passport is given to any patient undergoing major surgery. The passport acts as a tool to empower the patient and as a communication tool between the patient and health care providers. Also developed was a standard letter that can be sent from a surgeon to a GP informing them that their patient will be having surgery and requesting that the patient be seen to begin the pre-habilitation pathway. Finally, we co-created a patient pre-habilitation class with our Health Authority and community services.

RESULTS/OUTCOMES:
Surveys found that since the implementation of the patient passport and physician tools, 82% of physicians indicated that they had applied pre-habilitation principles more than before. Specialists reported improved communication with GPs and with patients, as well as coordination of care prior to surgery. Patients found the passport easy to use, and that it was a useful tool to communicate with care providers.
Goals of Care: Conversations with Patients of Chinese Ethnic Background

Contact: Dr Amrish Joshi | Community Palliative MD
Richmond Integrated Hospice Palliative Care Program
Amrish.Joshi@vch.ca

Having a discussion about advanced care planning with patients to understanding their goals of care (GOC) in event of a serious illness reaps benefits for both patients and family and can result in improved quality of life and reduced aggressive interventions when the patient is no longer able to direct care. The present approaches to advanced care planning (ACP), however, use a Western approach and may be less effective among patients of Chinese ethnic background.

Qualitative data were collected through focus groups with 27 individuals of Chinese ethnic background who were able to communicate in English. Theoretical constructs, themes, and sub-themes were identified, analyzed, and distilled into "pearls," which summarized the contextual and sociocultural aspects that care providers need during GOC discussions.

In parallel to the "pearls," a checklist based on the Serious Illness Conversation Guide (Ariadne Labs, 2017) was adapted and added to the EMR. The checklist and guide were presented to nursing staff, who were also asked to use them with patients. Subsequently, EMR records were audited to assess the extent of completeness of the conversations, and whether staff had followed the Conversation Guide approach.

Results: ‘Pearls’ were prepared on “Awareness of Advance Care Planning/Advance Directives” (e.g., education, religion, and age); the potential perception by clients with respect to GOC discussions (e.g., “the facade”, “family centricity”, “palliative care services”); and how they are delivered (i.e., “the power of words: positive/negative”).

A larger audit of 22 records of clients of Chinese ethnic background was assessed with these findings:

- 17 (77.2%) had some documentation of GOC.
- Of the 17, 8 (47%) had evidence of usage of the Conversation Guide.
- 5 of the 8 (62.5%) had >= 50% of the Conversation Guide covered.

Now that a baseline has been determined, the “pearls” will be used to improve the level of completeness of GOC conversations with clients of Chinese ethnic background. Feedback from the users of the “pearls” will help identify other measures or approaches that can continue to build on increased GOC conversations.
C3
INNOVATION IN SYSTEM IMPROVEMENTS

Social Workers in Family Practice

Contact: Shona Brown | Executive Director
Mission Division of Family Practice
sbrown@divisionsbc.ca

ISSUE:
Mission family doctors lacked the knowledge of community resources to adequately support their patients who presented with social needs. For physicians, locating and connecting patients to these resources was noted to be time consuming and burdensome.

SOLUTION:
The Mission Division of Family Practice implemented a 9 week pilot project wherein a Community Resource Navigator (CRN) would assist physicians to better support the needs of vulnerable patients by identifying health and social support services and linking patients to these services.

ACTIONS:
The family physician makes a referral to the Community Resource Navigator. The CRN then connects with patients over the phone and/or in the Division office to assist them in addressing the social, emotional, and financial factors that have a significant impact on health care and health status. Using a patient centered approach and working within the framework of the determinants of health, the CRN helps make the necessary links between the physical, social, emotional and economic impacts of health as well as confirm and strengthen the doctor-patient relationship, including better support for the needs of vulnerable patients.

RESULTS/OUTCOMES:
This initiative addresses the barriers impacting health and treatment, potentially improving patient outcomes, increases the capacity of the primary health care system and increases physician awareness about social support services available in the community. It also facilitates increased communication among service providers, and coordination of services and between community resources. The Community Resource Navigator received 157 Referrals between June 2017 and November 2018.
Elk Valley was in crisis with the retirement of their only surgeon and failed attempts to recruit a replacement. The purpose of this project was to identify creative solutions to maximize the use and efficiency of our Operating Room and OR Staff.

Together, we understood where we were – # of OR days available, # of visiting physician days, available equipment, types of operations we can accommodate, and impacts on staffing.

We reached out to specialists at our regional centre – East Kootenay Regional Hospital (EKRH) to build relationships, identify mentorship opportunities, and seek participation in ‘close to home care’.

We sent an ‘Expression of Interest’ to each EKRH Specialist to gauge their interest in working with us. Our team went to Cranbrook to present this opportunity to the EKRH Surgical Staff and conduct a ‘meet & greet’.

We mobilized a Rural Surgical and Obstetrics (RSON) sub-committee to work on the Readiness Assessment and Project Funding proposal.

A review of our manpower plan was done to ensure we could match the need with the current staff.

Secured a Letter of Intent for a new graduate FPESS to join our team upon graduation in 12 months.

Sent our OR Nursing Staff to EKRH to spend a day in the EKRH Operating Room to build relationships and create a sense of confidence in their skills.

Created a welcoming environment with a dedicated office and examining room for visiting specialists. Hosted a Welcome Lunch for EVH Physicians, Staff and the visiting surgeon.

Our results include:

- Four EKRH General Surgeons are taking consults and procedures in our OR weekly.
- Other Specialists are visiting more often.
- Fostered positive relationships with our regional centre.
- Coaching and Mentoring opportunities for our FPESS staff
- Significant reduction in ‘green’ OR days at our Facility
- A successful RSON proposal to facilitate increased capacity in our OR and Maternity program.
- Staff retention and increased level of satisfaction
PARTNERSHIPS FOR SYSTEM IMPROVEMENTS

A Community Vision for Primary Health Care in the Thompson Region

Contact: Rhonda Eden | Project Lead
Thompson Region Division of Family Practice

The intent of this project was to work collaboratively with a diverse subset of stakeholders in the region, including Indigenous people, to understand challenges and opportunities associated with the patient-health provider experience, and garner feedback to develop a region-wide shared vision for primary health care. The GPSC PMH Practice Characteristics Matrix was used as a guide to inspire stakeholder feedback. A multi-faceted approach to engagement was taken, including an online survey, patient interviews, public events, and targeted stakeholder focus groups and / or workshops. A webpage was also developed for stakeholders to find out information on the project and take the survey. Communities involved included Logan Lake, Kamloops, Barriere, Sun Peaks, Chase and Scotch Creek and between the survey and in-person events the engagement efforts reached over 700 people. The benefits of this project include, a greater awareness of the primary health care system, the need for individuals to play a more active role in their health outcomes, the need for communities to play a more active role in supporting delivery of comprehensive primary care, and an opportunity to create new community partnerships. This project supported a more collaborative effort to enhance health care and a move toward a more team-based approach to primary health care. The information gathered has the potential to help inform primary care networks and / or community health services planning, as well as guide future Division work and public education.
Heart Health for Mothers in Rural BC: The Prince Rupert Post-Partum Clinic Experience

Contact: Dr Marius Pienaar | Obstetrician & Gynecologist
Prince Rupert General Hospital

ISSUE:
Heart disease is the leading cause of death among women in Canada. Evidence has shown that pregnancy is a great place to evaluate cardiac risk. Pregnancy provides a ‘stress test for future cardiovascular disease’ and a significant amount of data is routinely collected during pregnancy, yet presently most maternity units do not utilize this data. There is an opportunity to change the future course of women’s heart health during the reproductive phase of her life by reviewing her risk factors that become apparent during pregnancies.

SOLUTION:
Our health care team saw the opportunity to build in a process to review this routinely collected data to help women become aware of their risk factors during the reproductive phase. We adapted the "Mother’s Program" from Kingston, Ontario, to screen and review risk factors for Cardiovascular Disease Risk post-partum for all women who deliver at the Prince Rupert Regional Hospital, and coordinate follow-up referrals and supports. This is the first such clinic in BC, and the first rural clinic in Canada specifically geared to evaluate cardiovascular risk in post-partum patients.

RESULTS:
During the project, we screened 497 cases for cardio-vascular disease risk, of which 104 presented at list one risk factor. All of these 104 women were offered the post-partum review process, of which 75% of the women accepted and attended the clinic. Women who attended the clinic have provided very positive reviews of the experience. Through our computer program we have made this service simple, efficient and largely automated. It is a cost effective service, and our team will share how the process can be adopted by other health care teams.
C4
PARTNERSHIPS FOR SYSTEM IMPROVEMENTS

Family Practice: Psychiatry Partnership
Contact: Denise Ralph  |  Executive Director
Richmond Division of Family Practice
dralph@divisionsbc.ca

With long wait times for referrals to Richmond Mental Health Services and no private practice psychiatrists accepting
new referrals, there was a need to improve access to psychiatry in Richmond. Supported by funds from the Shared Care Committee, the project took a two-pronged approach:

- Developing a new model of care that co-located psychiatrists in GP offices.
- Building capacity in primary care by providing knowledge and skill-building sessions to GPs.

The service was built with sustainability and scalability from the start: GP offices offered in-kind office space and support from their MOAs for patient bookings, and Richmond Mental Health Services (VCH Richmond) deployed psychiatrists into GP practices and offered in-kind dictation and transcription services. One-time project management support was used to support psychiatrists and GPs, and to oversee project planning to implementation.

Prior to a patient’s appointment, the GP and psychiatrist would have a face-to-face meeting and review the referral. Following the appointment, they would meet again develop a plan of care. The GP would remain the most responsible physician for ongoing care. The vast majority of referrals was a one-time consultation, although the psychiatrist would be available for ongoing support for the GP or reassessment if needed.

After the two-year project term, the impacts of this initiative were identified:

- Better access for patients right in their medical home.
- High patient satisfaction with the service.
- Improved GP capacity and support.
- Significant cost efficiencies.
- Increased appropriate access to specialist consultation and support.

The project ended in 2016, at which time it shifted to a program supported by VCH Richmond and Richmond Division of Family Practice. The initiative has continued to grow and supports more GP practices. In January 2019, a psychiatrist who specializes in addictions will be added to the general psychiatrist service.
There is a pressing need for the medical profession (specialists and generalists) and health care leaders working together to provide just-in-time clinical support and deliver high-quality emergency and critical care services to our patients throughout BC by improving equity of access. This issue is particularly critical in underserviced, rural, and remote areas. Digital technologies can now readily offer real-time virtual support for clinicians to provide timely interventions and interdisciplinary team-based care to patients.

As a key pillar of the BC Emergency Medicine Network (BCEMN), Real-Time Virtual Support focuses on working with health professional colleagues, patients, and health policy makers to understand, path-find, and take action to translate the concept of virtual health into tangible actions in emergency medicine. The UBC Digital Emergency Medicine Unit (DigEM) has worked with different stakeholder groups in BC through surveys, focus groups, evaluations, pilot studies, and active discussions with JCC committees.

A summary of DigEM’s findings that reflect on the opportunities and challenges related to implementing virtual emergency medicine in BC, and that facilitate a dialogue with participants, should be our path forward with the goal of achieving equitable access to emergency medicine for all in BC.
Finding a Better Way: Improving the Referral Process with an Electronic Platform

Contact: Cary Sheppard | Program Coordinator  
White Rock/South Surrey Division of Family Practice  
csheppard@wrssdivision.ca

The GP Specialist Referral Process – a White Rock/South Surrey Division of Family Practice project – aims to improve the referral process between GPs and Specialists. Through a thorough exploration of issues and challenges, we identified a need for a solution that ensured that no one party bore the burden of the workload. Therefore, in partnership with Pathways BC, we built and implemented, an electronic referral and patient notification platform. This system tracks, in real time, the status of the patient’s referral from the moment of initiation until completion. GP and Specialist offices, through a common dashboard, can see every step of the process. The system electronically notifies the patient with wait times, appointments with automated confirmation and pre-visit instructions, as well as appointment reminders.

Join us to hear what we learned through our project journey and how alignment, integration and collaboration is improving the referral process in our community.
Quality improvement (QI) is currently a popular catchphrase in health care. The idea is simple: there are ways to deliver better patient care (safer, patient-centred, efficient, etc.) that will ultimately lead to a healthier population, a more reliable health care system, and decreased costs. At the Royal Columbian Hospital (RCH), most QI initiatives focus on the duplication of literature-supported clinical best practices. Despite this, many of the QI initiatives did not lead to sustainable improvements in patient care. We hypothesized that we had a “culture” issue.

The culture of an organization is the manifestation of its core values and attitudes, driving practice, process, policy, and outcomes. In the context of QI, culture not only drives what we do to improve patient care but also who does it, how we do it, and why we do it. The RCH QI League was formed to shift organizational culture based on these principles:

1. Continuous improvement is the responsibility of all staff.
2. QI is frontline driven and supported by leadership.
3. QI efforts are guided by data and scientific QI methodology
4. Local context is critical
5. We learn from successes and failures.

Through the development of QI workshops, frontline QI grants, project mentorship, and an annual QI day, the RCH QI League has engaged over 400 frontline staff in the improvement process. Importantly, we are starting to see evidence of sustained improvements in patient care.