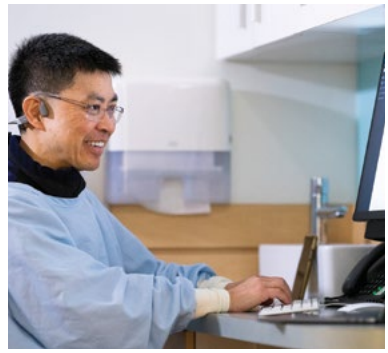
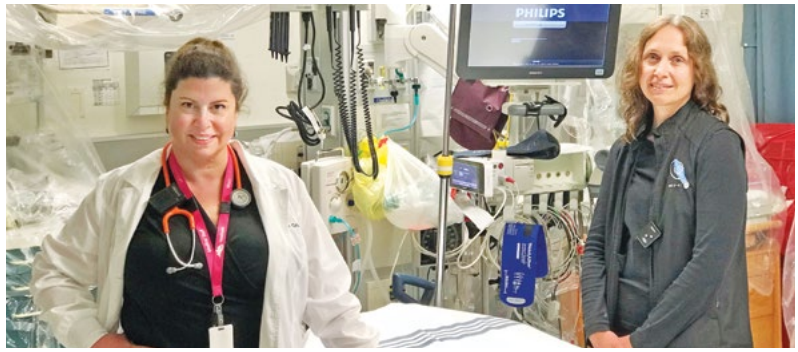
Joint Collaborative Committees
A partnership of Doctors of BC and the BC Government

COLLABORATE ON HEALTH IN BC

JANUARY 2021

Stories of innovation in health care





CONTENT

2,154

doctors engaged in the
Health System Redesign

248

doctors attended the
JCC Pre-Forum

72

doctors participated in the
BC Physician Integration Program

WELCOME

Collaboration and innovation are at the core of what physicians do. A thriving health care system depends on partners – in medicine, government, health authorities, communities, health professions, and many other areas – working together to ensure patients have access to quality care.

In BC, the Joint Collaborative Committees (JCC) have been working for nearly 20 years to bring these partners together to support physician-led work and advocate on behalf of primary care doctors and specialists.

This unique partnership between Doctors of BC and the BC Government, including health authorities, allows doctors to follow their passions through research and projects, access learning opportunities, and develop leadership skills. The four JCCs are:

Joint Standing Committee (JSC) on Rural Issues
Enhances the availability and stability of physician services in rural and remote areas of BC.

General Practice Services Committee (GPSC)
Strengthens full-service family practice and patient care.

Shared Care Committee (SCC)
Supports family and specialist physician collaboration for improved coordination of care.

Specialist Services Committee (SSC)
Engages doctors to collaborate, lead quality improvement, and deliver quality services.

Funding and support from the JSC, GPSC, and SSC, enables the Rural Coordination Centre of BC, divisions of family practice, and medical staff associations, respectively, to take a grassroots approach to enhance patient care and improve professional satisfaction for doctors in communities and facilities.

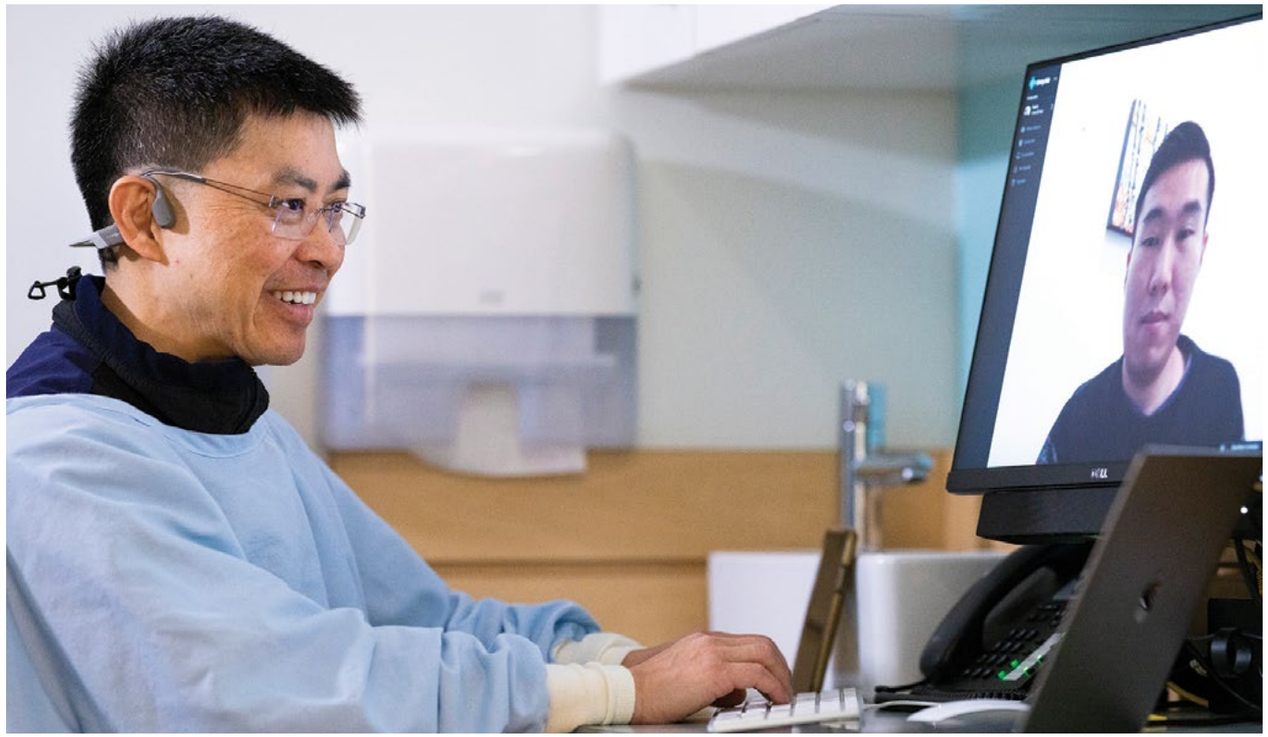
Over the past year, it was this strong foundation of collaboration that positioned the JCCs to quickly respond to the pandemic and support doctors in their time of need. From virtual care supports, to introducing temporary fee codes, to supporting physician health and wellness, the JCCs pivoted in response to COVID-19, in addition to continuing the regular work of the committees.

The unusual and challenging times we found ourselves in during 2020 sparked some unprecedented creativity as well. This inaugural issue of *Collaborate on Health in BC* highlights ways doctors used technology to solve problems, how innovation improved patient outcomes, and why collaboration is at the heart of the work of the JCCs.

We hope you enjoy these stories describing how your colleagues are making a difference in BC's health care system. You can learn more about the work of the JCCs and how you can get involved at www.doctorsofbc.ca.

Co-chairs
Joint Collaborative Committees

PATIENT CARE TOOLBOX EXPANDS WITH VIRTUAL CARE



"We also know patients benefit from having a doctor who knows their history, so continuing to offer virtual care to my patients will make it easier for them."

New Westminster-based Dr John Yap remembers the exact date he and his four colleagues knew the way they provide care was about to change dramatically: Friday, March 13.

"We got official word to consider shifting to virtual care to help curtail COVID-19," said Dr Yap. "The following Monday, we showed up to work as usual but as patients started cancelling their appointments, we realized we had to adapt, and quickly."

Dr Yap is one of thousands of doctors around the province who, in response to the pandemic, quickly embraced virtual care. Doctors were able to pivot with the timely introduction of new billing codes that extended fees for in-person visits to telephone and video appointments. Many who did not have a lot of experience sought much-needed support from the GPSC's Doctors Technology Office. Staff provided a suite of online virtual care resources that proved invaluable to help doctors get up to speed quickly. They also hosted online education and peer-support sessions.

"We immediately signed up for secure video-calling accounts but it wasn't a seamless transition," said Dr Yap. "We had a lot of tech issues those first weeks. Also, my practice has a lot of seniors who aren't comfortable with technology, so the ability to serve patients by phone was important."

The practice also continued to see some patients in person thanks to ample office space and funding for COVID-19 adaptations from the Fraser Northwest Division of Family Practice. The doctors were able to set up their clinic to safely see non-respiratory patients and those who tested negative for COVID-19, including community patients referred from clinics that suspended in-person appointments due to lack of personal protective equipment or safety concerns. All possible or confirmed COVID-19 patients were seen at a dedicated clinic in the area.

At the height of the pandemic, Dr Yap was seeing approximately 90 per cent of his patients virtually.

"While it's not ideal for every situation, it's definitely here to stay," he said. "It can be very efficient in some cases. We also know patients benefit from having a doctor who knows their history, so continuing to offer virtual care to my patients will make it easier for them to see doctors from their own patient medical home even when they can't make it to the office."

Patients agree. "It saves a lot of time," said Peggy Tam. "No getting ready, no driving, no waiting room. I'm glad we've had this option during the pandemic and hope it continues, though there are still some things you need to be seen in person for."

"Of course, in-person appointments will continue to be vital, particularly for preventative care," said Dr Yap. "At our practice, we never stopped in-person care for patients who need physical examinations. We each spend a day a week in the office and will see each others' patients. I look forward to going back to more in-person support but there's no question we have a new tool in our patient care toolbox and that's a great thing."

Supported by Divisions of Family Practice and Doctors Technology Office, initiatives of the General Practice Services Committee.

HOSPITAL AT HOME

Physicians lead the way to bring program to BC

Victoria hospitalists Dr Elisabeth Crisci and Dr Shauna Tierney have been unwavering in their pursuit of a new kind of care for patients. Now, their passion project is about to become a reality with the BC Government's launch of Hospital at Home (HaH), across the province. They were supported in their journey by the partners of the Joint Collaborative Committees (JCCs), who help transform great ideas developed grassroots level –in communities and hospitals– into reality.

With HaH, acutely ill adult patients who are at lower risk and have a predictable clinical path can get hospital-level care from a team of professionals at home, safely and effectively. It has been used for years in Australia and the UK. Compared with standard hospitalization, HaH can provide equivalent or better clinical outcomes, shorter stays, and higher satisfaction among patients, their caregivers, and health care workers.

Dr Crisci first saw HaH in action a few years ago while doing fellowship training in Australia.

"This was not home and community care. It was acute, hospital-level care: IV medications, blood transfusions, oxygen."

"A hospital is an unsettling environment, especially for frail and elderly patients," she said. "I thought, 'why can't we do the same in Canada?' The expertise and therapies that we associate with hospital care are all portable, and so is the hospital staff. It is an opportunity to offer safer, more patient-centered care for our patients and for less cost. It is the right thing to do."

Supported by Facility Engagement, an initiative of the Specialist Services Committee; Divisions of Family Practice, an initiative of the General Practice Services Committee; and the Health System Redesign, a shared initiative of the Joint Collaborative Committees.

"The collaborative effort [with] frontline physicians has been incredible; something I never thought I'd ever witness in my career."

Back in Canada, she often thought about HaH and in 2019, an opportunity came up to take action. Her colleague, Dr Shauna Tierney, read about a HaH program for chronic obstructive pulmonary disease and was inspired.

"I saw that we could do better for our patients' dignity and comfort, and thought, 'we have a moral imperative to do this.'"

HaH also had the potential to ease capacity pressures in hospitals, with five to 10 per cent of admitted patients able to meet the clinical criteria for management in their homes.

Dr Tierney and Dr Crisci quickly joined forces to develop a HaH program for BC, and needed help to really get their program off the ground. The JCC, its programs and partners, stepped up to help.

They included: South Island Medical Staff Association and the Health System Redesign program (administered by the Specialist Services Committee), South Island and Victoria Divisions of Family Practice (funded by the General Practice Services Committee); Vancouver Island Health Authority, Doctors of BC and the Ministry of Health.

Dr Crisci also benefitted from her enrollment in the UBC Sauder Leadership Program offered by the Specialist Services and Shared Care Committees.

As agents of change, they had to challenge some old-standing beliefs. "We argue that what should define hospital-level or acute-care is the type of patient and the type of clinical interventions required, rather than adhering to a definition based on the physical location of the patient."

Taking the hospital team and interventions to the patient's home would require further support from the Ministry of Health to ensure alignment with the BC Hospital Act.

"Even at home, these patients are admitted and under the responsibility of the hospital."

To their delight, the Ministry was interested in doing much more, and in September 2020, announced that HaH would be introduced to BC.

"It has been quite an adventure. It started with two doctors with an idea, and now HaH is one of the priorities for BC's health care system," says Dr Tierney.

"The collaborative effort between the Ministry, Island Health, and the frontline doctors has been incredible; something I never thought I'd ever witness in my career," says Dr Crisci.

"Here we are, side by side, not only improving patient care but also making our system more sustainable."

COVID-19 AND MENTAL HEALTH

Advocating for children and youth

The implications for the mental health of children and youth, as a consequence of the COVID-19 pandemic, cannot be overestimated. For those in British Columbia already concerned with the long-term impact of trauma and adverse childhood experiences (ACEs), the pandemic provided an even greater sense of urgency.

With a comprehensive history of work in this area, one such group, a Child and Youth Mental Health and Substance Use (CYMHSU) Community of Practice (CoP), comprised of more than 250 physicians and partners, was well positioned to mobilize members and ramp up activities to advocate for those at risk.

The CoP's collaborative efforts to build relationships between physicians, government, schools, and community partners prior to the pandemic provided a strong foundation to react efficiently to COVID-19.

"Because we built relationships in a relaxed and peaceful time, and broke down those silos, we've been able to respond quickly and efficiently to emerging priorities," said Dr Matthew Chow, a child and adolescent psychiatrist, and one of the founding members of the CoP.

With children and youth isolated as a result of the pandemic, and families experiencing increased stress, the CoP realized the urgent need to assess needs for children and youth at risk, and determine where they could fall through the cracks.

They quickly convened a town hall meeting of 32 partners involved in child and youth mental health across the province, including the BC Pediatric Society, BC School Counsellors Association, CMHA, FamilySmart, Foundry, health authorities, and many others.

Discussions centred on challenges arising from the health care crisis in delivering services, actions that would ensure supports are available, and urgent priorities faced by organizations and how to help. Gaps in care were identified.

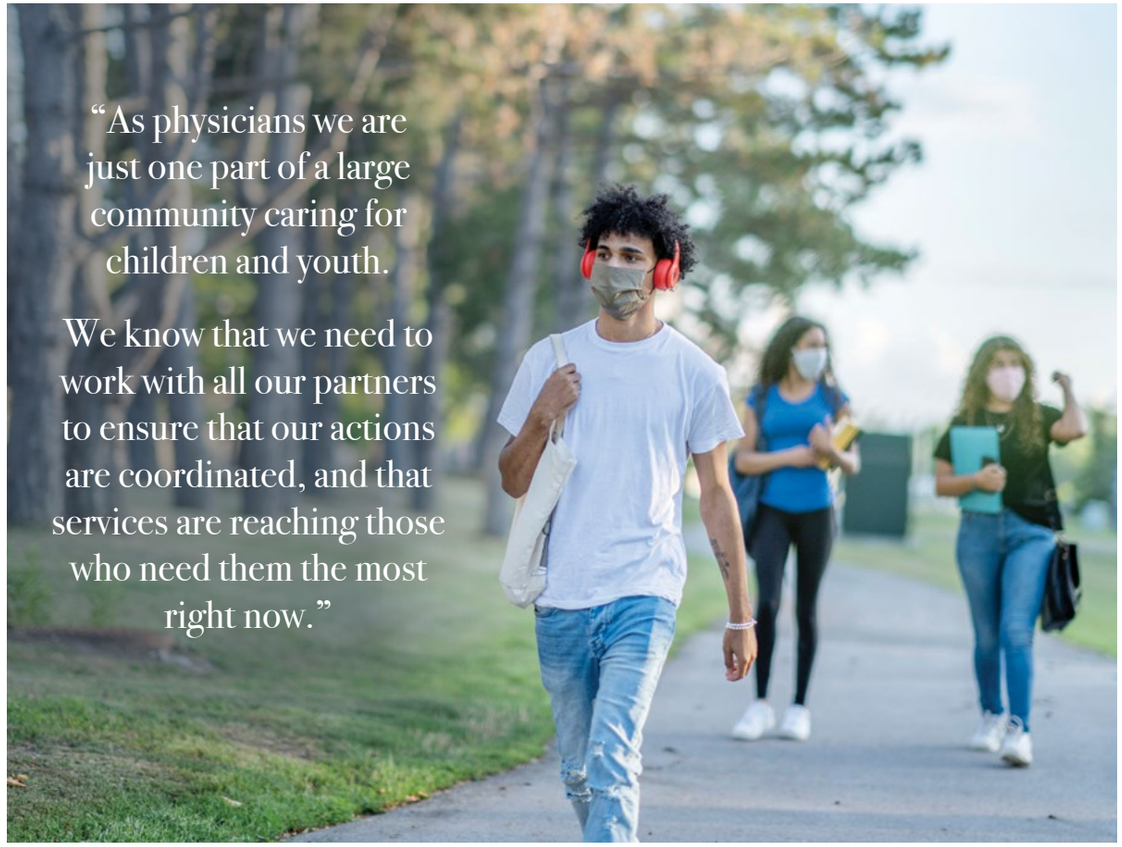
"We've identified vulnerable populations such as youth without access to the internet, Indigenous youth, youth with developmental challenges, and youth living in situations of neglect and abuse. The CoP advocates for these groups to receive priority attention and are connecting with organizations that could help. We need to address barriers and blind spots now more than ever."

The CoP has continued to work with partners and leaders over the past months to identify areas of concern, raise awareness of mental health risks, and educate and inform on preventing and addressing ACEs.

Dr Chow stressed the commitment of the CoP to continue working with partners during the pandemic and in the future: "As physicians we are just one part of a large community caring for children and youth. We know that we need to work with all our partners to ensure that our actions are coordinated, and that services are reaching those who need them the most right now."

ACEs resources, including articles and webinars, are available at www.collaborativetoolbox.ca.

Supported by the Shared Care Committee.



Leading change to address ACEs in BC

The CYMHSU Community of Practice and the work around ACEs are both legacies of the CYMHSU Collaborative – a large change initiative funded in BC from 2013-2017 by the Shared Care Committee, a Joint Collaborative Committee of Doctors of BC and the BC government.

During the course of the initiative, more than 2,600 people worked to improve access to timely, integrated mental health and substance use care for children, youth, and families in the province.

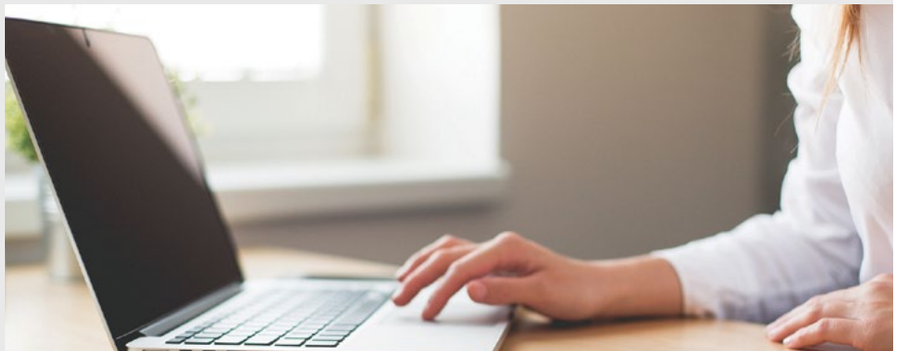
Increasing awareness and understanding of the impact of abuse, neglect, divorce, domestic violence, and other ACEs on individuals and society was integral to the Collaborative's work. The Community of Practice (CoP) continued to build on these efforts by creating an ACEs Working Group.

"With prevention and mitigation of ACEs being paramount, our hope is for integrated, seamless, trauma-informed, and culturally safe care for our citizens in BC and beyond," said Dr Shirley Sze, a founder of the Collaborative, and Chair of the ACEs Working Group.

As a result of both initiatives, two provincial ACEs Summits have been held, drawing more than 1,100 attendees in BC to prioritize and build strategies to address ACEs within every sector of society.

Health care priorities focused on embedding ACEs screening and trauma-informed care into practice for maternity care, primary care, Indigenous communities, and others.

PATIENTS ACCESS CARE CLOSER TO HOME



On Vancouver Island, patients with multiple sclerosis (MS) are travelling a lot less for specialized care because of a new physician-led program.

A Victoria-based neurologist and director of the Vancouver Island MS Clinic headed the Island Health's RuralHealth TeleMS program, funded by the SSC. It uses telehealth technology to connect neurologists at the MS clinic in Victoria with patients in Nanaimo.

The clinic hired a part-time MS nurse clinician to meet in-person with patients in Nanaimo. During a visit, the nurse performs any necessary tests, faxes test results to the clinic in Victoria, discusses any issues with the patient's neurologist via the telehealth screen, and provides patients with further information based on the doctor's remarks.

The Nanaimo nurse clinician now serves as a conduit between patients and the Victoria clinic's team of health professionals including neurologists, cardiologists, urologists, physiotherapists, and others. The program helped attract a neurologist to Nanaimo, and for patients, has reduced the distance to commute by nearly 156,000 kilometres, reduced driving time by 120,000 minutes, and saved them more than $30,000 in gas.

MEDICATION RISKS REDUCED FOR SENIORS

Polypharmacy has well-known risks—confusion, delirium, falls, and other negative consequences—that can seriously impact a person's quality of life, especially those who are elderly or frail.

A physician in Penticton with extensive experience in polypharmacy shares his approach through telling Edna's story—a case study of an elderly woman on multiple medications whose deteriorating health has meant losing her independence. The physician likens his role to a "suspicious detective" as he reviews Edna's medications to determine if polypharmacy could be responsible for her decline. He also describes looking for clues to assess which drugs may be causing more harm than benefit, and how he ranks drugs to develop a medication plan to stop, taper, or substitute the culprits potentially causing adverse reactions and drug cascades.

The physician emphasizes the importance of collaboration and good communication between the care team, patients, families, and caregivers around medication deprescribing. Frequent, honest conversations about goals of care, and the wants and needs of an individual for best quality of life, make the process of deprescribing like "dancing rather than wrestling."

GPSC General Practice Services Committee

CREATIVE APPROACH GETS FLU SHOTS TO PATIENTS

Flu season is an annual challenge, but 2020's vaccine rollout amid the global COVID-19 pandemic sparked the creativity and organizational skills of physicians across BC. In Vancouver, physicians joined forces with partners to meet the immunization demand across the city. Through the Vancouver Division of Family Practice, member physicians flagged areas such as PPE, clinic space, and patient flow; and with partners such as the City of Vancouver and Vancouver Coastal Health, the Division quickly identified shared goals. An action plan soon followed.

Working with the city, the Division helped physicians organize logistics and permits to create sidewalk and other outdoor immunization hubs, such as the one set up at Bayswater Family Practice in Kitsilano. Physicians worked on the sidewalk adjacent to four closed-off metered parking spots to safely immunize patients during a late October weekend. To help meet the demand across the city, physicians had the support of more than 100 UBC medical students.

A new vaccine delivery pilot project was also featured as a solution to obtaining vaccines in a more efficient way. While still in its proof-of-concept stage, doctors' offices across the city have signed up for the initiative.

JSC Joint Standing Committee on Rural Issues

COMMUNITY VOICES HEARD TOGETHER

More than 950 participants signed up to join virtual discussions with peers and other stakeholders at the BC Rural and First Nations Health and Wellness Summit. Held in June, the summit was supported by the First Nations Health Authority and the Rural Coordination Centre of BC, and funded by the JSC.

Across 250 virtual rooms, groups discussed gaps and advances in rural and Indigenous health in priority areas including virtual care, transportation, team-based care, cultural safety and humility, addictions and overdose, and COVID-19.

Panel conversations discussed the role of academia in ensuring that health care in BC is equitable, inclusive, and diverse.

They also discussed the power of building relationships to tackle problems together, and the importance of having safe places for difficult conversations, translating conversation into action, and defining cultural safety.

The summit culminated in commitments around the priority topics, as well as by looking at community governance structures to support grassroots solutions, working towards a common understanding around language and shared goals, and addressing racism to enable culturally safe, equitable care.

FIRST NATIONS VIRTUAL DOCTOR OF THE DAY

"You can't replace face-to-face, the physical space, the interaction, but this really does help meet a unique need."

Dr Kelsey Louie is describing a First Nations Virtual Doctor of the Day service created in March to ensure Indigenous people living in BC could readily access primary care during the COVID-19 crisis. Dr Louie is a medical officer for the First Nations Health Authority, and an Indigenous physician providing care as part of the service.

The First Nations Virtual Doctor of the Day program enables Indigenous people in BC without a doctor, or with limited access, to schedule appointments by phone or video, seven days a week. In the first three months, more than 400 patients accessed the service from 32 doctors. All physicians have training or experience in cultural safety and humility, and 30 per cent are Indigenous.

Supported by the First Nations Health Authority and the Rural Coordination Centre of BC, funded by the Joint Standing Committee on Rural Issues.

Patients appreciate the responsiveness and flexibility of the service, from initial contact with a medical office assistant, the help with technology, speed of physician call-backs, and help in accessing testing, treatment, and prescriptions.

Bringing care to patients during the pandemic is key, but quality of care is equally or more important. Dr Louie highlights the lack of culturally safe care as a significant barrier for Indigenous people, as significant as the burden of travel, and limited availability of providers and services.

"Unfortunately, some care is not necessarily being delivered in a safe way, which is adding to issues of attachment. It's great that a person has access to their family doctor, but if it's not a healthy relationship, a patient is not necessarily going to want to access that care anymore," he explains.

Asked what unsafe care looks like, Dr Louie replies: "Unsafe care relates to whether there's a lack of acknowledgment of the power dynamic that exists between a provider and a patient. Perhaps a lack of cultural understanding and appreciation of the historical context that still exists or has shaped the individual's experience with health care. As physicians involved in this service, we want to ensure a safe space for our patients, where they feel listened to, and comfortable opening up and sharing their feelings."

Issues of access and attachment are not limited to rural, remote, and isolated communities. Indigenous people living in urban centres are also encouraged to connect with the service.

"Statistically about 50 per cent of our Indigenous community are living away from home, and may be moving around and in flux. Consequently it's more difficult to get somebody to agree to take on care."

With successful projects such as this one paving the way for virtual care in the long term, doctors and patients agree the benefits can extend past the pandemic, to address multiple issues relating to access to quality care.

CREATING EASY ACCESS TO INFORMATION

For palliative care patients and families

Being diagnosed with a life-limiting condition is a challenging and emotional time for patients and their caregivers. A life-limiting diagnosis means patients will need to access many medical, community, and spiritual supports to prepare for their palliative care journey, and ensure they are well cared for and comfortable as their condition advances.

Rossland family physician Dr Lilli Kerby explains, "When patients and families are faced with the prospect of a life-limiting illness, this news can be devastating. Easy access to information allows health care providers to support families in all stages of their journey, and for patients and families to know that they are not alone."

With that in mind, Dr Kerby and a team of Kootenay Boundary Division of Family Practice doctors created a palliative care information guide. *When You Are Facing a Life-Limiting Diagnosis* is a comprehensive guide to community supports and resources in Nelson and Trail that physicians can use to support patients and their families.

Supported by the Shared Care Committee.

"Our community offers resources for patients," says Dr Kerby, "but families and health care professionals may not know what is available, so this guide helps those supporting patients with a life-limiting illness."

The guide explains that "palliative" not only refers to dying, but to the care provided over the months or years prior to the end of life. Patients and their families can take comfort in knowing that there are many services available to help improve patients' function and quality of life throughout this time.

Patients are also provided with a comprehensive list of topics they should discuss with their primary care provider, so that no detail in their care is overlooked.

"One key goal is making patients and families aware of the services available to them early on, so they can be prepared," says Dr Kerby. "This way, when families are struggling, they know about the supports and can access them when they feel the time is right."

Perhaps most pertinently, the pamphlet provides information and contact numbers for a wide array of resources available to palliative care patients, including BC Palliative Benefits (home care nurses, palliative medication, and medical supplies) and Federal Compassionate Benefits (Employment Insurance benefits paid to people unable to work while providing care or support to a family member). Each version of the guide also contains a comprehensive list of local numbers that patients can call when they need help—from practical support like personal care and medication delivery, to emotional support.

SPEAKING THE SAME LANGUAGE IN THE ER

Supported by the Vancouver Coastal Health Authority and Physician Quality Improvement, an initiative of the Specialist Services Committee.

Emergency room (ER) visits are stressful for most people, especially those who don't speak the language of the health care providers. That is the ongoing challenge at Richmond Hospital's ER, where more than half of patients speak mainly Mandarin or Cantonese and interpreters are not always available.

COVID-19 infection concerns increase this challenge by preventing family members or friends from escorting patients into the ER and acting as interpreters.

For Dr Matthew Kwok, an emergency physician at the hospital, the drive to address this challenge is both professional and personal.

"I came to Canada in fifth grade and remember the struggles of not being able to communicate." This is an especially important challenge in an emergency room where "patients have added physical pain and need to be understood accurately."

In searching for a solution, Dr Kwok spearheaded a project to determine whether a rolling iPad device called Interpreter on Wheels (IOW) would be as effective. His project team included physicians, nurses, the health authority, provincial language services, and a Physician Quality Improvement (PQI) project manager.

Rolled up to the patient, IOW operates like a three-way Zoom call between patient, interpreter, and health care provider. Expert medical interpreters – not robots – provide the service. About 200 languages are available, including 20 Chinese dialects. Patients select the language or dialect they're most familiar with and choose audio or video. Audio is less expensive for the hospital and works like a phone. The video option is better in certain situations, such as when a health care provider needs to show the interpreter information about a medicine.

> "We were able to take an accurate history, guide him through a focused physical exam, provide discharge instructions, and answer his questions."

The COVID-19 pandemic provided an opportunity to test IOW when patients were unable to bring family members or friends into the ER. Wiping the iPad after use controls infection risk.

Patients now feel that someone in the ER speaks their language, Dr Kwok noted, adding that, "Everyone loved it."

Satisfied patients included a man experiencing deafness with hip pain, who ordinarily would have had to explain his symptoms in writing. Instead, within seconds of being admitted, he was able to communicate in sign language.

"We were able to take an accurate history, guide him through a focused physical exam, provide discharge instructions, and answer his questions," said Dr Kwok.

IOW affects patient care in three ways: improved communication, heightened privacy, and patient satisfaction. It enables a neutral third party to act as an interpreter, rather than a family member, increasing their privacy. With clear communication, care can better meet patient needs, which also means greater job satisfaction for staff.

The device can be more expensive than a live interpreter, because it's priced per-minute rather than at a fixed hourly rate, but it's extremely diverse and always available.

"I hope we can keep the technology long term," he concluded. "It's good, safe medical care and it also improves patient satisfaction."

PHYSICIAN WORKLOAD AND PATIENT WAIT TIMES

Reduced with in-practice support

Dr Ruth Demian runs a busy family practice with a complex patient panel, including many elderly patients.

Despite her best efforts to balance her appointment schedule and workload, she frequently found herself running behind and keeping patients waiting. Patients were complaining and Dr Demian was leaving the office late each day, spending at least two hours on paperwork at home every night.

Feeling frustrated and burned-out, and wanting to serve her patients in a more timely way, Dr Demian reached out to their regional support coach through the Practice Support Program (PSP).

"Having an independent expert—and, simply, a fresh pair of eyes—was very helpful in seeing barriers to the office running smoothly," explains Dr Demian.

The PSP coach supported Dr Demian and the clinic team to work through quality improvement activities, including completing an electronic medical record (EMR) functionality assessment, organizing a review of team communication processes and roles, and identifying measures for planning improvements.

Dr Demian and the team implemented several changes to clinic workflow related to patient visits.

New patients now receive an education letter explaining that each appointment lasts 10 minutes and covers one to two problems. For existing patients, clinic staff ask the reason for the visit when booking an appointment. When appointments are booked, patient visit information is clearly documented in the EMR schedule.

The clinic also created customized visit EMR templates to reflect visit types and support easier documentation and completion during the workday. For example, the medical office assistant (MOA)—who now knows the reason for each visit— opens a new patient visit template and documents aspects that would be helpful for Dr Demian. During the appointment, the template and EMR clinical decision support trigger reminders for Dr Demian.

To encourage patients to book their next appointment (if needed) before leaving the clinic, the clinic staff implemented a new follow-up appointment booking process.

Dr Demian and her MOA use the MedAccess appointment schedule for patient visit bookings, and created a customized "visit type and preparation" document for this process.

A 10-minute huddle between Dr Demian and her MOA at the end of each day enables them to quickly prepare for the following workday.

"The system keeps us on track and ensures clinic staff are able to work at the top of their scope."

Supported by the Practice Support Program, an initiative of the General Practice Services Committee.

COLLABORATING FOR PUBLIC HEALTH IN NORTHERN BC

> "I took a particular interest in harm reduction because it offered a pragmatic and dignified care approach to people most marginalized in our society. It felt right to me."

Dr Andrew Gray, a medical health officer in Northern Health chose his specialty based on a desire to contribute to the well-being of people in a variety of ways.

Upon entering medicine, he found his fit with public health where population-level statistics and systems thinking aligned with his mathematics background. "I started looking at policies and social conditions and it seemed clear it would have a bigger impact to change policies and the circumstances that people were living in." Dr Gray found kindred spirits in the people working in public health, who were also interested in social justice and equity.

Dr Gray's work with Northern Health touches on a wide range of areas including harm reduction; communicable disease control; environmental health, including air quality and drinking water protection; injury and chronic disease prevention; and advocacy on climate change mitigation. This often means working with groups outside of the health care system, including local governments, the education sector, police, NGOs, and the private sector.

"I took a particular interest in harm reduction because it offered a pragmatic and dignified care approach to people most marginalized in our society. It felt right to me," he said.

One example of this type of collaboration is Northern Health's work with resource development projects such as oil, gas and mining, to help anticipate and mitigate health, environmental, and community impacts. "We are working directly with the resource companies and promoters of these development projects to better influence their plans. As far as I know it's a fairly unique organized effort to engage with private industry on public health matters."

While he enjoys the variety of projects he is involved in, overdose emergency has been the largest part of Dr Gray's work these last few years and his focus when he participated in UBC Sauder Physician Leadership Program, supported by the Specialist Services Committee.

The goal of his project is eliminating a barrier to care for people with addictions by working to shift hospital policies from zero tolerance to something more grounded in patient safety and patient-centred care. The project is in its early stages, as Dr Gray notes, "systemic change takes a long time to happen."

He credits the program with broadening his skills, particularly in listening and influencing change. He learned how to structure a pitch and create compelling ways for different audiences to view issues and communicate ideas that resonate. In addition, he learned to facilitate conversations, to be open to other people's ideas, and collectively define a problem to find solutions. "It's not a skill set most physicians get from their training," he said of the leadership program, adding, "it opened my eyes to the wealth of ideas all around me and gave me a much clearer road map on how to make change."

Supported by the Specialist Services Committee.

STRENGTHENING THE CIRCLE OF CARE AROUND PATIENTS

Communication between hospital and community physicians

"Hospital and family physicians are now feeling more like colleagues in the care of their shared patients."

It's often difficult to get a snapshot of a patients entire medical history, even with pieces of information from Pharmanet, shares Dr Matt Billinghurst, a Victoria-based locum and hospitalist who works at both Royal Jubilee and Victoria General hospitals.

"A patient summary helps bridge this gap."

The Patient Summary Project—a Shared Care Committee initiative with the Victoria and South Island Divisions of Family Practice— creates a system to easily share patient summaries between family physicians and hospitalists to inform care when a patient is admitted to hospital. The summary includes information that could be relevant to care but is not typically listed on a patient's electronic hospital record, for example: details about past heart attacks or cancer diagnoses, specialist consults, social histories or special care requirements, allergies, and past adverse drug reactions.

Before patient summaries could be introduced, physicians needed a system to alert them when their patients were admitted, discharged, or had died in hospital. Developing this e-notification system was a challenging but necessary first step.

"It required a system change," recalled Victoria-based Dr Lisa Veres, who led the work with Dr Laura Phillips. "We went through many people and many layers of medical administration. It became apparent that e-notification wasn't going to happen unless we formed a committee, created a formal project, received major funding, and had the power to work with the health authority at a different level."

With e-notification in place and spreading across the region, physicians turned their attention to the next stage of the work – instituting patient summaries.

At the start of the initiative, the patient summaries project saw 40 family physicians provide summaries for their hospitalized patients via a mix of paper and various digital formats. The summaries were faxed into individual hospital wards or the ED to be manually appended to patient charts. While some were used, others were lost or misplaced.

Enough value was realized through this phase that 100 more physicians participated in the second phase.

In phase two, the Vancouver Island Health Authority (VIHA) established a central number where summaries could be faxed and tubed to the wards in the old fashioned way. While successful in the moment, the summaries would eventually be buried within the paper-based charts, with no additional system to flag them.

One hundred more doctors participated in the third phase. VIHA arranged for health authority staff to scan the faxed summaries into PowerChart to make the information part of the electronic medical record. This development was so successful and popular that physicians and other health providers across Vancouver Island began sending in their summaries— overwhelming the health authority staff who were scanning and uploading the documents.

In response, VIHA created a web portal where physicians could upload and export their own summaries. Work is now taking place to develop templates for each EMR and to address the unpaid time physicians spend completing and uploading summaries into the new system.

The value of connecting physicians to share information has resulted in many benefits, including a new sense of teamwork.

"Hospital and family physicians are now feeling more like colleagues in the care of their shared patients," says Dr Veres. "It's been a big success that's arisen from this project."

Supported by Divisions of Family Practice and funded by the Shared Care Committee.

TAKING CARE OF VULNERABLE POPULATIONS DURING COVID-19

Primary care networks (PCN) have enabled the Burnaby Division of Family Practice to implement programs and supports that address the health care needs of both the homeless and underhoused population and those who suffer from opioid use disorder. In March of this year, the Burnaby PCNs acted quickly to respond to the ongoing COVID-19 crisis, as people in both groups targeted by these programs and supports are particularly vulnerable to COVID-19.

PCNs in Burnaby were able to address the needs of both of these vulnerable groups by utilizing the skills and expertise of Dr Birinder Narang, a family physician, and Pippin O'Neill, a nurse practitioner (NP). Both Dr Narang and O'Neill were deployed at various facilities throughout the community such as the Progressive Housing Emergency shelter or the City of Burnaby warming centres. Prior to COVID, there were no regular primary care services available, and offering primary care at the shelter and warming centres gave people access to COVID related care and education. The services also reduced travel to receive care, thus lowering the risk of contracting or spreading COVID during transit.

Dr Narang originally offered his services to the PCN in hopes of providing better care to homeless and underhoused people in the community.

"It has been my privilege to visit the under-served population in Burnaby at warming centres," says Narang. "Having access to pandemic prescribing, including safe supply guidance, is an integral part of their overall care. Ongoing recognition of the dual public health crisis is essential as we plan for our future."

Narang and O'Neill not only provided patients with immediate primary care, but could also assess for their pandemic prescribing needs. Through multiple clinic outreach locations, patients could access safe supply medication for opioid use disorder. This was critical as contamination in street drug supplies increased, placing this population at even greater risk of overdose. The Burnaby PCN brought in allied team members including social work and counselling services for patients who needed additional support.

"I know I make a difference when I offer safe supply to people who just need a little help to get back on track." added O'Neill.

The need for primary care services in this area continues to increase. The PCN is responding by focusing an additional NP to continue to work with their community partners and the city to ensure those most vulnerable have access to the care that they need.

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