JCC Joint Collaborative Committees

A partnership of Doctors of BC and the BC Government

JANUARY 2022

COLLABORATE ON HEALTH IN BC

Stories of physicians improving access to care

Dr Chelsea Elwood brings together care from two hospitals in one space for comprehensive maternity and pediatric care.

Contents

A partnership of Doctors of BC and the BC Government, the Joint Collaborative Committees (JCC) bring together health care stakeholders to improve access to care through four committees: Joint Standing Committee on Rural Issues, General Practice Services Committee, Shared Care Committee, and Specialist Services Committee. Funding and support from the committees enables the Rural Coordination Centre of BC, divisions of family practice, and medical staff associations to take a grassroots approach to enhance patient care and improve professional satisfaction for doctors in communities and facilities across the province.

Welcome

Another year of living and caring for each other during a global health pandemic has come and gone. Throughout it all, BC doctors continued to model resilience and strength – in taking care of their patients and each other.

Not only strong in a time of extraordinary adversity, doctors adapted to virtual environments and battled rising rates of physician burnout and moral distress.

Recognizing the challenges that doctors were facing, we leaned on our strong relationships with health care partners at community, regional, and provincial levels.

Following a year-long consultation, we released a set of statements that provides doctors guidance on the use of virtual care for practices and in service delivery. Feedback was also provided to help shape the Ministry of Health's digital health policy and the College's standard of practice.

We also partnered with the Physician Health Program of BC to start to develop and support provincial resources including networks of trained physicians offering their colleagues one-to-one peer support; facilitating and matching physicians with their own family physician to support their primary care needs; and core cognitive behavioural skills training for physicians to support their health and wellness, as well as delivery of care to patients with mild to moderate mental health issues.

All the while, we continued to support recruitment of doctors. This year, twice as many practice-eligible international medical graduates participated in our BC Physician Integration Program to help them transition to practice medicine in our province.

Strengthening their communities, doctors also innovated health system redesign projects through their health authorities. With funding from our committees, more than 1,800 doctors led over 60 projects, including one that brought together 45 family doctors as part of two new networks – youth addiction medicine and perinatal addiction medicine. After working years in isolation, these physicians created a community where they can exchange knowledge and expertise as they to provide care for these vulnerable populations.

As co-chairs of the Joint Collaborative Committees, we are proud to have played an important role in coming together with our partners to promote innovation in the health care system and leadership among physicians.

In this issue of *Collaborate on Health in BC*, read stories about how your colleagues improved access to care with support from our committees and partnerships.

Co-chairs,
Joint Collaborative Committees

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Dr Jiwei Li	Ms Shana Ooms
SPECIALIST SERVICES COMMITTEE	
Dr Ahmer Karimuddin	Mr Ryan Murray

Cultural connections: Collaborating for healing in health care

Tla-o-qui-aht First Nation community members led a group of Tofino health care professionals through a cultural ceremony where they experienced traditional healing practices firsthand. Together, they wanted to explore how these practices and stronger cultural connections might blend with medical care to support people who experience trauma and pain.

Tla-o-qui-aht First Nation healer Nora Martin and cultural worker Chris Seitcher led the ceremony. “We carry trauma around with us, and sometimes never deal with it,” Martin explains. “In our community, if there is a serious incident or death, we do these ceremonies for community members right away. It makes a big difference.”

Those benefits caught the attention of Tofino primary care and emergency room physician Dr Luke Williston. He had seen traditional cultural practices help a group of patients who were dealing with trauma and experiencing substance use requiring frequent treatment in hospital.

Nora Martin (l) and Dr Luke Williston (r)

“A cultural worker came to the hospital to do a cleansing ceremony for some patients,” he says. “We didn’t see any of those patients for more than a year after. When I would see them in the community, I could see they were doing better. That is hard to ignore.”

“While our current medical therapies are good, they do not always hit true with everyone.”

Williston observes that traditional practices help people reconnect with their identity, community, and culture. “That, in turn, can give them more of an anchor and focus, so they can keep on track longer.”

Williston connected with Martin and Seitcher to explore ways to introduce health care colleagues to traditional practices and contribute to a more connected healing community. Martin and Seitcher arranged a traditional cultural ceremony with Tla-o-qui-aht members, physicians, nurses, X-ray and laboratory technicians, and a firefighter. It incorporated a talking circle, breathing exercises, drumming and singing, and cold-water cleansing pools.

“Any time there was trauma in the community, or family, grief, or loss, we would bring members to the river or ocean to do a cleansing,” explains Martin. “Cold water rebalances us – it refocuses negative energy and helps clear the mind.”

It was an insightful learning experience. “It is quite different from our usual kind of medical work – a much slower pace,” says participant Dr Pam Frazee.

“A different part of your brain is working – your emotions are more present.”

The aim is to introduce traditional healing practices more widely among health care and emergency professionals, and create stronger cultural connections with patients.

Williston sees potential in integrating cultural workers into the hospital to perform ceremonies for sick patients and those about to be discharged.

“That surrounding care might help [patients] stay better, longer,” says Williston.

Seitcher, who has worked in the helping field for many years, also sees many benefits to blending in traditional practices. “Culture means connection. We can bring our culture to the hospital and create a safe space to connect and work through some tough issues.”

Martin, reflecting on her first time working with the medical community, says she is pleased to see the openness to new ways and learning. It supports an aim of the First Nations Health Authority and BC’s health care system to have Indigenous communities and members work in partnership with doctors and health care professionals to support people’s health, wellness, and care.

“We have a lot to offer,” she says. “We can help each other – instead of living and working in isolation – and provide more services to many more people.”

A proven combination of technology and training

The COVID-19 pandemic's impact has been felt across the world. Throughout its challenges and tragedies, the pandemic has also been a catalyst for positive effects.

For one small-town Vancouver Island clinic, the pandemic sparked a transformation in care delivery.

"Before COVID-19, my clinic did not offer virtual care. All visits were in person," says Dr Ashraf El Karsh, a family physician in Qualicum Beach. "The pandemic changed everything, and we had to change as well – and move quickly."

Dr El Karsh immediately started offering phone visits, then added video visits by enabling his EMR's video capability and using Zoom for Healthcare. To mitigate difficulties, staff spent about five minutes with patients who needed help with the change.

Interested in optimizing technology in his practice, Dr El Karsh attended a physician-led three-part webinar series about video-based virtual care. Motivated and inspired to apply his learnings, Dr El Karsh worked with a regional practice support coach to implement quality improvement projects.

Dr El Karsh and the practice team developed and actioned a plan to update patient contact information, including email addresses so the clinic could efficiently provide patients with general clinic information and COVID-19 updates, and to implement a new workflow to get patient consent for electronic communications and virtual care.

The webinars taught Dr El Karsh to record verbal consents and verify consent documentation in patients' charts. He created and implemented an EMR template that alerts him each time he views a patient's chart. The EMR also helps track how many patients have consent on record.

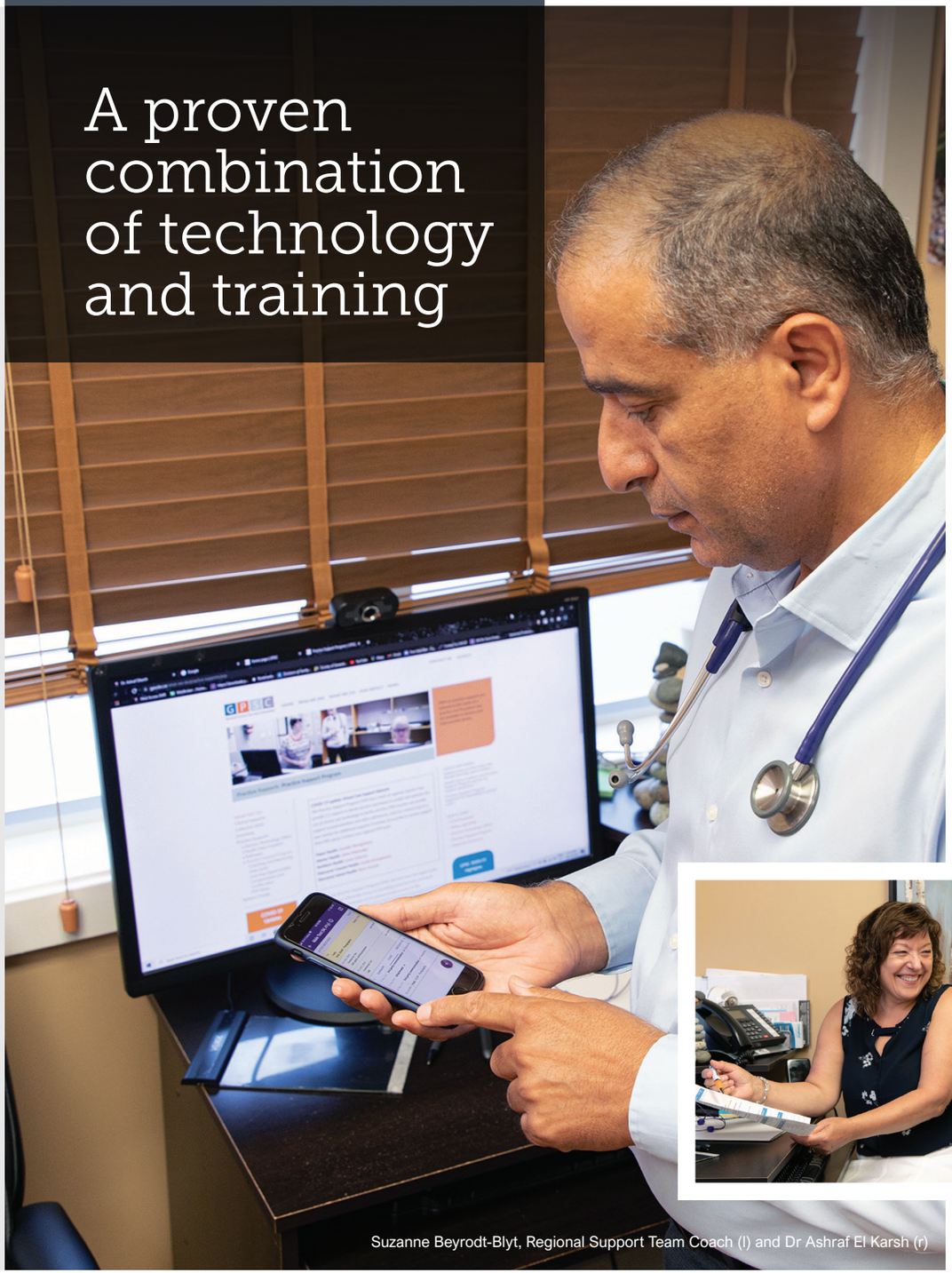
Dr El Karsh continues to add functionality to his EMR, including a signing pad for wet signatures. "This was a big improvement for just about $40. It makes a lot of sense considering how much I use it."

In about one year, the clinic went from providing zero visits virtually to about half, including for elderly patients who prefer virtual visits for prescription renewals and blood sugar levels. Dr El Karsh notes that seeing patients' behaviour during video visits is helpful for assessment.

The clinic reports that 5% to 10% of virtual visits are rescheduled for an in-person visit based on the doctor's judgement.

These changes increased the physician's self-reported productivity and connection with specialists, increased the clinic's capacity by 10%, and saved the clinic about 5,000 sheets of paper per month by switching to an e-faxing platform.

Offering many benefits, including enhanced access to care, virtual care is a positive outcome from the pandemic. It complements, but can't replace, in-person care.



Suzanne Beyrodt-Blyt, Regional Support Team Coach (l) and Dr Ashraf El Karsh (r)

"It is important to maintain quality of care at the same level as with in-person care. Besides, sometimes I feel I miss the link and human touch."

DR ASHRAF EL KARSH

Reversing a dementia diagnosis is one of many profound and life-changing results from a project to reduce risks of polypharmacy (i.e., multiple medications) for seniors in three communities in northern BC.

When project lead Dr Charles Helm speaks about the benefits witnessed by the teams, his excitement is palpable.

"Imagine the joy of being able to tell a patient in her 70s diagnosed with dementia, 'We don't think you have dementia; we think stopping the medication did the trick. Go out and enjoy your life.'"

This was weeks after stopping a drug commonly prescribed for anxiety and pain. It had worked well but was now causing increased confusion. Her husband and daughters concurred that she was back to her old self.

Seniors reap benefits from medication reviews

TAKING MULTIPLE MEDICATIONS, OR POLYPHARMACY, IS A RISK FACTOR FOR SERIOUS ADVERSE EVENTS FOR THE ELDERLY, ESPECIALLY FOR THE FRAIL ELDERLY.

This patient outcome was made possible by an hour-long medication assessment – a key component of the project to develop a formalized, team-based structure for providers, pharmacists, patients, and families to communicate about medications.

A pre-project survey highlighted a lack of structure and consistent communication as risk factors for polypharmacy, errors, and adverse events for patients, especially those transitioning in and out of hospital.

The three northern communities each use different approaches. In Tumbler Ridge, patients over 65 who are on more than five medications are encouraged to attend a medication assessment with Dr Helm and pharmacist Charissa Tonnesen.

The whole process, including chart review, correspondence, and follow up, takes the team about three hours a week.

"Charissa and I help each other. We have different training and skill sets. Having free flow of ideas and conversations helps you pick up things that you wouldn't have noticed on your own," shares Dr Helm.

The goal is to inform and empower patients and families.

The teams talk through each medication's risks and benefits, identifying those that could cause issues and impact the patient's quality of life. A written record is sent to the patient and their doctor after the review – relieving patients from taking notes and being distracted during the conversation.

"Some patients are on 15 medications and don't have a clue why they're taking some of them. It's easy for medications to build up over time, and some prescriptions continue getting renewed even though that issue may have been resolved."

Other reviews led to palliative care patients discontinuing medications that were causing debilitating symptoms; and identification of drugs that were causing dizziness and fainting spells in an elderly patient, and dangerous hypoglycemia symptoms in a chemotherapy patient. Another family was relieved when a dementia patient in her 80s was able to reduce medications to one dose a day rather than around the clock.

"Sometimes the simplest changes have profound effects on caregivers," says Dr Helm.

These case studies are reviewed during monthly webinars, which engage local providers and prompt thought-provoking dialogue around widely prescribed medications.

"Starting medications is remarkably easy, even when they turn out not to be a good idea. Stopping them seems to be much harder in the real world. This project has taught us how we can involve patients, families, and professional colleagues in timely, wise reviews. We're seeing significant health benefits by stopping medications when appropriate. Extending this effort to include everyone who takes multiple medications would reduce the risks of polypharmacy and have a broad impact on public health," says Dr Tom Perry, an internist involved in the project who has been working for more than 20 years to increase awareness of the risks of polypharmacy.

Virtual physicians help keep emergency room open in rural BC

MORE THAN 150 VIRTUAL PHYSICIANS PROVIDE RURAL HEALTH CARE PROVIDERS WITH ON-DEMAND CLINICAL SUPPORT VIA VIDEO OR TELEPHONE WITH OVER 40,000 ENCOUNTERS TO DATE.

A Dawson Creek hospital's emergency room stayed open thanks to physicians making themselves available virtually.

Wrapping up a 10-shift stint, the group of doctors used video technology to assist nurses with emergencies including leg injuries, chest pain, and mental health concerns. Doctors were on call in the community, but none scheduled at the hospital.

Understanding rural and remote communities, the virtual physicians are part of the Rural Urgent Doctor in aid (RUDi) pathway, one of seven pathways forming the Real-Time Virtual Support (RTVS) program offered by the Rural Coordination Centre of BC (RCCbc). RTVS enhances health equity in rural, remote, and Indigenous communities across BC where there is not normally a doctor present.

RUDi pathway co-lead Dr Brydon Blacklaws says that technology makes it easier to connect with patients to get additional information, offer face-to-face reassurance when needed, and consult with nurses to work together towards solutions.

"The nurses on the ground are the true heroes in this situation. If it wasn't for them, we couldn't do this."

Dr Blacklaws, who worked some shifts from his home in Powell River, recognizes that rural communities have issues with physician recruitment and retention.

"The summer is usually more of a challenge because people take much-needed vacations. We're extremely pleased that RUDi provided a temporary solution in Dawson Creek and prevented patients from being diverted to Fort St. John."

Dr John Pawlovich, RCCbc's virtual health lead, says, "Virtual health is integral to reducing health inequity in rural, remote, and Indigenous communities. But virtual physicians aren't a replacement for on-the-ground physicians in these communities. Rather, they're an additional and important tool."

Fewer ER visits. Better seniors care.

Long-term care facilities in BC can now routinely reach a family doctor after hours more than 85% of the time through physician-led, locally designed solutions.

In Chilliwack, Agassiz, and Hope, the local long-term care (LTC) initiative was initially headed by Dr Erin Lynch. She explains that every person in the nine local facilities now has an most responsible provider. About half have their own family doctor. The others receive care from physicians who work in a "cluster" model in the LTC facilities, each taking on about 10 to 20 unattached patients.

The pandemic's first wave reinforced the cluster model's positive impact. In Chilliwack, it enabled a small group of dedicated LTC physicians to cover all facilities, with twice-weekly proactive visits to promptly address care needs and participate with nurses in more robust team-based care.

To reduce ER visits, a 24/7 call schedule simplifies physician access for staff. The doctor on-call reviews all potential ER visits, which has reduced the number of transfers. If avoiding the ER isn't possible, the doctor will expediate a visit.

For example, a person living with dementia, who paced to manage restlessness, fell on a Saturday. The physician on-call arranged a same-day x-ray – which confirmed a broken hip – and surgery for the next day. The patient was able to spend the night at home in her facility, where she had pain relief and care from staff who knew her needs. The next day, she was admitted directly for the operation and discharged home within two days. Ultimately, this patient received most of her care in her residence with people she knew, which reduced stress and aided recovery. This senior had the best opportunity to maintain her quality of life while reducing her risk of delirium and other complications.

Adopting technology cuts patient wait times by half

After hearing patients' concerns about long waits for walk-in lab test results, Dr Sophia Park, a Vancouver Coastal Health regional medical lead, began developing a solution for the Gordon and Leslie Diamond Health Care Centre.

Dr Park collaborated with laboratory and clinical colleagues and a Vancouver-based company to develop a secure online system that enables patients to book appointments by phone or computer. The tool helps patients choose the ideal time to get their bloodwork done, enables them to do it quickly, and improves patient flow in the outpatient lab.

Clinic navigators at Vancouver General Hospital first trialed the tool, quickly and easily creating accounts for their patients and booking lab appointments based on patients' preferred dates and times. Clinic staff provided feedback to help optimize the system before making the tool available to the general public.

In the first six months, patients with appointments had wait times reduced by more than 50%, with 90% waiting 20 minutes or less. In its first year, the system had more than 25,000 users and was adapted for use by 67 hospital labs across BC.

The service has particularly benefitted vulnerable organ transplant patients by reducing lab wait times and allowing them to coordinate lab work around other medical appointments. In the future, the online booking tool could be extended to areas including radiology.

"There are very simple tools we could adopt from other industries to provide huge benefits to patients," Dr Park says. "I definitely think it's worthwhile to consider how they could be incorporated into day-to-day care."

"We consistently received feedback that the care is complicated and does better in a multi-disciplinary setting, but that it is really important for women and families to receive care within their communities."

DR CHELSEA ELWOOD

A new space brings together care from two hospitals

A MULTI-DISCIPLINARY APPROACH HELPS CREATE A MORE COMPREHENSIVE MODEL OF MATERNITY AND PEDIATRIC CARE.

BC Children's Hospital and BC Women's Hospital and Health Center have many available experts and resources to address reproductive infectious diseases (RID) affecting mothers and their infants. But until recently these services were siloed in their respective hospitals. Mothers with RID delivered at BC Women's and infants born with congenital infections received care at BC Children's.

Under the leadership of Dr Chelsea Elwood and support of the Provincial Health Services Authority, the RID and Pediatric Infectious Disease (PID) programs are transitioning into one space and joining the multi-disciplinary care offered at the BC Women's Oak Tree Clinic (OTC).

Established more than 20 years ago, the OTC provides complex care to women with HIV and hepatitis C with a particular focus on pediatrics, as well as pregnancy and adult HIV care. It is a provincial resource for providers seeking information on best practices and evidence-informed care.

Dr Elwood states, "We know that infectious diseases often come with social determinants of health, which are fairly complicated to manage and treat, so the clinic contains social workers, psychiatrists, pharmacy support, multi-disciplinary care providers such as pediatricians, OB/GYN physicians, and adult HIV care, who all specialize in infectious diseases and will help close any gaps in care." Dieticians and outreach workers are available to assist with access issues, housing stability, and other issues that often accompany these kinds of infections.

As part of this JCC-funded project, all health authorities providing maternity care and pediatric care were asked about their satisfaction rates with accessing the RID program offered within BC Women's, the PID program within BC Children's, and what services could be improved.

Dr Elwood explains, "We consistently received feedback that the care is complicated and does better in a multi-disciplinary setting, but that it is really important for women and families to receive care within their communities."

These consultations led to establishing three streams of access to the OTC: family doctor or specialist referral, collaborative consultations and care to patients through Telehealth, and provider consultations with infectious disease experts.

The RID program transitioned to OTC in April 2021 and the PID program is anticipated for later in the year.

A provincial HIV care resource, the OTC website is being upgraded to include information on RID and pediatric infectious diseases; the website will provide easy access to clinical pathways, resources, and consultations for all three programs. In the meantime, program access is incorporated into the standard referral process and available through a call service at BC Women's.

"We are fortunate in BC to have a really strong group of infectious disease physicians thanks to the long-standing provision of care to HIV mothers and their children, and being a world-leader in multi-disciplinary women's health," says Dr Elwood.

No time to lose: New lung cancer pathway reduces time to treatment

"We didn't think that we would see something this dramatic. It reinforces that we're on the right track; keeps the momentum going."

DR KAREN UNG

Dr Karen Ung (l) and Dr Jeremy Ho (r)

Over the past decade, options for diagnosing and treating lung cancer have expanded rapidly. While that's good news for patients, the health care system hasn't always kept pace with the moving parts. Oncologists have been challenged to get the diagnostic information they need in a timely way to start treatment with patients.

Dr Jeremy Ho, an oncologist at Richmond Hospital (RH), explains that patients presenting to their family doctor or the emergency room need to pass through several tests and specialists. But it doesn't stop there.

"It's not sufficient to get just a biopsy that says lung cancer. Cancer care is very protocolized; we have to plan treatments strategically. We need to send tissue to the BC Cancer Agency (BCCA) for more tests; to do biomarker or molecular testing and look at the specifics of the cancer itself. That tells us what treatments are best directed at it."

Dr Ho says the back-and-forth process is cumbersome. Ideally, oncologists have the information needed for a treatment plan at the first appointment; but in reality, it can take up to eight weeks to get that information back.

"When we're dealing with an aggressive type of cancer, families often don't understand why things take so long. I can try to explain and address their anxieties, but at the end of the day, I agree, it's too long," he says. "Just because it's always been this way, doesn't mean we have to accept it."

After discussing the problem with Dr Karen Ung, a pathologist at RH, they engaged interdisciplinary colleagues to create a new lung cancer diagnosis and treatment pathway. With support and funding from system partners, they brought together cancer specialists from RH radiology, respirology, oncology, and pathology. These specialists typically provide services independently, and this was an opportunity to coordinate and improve diagnoses and management pathways for patients.

Over multiple meetings, the team laid out the pathway visually to identify barriers and consider solutions to save time and improve the standard of care. Discussions were eye-opening. Hearing each other's perspectives helped the team identify mistaken assumptions about patient care pathways and increased everyone's knowledge about their respective roles and requests. Seeing the bigger picture highlighted how each of their decisions impacts the overall patient journey.

The team identified where delays occur, and how small shifts in everyone's roles could help. Examples ranged from respirologists taking multiple biopsy tissue samples in the initial diagnostic for BCCA molecular testing; to having investigations occur simultaneously rather than waiting for one result before performing the next test; to improving process coordination with the BCCA.

The collective efficiencies added up and the data showed that the average turnaround time from biopsy to starting treatment shortened from 55.7 to 34.5 days – a improvement of more than 21 days.

"We didn't think that we would see something this dramatic," states Dr Ung. "It reinforces that we're on the right track; keeps the momentum going."

Plans include connecting with emergency department colleagues and to the community family physicians to further refine the pathway.

Dr Ung adds that the "success gives us the momentum to be able to keep doing it for other things – apply to other oncological treatments that might use this similar type of testing. It's portable and replicable across everyone in the community or in a big centre."

The power of story: Creating the best last chapter for palliative patients

Melody (front l) and Dick Farmer (front c), caregiver and patient participants

The East Kootenay region is home to a large retirement community with a relatively high incidence of people who live with chronic disease who benefit from a palliative approach. In Dr Greg Andreas's view, palliative care should not focus on an individual's imminent death, but on understanding who they are, where they've been, what they love, and their vision of their best life. Caregivers should focus on helping that person continue savouring what they have, right to the end.

"I could be living with a cancer, I could be living with a disease process that is taking the sands of my life – or my story – faster than maybe I anticipated," he says. "But I'm still living every day, and that is part of dying."

Through the East Kootenay Division of Family Practice, Dr Andreas, a family physician and physician project lead, brought together palliative care providers from the region for information-sharing events. The objective was to encourage all palliative caregivers – including physicians, allied health care providers, paramedics, families of patients, and members of other related organizations – to be curious, to get to know, appreciate, and empathize with each patient as a person, understanding that they are on a journey with that person. He believes the best palliative care makes that journey as fulfilling as possible, every day.

Providers engaged in facilitated discussions meant to nurture a more holistic, collaborative, and patient-centred approach to palliative care. Identifying and using all available services is key to optimal palliative care. Before the Creston event, for example, many participants didn't know that local paramedics have special expertise in assisting palliative patients at home.

Each event kicked off with a deeply personal story of an individual's palliative journey, as told by a relative who had been by their side – allowing participants to step outside their official responsibilities and appraise the state of palliative care as someone whose relatives might experience it, or who might experience it themselves.

Before the events, the project team identified physician champions with a special interest in palliative care and asked them to find a local person willing to share a close relative's final story. Those participants were invited to write an account of that final period, and to read their story aloud at the start of an event. The palliative care community's role was simply to listen, not comment.

Each story was unique. One described a patient who chose to palliate and pass away at home, supported by pharmacists, nurses, physicians, friends, and family. Another traced a cancer patient's path to choosing medical assistance in dying.

The project brought people together, encircling the palliative patients' families, recognizing them as part of the care team.

"Perhaps the story ingredients we are all looking for at life's end are empathy, vulnerability, and unconditional caring," says Dr Andreas. "We ask people to connect, to become a character in someone else's story – hopefully, for the better."

Mindfulness program empowers youth resilience and stress reduction skills

Dr Janice McLaughlin (l) and Tanisha Adams, medical office assistant (r)

A new family doctor-led mindfulness group for youth is making a tremendous difference in the Comox Valley by equipping adolescents with techniques for managing stress, pain, and anxiety, and preventing depression relapse.

Thirteen youth between 15 and 19 years participated in the eight-week pilot program led by Dr Janice McLaughlin, family doctor with the Comox Valley Division of Family Practice.

> **"Patient feedback was overwhelmingly positive, with proven viability for delivery within family practice. The group setting works; the kids are engaged, the online setting works for them."**
>
> DR JANICE MCLAUGHLIN

During the program, family doctors led virtual group medical visits for the teens who built their own self-care plans on an online platform. The teens shared observations from their mindfulness practices on the platform, where the care team promptly responded to their posts. On the day of each visit, the care team promoted engagement by texting participants from their EMRs. The team sent weekly emails to the teens with links to meditations and information about practicing at home.

Participation rates were high, with about 10 youth attending each weekly meeting. Following the spring 2021 program, one youth finished an exam without a panic attack. Another said that belly breathing helped them manage challenging situations or interactions.

The program is based on BC Children's Hospital's skills program and adapted to the online setting to meet the needs of teens in the community during the pandemic. Supported by the Rural Education Action Plan, Dr McLaughlin completed 16 weeks of online training with physicians at BC Children's Hospital.

Dr McLaughlin turned her ideas into a manageable plan with support from a regional practice support coach and received compensation for 15 hours of program-related admin time and having a second physician in the room as a mindfulness facilitator during program delivery. Her medical office assistant, who also practices mindfulness, organized intake interviews and communication with the families.

Dr McLaughlin has practiced mindfulness for the last 10 years.

"It's important to facilitate mindfulness from a place of personal practice," she says. "Youth in particular are very aware of authenticity."

With the care team already receiving referrals, Dr McLaughlin plans to continue offering the program in early 2022.

Innovative e-coaching standardizes care delivery

A Revelstoke-based family practice anesthetist (FPA) used virtual coaching innovations to bring local FPAs the latest recommendations and help develop a safe standardized approach for a regional anesthesia technique that reduces patients' post-operative pain and their need for opioids.

Dr Kirk MCarroll, FPA Network Lead with the Rural Coordination Centre of BC, coordinated Vancouver-based anesthesiologists to beam into an operating room in Revelstoke via videoconference during anterior cruciate ligament (ACL) surgeries. Their screen connects to the ultrasound, giving them a perfect view of the needle, the nerve, and the local anesthetic spreading over it and allowing them to observe and provide feedback to the FPA conducting an adductor canal block.

"It can be difficult to go back for additional training in regional anesthesia because space is competitive and you often have to go out of town, away from your practice," said Dr McCarroll. "E-coaching, like this, brings unique skills and knowledge that you really only find in large centres, out to the periphery."

The patient benefits are enormous. Expanding ACL surgeries in Revelstoke means local patients no longer need to travel to Kamloops, Vernon, or even Banff. In fact, patients from larger centres are now traveling to Revelstoke for the procedure.

"Overall, it was an easy educational opportunity that didn't slow down our days," says Dr McCarroll. "The specialists on the other end really want to provide support, are non-judgmental, and like to share their knowledge with us. One-on-one training from the most up-to-date specialists in anesthesia – you really can't get better than that."

Promoting healthy medication use

The *Coyote's Food Medicines* story was nominated for a 2021 provincial award for excellence in quality in the strengthening health and wellness category. It was recognized for empowering Indigenous people to discuss the importance of maintaining good health when taking multiple medications, and to encourage conversations with health care providers.

Storytelling is the traditional way for Indigenous communities to share knowledge, wisdom, and humour.

The *Coyote's Food Medicines* story emerged from conversations with Secwépemc Elders about medication use in their community during a gathering in Williams Lake, where people came together for easy conversations, lunch, and visits by some of the Elders' grandchildren.

Secwépemc Elders, Clara Camille (l), Jean William (c), and Cecelia de Rose (r)

"In the past, our Elders didn't take lots of medication, mostly just Aspirin. But now cupboards look like pharmacy shelves," shared Elder Jean William.

Dr Keith White, a physician lead for a provincial polypharmacy risk reduction initiative, planted the seed for the project, and through the initiative the *Coyote's Food Medicines* story was created in partnership with the First Nations Health Authority and Interior Health Authority and with guidance from the Elders, illustrations by Georgia Lesley, and design and production by Drawing Wisdom.

doctors of bc

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