JCC Joint Collaborative Committees

BRITISH COLUMBIA doctors of bc HQBC HEALTH QUALITY BC

Collaborative Compassion:

The Power of Connectedness

PROGRAM GUIDE June 6, 2023, Vancouver BC

Accredited by UBC CPD

THE UNIVERSITY OF BRITISH COLUMBIA
Continuing Professional Development
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CFPC Session ID: 199930-001

Collaborative Compassion: The Power of Connectedness

PROGRAM GUIDE June 6, 2023, Vancouver BC

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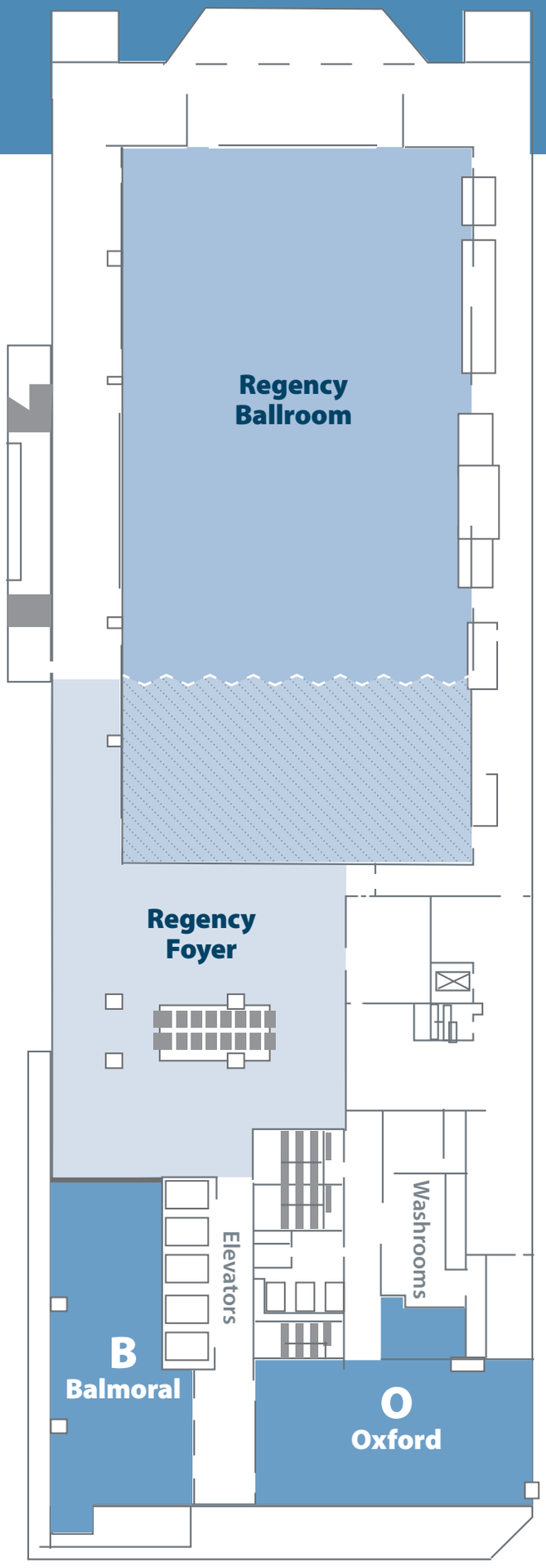


Regency Ballroom and Foyer

MORNING SESSION 7:00 - 9:30 AM

7:00 – 8:00am | Breakfast & Registration

8:00 – 8:25am | Territorial Welcome

8:25 – 8:45am | Doctors of BC President, Dr Josh Greggain, Welcome

8:45 – 9:30am | Keynote Speaker, Dr Susan Biali Haas

LUNCH AND KEYNOTE 11:45 - 1:30 PM

11:45 – 12:45pm | Lunch

12:45 – 1:30pm | Keynote Speaker, Dr James Makokis

PANEL, CLOSING AND RECEPTION 3:00 - 4:30 PM

3:00 – 3:30pm | JCC Co-Chairs Panel Presentation

3:30 – 4:30pm | Closing & Storyboard Reception

B - Balmoral Room

9:45 – 10:30am | **B1. A PARTNERSHIP APPROACH FOR SPREADING PHYSICIAN LEAD QI PROJECTS**

10:45 – 11:30am | **B2. INTEGRATING AN RN INTO PRIMARY CARE**

1:45 – 2:30am | **B3. REFERRALS, CONSULT LETTERS & OFFICE STAFF – OH MY!**

O - Oxford Room

7:30 – 9:00am | Ceremonial Smudging & Brushing (Optional)

9:45 – 10:30am | **O1. PHYSICIAN & TEAM BURNOUT**

10:45 – 11:30am | **O2. CO-CREATING VIRTUAL COMMUNITIES OF PRACTICE THAT TRANSCEND BORDERS AND PROFESSIONS**

1:45 – 2:30am | **O3. RURAL CARE**

34th Floor

C - Cypress Room

9:45 – 10:30am | **C1. OLDER ADULTS**

10:45 – 11:30am | **C2. MULTIDISCIPLINARY TEAMS**

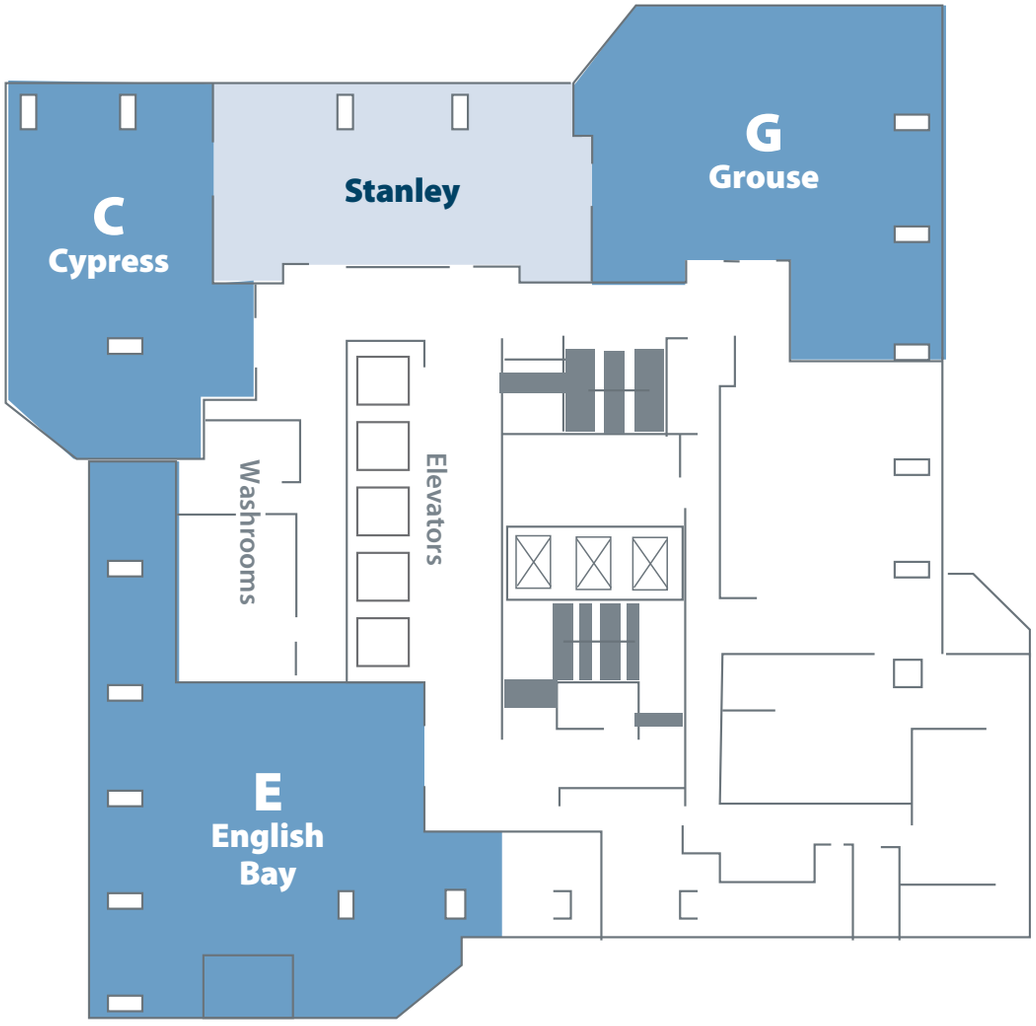
1:45 – 2:30am | **C3. CONNECTIONS & ENGAGEMENT**

G - Grouse Room

9:45 – 10:30am | **G1. VIRTUAL CARE**

10:45 – 11:30am | **G2. LEADERSHIP**

1:45 – 2:30am | **G3. PRIMARY CARE**



E - English Bay Room

9:45 – 10:30am | **E1. EDI/CULTURAL SAFETY & HUMILITY**

10:45 – 11:30am | **E2. COLLABORATIVE SOLUTIONS**

1:45 – 2:30am | **E3. QUALITY IMPROVEMENT**

The Joint Collaborative Committees, a partnership between Doctors of BC and the BC government, acknowledge that we work on the traditional, ancestral, and unceded territories of many different Indigenous Nations throughout British Columbia.

Acknowledging that we are on the traditional territories of First Nations communities is an expression of cultural humility and involves recognizing our duty and desire to support the provision of culturally safe care to First Nations, Inuit, and Métis people in BC.

Welcome to Collaborative Compassion: The Power of Connectedness!

On behalf of the Joint Collaborative Committees (JCCs), a unique collaboration between Doctors of BC and the BC government, and Health Quality BC (HQBC), we warmly welcome you to the 2023 JCC Pre-Forum.

Today is an opportunity to come together to reflect on the interconnectedness of our work across the JCCs and with our peers in the health care system. By focusing on bolstering patient-centered care, building physician capacity, and coordinating health care systems through meaningful quality improvement (QI) methodology, the accomplishments that we celebrate across the JCCs are so much more than the sum of its parts.

The theme this year is Collaborative Compassion: The Power of Connectedness and the purpose of today is to celebrate the value of collaboration. A commitment to harnessing compassion and connectedness will increase opportunities to expand and positively influence patient care and the health care system.

Today, we are one.

We are honoured to welcome Dr Susan Biali Haas and Dr James Makokis as our distinguished keynote speakers. With a key focus on the importance of fostering connections and inclusivity within our communities and addressing mental health and burnout prevention, our guests' extensive medical expertise and lived experience will set the tone for our day of sharing and learning.

In the breakout sessions, you'll hear from colleagues and peers on their quality improvement projects in various presentation formats such as rapid fire, workshops, and storyboard displays. We urge you to connect with colleagues from across the JCCs and beyond to strengthen this shared experience.

As you move through the day and hear the challenges and accomplishments of your peers, partners, and friends, we urge you to look for the many threads of commonality that weave the system and the people in it together, inextricably linked in pursuit of our goal.

We sincerely thank you for joining us today.

Planning Committee

JCC Representatives

Dr Mitch Fagan
Family Physician Representative
Family Practice Services Committee,
Doctors of BC

Dr Reena Khurana
Specialist Physician Representative
Specialist Services Committee, Doctors of BC

Dr Jane Bishop
Rural Physician Representative
Joint Standing Committee on
Rural Issues, Doctors of BC

Kate Lyons
Primary & Community Care Portfolio Liaison
Family Practice Services Committee,
Doctors of BC

Kristin Smillie
Senior Manager, Quality Impact
Performance Measurement & Evaluation
Specialist Services Committee, Doctors of BC

Sarah Forster
Initiative Liaison, Quality Impact, Interior
Shared Care Committee, Doctors of BC

Tania Webb
Analyst, Rural
Joint Standing Committee on Rural Issues,
Doctors of BC

Margaret English
Director, JCC Alignment
Doctors of BC

Rachel Nolte-Laird
Manager, JCC Measurement & Planning
Doctors of BC

Lauren Moline
Liaison, Joint Collaborative
Committee Initiatives
Doctors of BC

Tracy Elke
Liaison, Joint Collaborative
Committee Alignment
Doctors of BC

Jennifer Keenan
Communications Officer, Joint
Collaborative Committees
Doctors of BC

Sayina Bavarsad
Project Coordinator, Accreditation
& Certification, Learning & Development
Doctors of BC

Britt Poulsen
Senior Administrative Assistant,
JCC Strategic Initiatives
Doctors of BC

HQBC Representatives

Briar Mayoh
Project Coordinator, People & Strategy
Health Quality BC

Andrew Wray
Executive Director, Learning,
Analytics & Strategic Initiatives
Health Quality BC

Committee Descriptions

JCC Joint Collaborative Committees

Joint Collaborative Committee

Twenty years ago, Doctors of BC and the BC government committed to a unique partnership — **the Joint Collaborative Committees** (JCCs)— to improve BC's health care system.

The JCCs bring together doctors, government, health authorities, patients and families, health professions, and other stakeholders to improve access to care by centering it on patients and families/caregivers, building physician capacity, and coordinating system services.

The four JCCs are: Family Practice Services Committee (FPSC), Specialist Services Committee (SSC), Shared Care Committee (SCC) and the Joint Standing Committee on Rural Issues (JSC)— were created to support this shared goal, with funds allocated to the committees from the Physician Master Agreement (PMA) — an agreement negotiated between Doctors of BC and the BC government.

The JCC co-chairs committee meets six times per year to promote strategic alignment with JCC principles, to advance core committee mandates, and to provide oversight, direction and create alignment on shared initiatives.

Each committee is represented by two co-chairs - a practicing physician and one Ministry of Health representative.

FPSC

Family Practice Services Committee (FPSC)

Since its inception in 2002, the **Family Practice Services Committee** (FPSC) has changed the way family doctors work and how they care for their patients and works on behalf of doctors to strengthen full-service family practice and patient care in BC.

FPSC started out with the name General Practice Services Committee (GPSC). It was renamed the Family Practice Services Committee (FPSC) following ratification of the 2022 Physician Master Agreement (PMA). The name FPSC reflects a shift away from "general practice", which carries connotations of rotating internships, in favour of "family practice", which reflects the recognized expertise of family physicians. It also highlights the support FPSC offers for the coordinated, continuous, relationship-based care provided by community longitudinal family physicians and practice teams throughout a patient's lifetime.

Specialist Services Committee (SSC)

The **Specialist Services Committee** (SSC) improves patient care by engaging physicians to collaborate, lead quality improvement and deliver quality services with SSC supports and incentives.

The SSC is focuses on the following three areas:

1. Develop Physician Capability: Helping specialist physicians develop leadership and quality improvement skills to effectively lead and champion change.
2. Engage Physicians & Partners: Strengthening relationships between physicians, health authorities and partners, so that collaboratively we can address health system challenges and support quality patient care.
3. Transform Care Delivery: Improving key patient care and health system priorities as delivered by specialist physicians.

Shared Care Committee (SCC)

Since 2006, the **Shared Care Committee** (SCC) has supported physicians and partners to work together on over 450 projects across BC. The mandate of this Joint Collaborative Committee is to support family and specialist physicians to improve the coordination of care from family practice to specialist care. The relationship between family physicians and specialists is fundamental to the delivery of effective health care, especially for patients with chronic health conditions.

By facilitating collaboration between physicians, Shared Care initiatives foster mutual trust, respect and knowledge of each physician's expertise, skills, and responsibilities, all of which are integral to effective collaboration and collegial relationships.

Long term, Shared Care work helps to build a collaborative infrastructure to support sustainable improvements for a coordinated health care system in BC.

Joint Standing Committee on Rural Issues (JSC)

The **Joint Standing Committee on Rural Issues** (JSC) was established under the Rural Subsidiary Agreement (RSA) in 2001. It's made up of representatives from Doctors of BC, the BC Ministry of Health, and the health authorities. The JSC advises the BC government and Doctors of BC on matters pertaining to rural medical practice.

Its goal is to enhance the availability and stability of physician services in rural and remote areas of British Columbia by addressing the unique and challenging circumstances faced by physicians.

Doctors of BC President

Dr Joshua Greggain

Doctors of BC President

For more than 18 years, Dr Greggain has been a family physician caring for rural, Indigenous, and under-served populations. He has been privileged to spend most of his career in Hope and the Fraser Canyon – the traditional, ancestral, and unceded territory of the *Stó:lō, Yale* and the *Nłeʔképmx* First Nations – where he had the opportunity to provide office, emergency, in-hospital, and palliative care. During that time, he also helped work alongside the *Nłeʔképmx* Nation in the development of the *House of Sexwna7m*, an Indigenous-led primary care outreach clinic on reserve in Anderson Creek Dr Greggain became involved with Doctors of BC in 2018, when he joined the rural issues committee, and ultimately became a member of the Joint Standing Committee on Rural Issues. Prior to that, he held several medical leadership roles including: medical director at the Hope Medical Centre and the Fraser Canyon Clinic, site medical director at Fraser Canyon Hospital, and board member and chairperson of the Chilliwack Division of Family Practice.

During his presidency, which started in January 2023, Dr Greggain aspires to build community by creating space, fostering humanity, building trust, and inspiring hope among colleagues and within the profession, as well as partners including indigenous communities and patients.

He currently resides in Victoria, BC, providing virtual care through Real Time Virtual Care (RTVS) as well as urgent care and rural locums throughout the province.

Keynote Speakers Bios

Dr Susan Biali Haas

Burnout & Stress Management Coach,
Mental Health, Wellness & Resilience Expert

Dr Susan Biali Haas, M.D. is an award-winning medical doctor, health and wellness expert, coach, speaker and author. She helps people worldwide to reduce stress, prevent burnout, improve mental health, and live with increased wellness and resilience.

Dr Biali Haas overcame burnout and depression at the beginning of her medical career, quickly becoming an internationally recognized influencer in health and well-being. With over two decades spent studying wellness and resiliency, twenty years of clinical experience with thousands of patients, and more than ten years coaching high-performance clients worldwide, she expertly applies her experience and skills to equip people to live better lives.

Dr Susan's long list of speaking clients includes the US Navy, Google, the Massachusetts Institute of Technology (MIT), McKinsey & Company, and Deloitte.

She also inspires a broad range of clients — from military leaders and senior executives to physicians and other healthcare professionals — to take control of their health and start living more impactful, meaningful lives. Dr Susan Biali Haas has also provided focused support to patients with mental health challenges, providing virtual medical psychotherapy treatment during the first year of the COVID-19 pandemic.

A popular blogger for Psychology Today, Dr Biali Haas' posts on wellness, mental health and resilience have attracted over 10 million views. She has been featured on The Today Show and The Marilyn Denis Show, and her opinions have appeared in Oprah.com, Forbes, Fast Company, The Chicago Tribune, Health, Martha Stewart Living, People, InStyle, Elle, Prevention, The Washington Post, The New York Post and The Globe and Mail. She has also been a health columnist and "Embrace Life Expert" for Reader's Digest Best Health.

Dr Susan Biali Haas has also partnered with organizations such as American Express, Hilton, Procter and Gamble, Toyota, and Bayer to provide information on health and well-being to the public. American Express recognized Dr Biali Haas as a "Real Life Potentialist" who has broken away from traditional paths and followed a unique calling in life.

In addition to her Doctorate of Medicine and Bachelor of Science in Dietetics from the University of British Columbia, Dr Susan Biali Haas has received a number of awards, including the Rakesh Goel Prize for most outstanding clinical skills, the UBC Medal in Dietetics, and the Woman of Worth Award in Health & Wellness. She loves to attend courses in preventive and lifestyle medicine at Harvard Medical School and is continually on the lookout for the latest science and data that will help you to thrive in both work and life.

Dr Susan Biali Haas' latest book, The Resilient Life, was released in the Fall of 2022.

Dr James Makokis

Two Spirit Doctor – LGBTQ2S,
Indigenous, Diversity & Inclusion Expert

Dr James Makokis leads one of North America's most progressive family Dr James Makokis is a Nehiyô two-spirit Family Physician from the *Onihcikiskapowinihk* (Saddle Lake Cree Nation) in Treaty Number Six Territory. He practices Family Medicine in *Kinokamasihk* Cree Nation in northeastern Alberta and has a transgender health focused practice in South Edmonton. He was the inaugural Medical Director at Shkaabe Makwa at the Centre For Addiction and Mental Health in Toronto - the first Indigenous health centre designed to lead systems' transformation in Indigenous mental health across the country. He is also an Associate Clinical Professor in the Department of Family Medicine at the University of Alberta and an Adjunct Faculty at the Dalla Lana School of Public Health at the University of Toronto. He has worked with the College of Physicians and Surgeons of Alberta as an External Investigator, specifically on anti-Indigenous racism and restorative based processes.

In 2019, Dr Makokis competed alongside his husband Anthony Johnson as "Team Ahkameyimok" (Never Give Up in the Cree Language) on the Amazing Race Canada and won, becoming the first two-spirit, Indigenous, married couple in the world to do so. In 2020 Dr Makokis was named one of 30 most powerful physicians in the country by The Medical Post, but believes power is a concept that should be shared amongst others. Dr Makokis is passionate about revitalizing the *Nehiyô* medical system, educating people about Treaty, and working toward the vision of Turtle Island, which is to live together in peace and friendship. He believes there is no place for racism, discrimination, or hate within the medical system, as the basis for health and healing within the *Nehiyô* medical system is *sahikotowin* (love).

JCC Co-Chair Panel

Doctors of BC President, Dr Josh Greggain will welcome and moderate the Joint Collaborative Committee co-chairs for a panel discussion, as they answer your questions and discuss advancing alignment across the Joint Collaborative Committees.

Kevin Brown

Executive Director, Physician Services Branch, Ministry of Health

Kevin is a health care executive with over 25 years' experience in the provincial public service, with the majority of his time focused on major health system redesign initiatives. He has held multiple senior management portfolios within the Ministry of Health, including time as executive director of HealthLink BC. Kevin has established strong relationships with provincial and federal governments, private industry, health authorities and professional associations across Canada. Currently, Kevin is the executive director of the Physician Services Branch, responsible for the Physician Master Agreement negotiations and post-graduate medical education. He holds a Masters Degree in Political Philosophy from the University of Victoria.

Dr James Card

Co-Chair, Joint Standing Committee on Rural Issues

Dr James Card MD CCFP is a proud father of an 11-year-old daughter, and husband to a very understanding spouse. He is also a rural generalist family physician in Valemount, British Columbia. Dr Card is the Doctors of BC co-chair for the Joint Standing Committee on Rural Issues. He has a strong focus on physician recruitment through integration with medical education. He is currently the site director for the Prince George and Northern Rural UBC Family Practice Residency Programs. Dr Card is also involved in undergraduate medical education through the Rural Coordination Center of British Columbia, sitting on the Northern and Rural Admissions Subcommittee, and running the Rural Medicine Interest and Mentorship program for the Northern Medical Program students.

Dr Sari Cooper **Co-Chair, Family Practice Services Committee**

Dr Sari Cooper is the physician cochair of the Family Practice Services Committee. She has been a member of the Committee since 2019, and was appointed to the cochair role in 2022. She looks after a panel of complex patients in Victoria, and has been practicing longitudinal family medicine since finishing her residency in 2001.

Sari has worked in several different models of primary care across different provincial systems, and understands from experience the value of team based care, system evolution and collaboration. In 2010 she was part of the development team that created a thriving family medicine residency program in Barrie, Ontario, which has been a driving force of recruitment and retention in the area. During her time as a family medicine residency preceptor in Barrie, Sari received a teaching award for Role Modeling Clinical Excellence from the Department of Family and Community Medicine, University of Toronto.

She moved to British Columbia with her family in 2014, and holds a clinical appointment at UBC. She previously served as a Division Head for Geo 4 with Island Health's Department of Family Practice Outside of her medical career, she has a busy and active family, and has recently become a published author of a middle-grade novel.

Dr Jason Kur **Co-Chair, Specialist Services Committee**

Dr Jason Kur has a Bachelor of Science and Doctor of Medicine from the University of Alberta and completed internal medicine and rheumatology training at the University of British Columbia. He is a medical director of the Artus Health Centre in Vancouver, and also sees outreach patients in Whistler and previously Terrace, British Columbia for 13 years. He is a member of the clinical staff of Vancouver General Hospital and a Clinical Associate Professor at the University of British Columbia. He has a busy general rheumatology practice with a focus on inflammatory arthritis and autoimmune diseases. He is the President of the BC Society of Rheumatologists and co-chair of the Specialist Services Committee with an interest in physician resource and nursing models of care.

Dr Ian Schokking **Co-Chair, Shared Care Committee**

Dr Ian Schokking is a full-service longitudinal family physician in Prince George with OB, ER, hospital, house calls & geriatric consultations. He has prior experience as an Ontario fly-in physician and has also worked in Nepal and Pakistan. Dr Schokking is the co-chair of Shared Care, is on the Representative Assembly, is the Prince George Facility Engagement physician lead, and is also the Prince George Division of Family Practice and The Rural Continuing Medical Education Community Program & Evaluation physician lead. He is a father of 4 and married to a naturopath.

Agenda JUNE 6, 2023

7:00 – 9:30am

REGENCY BALLRROOM AND FOYER | 3RD FLOOR

7:00 – 8:00am | Breakfast & Registration

8:00 – 8:25am | Territorial Welcome

8:25 – 8:45am | Doctors of BC President, Dr Josh Greggain, Welcome

8:45 – 9:30am | Keynote Speaker, Dr Susan Biali Haas

9:30 – 9:45AM — BREAK / TRANSITION TO BREAKOUT ROOMS

9:45 – 10:30am

G - GROUSE ROOM | 34TH FLOOR	C - CYPRESS ROOM | 34TH FLOOR
G1. VIRTUAL CARE	**C1. OLDER ADULTS**
Virtual Reproductive Healthcare in the Pacific Northwest	Long Term Care Facility Wound Care Clinic in Victoria, British Columbia
Virtual Psychiatry Consultations (VPC)	Palliative/ End of Life Resource Streamlining and Usage
RACE: An Upgraded RACEApp+ to support an Integrated Provincial Shared Care Model	Primary Care Community Connections: Seniors Outreach Referral Pilot

10:30 – 10:45AM — BREAK / TRANSITION TO BREAKOUT ROOMS

10:45 – 11:30am

G2. LEADERSHIP	**C2. MULTIDISCIPLINARY TEAMS**
Fostering Thompson Region Primary Care Provider Leadership	Specialist & Learn - Quickfire way to build family physician and specialist relations
How to infuse joy into your workplace and spread it around!	Surgical Patient Optimization Collaborative (SPOC)
Learnings from a Provincial Physician Peer Support Initiative	Pediatric inpatient asthma quality improvement project

11:30 – 11:45AM — BREAK / TRANSITION TO REGENCY BALLROOM FOR LUNCH

11:45am – 1:30pm

REGENCY BALLROOM | 3RD FLOOR

11:45 – 12:45pm | Lunch

12:45 – 1:30pm | Keynote Speaker, Dr James Makokis

1:30 – 1:45PM — BREAK / TRANSITION TO BREAKOUT ROOMS

1:45 – 2:30pm

G3. PRIMARY CARE	**C3. CONNECTIONS & ENGAGEMENT**
The South Okanagan Team-Based Care Primary Care Clinic Model	Meaningful Patient Partner Engagement for Projects & Committees
Strengthening primary care providers' access to tools and resources for supporting long COVID patients in BC	Elevating Medical Staff Engagement through Consultant Physicians at Providence Health Care
The Primary Care Game - A Complexity Model to Support System Change	Strengthening Connections Between Family Physicians and Community Health Nurses

2:30 – 2:45PM — BREAK / TRANSITION TO REGENCY BALLROOM

3:00 – 4:30pm

REGENCY BALLROOM | 3RD FLOOR

3:00 – 3:30pm | JCC Co-Chairs Panel Presentation

3:30 – 4:30pm | Closing & Storyboard Reception

O - OXFORD ROOM | 3RD FLOOR

7:30 – 9:00am | Ceremonial Smudging & Brushing (Optional)

E - ENGLISH BAY ROOM | 34TH FLOOR	O - OXFORD ROOM | 3RD FLOOR	B - BALMORAL ROOM | 3RD FLOOR
E1. EDI/CULTURAL SAFETY & HUMILITY Growing an Organization through the Lens of Equity, Diversity and Inclusivity Amplifying Indigenous Voices First Steps in Addressing Indigenous Health in Our PCN	**O1. PHYSICIAN & TEAM BURNOUT** The Division and Physician Co-Clinic Management Model The 4 Cs of Emergency Medicine & Family Practice Supporting the mental health of physicians through the CBT Skills Physician Wellness Groups	**B1. A PARTNERSHIP APPROACH FOR SPREADING PHYSICIAN LEAD QI PROJECTS** **Workshop**
E2. COLLABORATIVE SOLUTIONS Engaging BC Cancer Physicians to Transform Cancer Care Delivery Emergency department physician tarmac assessment and site by-pass to reduce secondary ambulance transfers Collaborating with FHA to Provide Childhood Immunizations During the COVID-19 Pandemic	**O2. CO-CREATING VIRTUAL COMMUNITIES OF PRACTICE THAT TRANSCEND BORDERS AND PROFESSIONS** **Workshop**	**B2. INTEGRATING AN RN INTO PRIMARY CARE** Developing a patient-focused team-based approach **Workshop**
E3. QUALITY IMPROVEMENT The Power of Podcasting for Sharing Quality Improvement and Facilitating Collaboration Setting up a provincial After Hours Coverage Program Provincial osteoporosis physician collaborations: BC coalition of osteoporosis physicians	**O3. RURAL CARE** Providing Gender Affirming Care in the Kootenay Boundary Region Rapid Deployment of a Video-Enabled Virtual Health Tool to Support Pediatric Critical Care in BC during the 2022 Pediatric Respiratory Surge Standardizing Goals of Care Documentation on the Sunshine Coast – The Green Sleeve Initiative	**B3. REFERRALS, CONSULT LETTERS & OFFICE STAFF – OH MY!** Join us to learn and share practical tools to support complex care coordination **Workshop**

RAPID FIRE PRESENTATION WORKSHOPS

Workshops

B1. | A Partnership Approach for Spreading Physician Lead QI Projects
Balmoral Room – 3rd Floor from 9:45am - 10:30am

Speakers: **Daisy Dulay**, Island Health
Lee Ann Martin, BC Cancer
Sandy Ketler, SCC

Few QI projects sustain or spread, as evidenced within the literature, at national/international quality meetings, and within BC. SQI (Spread Quality Improvement) is a new funded DoBC/MoH collaborative purposed to spread physician-led projects achieving a IHI Quadruple Aim outcome in a local setting and previously funded by any SSC initiative (PQI, HSR, FE, Sauder). Eighteen projects approved at the Health Authority (HA) level for spread have been onboarded. in sequence between September of 2021 and August 2022.

This Spread Collaborative has enabled local teams, new Spread Leads within each HA, HA Quality Sponsors, HA leaders, patient partners, and the Ministry to learn from each other how to apply the Model for Improvement using a "wedge model" and overcome regional constraints in spreading from one site to one or more sites within a region. Patient partner voices were included throughout the process. We will summarize both learnings, and outcomes and present our story of spread across the province.

O2. | Co-creating virtual communities of practice that transcend borders and professions, Workshop
Oxford Room – 3rd Floor from 10:45am - 11:30am

Speakers: **Jeff Beselt**, RUDi/RTVS,
Kendall Ho, HeiDi/RTVS
Kelly Gunn, Northern Health
Kim Williams, Rural Coordination Centre of BC

The Rural, Remote, First Nations and Indigenous COVID-19 Response Framework is mandated to help ensure people living in rural, remote and Indigenous communities in B.C. have access to critical health care they can count on to meet their unique needs. Virtual health has a vital role to play by improving equity, access, and the care experience, and by supporting the provider's experience. However, alongside the explosion in need for virtual health solutions caused by the COVID-19 pandemic, there developed a vulnerability – disparate groups providing different solutions with the potential result being system instability and fragmented care.

Working in partnership, the Rural Coordination Centre of BC, the First Nations Health Authority (FNHA), Northern Health, Healthlink BC, the BC Ministry of Health, the BC Emergency Medicine Network and others are co-creating virtual communities of practice that transcend borders and professions. These contribute to increased equity of access to care, both primary and specialized, for the people of B.C., while respecting the foundational need for longitudinal, relationship-based care. The result is the creation of numerous virtual pathways to care.

Real-Time Virtual Support (RTVS) peer pathways connect rural providers in 134 rural communities to a Virtual Physician. The FNHA Virtual Doctor of the Day, another RTVS pathway, connects Indigenous patients and their families to care no matter where they live. Healthlink BC HEiDi physicians assist 8-1-1 provincial hotline nurses with urgent health inquiries they receive, giving patients just-in-time information and comfort, and ensuring appropriate triage to health services. While the service is valuable across the province, it can be especially valuable to rural patients, as it can save them from travelling long distances for care.

All of the RTVS pathways enable timely access to culturally safe and humble care. The peer pathways and FNHA Virtual Doctor of the Day emboldens providers and learners to experience the value of living and caring for people away from urban and regional centres.

At the core of this work is relationship-building, compassion, and ingenuity aimed at improving patient

outcomes and patient and provider experience. Successes so far have involved work at local, regional and provincial levels across health partners and existing networks of support. Moving forward, the ability to be responsive to emerging needs is pivotal to continued success.

B2. | Integrating an RN into Primary Care - Developing a patient-focused team-based approach, Workshop
Balmoral Room – 3rd Floor from 10:45am - 11:30am

Speakers: **Erin Lutz,** Doctors of BC
Carleigh Reynolds, Doctors of BC
Ruthann Robinson, Doctors of BC

For over fifty years, the Province of British Columbia (BC) has delivered primary health care services primarily through family physician-owned and operated clinics (Fritz, 2015). However, an increasing number of people do not have access to a family physician. Currently, one in five people in BC do not have a family physician, equivalent to almost one million people (BC Family Doctors, 2022). Additionally, physicians are experiencing high levels of burnout and stress, causing physicians to leave family practice (Doctors of BC, 2022). All of this, plus many physicians retiring, accumulates into a departure from primary care and remaining physicians experiencing unmanageable patient panel sizes for a single provider. Research shows providing all recommended evidence-based preventive and chronic illness care to an average panel of patients would take primary care provider at least 18 hours a day. The Family Practice Services Committee and the Practice Support Program are committed to enable team based primary care to support the delivery of longitudinal patient care. Integration of an RN into practice can significantly increase access and reduce provider burnout, however, as the PSP program offers at the practice level coaching to support Team Based Care implementation the RN role experiences challenges and successes in fully integrating into a team based approach. This workshop will explore tools, resources and case examples of building powerful teams by incorporating registered nurses into practices to add capacity to care for large panels while reducing burnout.

B3. | Referrals, consult letters & office staff – oh my! Join us to learn and share practical tools to support complex care coordination, Workshop
Balmoral Room – 3rd Floor from 1:45pm - 2:30pm

Speakers: **Carla Bortoletto,** Cowichan Division of Family Practice
Chester Morris, Dr Chester N. Morris Inc.
Nicolette Morris, Consultant

Based on Shared Care Project resulting in "**The 3Cs Model**"

Who should attend?
FPs, SPs, NPs, Divisions of Family Practice, Specialist Support Committees

Why attend?
Save time. Build relationships. Support your staff. Tools for your staff. Open tough communication doors. Breakdown entrenched barriers. Change entrenched culture. Perspective taking tools for your staff. Busting assumptions and misunderstandings. Rapidly developing jargon and miscommunication.

Why did we embark on this project?

- Building on strengths: In Cowichan, there has been significant work in establishing a common electronic medical record (EMR) system & physicians have engaged extensively in panel readiness projects with the Practice Support Program
- What's missing? The hard "human" relational work - this Shared Care team identified the need to dive deeply into improving the relational aspects and workflow of the humans using these EMRs
- The result? A better understanding of this gap and tools that target each of the key players.

Rapid Fire Breakout Session 1
9:45 - 10:30 am

G1. VIRTUAL CARE | Cypress Room – 34th Floor from 9:45am - 10:30am

G1.1 | Virtual reproductive healthcare in the Pacific Northwest

Speakers: **Leila Dale**, Kootenay Boundary Division of Family Practice
Heather Gummow, Northern Health
Mona Mattei, Kootenay Boundary Division of Family Practice

Virtual care is of particular importance to geographically remote communities of the Pacific Northwest (PNW) region of the Northern Health Authority. The OB/GYN specialists in Terrace BC undertook a quality improvement project to support these remote communities by building on their use of telephone-only virtual care during the COVID pandemic. The aim was to ensure rural patients in the PNW region had access to and were satisfied with their OB/GYN virtual care experience, and to improve provider satisfaction of OB/GYN virtual care.

Intervention
The participating OB/GYNs committed early on to enhance access for patients through virtual components. Initial outreach to rural primary care locations revealed significant interest in options for access and three-way (tripartite) care planning, particularly for the following value propositions: if patients could access specialist care virtually early on in their pregnancy; to reduce missed appointments/no-show; and increase frequency of appointments if needed. Real-time satisfaction from the virtual appointment, as well as the type of technology used and any difficulties encountered, were captured using a survey built into the specialists' EMR.

Impact
The project team struggled at times with the project objectives and developing clinic workflows with the OB/GYN team. Primary care sites were hesitant to book despite many communications. EMR survey responses showed the majority of appointments were patient-direct telephone (n=23/28; 82%), three were patient-direct video conference appointments, and two were tripartite care calls. Towards the end of the project timeline the specialists chose to migrate EMRs in order to better support virtual care and intend to continue developing this aspect of practice. Despite challenges, patients (n=3) and practitioners (n=3) reported being satisfied with their virtual care experience. This project demonstrates interesting lessons learned from PDSA cycles and the impacts of changing ecosystems on project plans.

G1.2 | Virtual Psychiatry Consultations (VPC)

Speakers: **Claire Doherty**, Providence Health Care (PHC)
Karl Torbicki, Providence Health Care (PHC)

In Vancouver City Centre, 11% of residents have a mood or anxiety disorder. Family physicians (FPs) are key partners in patients' mental health journeys. This partnership is most effective when a psychiatrist can assist with clarifying diagnoses or adjusting medications. Unfortunately, access to outpatient psychiatry is limited. In response, our team developed the Virtual Psychiatry Consultations (VPC) program, based on input from patients, FPs, psychiatrists, nurses, clerks and others.

Participating psychiatrists see 1-2 VPC patients per week and continue their pre-existing work. Participating FPs can refer

patients to VPC if they are aged 19-64, likely to benefit from short-term psychiatric care, and not already working with a psychiatrist or mental health team. A nurse case coordinator reviews all referrals and completes an intake assessment with eligible patients. Next, a psychiatrist meets with the patient virtually 1-3 times. After completing a debrief call with the psychiatrist and receiving consult notes, the FP continues to care for the patient.

VPC launched in October 2020. As of December 2022, VPC involves 4 psychiatrists, 1 case coordinator, 1 clerk, 14 referring providers and 1 clinical nurse specialist. VPC has enabled >200 psychiatry visits for >100 patients who might otherwise not have had access to specialized mental health care. Survey results show >90% of discharged patients agreed that their VPC psychiatrist understood and addressed their concerns and questions. The majority of patients responded they would not have been able to see a psychiatrist for their current concerns without VPC, and the majority agreed they had a good understanding of their medications and care plan.

VPC is primarily funded by Shared Care, a partnership of Doctors of BC and the BC government. We also received in-kind support from the BCPSQC in the form an intern, who played a key role in engaging stakeholders and co-designing VPC.

G1.3 | RACE: An upgraded RACEApp+ to support an integrated provincial shared care model

Speakers: **Margot Wilson**, Providence Health Care
Anosha Afaq, Providence Health Care

The Rapid Access to Consultative Expertise (RACE) advice line was launched by Providence Health Care (PHC) in June 2010. The RACE model allows physicians, medical residents, nurse practitioners and midwives to go to one online application, the RACEApp+, and speak directly to specialists. A timely, collegial and educational interaction is encouraged when specialists return calls. The service allows for just in-time learning, often when the patient is still present with their primary care provider.

The RACEApp+, was created in 2015 and underwent major app upgrades in 2022. The program is managed provincially by PHC, and has over 85,000 calls to date. The service currently has 80+ speciality services, over 1,500 calls per month, and services more than 4,300 primary care providers and 800 specialists. In the post-evaluation survey, 97% of users were satisfied with the interaction, 80% said it prevented a specialist consult and 76% stated it prevented an emergency department visit.

This past summer, RACEApp+ rolled out many improvements in keeping with the program's commitment to improving patient care: (1) the ability to connect to local specialists when available (if not available locally, the caller can easily connect with a specialist in another region); (2) accessibility and ease-of-use upgrades, including consistent formatting for patient demographics, and badge notifications to indicate new requests; (3) the ability to facilitate an integrated provincial service; (4) follow-up automatic text messages are sent out to requests that are incomplete and (5) two-factor authentication for improved security and ease-of-use for providers.

The app updates make it easier to use, streamlining the sharing of patient information between family physicians, nurse practitioners and specialists, all while creating a better app experience. RACE is funded in part by the Shared Care Committee, a joint collaborative committee representing a partnership between Doctors of BC and the BC government.

Rapid Fire Breakout Session 1
9:45 - 10:30 am

C1. OLDER ADULTS | Cypress Room – 34th Floor from 9:45am - 10:30am

C1.1 | Long Term Care Facility Wound Care Clinic in Victoria, British Columbia

Speakers: **Todd Yip,** South Island Medical Staff Association
Sarah Rosen, Island Health
Kirsten Rea, The Summit LTC

Worsening (stage 2-4) pressure ulcers are a treatable and largely preventable complication occurring among Long Term Care (LTC) residents. In 2021, a review of quarterly quality indicators showed the rate of these ulcers in Island Health LTC facilities exceeded both the British Columbian and the Canadian averages. These data were particularly concerning because of the negative impact on the quality of life of residents who experience the psychological and physiological burdens of this condition. Due to mobility issues, transportation challenges, and a shortage of human resources, residents struggled to get timely ulcer care in a tertiary care facility.

Drawing on the insights and resources of an interdisciplinary team, including LTC managers, social workers, occupational therapists, nurses, family practitioners, and a project manager, the team implemented a pilot intervention which aimed to reduce the rate of stage 2-4 pressure ulcers at The Summit LTC facility in Victoria, British Columbia.

The intervention involved a half-day monthly clinic led by Dr Todd Yip, Physiatrist. The multidisciplinary care team would visit each resident in their room, conduct a thorough medical history and examination before discussing diagnosis and treatment options with the patient, and enacting a plan.

After one-year of pilot implementation, the rates of worsening pressure wounds decreased from 8.5% to 3.3%.

In designing the spread and scale of this initiative to other LTC facilities, several best practices are salient. Traditional clinic models operating in centralized locations with designated patient bookings were not suitable for LTC residents, many of whom have mobility issues. Attending bedside added flexibility to the schedule. The physical movement through the wards also contributed to a culture of enthusiasm and learning among the staff, encouraging teaching and brainstorming. The team has begun outreach to other LTC facilities to spread recommendations and share best practices for wound care between sites.

C1.2 | Palliative/ end of life resource streamlining and usage

Speakers: **Shiraz Mawani**, Ridge Meadows Division of Family Practice
Natasha Raey, Ridge Meadows Division of Family Practice

Palliative Care in Ridge Meadows has a robust system of physician and nurse specialists that liaise with family doctors to provide seamless and impactful care for patients at the end of their journey. However, there were still several gaps identified in this system that spoke to the need for enhanced connection between the palliative care program and family physicians within Ridge Meadows. In addition, the number of resources, referrals and care pathways for palliative care were overwhelming and hard to navigate. The Ridge Meadows Palliative Care Shared Care Leadership Team therefore decided to focus on the development of a streamlined resource for family physicians to be able to quickly access information for their patients.

The development of this resource was carried out by a subcommittee of family physicians, palliative specialist physicians and other clinicians. Within this trajectory, the project subcommittee collected and streamlined over 150 pages of resources, pathways and documentation into a more concise 38-page document that is easily navigated and searchable. The document is organized in a format that allows family physicians to quickly access resource links according to when they expect their patient to pass away. The resource was socialized and tested with Ridge Meadows family physicians and is also part of an overarching "meaningful use strategy" that the Division is implementing to ensure that developed resources are utilized and at top-of-mind for our physicians when they need them.

The development of this resource has highlighted the ability for our Shared Care leadership teams to be able to re-package resources to be easier to access for family physicians. This resource also has immense spread potential throughout Fraser Health as it covers information relevant to all Divisions in the region. This resource is also a key focus of the meaningful use strategy that will also serve as a learning opportunity for all Divisions to know how to best disseminate resources amongst their members for optimized usage.

C1.3 | Primary Care Community Connections: Seniors Outreach Referral Pilot

Speakers: **Kimberly Barwich**, Burnaby Neighbourhood House
Veronica De Jong, Burnaby Primary Care Networks
Baldev Sanghera, Burnaby Family Physician, PrimeCare Medical Clinic and Edmonds UPCC

The Burnaby Primary Care Network (PCN) brings together community service providers, its family physicians and Fraser Health community services to collectively drive city-wide health and wellbeing. Each of the three neighbourhood PCNs in Burnaby has a Local Leadership Team (LLT) to plan and oversee the local delivery of health and wellbeing services. As a key part of this work, the LLTs are creating multiple linkages from family practices to community agencies so that patients' experiences of health care teams not only include doctors or health authority providers, but also their community agency providers.

The Edmonds neighbourhood LLT has been working with Burnaby Neighbourhood House (BNH) to pilot the Seniors Outreach Referral Program that launched late July 2021. Community based social service agencies like BNH often struggle at reaching the most isolated members of society. Primary Care Providers are often the only touch point many of these isolated seniors have with a service delivery system. As such, the pilot engages Primary Care Providers from a local family practice clinic and an Urgent and Primary Care Centre (UPCC) to identify isolated seniors who could benefit from community support services and/or programs.

Physicians were consulted on the referral form and pathway which outlines the seniors supports (e.g., meal services, targeted social or physical group activity programs) offered by BNH and partner organizations. To date, 20 referrals have been received by BNH, over half of which have been successfully matched to a program, many of whom were previously not connected to any community services. The goal is to continue to evaluate the pilot's uptake and success in forging links between medical services and community supports in anticipation of making this referral service available to additional medical settings across Burnaby and as a model for other communities.

Rapid Fire Breakout Session 1
9:45 - 10:30 am

E1. EDI/CULTURAL SAFETY AND HUMILITY | English Bay Room – 34th Floor from 9:45am - 10:30am

E1.1 | Growing an organization through the lens of equity, diversity and inclusivity

Speakers: **Anya Phillip**, Vancouver Division of Family Practice
Oshin Maheshwari, CBT Skills Group Society

The Cognitive Behavioral Therapy (CBT) Skills Group Society is a provincial non-profit organization that administers physician-led mental health skills groups. In 2021, the Society received multi-year funding from the Shared Care Committee to establish a province-wide program, consolidating existing programs and expanding the training of physician facilitators for the entire province. As part of the expansion, the Society and its delivery partners, which includes the Vancouver Division of Family Practice (VDoFP) and UBC Continuing Professional Development (UBC CPD), identified Equity, Diversity, and Inclusivity as a core value in the organization as it expanded. Continuous evaluations of the CBT Skills Group Program with an EDI lens focused on assessing patient and facilitator feedback in addition to organizational culture. Patient feedback highlighted the need to prioritize improvements in Gender Inclusivity, Socioeconomic Inclusivity, Anti-Ableism, and Cultural Inclusivity. Many PDSA cycles in action were conducted to include the development and implementation of an EDI Facilitator Guide, UBC CPD Facilitator Workshops (on EDI, trauma-informed care, and facilitator skills), the translation of CBT Skills into 8 Languages, EDI-themed facilitator webinars and small group sessions to debrief content, and rewriting the facilitator guide and workbook to be more inclusive, especially in regards to the specific examples offered. The Society also prioritized recruiting a more diverse facilitator group, including improved representation from different language, gender, sexual orientation, geographic and cultural groups. New group orientations for participants included invitations to share pronouns, offer feedback on psychological safety, and land acknowledgements. Evaluations were updated to include specific EDI measures. Next steps include the creation of an EDI physician lead role, EDI physician champions as part of the team, the intentional support of the organizational culture of the Society to center around EDI, ongoing webinars, podcasts, and debriefings, and ongoing EDI-themed PDSA cycles.

E1.2 | Amplifying Indigenous voices

Speakers: **Ben Cheng**, Doctors of BC
Tracy Elke, Doctors of BC
Samantha Jack, Len Pierre Consulting

The Joint Collaborative Committees (JCCs) are taking steps to eliminate Indigenous Specific Racism and support physician members in their journey towards Indigenous Cultural Safety through humility. As settlers, we recognize that we have benefited systemically from having a platform and a voice. Our action, as aspiring allies, is to privilege the Indigenous voice and provide a platform for physician members to hear the truth through various avenues including the Indigenous Cultural Safety Webinar Series, Longhouse experience sessions and Compassionate Leadership Training.

This panel presentation will focus on the topic of Indigenous Cultural Safety and Humility, specifically the importance of amplifying the Indigenous voice in healthcare. Indigenous people have historically been marginalized in healthcare and often experience discrimination and lack of cultural understanding from healthcare providers. This has resulted

in poor health outcomes and a lack of trust in the healthcare system for Indigenous communities.

In the JCCs initial offering of resources, Indigenous leaders establish the importance of Indigenous cultural safety and the role of healthcare providers in creating a safe and culturally responsive healthcare environment for Indigenous patients. The panel addresses the importance of amplifying the Indigenous voice in healthcare, including the incorporation of Indigenous knowledge and culturally responsive healthcare policies and practices to change perspectives in healthcare systems and education.

With these foundational learnings in place, we will highlight the importance of ongoing education and training for healthcare providers on Indigenous cultural safety, and the need for ongoing dialogue and consultation with Indigenous communities to ensure that healthcare services are meeting the needs of Indigenous people. The panel hopes to provide a platform for Indigenous voices to be heard and to educate healthcare providers on how to create a more culturally safe and responsive healthcare environment for Indigenous patients.

E1.3 | First Steps in addressing Indigenous Health in our PCN

Speakers: **Jody Friesen**, Surrey-North Delta Division of Family Practice
Nazia Niazi, Board Co-Chair Surrey-North Delta Division of Family Practice

Motivated by our vision of a welcoming and safe community for all people accessing primary health care in Surrey and North Delta (SND) and by the glaring health gaps uncovered during our Primary Care Network (PCN) discovery process, the Surrey-North Delta Division of Family Practice (division) has been taking steps towards implementing the Truth and Reconciliation Commission's health care recommendations.

Our division represents 350 Family Physicians (FPs) serving a population of 600,000 people. Indigenous People in SND are largely urban and away from home, and many choose not to self-identify as Indigenous when accessing health services.

Recognizing the importance of the task, we are now building a foundation of cultural humility and curiosity among members and staff.

FPs and staff have been encouraged to attend learning events that increase understanding of the culture and history of Indigenous Peoples, including the San'Yas training and the JCC's Indigenous Community and Longhouse Experiential Learning Sessions.

Staff are encouraged to share and discuss their impressions and thoughts in our team meetings after these events. These team meetings have resulted in new ideas for building bridges with our First Nations, Inuit and Métis sisters and brothers.

In October, we invited Elder William from the Tsleil-Waututh Nation and Senior Cultural Advisor at Fraser Health to speak at our Annual General Meeting about some of his traditional wellness practices. Attendees had the opportunity to participate in a smudging ceremony, which provided time for reverence and reflection on wellness and its intersection with spirituality.

Our next steps include creating a Community of Practice to support ongoing cultural learning and compassionate leadership. We are thankful for the partnerships we have made with First Nations Health Authority and Fraser Health Indigenous Health who are supporting us in taking thoughtful first steps towards fostering a welcoming and safe community.

Rapid Fire Breakout Session 1
9:45 - 10:30 am

O1. PHYSICIAN AND TEAM BURNOUT | Oxford Room – 3rd Floor from 9:45am - 10:30am

O1.1 | The Division and Physician Co-Clinic Management Model

Speakers: **Kelly Hawes**, South Okanagan Similkameen Division of Family Practice
Tracy St. Claire, Executive Director South Okanagan Similkameen Divisons of Family Practice
Jennifer Begin, Family Physician Ponderosa Primary Care Centre, South Okanagan Similkameen Divisons of Family Practice Board Vice Chair

Clinic ownership and management has increasingly become a deterrent to longitudinal family practice. Physicians have expressed reluctance to sign long-term leases and manage staff, but value the clinic autonomy of working in a physician-run clinic.

In response to requests from Division members, the South Okanagan Similkameen piloted a Division owned and operated clinic as part of the Primary Care Network in 2019. Just over a year later, the Division took on management of another clinic when the managing physician retired. Transition to Division management of a third clinic is underway as the model proves itself to be sustainable, cost-effective and allows providers and the healthcare team to all focus on medicine while retaining clinical autonomy.

In this model Medical Office Assistants are Division employees and physicians and nurse practitioners remain independent. Overhead from primary care providers and allied health staff covers all of the expenses, including at least a 5% contingency. The team meets regularly to discuss clinic operations and agree on how they wish to work together as a group.

This model is based on providing the proper care, at the right place, at the right time, and with the right expertise. The clinicians provide the care; the Division provides the operational expertise and innovative leadership. Each clinic is unique and the Division works with the providers and clinic staff to maintain each clinic's culture. As teaching and training facilities, these clinics host learners from all disciplines and the quality improvement learnings are shared with other practices.

This dynamic and financially sustainable clinic management model has resulted in recruitment of seven new family physicians and six nurse practitioners, replacing six retiring physicians and increasing access and attachment. It has generated additional interest for Division management of new clinics if space is found.

O1.2 | The 4 Cs of Emergency Medicine & Family Practice

Speakers: **April Bonise**, Surrey-North Delta Division of Family Practice
Tomas Reyes, Surrey-North Delta Divison of Family Practice

In November 2022, the SND Division hosted an engagement event between Family Physicians (FPs), ER physicians from Surrey Memorial Hospital (SMH) and SMH hospitalists.

This event came about as an identified action item in the very early stages of our Admission and Discharge Communication Shared Care project. It was originally envisioned as a small group setting to foster early relationship building, with an attendance goal of 50 attendees. The event focused on the 4 Cs: Connection,

Communications, Care and Collegiality and included focused presentations and guided facilitation breakout rooms for small-group discussion.

However, due to an unanticipated ER surge in the community in the weeks leading up to the scheduled event, coupled with a significant FP shortage, local FPs and ER physicians were straining to meet patient demands. This strain was leading to a heightened sense of tension and stress between the separate provider groups.

The ER crisis led to 111 physicians registering for the event and the project team deciding to adjust their original agenda format to instead focus on providing opportunities for attendees to share their experiences and frustrations and then to brainstorm possible solutions together.

Event goals included:

- Improving communication and collegiality between acute care physicians and community doctors.
- A solutions-oriented and positive atmosphere
- Emphasizing engagement with different peer groups
- Providing opportunities for attendees to brainstorm: "How do we take ownership and responsibility for our sphere of influence?"

Results

The feedback from participants was overwhelmingly positive. While discussions were passionate, evaluation survey results indicated that the majority of participants felt that discussions were balanced and solutions-focused. Following the event, 92% of participants felt more connected to their colleagues and 100% said they place a high value on discussions such as these. The Division is now working on implementing a number of the ideas proposed during the session.

O1.3 | Supporting the Mental Health of Physicians through the CBT Skills Physician Wellness Groups

Speakers: **Fiona Petigara**, CBT Skills Group Society
Lisa Miller, CBT Skills Group Society

The pandemic highlighted the growing problem of physician burnout and mental health difficulties, with the CMA National Physician Health Survey in November 2021 showing 53% of physicians reporting high levels of burnout, 46% considering reducing clinical work, 59% reporting worsening mental health since pandemic, and 47% reporting low levels of social wellbeing. As a response, the Cognitive Behavioral Therapy Skills Group collaborated with UBC CPD, the Physician Health Program (PHP) and several Divisions of Family Practice to offer physician-based groups to support physician wellness. These groups provided doctors with the opportunity to begin learning and practising skills for mental health within a collegial environment, in addition to providing peer support and connection. Continuous evaluations on the program showed statistically significant improvements in the Stanford Fulfillment Index (measuring physician wellness), while qualitative measures showed themes of reduced isolation, stigma, and becoming energized in work, in addition to improved confidence in supporting the mental health of their own patients. Physician Wellness groups appear to be a cost-effective delivery of mental health supports while providing social support and belonging for physicians. This workshop will include experiential demonstrations of wellness exercises offered in these groups.

Rapid Fire Breakout Session 2
10:45 - 11:30 am

G2. LEADERSHIP | Grouse Room - 34th Floor from 10:45am - 11:30am

G2.1 | Fostering Thompson Region Primary Care Provider Leadership

Speaker: **Chelsea Brookes**, Thompson Region Division of Family Practice

Extreme weather events such as wildfires and floods have impacted rural communities in British Columbia's interior in recent years. This action-oriented research study was completed in partial fulfillment of the requirement for a Master of Arts in Leadership Degree at Royal Roads University and in partnership with the Thompson Region Division of Family Practice (TRDFP). It explored the following primary research question: "How might the TRDFP foster primary care provider leadership during extreme weather events?" This project was designed following the Royal Roads University Ethics Policy and Tri-Council Ethical Guidelines and used qualitative interviews in combination with an arts-based method to generate stories about leadership during displacement due to wildfires and floods from rural-practicing primary care providers. Study findings revealed five key themes: lack of primary care provider involvement in emergency response, preparation and experience, values and leadership styles, collaboration and teamwork, and personal and professional balance. The resulting recommendations were to involve primary care providers in emergency preparedness and response, offer or promote leadership opportunities for primary care providers, and share supports for providers and patients. Key stakeholders from the TRDFP validated and operationalized the recommendations by prioritizing next steps.

G2.2 | How to Infuse Joy Into Your Workplace and Spread It Around!*

Speakers: **Marianne Morgan**, IHA/SSC
Jessica Barker, Interior Health

Compassion fatigue and burnout are exhausting, and physicians and staff are leaving in record numbers. The evidence shows that individuals and teams who are connected to meaning and purpose give better patient care, take less sick time, and make less errors. We call on health care organizations, teams and individuals to come together to build safe, humane places for people to find meaning and purpose in their work. Come and discover how Joy in Work (JIW) is possible for you and your teams.

We embarked on a journey as a physician and operational manager – and undertook a JIW project with our Palliative Care Team. We identified that in order to build a healthy, productive team the ideas must come from within the team. Through team connection, we co-created a plan of meaningful strategies based on what matters to them and were able to reduce absenteeism by 50% in one year. We applied a Safety 2 quality improvement approach. By focusing on what goes right, we created space to share stories and techniques of how to help manage personal and team stressors and improve job satisfaction. These approaches were integrated into day-to-day practice using the Institute for Healthcare Improvement's (IHI) Joy in Work framework.

*This rapid-fire presentations will also be presented during the Quality Forum Wednesday June 7, 3:30-4:30pm.

Even with understaffed and overworked teams you can discover joy and how to foster camaraderie and teamwork. We are now in the process of developing a quality improvement methodology for spreading JIW to other units and healthcare environments. You will come away from this session with concrete ideas to succeed and easy ways to measure your progress. Join this social change movement and learn how to empower front line team members, but also engage operational leaders within health authorities to enable a system wide impact of JIW.

G2.3 | Learnings from a Provincial Physician Peer Support Initiative

Speakers: **Felicia Phan**, Doctors of BC
Ingrid Cosio, Prince George MSA

Physicians continue to face on-going stressors such as increased professional isolation, moral distress and administrative burdens which all contribute to physician burnout, suicide and other mental health concerns. Furthermore, poor physician health outcomes are known to impact quality of care and patient safety. Peer support has been identified as one a strategy to promote physician wellbeing by building a culture where physicians care for each other and seek support earlier.

In 2022, the Physician Health Program (PHP) and the Joint Collaborative Committees (JCCs) partnered to develop a provincial Peer Support Initiative that aims to build capacity for physician organizations to implement local peer support programs that facilitate responsive, formal peer support for physicians needing emotional support around work or life-related stressors. This Initiative was developed in response to the doubling of PHP's caseload since the pandemic began, needs expressed by local physician organizations as well as evidence demonstrating the power of peer support and compassionate conversations in addressing physician burnout and improving workplace cultures.

Since the Initiative has launched, five physician organizations were selected as prototype sites, 28 physicians were trained as peer supporters and various collaborative and support structures have been developed to set these local programs up for success. Evaluation and various feedback mechanisms have been integrated into the program design to facilitate adaptation of the Initiative as it grows. During this presentation, we will share our collaborative, hybrid Peer Support Initiative model, how local physician programs have adapted this Initiative to their local context, learnings from the prototyping phase and insights into the training process.

Rapid Fire Breakout Session 2
10:45 - 11:30 am

C2. MULTIDISCIPLINARY TEAMS | Cypress Room - 34th Floor from 10:45am - 11:30am

C2.1 | Specialist & Learn - Quickfire Way to Build Family Physician and Specialist Relations

Speakers: **Melodie Prem-Smith**, Ridge Meadows Division of Family Practice
Treena Innes, Ridge Meadows Division of Family Practice

Through Shared Care projects, the Ridge Meadows Division of Family Practice has developed and tested a tried and true format to build effective relations between family physicians and local specialists. Through an informal, virtual 45 minute session, specialists join a group of family physicians to share areas of interest, referral pearls, followed by case-based discussions and wrapped up with cell phone number sharing. We strive to keep these sessions easy for all, meaning very little preparation and no slide decks. This 'Specialist and Learn' format has had a positive impact on local relationship building and is sustained through our 'Just Call' campaign; an additional tried and true strategy we'd love to share with you. Learn more at this rapid fire presentation.

This format was developed in response to COVID 19, and is one that we will continue offering in Ridge Meadows.

C2.2 | Surgical Patient Optimization Collaborative (SPOC)

Speaker: **Geoff Schierbeck**, Doctors of BC

The Surgical Patient Optimization Collaborative (SPOC) launched in May of 2019 and includes 16 teams from across the province of British Columbia, Canada.

The purpose of this collaborative was to improve assessment and management of elective surgical patients, which will in turn reduce adverse events, increase patient and caregiver satisfaction, and improve post-operative outcomes. Utilizing the Institute for Healthcare Improvement (IHI) Collaborative Framework, SPOC is a time-limited collaborative, completed in May, 2021. Teams included surgeons, anesthesiologists, family practitioners, nurses, allied health professionals were empowered to select the most appropriate surgical specialty based on interest, need and engagement.

Of the 16 teams throughout the province of British Columbia, 13 teams were able to complete the collaborative. Three of the teams were not able to complete the collaborative due to competing priorities during the COVID-19 Pandemic. In addition to screening patients for COVID-19, teams were able to accomplish the following:

- 5212 patients were screened for 18,789 of the above listed components
- 4166 patients who were screened required prehabilitation based on the screening tools used for each component
- 3977 patients who required optimization received appropriate prehabilitation based on their specific needs.
- 96% of patients who required prehabilitation, received appropriate prehabilitation
- (PROM) 86% of patients felt their overall health improved as a result of the information and care provided by the surgical prehabilitation team
- (PREM) 91% of patients felt their surgical experience was improved as a result of the information and care provided by the surgical prehabilitation team.
- Statistically significant decrease of length of stay was reported by the teams
- Patient morbidity was statistically decreased where prehabilitation was provided to patients.

Way Forward

After the completion of SPOC in May 2021, the optimization practices introduced by the collaborative are expected to be integrated in routine surgical practices in BC. With the success of the first cohort of SPOC, a second cohort of 14 teams have launched in May of 2022 and continue to implement surgical patient prehabilitation throughout the province.

C2.3 | Pediatric Inpatient Asthma Quality Improvement Project

Speakers: **Marie-Noelle Trottier-Boucher**, Island Health
Melissa Holland, Island Health

Asthma is the most common chronic pediatric condition and a leading cause of hospital visits. Studies have shown that the use of a pediatric asthma pathway is associated with decreased length of stay, costs and increased teaching.

The main objective of this project was to decrease to less than 48 hours the length of stay of children hospitalized for asthma exacerbation at Victoria General Hospital between May 2021 and 2022.

A multidisciplinary team, including pediatricians, resident, nurses, respiratologists, pharmacists, parents and administrators was created in January 2021. The interventions were the adaptation and implementation of a standardized discharge checklist (May 2021) and of an asthma pathway that included a nurse lead bronchodilator weaning algorithm (October 2021). Education regarding asthma, clinical scoring system and families' education was provided before and during the project.

The median inpatient length of stay decreased from 50 hours (35-68.5 hours) pre interventions to 37.5 hours (23.5 – 64 hours) post second intervention, which represent a 25% decrease. A positive trend was noted in the physician's prescription rate of the algorithm. Discharge checklists were found in at least 70% of the charts and had a median completion rate of 88%. Health care providers' comfort level providing asthma education and using the algorithm increased during the project (4.2/5 to 4.8/5 and 3.8/5 to 4.3/5 respectively). Families' confidence regarding asthma management increased post-asthma teaching (average 3.8/10 increased). No significant increase in admission to the pediatric intensive care unit, use of high flow or consultation for asthma exacerbation within 10 days of discharge was noted.

Implementing a standardize asthma pathway resulted in a 25% decrease in median inpatient length of stay. Regularly reviewing and sharing the results of the project with the team and making sure new staff are aware of the project will result in continuous and sustainable improvement.

Rapid Fire Breakout Session 2
10:45 - 11:30 am

E2. COLLABORATIVE SOLUTIONS | English Bay Room – 34th Floor from 10:45am - 11:30am

E2.1 | Engaging BC Cancer Physicians to Transform Cancer Care Delivery

Speakers: **Dan Le**, BC Cancer
Jane Sun, BC Cancer

The Engaging Physicians to Transform Cancer Care Delivery (EPTTCC) Facilitated Physician Engagement Sessions were held virtually across all 6 BC Cancer Centres in March and April of 2022. Over 70 radiation oncologists, medical oncologists, and general practitioners in oncology were engaged throughout the process. Engagement discussions were held within the context of the ambulatory care oncology setting within the BC Cancer regional centres, considering growing demands on the cancer care system, space constraints, increased complexity of care, and medical staff moral distress.

The purpose of the discussions were to obtain detailed feedback from physicians about solutions that BC Cancer could implement to address the multitude of challenges within the cancer care system. Challenges that physicians encountered providing quality care were voiced through numerous physician engagement initiatives over the years preceding this project, and included topics related to the functioning of multidisciplinary teams, workflow, physician autonomy, workload, and lack of efficiencies.

There were 4 solutions that were most highly prioritized by physicians attending the engagement sessions. These included: implementing and sustaining a multidisciplinary team approach, ensuring that multidisciplinary teams can function in a way that is tailored, changing workflow to ensure that the right tasks are performed by the right team members, and building in ways to recognize and mitigate increasing oncologist workload.

These recommendations were communicated broadly with the BC Cancer Executive, Centre Dyad Leadership teams at all regional centres, and stakeholders working on all aspects of BC Cancer's current and future planning.

E2.2 | Emergency Department Physician Tarmac Assessment and Site By-Pass to Reduce Secondary Ambulance Transfers*

Speakers: **Leila Dale**, Kootenay Boundary Division of Family Practice
Bbandama Makwati, Kootenay Boundary Division of Family Practice
Mona Mattei, Kootenay Boundary Division of Family Practice

Context

The Castlegar and District Health Community Health Centre (CDCHC) offers emergency health services from 0800 to 2000 hours seven days a week. Frequent patient discharges beyond 2000 hours and resulting emergency department (ED) staff overtime led to a system improvement change by CDCHC physicians and nurses in partnership with BCEHS and the regional hospital in Trail, BC. Stakeholders were interested in collaboratively developing a system that ensured patient safety, supported best patient care, and appropriate transport destination decisions between 1800 and 2000 hours.

Intervention

The aim of the 4-month quality improvement pilot project was to improve efficient access to care through reducing the number of secondary transfers when appropriate criteria were met. A secondary aim was to reduce the number of overtime hours in the CDCHC ED relating to delayed transport. The system change developed by stakeholders included a rear of ambulance assessment

(i.e. tarmac assessment) by an ED physician when an ambulance arrived at CDCHC between the hours of 1800-2000. The physician would then follow the by-pass protocol if the patient was stable to transport to the regional hospital 30 minutes away.

Impact

Stakeholders went through several quality improvement cycles to develop the protocol and communicate the system change to physicians at both CDCHC and the regional hospital and BCEHS paramedics. At the conclusion of the 4-month pilot project, stakeholders reported high satisfaction with the system change, improved work morale, and fewer late patient discharges. An unintended benefit of the tarmac assessment was that the team began using the protocol even before 1800. Secondary ambulance transfers and overtime data is currently being collected. Patient chart reviews will be completed in early 2023 to determine if the patient transfers were appropriate. If successful, this pilot project could be implemented in other 12-hour ED sites throughout Interior Health.

*This rapid-fire presentations will also be presented during the Quality Forum, Wednesday June 7, 11:00 -12:00pm.

E2.3 | Collaborating with FHA to Provide Childhood Immunizations During the COVID-19 Pandemic

Speakers: **Alan Huang**, Surrey-North Delta Division of Family Practice
David Luk, Family Physician

At the end of October 2020, the Surrey-North Delta Division of Family Practice was approached to assist with Public Health immunizations. Childhood immunizations needed coverage most critically due to their time sensitive nature and the risk of immunization-eradicated disease re-emergence.

Historically in many communities within the Fraser Heath Authority, Public Health has carried out most of these immunizations. During the second phase of the COVID-19 pandemic Public Health nurses were redirected to contact tracing work. This left over 4000 time-sensitive childhood appointments on waiting lists throughout Fraser Health communities.

Actions Taken

The Surrey-North Delta Division of Family Practice and community physicians worked in collaboration with FHA leadership and Public Health to enact strategies for reducing the childhood immunizations waitlists, including having community physicians immunizing in five different public health clinics within Surrey-North Delta.

The division's main roles included:

- Physician recruitment
- Setting up a system for scheduling
- Facilitating the scheduling for 5 different public health units
- Facilitating last minute changes and conflict resolution

Results

Between Nov 12, 2020 to Jan 22, 2021, we:

- Had 34 physicians assisting with the childhood immunization effort;
- Completed ~935 hours or over 3,200 clients;
- Reduced the waitlist within Surrey-North Delta by over 50% in approximately 2 months.

The project ended on Sept 31, 2021 (~10 months) with Public Health returning to their full capacity in key priority areas and physician support at Public Health units concluding. The waitlist was maintained at a significantly lower percentage than prior to the start of the effort.

Between November 2020 and September 31st 2021, 37 physicians supported the routine vaccination (CIC) and catch up vaccination (IC), with a total of more than 6,500 hours of clinics providing more than 17,500 shots.

Rapid Fire Breakout Session 3
1:45pm - 2:30pm

G3. PRIMARY CARE | Grouse Room – 34th Floor 1:45pm - 2:30pm

G3.1 | The South Okanagan Team-Based Care Primary Care Clinic Model

Speakers: **Kelly Hawes**, South Okanagan Similkameen Division of Family Practice
Kristine Robbins, Primary Care Network Lead South Okanagan Similkameen Division of Family Practice
Jennifer Begin, Family Physician Ponderosa Primary Care Centre, South Okanagan Similkameen Division of Family Practice Board Chair

In November 2019, the first integrated team-based care clinic was introduced in the South Okanagan as part of the Primary Care Network initiative. Ponderosa Primary Care Centre was conceived as a recruitment strategy to respond to increasing unattached patients and declining family physician numbers due to burnout and retirement.

The healthcare team is fully integrated and works in one location, seven days per week. The clinic is owned and operated by the Division of Family Practice in partnership with the primary care providers. The team collaborates to provide patient-centred care, sharing one Electronic Medical Record (EMR). The clinicians all work to full scope, significantly accelerating patient attachment and access. Team roles are clear and complementary. The Division's deep knowledge of clinic operations and the primary care environment supports the clinicians to focus on medicine while driving innovation. As a result, patients benefit from increased clinic access, proactive preventative screening and risk assessments. EMR data shows improved patient access.

The clinic has attached 6,800 patients, 49% being new attachments. Four family physicians have joined the practice in the last three years, taking over three retiring practices.

G3.2 | Strengthening Primary Care Providers' Access to Tools and Resources for Supporting Long Covid Patients in BC

Speakers: **Anosha Afaq**, Providence Health Care
Michelle Malbeuf, Providence Health Care

Little is known about the long-term effects of COVID-19 and managing these symptoms can be challenging. Without a coordinated approach, patients may not receive the care they need. Providence Health Care (PHC) – in partnership with the Shared Care Committee, the Specialist Services Committee, and the Post-COVID-19 Interdisciplinary Clinical Care Network (PC-ICCN) – supported a Post-COVID-19 Response Project that allowed primary care providers (PCPs) and specialists to collaborate on creating referral processes, communication pathways, and educational opportunities to ensure patients receive accessible, appropriate, coordinated care for their ongoing COVID-19 symptoms.

The team developed a referral form for the Post-COVID-19 Recovery Clinics (PCRCs) across the province. In addition, the team developed a Post-COVID-19 Recovery Pathway in partnership with Pathways BC. The Pathway is available to PCPs in BC to support patients who are struggling in their COVID-19 recovery. Grounded in the experience of physicians in the PCRCs, it guides primary care assessment, investigative approaches and self-management tools for common post-COVID-19 symptoms, which consist of chest pain, shortness of breath, fatigue, anxiety, brain fog and headache. Further, the team developed a PCP educational program, BC ECHO for Post-COVID-19 Recovery, which uses instructive and case-based learning to improve care for patients recovering from COVID-19.

There has been remarkable uptake of these resources. As of December 2022, there have been 7,244 referrals sent to the PCRCs, 4,486 page views for the Post-COVID-19 Recovery Care Pathway, and 1,642 attendees at the BC ECHO for Post-COVID-19 Recovery sessions.

A recent provincial survey through the PC-ICCN identified needs primary care providers will have once the PCRCs are no longer available. The next steps for this project include working on prototypes to meet the needs identified in the survey. The PC-ICCN has improved accessibility of care for post-COVID-19 patients in BC.

G3.3 | The Primary Care Game - A Complexity Model to Support System Change

Speakers: **Andrew Earnshaw**, Kootenay Boundary Division of Family Practice

Jen Ellis, Kootenay Boundary Division of Family Practice

KB Division, in partnership with Selkirk College, is developing a tool we call "The Primary Care Game" (https://familypractice.smartkootenays.ca/) that allows individuals to test the cumulative impacts of various system improvement choices, trying to "solve" the growing primary care attachment and encounter demand crisis in BC, and engage in creative discussions regarding potential ways forward.

To win the game, players must apply the options available to them to generate enough encounters to meet projected demand to 2036. Players are encouraged to make choices that they see as realistic based on their knowledge of the primary care system. Demand projections for encounters are based on data from the Ministry of Health on both growth in health care user types and encounter demand for each user type. Metrics for the impact of various system improvement choices are based on a mix of leading system evidence and experience in implementation of PCN. The current version of the Game was also developed using local data from the geographic region of Kootenay Boundary, but can easily be modified for other catchment areas.

Goals of the Game include:

- Inform players regarding the nature of the challenge and system constraints, without inducing fear/anxiety/apathy.
- Inspire players regarding potential solutions to the problem, with a healthy dose of realism, while still inducing optimism.
- Foster efforts to improve the data around the projections, evidence and assumptions, increasing evidence-informed decision making.
- Increase the readiness for change within the health system.
- Secure support for optimal policy and governance decisions of local and provincial leaders.

The Game can be engaged with individually, or in a group context supported by a facilitator's guide (https://docs.google.com/document/d/1_MRIXbu2hepxVY74ApZfpqmavQC-UVsrLKPRT4oFMWc/edit?usp=sharing). If the Workshop format is approved as per this Abstract, this guide gives some ideas re. how we'd approach it (albeit abridged). A much less interactive Rapid Fire presentation can also be provided.

Rapid Fire Breakout Session 3
1:45pm - 2:30pm

C3 CONNECTIONS AND ENGAGEMENT | Cypress Room – 34th Floor from 1:45pm - 2:30pm

C3.1 | Meaningful Patient Partner Engagement for Projects & Committees

Speakers: **Jennifer Atchison**, Doctors of BC
Daniel Angrignon, Doctors of BC
Linda Riches, Northern Health

In 2021, the Patient Partner Engagement Working Group (PPEWG) was formed out of a need to improve how the SSC Physician Quality Improvement (PQI) initiative supports patient partner engagement across the province. The PPEWG is made up of volunteers representing each PQI team across BC and the various roles that support the initiative (patient partners, physicians, and PQI staff). The PPEWG committed to working with one another to determine what mattered to them, and identified that there was a need to develop a resource to support PQI staff, key partners, and initiative participants with meaningful patient partner engagement at both the project and committee level. First, an environmental scan of best practices and resources for patient engagement was conducted, and robust consultation with internal and external groups was undertaken. The PPEWG began developing a resource in August 2021, using a consensus-based decision making process to work collaboratively together. The PPEWG worked collaboratively on the content and structure of the guide, and feedback from key partners across PQI, SQI, and PVN was collected and incorporated into the document.

What resulted was a comprehensive document, titled "Meaningful Patient Partner Engagement: A Guide for Projects and Committees". The guide is intended to provide health care partners and patient partners an overview of best practices, tips, and resources for meaningful patient engagement, using the IAP2 Spectrum for Public Participation as a foundation.

The guide, which was initially intended to be a resource for PQI, has since been expanded to be inclusive of other initiatives across the SSC and Shared Care, and is currently being implemented provincially across PQI and the SSC Spreading Quality Improvement (SQI) initiative.

Successful uptake of the guide and improved perceptions around value of patient engagement amongst patient partners, physicians, and teams will be an indicator of the impact of this work. Efforts are underway to support PQI and SQI teams to foster a positive shift in culture, by helping them to embed the principles and processes outlined in the guide into their everyday work.

C3.2 | Elevating Medical Staff Engagement through Consultant Physicians at Providence Health Care

Speaker: **Julia Raudzus**, Providence Health Care Physicians and Surgeons Association
Adrienne Melck, Providence Health Care Physicians and Surgeons Association
Jennifer Scrubb, Providence Health Care Physicians and Surgeons Association

In response to the Specialist Services Committee Facility Engagement Funding (FEI) funding aimed at elevating physician engagement in the work of the Health Authority, Providence Health Care (PHC) formed the Physicians and Surgeons Society (PASS) to oversee utilization of FEI funds and establish formal engagement structures and processes.

This coincided with PHC's new 7-year strategic plan built around 4 foundational pillars. PASS allocated a large proportion of FEI funding to hiring 4 consultant physicians (CPs) to represent each of the 4 strategic pillars and collaborate with senior leaders to implement the plan and foster engagement.

The CP role is to serve as a liaison between medical staff and senior leadership as it relates to their pillars. Each CP meets regularly with their pillar advisory committee and a member of the Senior Leadership Team (SLT) designated as their pillar's sponsor. CPs are active members of the FEI Working Group and are invited regularly to SLT meetings related to strategic planning.

CPs conducted a "roadshow" reaching over 200 medical staff which improved widespread knowledge of the strategic plan and identified ways medical staff wanted to be engaged. The CPs and their PACs have implemented numerous highly interactive well attended educational and networking events on priority topics, including value-based health care, cultural safety and humility, physician burnout, and physician-led innovation, achieving engagement goals. CPs and PACs provide ongoing input to refine and validate the strategic plan. In the CPs' inaugural year, PHC's response rate for the annual HA Engagement Survey increased by 41% - a key metric for CP success.

CP roles have significantly improved engagement of MSA members and greatly enhanced the influence of the MSA on organizational decision making at the highest level.

Sustainability planning and consultation, currently underway, will help to determine the future direction of the CP role.

C3.3 | Strengthening Connections Between Family Physicians and Community Health Nurses

Speakers: **April Bonise**, Surrey-North Delta Division of Family Practice
Sharmila Yang, Family Physician, Gateway Medical
Catherine Barnardo, Surrey Community Health Services - Home Health

Beginning in March, 2021, the SND Division's CCCOA Shared Care working group began a project to improve connections between FPs and Home Health Community Health Nurses (CHNs). Prior to the pilot phase of the program, 89% of FP participants were unaware of who their CHN was, and of those who were aware, none described their relationship with their CHN as positive. This strained relationship was a focus of needed improvement as it had led to delays in care and prevented some FPs from referring their patients to Home Health.

The project consisted of two phases. In each phase, Meet & Greet sessions were facilitated between FPs and CHNs, with the goals of:

- Improving communication between FPs and CHNs, including reaching agreements on method and frequency of communication
- Familiarizing FPs with their CHN, and what the CHN's role is
- Ensuring FPs are aware of the process for referring their patients to Home Health

Evaluation Results

Between the pilot phase and the cohort 2 phase, 15 CHNs and 50 FPs participated in 6 Meet & Greets. 67% of pilot phase FP participants still knew who their CHN was 6 months after the Meet & Greet and the number of FPs who were aware of who their Home Health patients are doubled. Following the cohort 2 phase:

- 100% of FPs now know who their CHN is and what their role is
- 100% of FPs now know how to contact their CHN (compared to 27% prior to the Meet & Greet)

As a result of this project, a new Home Health communication process was created which consists of a quarterly CHN cover sheet and updated patient lists being sent out to community FPs, representing over 2000 Home Health patients in SND.

Rapid Fire Breakout Session 3
1:45pm - 2:30pm

E3. QUALITY IMPROVEMENT | English Bay Room – 34th Floor from 1:45pm - 2:30pm

E3.1 | The Power of Podcasting for Sharing Quality Improvement and Facilitating Collaboration

Speakers: **Deanna Danskin**, Northern Health / PQI
Shyr Chui, Northern Health

Sharing quality improvement successes is a vital part of quality improvement (QI), not only to celebrate the achievements of QI teams, but also to facilitate collaboration. Traditional methods of sharing QI successes, such as conferences, are challenging for rural providers to attend due to barriers associated with travel and coverage, especially in Northern BC. Patients and the general public may be unaware of local QI work, as they are not typically included in conferences. Podcasting is a relatively new media that has exploded in popularity over the past few years due to podcasts being accessible, portable, and engaging. Despite there being over 2 million podcasts worldwide, there are few podcasts about healthcare QI, and there were virtually none featuring QI work in Northern BC. In 2021 "Qualitycast North" was born to utilize podcasting as an innovative tool for communicating Northern Physicians successful QI projects. The podcast features interviews with physician leads, patient partners, and health authority leaders about their projects, career journeys, and the joys of healthcare work/life in Northern BC. It is promoted to local providers through internal channels, and on Northern Health's social media channels, so that patients and the public have an opportunity to access new episodes.

The first season of Qualitycast North included 10 episodes, and featured 4 specialists, 5 general practitioners, and 1 patient partner. Season 2 expanded beyond just QI projects and features co-leadership, medical education, and publishing. All participants expressed that the podcast interview was a fun and positive experience. The podcast has been downloaded over 2000 times with listeners in >20 countries. While there have been challenges with recording, scheduling, and promotion, podcasting is a fun, original, and innovative approach to communication. Podcasts can overcome traditional barriers to information sharing and allow QI successes to reach larger, more diverse audiences.

E3.2 | Setting Up a Provincial After Hours Coverage Program

Speakers: **Jaron Easterbrook**, Family Practice Services Committee
Kendall Ho, HEIDi program on behalf of HealthLink BC
Sandra Sundhu, HealthLink BC

How can health system work with family physicians together twoards a provincial strategy to support after hours patient care? During the summer, 2022 engagement with more than 1,000 Family Physicians, Doctors of BC identified the provision of care after hours as a significant burden to full service family physicians. FPSC, in a collaborative partnership with four Divisions of Family Practice, HealthLink BC, and UBC Digital Emergency Medicine Unit, set up a pilot for a provincial Family Physicians After Hours Program to demonstrate how equity of patient access to after hours service, linking episodic access to longitudinal care, can be achieved with cooperation between the health system and family physicians, thereby sharing the after hours coverage

to improve care for patients, reduce the burdens facing family physicians, utilize health system resources smartly, and strengthen the integrity of longitudinal patient care principle in action. This abstract will present the initial evaluation from this work and provide recommendations to determine the continuation and sustainability of the service.

E3.3 | Provincial Osteoporosis Physician Collaborations: BC Coalition of Osteoporosis Physicians

Speaker: **David Kendler**, Prohealth
Raheem Kherani, Richmond Hospital

The BC coalition of osteoporosis physicians (BCCOP) includes family medicine and specialist physicians from around the province. BCCOP is comprised of endocrinologists, rheumatologists, geriatricians, laboratory medicine physicians, orthopedic surgeons, internists, and family practitioners who are interested in the care of osteoporosis patients. There is also involvement of a pharmacist and a representative from Osteoporosis Canada.

There is a need for such a coalition to represent the needs of osteoporosis patients who are cared for from the practices of diverse specialists and generalists. As such, a forum for communication, sharing of ideas, development of educational materials, and progressing advocacy initiatives has proven very useful.

The BCCOP holds virtual meetings by teleconference approximately every two months. This forum provides opportunities for osteoporosis physicians to share ideas with colleagues to the benefit of osteoporosis patients. BCCOP has developed a website supported in part by osteoporosis Canada which helps to communicate the group's activities and educational materials. The website also has a registry of osteoporosis physicians helpful to primary care doctors seeking a referral specialist to help their patient. BCCOP has fostered activities through working groups including a physician informational sheet on osteoporosis needs during the COVID pandemic. Another working group has shared ideas regarding Fracture Liaison Services and fostered development of FLS programs benefiting postfracture patients in Fraser Health (White Rock, Chilliwack), Interior Health (Kelowna, Penticton), and Vancouver Coastal Health (Richmond). BCCOP has advocated to government directly and through MedAccessBC for expanded availability of pharmaceutical products required to manage osteoporosis. Through these activities, Pharmacare has initiated a review of the osteoporosis therapeutic area and related medications. A "bone and cancer" initiative involving oncologists is nearing completion with an informational piece helpful to oncologists managing patients with bone concerns in association with malignancy. Physicians participating in this group no longer feels isolated, but feel empowered to associate with other physicians managing osteoporosis patients in a collaborative group involving diverse specialties and associating with Osteoporosis Canada.

Rapid Fire Breakout Session 3
1:45pm - 2:30pm

O3. RURAL CARE | Oxford Room – 3rd Floor from 1:45pm - 2:30pm

O3.1 | Providing Gender Affirming Care in the Kootenay Boundary Region

Speakers: **Leila Dale**, Kootenay Boundary Division of Family Practice
Steve Anderson, Kootenay Boundary Division of Family Practice

Anecdotal evidence suggested that some primary care practitioners in Kootenay Boundary (KB) felt unqualified to provide certain types of gender-affirming care (GAC) to their patients, resulting in an increase of referrals, often out to different communities. The practitioners receiving the referrals then faced greater pressure to care for new patients. People with diverse gender identities can be well-served in primary care settings, and primary care practitioners can provide many aspects of GAC with additional knowledge and training.

Intervention
Strategies to improve GAC in primary care settings in KB included adapting existing resources and education opportunities for practitioners, improving the patient and practitioner experience through supporting more welcoming clinic environments, and increasing patient and/or family members' awareness of healthcare pathways, resources and support. Training opportunities have since been provided to clinic staff to normalize gender inclusive language, and clinics were sent inclusive signage. Additional learning events to increase confidence and capabilities of family and emergency physicians are planned for early 2023. Resources that map out gender-affirming healthcare pathways will accompany two learning events.

Impact
Nearly all clinic staff who took part in the TransCare BC training (n=36) felt the training improved their awareness and ability to use appropriate names and pronouns for their clinic's patients, and improved their understanding of GAC. Lessons were learned around selecting the inclusive signage for clinics. The project advisory team includes people with lived experience who challenged the genuineness of having posters prominently displayed in clinics that had not completed GAC training, and may not be providing adequate or well-informed GAC. These discussions highlighted the importance of early and open communication with stakeholders and changes were made to the type of signage before distribution. The project will continue to work towards reducing the adverse experiences that patients with diverse gender identity might encounter.

O3.2 | Rapid Deployment of a Video-Enabled Virtual Health Tool to Support Pediatric Critical Care in BC during the 2022 Pediatric Respiratory Surge

Speaker: **Jonathan Wong**, Office of Virtual Health - PHSA
Adela Matettore, Pediatric Critical Care - BC Children's Hospital

In British Columbia, pediatric tertiary care is centralized. The increased demand for pediatric consultative, transport, and inpatient services, as a result of the 2022 respiratory illness surge, required fast and innovative solutions to support patient assessment, community providers, and appropriate transfer decisions across a large geographical region. To meet this need, a virtual health solution, GoodSAM Instant.Help, that allowed an instant video connection, was deployed and evaluated.

Objective
The overall objective of the pilot project was to improve clinical decision making and peer-to-peer support services with timely and appropriate video conferencing consultations for pediatric critical care and inter-facility transfer during the respiratory surge.

Methods and Evaluation

The GoodSam web-based application was rapidly implemented over a 3-week period in winter 2022, in partnership with the Pediatric Critical Care Team at BC Children's Hospital, Child Health BC, BC Emergency Health Services/Patient Transfer Network, and the Office of Virtual Health at Provincial Health Services Authority.

The evaluation of this project was conducted using multiple data sources and a mixed-methods design, including both qualitative and quantitative data. Qualitative data was collected using a variety of surveys and interviews of care providers and patients/families, while quantitative data was collected from different clinical systems and metrics available from PTN, PICU, and the GoodSAM solution. Key areas for evaluation included: Adoption and Utilization, Patient/Family and Provider Satisfaction, Efficiency and Effectiveness, and Technical Performance and Data Security. Evaluation is ongoing and further data will be presented at the JCC Forum.

Conclusion

A real-time video enabled virtual health solution was rapidly implemented to improve provider-to provider clinical support and decision-making during a period of overwhelming demand for pediatric critical care. This type of solution is being considered to provide sustainable paediatric outreach services across BC and to support additional clinical areas including neonatology, maternity, and adult critical care.

O3.3 | Standardizing Goals of Care Documentation on the Sunshine Coast – The Green Sleeve Initiative

Speakers: **Carmen Goojha**, Sunshine Coast Palliative Shared Care - Green Sleeve Working Group
Jackie Scott, Sunshine Coast Hospice Society

Presentation Format

Rapid Fire Problem: Documenting Goals of Care (GOC) using official forms allows patients and health care providers to create a roadmap of what type of healthcare is acceptable to them should they lose their ability to communicate. The more specific and up-to-date the GOC form is, the clearer a patient's voice will be in making decisions in future medical situations. Context and Relevance: 67% of palliative patients on the Sunshine Coast (SC) did not have GOC documented in their Family Physician's (FP) electronic medical record, and only 31% of palliative patients had a Medical Orders for Scope of Treatment (MOST) form in their homecare chart. SC Hospice Society, SC Division of Family Practice, SC Palliative Shared Care Working Group, shíshálh Nation, and BCEHS collaborated and organized the Green Sleeve Initiative (GSI). Intervention: The team developed a "Green Sleeve" that stores medical documents (eg. MOST form), provided GSI education and implementation process maps for physicians, medical office assistants, homecare/hospital nurses, EHS providers, and unit clerks. PDSA cycles adjusted workflow using participant feedback. Sunshine Coast Hospice provided advance care planning education for the public: website resources, advance care planning workshops and 1:1 volunteers. Measurement: 1300 Green Sleeves were distributed. Thirty eight education sessions were held with a total of 541 participants. 1 year after project initiation we found: the percentage of physicians who felt confident in having GOC discussions increased from 60 to 100%, MOST Form completion for palliative patients increased from 31 to 55%, physicians are having more GOC conversations their patients, and the percentage of physicians having 5-10 GOC conversations per month increased from 30% - 45%. Lessons Learned:Collaboration between healthcare providers, community and volunteer organizations enhances service delivery and the care experience for patients.Establishing and documenting goals of care ensures more meaningful outcomes for patients and providers.

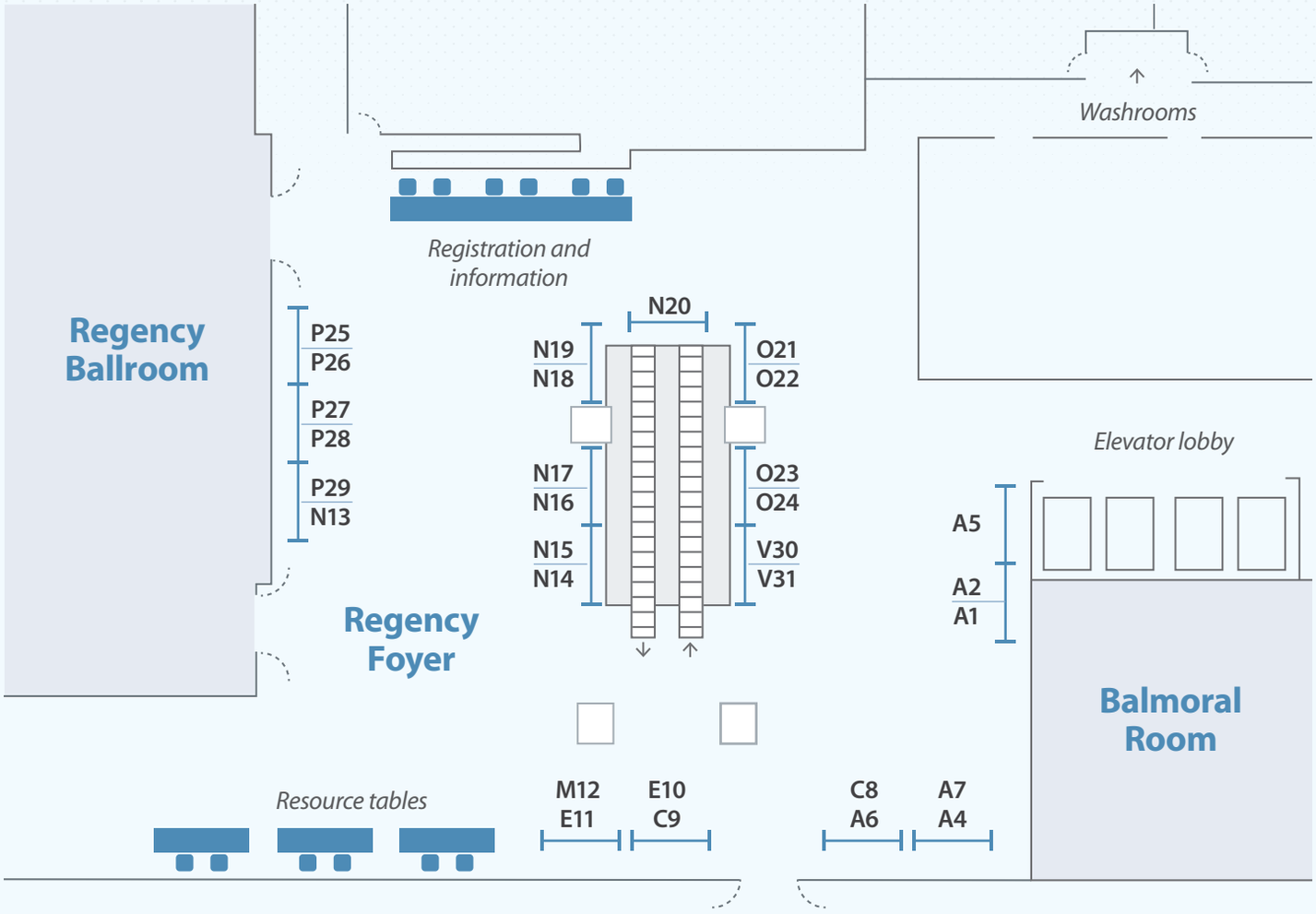
Storyboard Abstracts

Storyboard Poster Number Key

Storyboards are identified with a letter and number. The letter identifies the theme and the number is unique to each storyboard.

Themes

- **A** Alignment around the JCCs
- **C** Cultural Safety & Humility
- **E** Emergency Preparedness
- **M** Maternity
- **N** New Ways of Providing Care
- **O** Other
- **P** Physician Burnout
- **V** Virtual Care



A1 Improving Physician Engagement: A Systematized Approach

Speakers: **Saira Abra**r, Surrey-North Delta Division of Family Practice
Hala Ahmed, Surrey-North Delta Division of Family Practice

Increased physician engagement in healthcare administration and policy has been shown to lead to improved patient outcomes, reduced physician burnout and enriched physician development. It is therefore a central pillar of the Surrey-North Delta Division of Family Practice's mission.

Two tools have proven especially effective for engaging physicians in Surrey-North Delta: physician WhatsApp groups and the development of colour-coded engagement level indicators.

Using Social Media to Improve Physician Collegiality
At the start of the COVID – 19 pandemic, some of the challenges experienced by physicians included isolation and a general loss of connection. SND Division tackled this challenge with WhatApp groups. Since their inception, these groups have grown to include 229 physicians across 3 geographical regions within Surrey-North Delta, enabling members to connect, share information and provide feedback to division staff. SND also hosts smaller groups for physicians interested in more focused strategies or initiatives.

Engagement Level Indicators: Colour Coding
Over the past 4 years, the division has developed a colour coding system to indicate how involved a physician is in division initiatives, events and leadership opportunities. There are 3 colour categories: red, yellow and green. Red indicates the least engaged (including physicians who are not members of the division) and green indicates actively engaged members, many of whom are leaders.

The tool tracks transition from one colour zone to another with the goal of facilitating this transition towards the green zone.

Colour coding has provided an easy, visual way to track engagement, identify physician leaders, spot those with limited engagement and develop individualized solutions. It also enables us to easily identify regions where more strategic focus is needed and to identify when physicians become more or less engaged.

Since implementation, engagement level indicators have improved from 98 physicians in the green zone to 133.

A2 A 'think tank' to address complex discharge planning at the University Hospital of Northern BC

Speaker: **Deanna Danskin,** Northern Health / PQI

Discharge planning for medically complex patients involves a broad team that includes specialist physicians, general providers, nurses and allied health professional in both the acute and community setting. Team communication around discharge planning is a challenge at UHNBC, and barriers to communication impact many dimensions of quality of care. The Northern Health Physician Quality improvement (PQI) team saw an opportunity to engage providers and front-line leaders from nursing and allied health disciplines in a collaborative think tank event to collectively address barriers to communication across the discharge process. A group of key operational and physician leads met over several months prior to the event to identify the purpose and scope of the event, the problem, key team members to include, the vision of success, and logistics. In June 2022 the think tank event was held with 31 participants that included 12 physicians, 1 nurse practitioner, 18 health authority staff, and 5 facilitators.

Storyboard Abstracts

The event fostered new cross-disciplinary dialogue, networking, and the evaluation indicated it was a positive and valuable experience. The group worked through facilitated activities including an Ishikawa diagram and liberating structures. The think tank was the first of many steps to implementing meaningful improvements to discharge planning. Four key change ideas emerged during the event. A proposal for external funding through the Shared Care Committee (SCC), based on these key change ideas, was approved. This established funding, project management, and team commitment to refine and implement the ideas generated from the think tank over the next 1-2 years. Think tanks offer an engaging approach to bringing together physicians and their health authority teams to collaborate on complex problems and should be supported with longer term supports such as SCC funding to ensure sustainability of ideas and relationships developed during the event.

A4 Working Together to Optimize Quality Improvement Education in British Columbia, Canada

Speakers: **Jennifer Atchison**, Doctors of BC
Deanna Danskin, Northern Health / PQI

Across six health regions in BC, the Physician Quality Improvement (PQI) initiative provides QI training and support to physicians to enhance their QI capability and capacity. In an effort to reduce duplication while leveraging the unique benefits of each region, a group of representatives from across the provincial PQI initiative worked together to co-develop a provincially harmonized QI training framework. Harmonization efforts included collaboration to determine the knowledge, skills, and attributes learners would gain by the end of training, and development of new curriculum course goals and learning objectives. Three main factors contributed to the success of this work: neutral facilitation, a focus on relationships, and a commitment to consensus-based decision making. Through these methods, the CHAC was able to create a harmonized curriculum that has now been rolled out across PQI provincially.

A5 Meaningful Patient Partner Engagement for Projects & Committees

Speakers: **Jennifer Atchison**, Doctors of BC
Daniel Angrignon, Doctors of BC
Linda Riches, Northern Health

In 2021, the Patient Partner Engagement Working Group (PPEWG) was formed out of a need to improve how the SSC Physician Quality Improvement (PQI) initiative supports patient partner engagement across the province. The PPEWG is made up of volunteers representing each PQI team across BC and the various roles that support the initiative (patient partners, physicians, and PQI staff). The PPEWG committed to working with one another to determine what mattered to them, and identified that there was a need to develop a resource to support PQI staff, key partners, and initiative participants with meaningful patient partner engagement at both the project and committee level. First, an environmental scan of best practices and resources for patient engagement was conducted, and robust consultation with internal and external groups was undertaken. The PPEWG began developing a resource in August 2021, using a consensus-based decision making process to work collaboratively together. The PPEWG worked collaboratively on the content and structure of the guide, and feedback from key partners across PQI, SQI, and PVN was collected and incorporated into the document. What resulted

was a comprehensive document, titled "Meaningful Patient Partner Engagement: A Guide for Projects and Committees". The guide is intended to provide health care partners and patient partners an overview of best practices, tips, and resources for meaningful patient engagement, using the IAP2 Spectrum for Public Participation as a foundation. The guide, which was initially intended to be a resource for PQI, has since been expanded to be inclusive of other initiatives across the SSC and Shared Care, and is currently being implemented provincially across PQI and the SSC Spreading Quality Improvement (SQI) initiative.

Successful uptake of the guide and improved perceptions around value of patient engagement amongst patient partners, physicians, and teams will be an indicator of the impact of this work. Efforts are underway to support PQI and SQI teams to foster a positive shift in culture, by helping them to embed the principles and processes outlined in the guide into their everyday work.

A6 Strengthening Connections Between Family Physicians and Community Health Nurses

Speakers: **Sharmilla Yang**, Family Physician, Gateway Medical Clinic
Catherine Barnardo, Surrey Community Health Services - Home Health

Beginning in March, 2021, the SND Division's CCCOA Shared Care working group began a project to improve connections between FPs and Home Health Community Health Nurses (CHNs). Prior to the pilot phase of the program, 89% of FP participants were unaware of who their CHN was, and of those who were aware, none described their relationship with their CHN as positive. This strained relationship was a focus of needed improvement as it had led to delays in care and prevented some FPs from referring their patients to Home Health.

The project consisted of two phases. In each phase, Meet & Greet sessions were facilitated between FPs and CHNs, with the goals of:

- Improving communication between FPs and CHNs, including reaching agreements on method and frequency of communication
- Familiarizing FPs with their CHN, and what the CHN's role is
- Ensuring FPs are aware of the process for referring their patients to Home Health

Evaluation Results

Between the pilot phase and the cohort 2 phase, 15 CHNs and 50 FPs participated in 6 Meet & Greets. 67% of pilot phase FP participants still knew who their CHN was 6 months after the Meet & Greet and the number of FPs who were aware of who their Home Health patients are doubled. Following the cohort 2 phase:

- 100% of FPs now know who their CHN is and what their role is
- 100% of FPs now know how to contact their CHN (compared to 27% prior to the Meet & Greet)

As a result of this project, a new Home Health communication process was created which consists of a quarterly CHN cover sheet and updated patient lists being sent out to community FPs, representing over 2000 Home Health patients in SND.

Storyboard Abstracts

A7 The Power of Podcasting for Sharing Quality Improvement and Facilitating Collaboration

Speakers: **Deanna Danskin**, Northern Health / PQI
Shyr Chui, Northern Health / PQI

Sharing quality improvement successes is a vital part of quality improvement (QI), not only to celebrate the achievements of QI teams, but also to facilitate collaboration. Traditional methods of sharing QI successes, such as conferences, are challenging for rural providers to attend due to barriers associated with travel and coverage, especially in Northern BC. Patients and the general public may be unaware of local QI work, as they are not typically included in conferences. Podcasting is a relatively new media that has exploded in popularity over the past few years due to podcasts being accessible, portable, and engaging. Despite there being over 2 million podcasts worldwide, there are few podcasts about healthcare QI, and there were virtually none featuring QI work in Northern BC. In 2021 "Qualitycast North" was born to utilize podcasting as an innovative tool for communicating Northern Physicians successful QI projects. The podcast features interviews with physician leads, patient partners, and health authority leaders about their projects, career journeys, and the joys of healthcare work/life in Northern BC. It is promoted to local providers through internal channels, and on Northern Health's social media channels, so that patients and the public have an opportunity to access new episodes.

The first season of Qualitycast North included 10 episodes, and featured 4 specialists, 5 general practitioners, and 1 patient partner. Season 2 expanded beyond just QI projects and features co-leadership, medical education, and publishing. All participants expressed that the podcast interview was a fun and positive experience. The podcast has been downloaded over 2000 times with listeners in >20 countries. While there have been challenges with recording, scheduling, and promotion, podcasting is a fun, original, and innovative approach to communication. Podcasts can overcome traditional barriers to information sharing and allow QI successes to reach larger, more diverse audiences.

C8 DoFP East Kootenay Gender Affirming Care- A Shared Care initiative

Speaker: **Lisa Larkin**, East Kootenay Division of Family Practice

Transgender individuals are considered a vulnerable population with complex social and medical needs. Unfortunately gender-affirming care and local supports can be difficult to access in the East Kootenays. Some of the challenges include:

- Gap in knowledge between care providers and patients seeking gender affirming care.
- Resources are fragmented, Family physicians may not understand patient needs or what options are available locally.
- Geographical barriers exist. We live in a rural landscape, it can be difficult to travel in winter months and public transport options are limited.

In collaboration with physician leads and project partners, Trans Care BC and Trans Connect, we aimed to improve better access to knowledgeable care. We developed two specific resources, a community roadmap and provider roadmap that communicates different services and resources available locally and online.

The community roadmap highlights local resources and supports to help patients access care and social services

faster. We worked at distributing the information to common points of entry where youth and patients may go to for information. It was important for the resource to be visible and available to those who need it.

The provider roadmap connects local providers to their colleagues who are already offering gender affirming care, giving them a collaborative community of practice and a safe place to seek guidance. We've listed learning opportunities to support their learning needs and information on how to create a safe and respectful clinic environment.

We hosted a learning event that created opportunities for providers to hear from local individuals with lived experiences and learn about gender affirming care from local physicians and specialists.

This project has helped to break down barriers and improve access to gender affirming care amongst the rural backdrop of the East Kootenays. We've worked to create safer and more inclusive healthcare experiences for transgender people living in the region.

C9 First Steps in Addressing Indigenous Health in Our PCN

Speakers: **Jody Friesen**, Surrey-North Delta Division of Family Practice
Nazia Niazi, Board Co-Chair, Surrey-North Delta Division of Family Practice

Motivated by our vision of a welcoming and safe community for all people accessing primary health care in Surrey and North Delta (SND) and by the glaring health gaps uncovered during our Primary Care Network (PCN) discovery process, the Surrey-North Delta Division of Family Practice (division) has been taking steps towards implementing the Truth and Reconciliation Commission's health care recommendations.

Our division represents 350 Family Physicians (FPs) serving a population of 600,000 people. Indigenous People in SND are largely urban and away from home, and many choose not to self-identify as Indigenous when accessing health services.

Recognizing the importance of the task, we are now building a foundation of cultural humility and curiosity among members and staff.

FPs and staff have been encouraged to attend learning events that increase understanding of the culture and history of Indigenous Peoples, including the San'Yas training and the JCC's Indigenous Community and Longhouse Experiential Learning Sessions.

Staff are encouraged to share and discuss their impressions and thoughts in our team meetings after these events. These team meetings have resulted in new ideas for building bridges with our First Nations, Inuit and Métis sisters and brothers.

In October, we invited Elder William from the Tsleil-Waututh Nation and Senior Cultural Advisor at Fraser Health to speak at our Annual General Meeting about some of his traditional wellness practices. Attendees had the opportunity to participate in a smudging ceremony, which provided time for reverence and reflection on wellness and its intersection with spirituality.

Our next steps include creating a Community of Practice to support ongoing cultural learning and compassionate leadership. We are thankful for the partnerships we have made with First Nations Health Authority and Fraser Health Indigenous Health who are supporting us in taking thoughtful first steps towards fostering a welcoming and safe community.

Storyboard Abstracts

E10 Emergency Preparedness at the Comox Valley Hospital

Speaker: **Sarah Scott**, Island Health

Objective

To develop and implement a robust and sustainable emergency preparedness program at the Comox Valley Hospital.

Method

This presentation focuses on the process of developing a sustainable and reproducible emergency preparedness program that is flexible regarding category of disaster and facility type.

Results

Initial progress was slow due to human resource constraints and competing priorities (in particular, the COVID-19 pandemic).

The most critical component was bringing together a core team of dedicated individuals to begin the work. Beyond that, regularly scheduled meetings were required to keep things rolling. Furthermore, specific funding was procured via facilities engagement to ensure appropriate physician compensation.

We found the work to be engaging and the stakeholders heavily invested. The work is ongoing and includes plans for a) a tabletop Code Orange simulation with pre- and post-simulation surveys to help address preparation gaps; b) educational events such as informative emails and a Grand Rounds event to disseminate new plans and learning; c) data collection and processing regrading % of staff that have completed specific disaster training (in this case, the Code Orange learning module); d) conducting a Hazard Vulnerability Analysis specific to each emergency procedure we are reviewing; and e) regularly scheduled reviews of knowledge retention/gaps.

Conclusion

Lessons learned include:

1. Disaster planning is a critical piece of hospital preparedness, but frequently takes a backseat to more time-sensitive urgent matters.
2. A core group of invested stakeholders is critical to success.
3. There are means, such as physician engagement funding, to ensure that medical leaders are involved in the process.
4. Having a plan that is flexible enough to be applied to many emergency preparedness processes and having regularly scheduled sessions to keep the work moving forward allows for a sustainable and successful program.

E11 Fostering Thompson Region Primary Care Provider Leadership

Speaker: **Chelsea Brookes,** Thompson Region Division of Family Practice

Extreme weather events such as wildfires and floods have impacted rural communities in British Columbia's interior in recent years. This action-oriented research study was completed in partial fulfillment of the requirement for a Master of Arts in Leadership Degree at Royal Roads University and in partnership with the Thompson Region Division of Family Practice (TRDFP). It explored the following primary research question: "How might the TRDFP foster primary care provider leadership during extreme weather events?" This project was designed following the Royal Roads University Ethics Policy and Tri-Council Ethical Guidelines and used qualitative interviews in combination with an arts-based method to generate

stories about leadership during displacement due to wildfires and floods from rural-practicing primary care providers. Study findings revealed five key themes: lack of primary care provider involvement in emergency response, preparation and experience, values and leadership styles, collaboration and teamwork, and personal and professional balance. The resulting recommendations were to involve primary care providers in emergency preparedness and response, offer or promote leadership opportunities for primary care providers, and share supports for providers and patients. Key stakeholders from the TRDFP validated and operationalized the recommendations by prioritizing next steps.

M12 Strengthening an interprofessional maternity team and access to local maternity care

Speaker: **Carrera Teal**, Rural and Remote Division of Family Practice

North Vancouver Island maternity providers, in conjunction with FNHA and Island Health identified the opportunity to come together to sustain and improve maternity care in their rural and remote communities on the North Island with a focus on providing culturally safe, accessible care closer to home. At the project outset, it was noted that people giving birth and their families from the North Island had previously not had local access to midwifery care, despite local demand. This initiative was an opportunity to strengthen local access to care, support interprofessional teams, strengthen provider and community confidence and competence, and bring births closer to home. It built on the work of several other maternity care initiatives in the region.

Lessons learned from the project can apply to anyone who is looking to strengthen interprofessional teams and local access to maternity care in rural communities. Project outcomes can also support the integration of maternity care into Primary Care Networks in the rural setting.

N13 Co-Developing a Dashboard to Gather Critical Seniors Clinic Care Data

Speaker: **April Bonise**, Surrey-North Delta Division of Family Practice

In 2022, Surrey-North Delta Division of Family Practice supported a Family Physician (FP) working group to work with Jim Pattison Specialized Seniors Clinic (SSC) and subsequently, the Fraser Health data analyst team, to improve communication between SSC and community FPs. The loss of some seniors services in the community along with a lack of transparent two-way communication between FPs and SSC physicians had led to FPs encountering challenges in being able to appropriately support their patients in service at SSC and upon discharge.

In February and March, the working group and key SSC stakeholders completed a 4-part patient journey mapping exercise. This map detailed the start-to-finish communication process between FPs, patients, and SSC, providing a clear understanding of where and why communication gaps were occurring.

A presentation was then to the entire SSC interdisciplinary team in order to generate buy-in and solicit approval to proceed with next steps. The Seniors Clinic agreed with the importance of creating a Complex Care Interdisciplinary Rounds Toolkit as well as the creation of a KPI dashboard help align our project goals and outcomes.

Despite being told it would only be possible to include a maximum of 2 or 3 KPIs in the dashboard, the working group submitted a draft proposal with 12 KPIs in June. These KPIs will include information about length of stay, wait times and number of patients per provider, and will

support other strategies developed by the working group, such as communication with FPs (who will now know if their patient is in service at SSC) and post-discharge complex care rounds to enable shorter SSC stays.

Fraser Health approved the Dashboard proposal in October, and their privacy team is now reviewing the dashboard, with th e expectation that it will be rolled out regionally this year to all FH Seniors Clinic teams.

N14 East Kootenay Orthopedic Referral Project: Facilitators and barriers to an evidence-informed model

Speaker: **Alex Chan**, East Kootenay Division of Family Practice

(Background: Orthopedic surgical wait-times frequently exceed recommended benchmarks. Programs to reduce wait-times operate in a few locations. However, pragmatic approaches collaboratively designed for rural regional settings are needed and must address these settings' unique implementation barriers. The East Kootenay Shared Orthopedic Referral and Triage (SORT) Project aims to decrease orthopedic wait-times through implementation of an evidence-informed model.

Aim

To describe the co-design phase of a referral and triage model and explore implementation barriers and facilitators reported by GPs and orthopedic surgeons in validated surveys.

Methods

Two stakeholder groups (orthopedic and GP) are developing referral forms and a triage model following co-design methodology: 1) rapid literature review; 2) local longitudinal service data and professional guidelines review; 3) workshops with Think-Aloud methodology and clinical vignettes. Using the Theoretical Framework of Acceptability (TFA) questionnaire, East Kootenay GPs and specialists will rate SORT acceptability on: anticipated administrative burden; perceived effectiveness to improve patient or service outcomes; opportunity costs; and general acceptability. Other questions include perceived quality of current referral pathways, inter-professional communication, and free-text boxes.

Results

We will report outcomes of the co-design process including experienced challenges, finalised referral form, and triage details such as individual completing triage, indicators for patient redirection to conservative treatments (physiotherapy, sports medicine) or urgent consult, and preliminary patient flow data. Acceptability of SORT and implementation barriers will be reported through descriptive analysis of TFA items. Based on similar local surveys, we anticipate a response rate exceeding 60% (n=65).

Impact

The presented co-design process is relevant to individuals implementing 'New Ways of Care'. For orthopedic services, the results provide comprehensive detail on potential triage models and anticipated barriers. With a recent literature review reporting only 11 studies of similar referral and triage models, this presentation can contribute to overall discussion on emerging solutions to pragmatically tackle growing surgical wait-times.

N15 Found in translation (al simulation): Translational simulation for improving difficult airway management in an urban/rural hospital

Speakers: **Ava Butler**, Island Health Authority
Terra Lee, Island Health Authority
Liam Raudaschl, Island Medical Program at UBC

Translational simulation is an emerging framework for healthcare improvement. Most of the published

literature around translational simulation originates from tertiary care centres. On Vancouver Island, the majority of the population lives in communities that are urban/rural, rural and remote. This presentation describes the implementation of translational simulation in a urban/rural community hospital on Vancouver Island.

Physicians, nurses and respiratory therapists in the Cowichan District Hospital Emergency department are responsible for managing the unanticipated anatomically difficult airway, leading to a situation called can't intubate, can't oxygenate (CICO). As this is rare, staff are not always proficient with the location of difficult airway equipment or its use. A quality improvement project is underway to decrease the time to obtain equipment needed for unanticipated anatomically difficult airway management for adults in simulation by nurses, RTs, and physicians in the Cowichan emergency department to less than 90 seconds by May 2023.

Translational simulation was used to identify challenges and to create solutions in this project. A combination of tabletop simulation and semi-structured interviews identified problems with equipment layout, confusion around the process for managing difficult airways and discomfort using the difficult airway equipment. Change ideas for the ongoing PDSA cycles in this project were selected to respond to latent threats and challenges identified in the aforementioned simulations. These include the dissemination of a colour-coded shared mental model for difficult airway management and the creation of a corresponding airway cart, the use of which will be optimised through simulation in January-April, 2023. By April 2023, data on the time needed to obtain equipment and qualitative data from interviews of staff will have been collected and analysed. This data will demonstrate how translational simulation can be translated beyond tertiary care to quality improvement in urban/rural, rural and remote care settings.

N16 Enhancing palliative care models to support earlier referrals and care coordination improvements

Speaker: **Melanie Todd**, Thompson Region Division of Family Practice

Earlier palliative care consults and referrals to the palliative care on-call physician team, serving both Kamloops and outlying areas, are being encouraged for oncology patients and patients with chronic medical conditions, to improve quality of life. Physicians of the palliative care on-call team, however, do not all have ready access to clinical space for meeting and examining community-based palliative patients, nor does the team have a shared charting system. The gaps are seen to impact timely access and coordination of care, and the ability to effectively work as a team.

The palliative care on-call physician team is collaborating with the local Hospice House on a quality improvement project to address these gaps. Space is being allocated at Hospice, along with access to shared equipment and programs (electronic medical record, computer and associated technology, and medical equipment) for the physician team to provide in-person interviews and examinations of palliative care patients possibly needing intervention. Situating space within Hospice may provide more ready access for Hospice staff to palliative care physicians on site, might increase patients' comfort in accessing hospice services, may improve the patient and family experience associated with their palliative care journey; and might enhance supports for the physician team to better support palliative patients in a coordinated, and efficient way.

The quality improvement project is slated to begin in early January 2023 for three to six months and will undergo a formal assessment after 10 patients are seen on-site, or sooner. Palliative care on-call physicians, Hospice staff,

and patients/families will be invited to share their experience to allow for the group to examine the project impact and feasibility of sustaining the service model moving forward. The project group anticipates the enhanced service model will positively impact both the quality and experience of care for both patients and physicians.

N17 Specialists Team Care Collaborative

Speakers: **Tommy Gerschman**, Pediatric Rheumatologist
Michelle Teo, Community Rheumatologist

The Specialists Team Care (STC) Collaborative addresses the need for a coordinated approach to team care in the specialist's community practice. The Collaborative uses the Institute for Healthcare Improvement (IHI) Breakthrough Series to support 10 specialty practices across BC to change their models of practice.

Between January 2023 - March 2024, Collaborative teams will implement and strengthen models of care, collect site level data, and engage in system change strategies in order to achieve the following aim statement:

By March 31, 2024, 09% of collaborative sites will implement a team model or care to improve the provider and patient experience.

The cohort of STC will also work to achieve the following outcomes widely across all provincial teams:

- 90% of patients will indicate that they had an improved experience as a result of team care
- 0% of care providers will report improved job satisfaction due to the implementation of team care at their site
- specialist clinical capacity will increase by 50%
- utilization of health care resources outside of the specialist's team will decrease by 25%

Though the collaborative is still in early days, the JCC Pre-forum will be a good venue to advertise this work and how specialists are changing the model of service delivery in the community setting.

N18 Pediatric inpatient asthma quality improvement project

Speakers: **Marie-Noelle Trottier-Boucher**, Island Health
Melissa Holland, Island Health

Asthma is the most common chronic pediatric condition and a leading cause of hospital visits. Studies have shown that the use of a pediatric asthma pathway is associated with decreased length of stay, costs and increased teaching.

The main objective of this project was to decrease to less than 48 hours the length of stay of children hospitalized for asthma exacerbation at Victoria General Hospital between May 2021 and 2022.

A multidisciplinary team, including pediatricians, resident, nurses, respiratologists, pharmacists, parents and administrators was created in January 2021. The interventions were the adaptation and implementation of a standardized discharge checklist (May 2021) and of an asthma pathway that included a nurse lead bronchodilator weaning algorithm (October 2021). Education regarding asthma, clinical scoring system and families' education was provided before and during the project.

The median inpatient length of stay decreased from 50 hours (35-68.5 hours) pre interventions to 37.5 hours (23.5 – 64 hours) post second intervention, which represent a 25% decrease. A positive trend was noted in the physician's prescription rate of the algorithm. Discharge checklists were found in at least 70% of the charts and had a median completion rate of 88%. Health care providers' comfort level providing asthma education

and using the algorithm increased during the project (4.2/5 to 4.8/5 and 3.8/5 to 4.3/5 respectively). Families' confidence regarding asthma management increased post-asthma teaching (average 3.8/10 increased). No significant increase in admission to the pediatric intensive care unit, use of high flow or consultation for asthma exacerbation within 10 days of discharge was noted.

Implementing a standardize asthma pathway resulted in a 25% decrease in median inpatient length of stay. Regularly reviewing and sharing the results of the project with the team and making sure new staff are aware of the project will result in continuous and sustainable improvement.

N19 Provincial osteoporosis physician collaborations: BC coalition of osteoporosis physicians

Speakers: **David Kendler**, Prohealth
Raheem Kherani, Richmond Hospital

The BC coalition of osteoporosis physicians (BCCOP) includes family medicine and specialist physicians from around the province. BCCOP is comprised of endocrinologists, rheumatologists, geriatricians, laboratory medicine physicians, orthopedic surgeons, internists, and family practitioners who are interested in the care of osteoporosis patients. There is also involvement of a pharmacist and a representative from Osteoporosis Canada.

There is a need for such a coalition to represent the needs of osteoporosis patients who are cared for from the practices of diverse specialists and generalists. As such, a forum for communication, sharing of ideas, development of educational materials, and progressing advocacy initiatives has proven very useful.

The BCCOP holds virtual meetings by teleconference approximately every two months. This forum provides opportunities for osteoporosis physicians to share ideas with colleagues to the benefit of osteoporosis patients. BCCOP has developed a website supported in part by osteoporosis Canada which helps to communicate the group's activities and educational materials. The website also has a registry of osteoporosis physicians helpful to primary care doctors seeking a referral specialist to help their patient. BCCOP has fostered activities through working groups including a physician informational sheet on osteoporosis needs during the COVID pandemic. Another working group has shared ideas regarding Fracture Liaison Services and fostered development of FLS programs benefiting postfracture patients in Fraser Health (White Rock, Chilliwack), Interior Health (Kelowna, Penticton), and Vancouver Coastal Health (Richmond). BCCOP has advocated to government directly and through MedAccessBC for expanded availability of pharmaceutical products required to manage osteoporosis. Through these activities, Pharmacare has initiated a review of the osteoporosis therapeutic area and related medications. A "bone and cancer" initiative involving oncologists is nearing completion with an informational piece helpful to oncologists managing patients with bone concerns in association with malignancy. Physicians participating in this group no longer feels isolated, but feel empowered to associate with other physicians managing osteoporosis patients in a collaborative group involving diverse specialties and associating with Osteoporosis Canada.

N20 Collaborating with FHA to Provide Childhood Immunizations During the COVID-19 Pandemic

Speaker: **Alan Huang**, Surrey-North Delta Division of Family Practice
David Luk, Family Physician

At the end of October 2020, the Surrey-North Delta Division of Family Practice was approached to assist with Public Health immunizations. Childhood immunizations needed coverage most critically due to their time sensitive nature and the risk of immunization-eradicated disease re-emergence.

Historically in many communities within the Fraser Heath Authority, Public Health has carried out most of these immunizations. During the second phase of the COVID-19 pandemic Public Health nurses were redirected to contact tracing work. This left over 4000 time-sensitive childhood appointments on waiting lists throughout Fraser Health communities.

Actions Taken

The Surrey-North Delta Division of Family Practice and community physicians worked in collaboration with FHA leadership and Public Health to enact strategies for reducing the childhood immunizations waitlists, including having community physicians immunizing in five different public health clinics within Surrey-North Delta.

The division's main roles included:

- Physician recruitment
- Setting up a system for scheduling
- Facilitating the scheduling for 5 different public health units
- Facilitating last minute changes and conflict resolution

Results

Between Nov 12, 2020 to Jan 22, 2021, we:

- Had 34 physicians assisting with the childhood immunization effort;
- Completed ~935 hours or over 3,200 clients;
- Reduced the waitlist within Surrey-North Delta by over 50% in approximately 2 months.

The project ended on Sept 31, 2021 (~10 months) with Public Health returning to their full capacity in key priority areas and physician support at Public Health units concluding. The waitlist was maintained at a significantly lower percentage than prior to the start of the effort.

Between November 2020 and September 31st 2021, 37 physicians supported the routine vaccination (CIC) and catch up vaccination (IC), with a total of more than 6,500 hours of clinics providing more than 17,500 shots.

O21 Coordinating Dementia Care: A Co-developed Model by Patients, Families and Care Providers

Speaker: **Margot Wilson**, Miranda Defer, Providence Health Care

Older adults with complex chronic conditions need to have their primary care provider, specialist physicians, family caregivers and health services involved in their care. This can make it difficult to communicate and coordinate dementia care. Many Canadian primary care physicians felt they were not well prepared to manage dementia care.

The gap in dementia care may stem from the lack of coordination between care providers leading to unmet care goals. In response, our team aims to improve communication processes to enable coordinated dementia care. The team involved people with dementia, family caregivers, specialists, family physicians, community organizations, and allied health working to improve coordination and communication for dementia care.

To help with care coordination, our team developed two documents, a Primary Care Communication Tool and a Patient-Held Dementia Companion Guide. The Primary Care Communication Tool aims to improve communication processes by breaking down appointments into manageable sessions, including social support components to emphasize the importance of community services. Additionally, the Patient Companion Guide complements the Physician Tool to enable guided and collaborative communication between patients, families, primary care providers and specialists.

Physician Tool and Companion Guide testing began in June 2021 with over 100 primary care providers and 20 specialists. As part of PDSA cycles, physician and patient surveys indicated whether the tool and guide improved communication processes and dementia care coordination. Results on the physician tool survey indicated that the tool helped provide better care for patients and helped outline care in appointment-size pieces. Responses from the companion guide survey indicated that it was a comprehensive and great resource for patients. Overall responses from the surveys indicated that communication between providers and people living with dementia was improved. This project is funded in partnership by Doctors of BC and the BC government through the Shared Care Committee.

O22 Employee Engagement in the Healthcare Setting: Building Team via a Grassroots Approach

Speakers: **Dino Govender**, Burnaby Division of Family Practice
Georgia Bekiou, Burnaby Division of Family Practice
Veronica De Jong, Burnaby Division of Family Practice

Divisions exist to support family physicians in delivering effective patient care. It is not only critical to support physicians' health and wellness, but also that of their support teams. Finding ways to foster healthy, supportive, and engaging work environments, especially in the ever-fluctuating hybrid of virtual and in-person work, is often a challenge for healthcare leaders.

At the Burnaby Division of Family Practice, the onset of COVID-19 pandemic, combined with a quickly growing, largely virtual team, catalyzed the need to explore ways to effectively support and engage staff - as a result, the Employee Engagement Committee (EEC) was formed.

The EEC is a grassroots initiative where non-management staff self-select onto the committee and is fully supported by senior management and an allotted budget. Aimed at building an interconnected team, the EEC facilitated staff learning about each other, as evidenced by regular check-ins and annual surveys. Since 2021, the EEC has been responsible for organizing virtual and in-person events and workshops both in-and-out of work time.

According to the last survey, the average satisfaction rating for EEC activities was 4.5/5 with higher ratings for in-person versus virtual, with no relationship to cost. The unique features of the EEC include existing as a robust entity, utilizing a grassroots structure supported by senior management, managing a budget, building a cohesive team, and solidifying a supportive culture.

The successful structure and functioning of the EEC enabled it to expand select event offerings from staff-only to those that include family physicians and health authority allied health staff. As such, the EEC built greater connections within and between these broader teams. As a result of the EEC's efforts, the organization has maintained a team with minimal turnover, and created a culture of interconnectedness in a time when we are seeing significant turnover in workplaces across industries.

O23 Developing an equity framework in the Thompson Region

Speaker: **Sue Lissel**, Thompson Region Division of Family Practice

As part of the Thompson Region's Collaborative Services Committee (CSC) Primary Care Network service planning, an equity framework was developed in 2022 to support consistency and transparency for decision making and resource allocation. The CSC utilized the BCPSQC definition of equity in health care stated as, "the just distribution

of services and benefits according to population need" considering "individuals different experiences, histories and needs."

A desire to have data be foundational to decision making lead to consultation of population and health equity experts along with an environmental scan of available community patient health data. Precise, current or complete data is difficult to acquire and inconsistent based on the complexities of patient coding, panel management and individual provider habits. Making use of the data available alongside provider experience and knowledge resulted in some high-level recommendations and a three step process.

Three recommendations

1. Simple is best, decide on minimal, meaningful criteria.
2. Cultural safety must be incorporated into process and decision making.
3. Decision making is not objective, provide documentation and methods.

Three steps

Each situation is unique and will require time and effort to determine criteria and valid information. In our presentation we will expand on the below three steps and provide examples.

Step 1: Construct a framework with a short list of criteria that illustrate need in a meaningful way.

Step 2: Engage a small group of stakeholders in discussion to unpack context and discuss criteria that do not fit easily into your framework.

Step 3: Set realistic expectations, goals, timelines. Improving equity takes time and requires consideration of the entire system. If not considered, new resources may perpetuate the inequities that currently exist.

O24 Timely Access at the Northern Haida Gwaii Hospital & Health Centre

Speaker: **Denise Cerqueira-Pages**, Doctors of BC

Timely access to patient appointments in a family practice is essential for the delivery of patient centered care. Masset Clinic has presented many challenges in this area for many years and the medical practice believes that there are many factors that impact access: panel size and complex care, physician time management, approach of care, patient commitment for their own care (no show appointments), and when new physicians start at the clinic with a panel, some appointments need to be longer. Practice B physician started working at the Masset Clinic in April 2022. This physicians panel of patients was new and to understand the patients' needs he/she had to change their appointments from 20 minutes to 30 minutes. This resulted in the next available appointment being almost 47 days for a patient to book a visit with this physician last fall.

Aim statement

Practice B Medical team would like to decrease the next available appointment time from 47 days to 15 days over a three-month time frame (October-December 2022).

Methodology

The physician and team worked with the Practice Support Program and utilized the facilitation cycle as a quality improvement approach. The physician and team identified the following action plan: increase the amount of appointments/day to increase patient access.

Results

The physician and team implemented the new schedule increasing the amount of appointments/day including in-person visits and virtual visits (phone calls). From September 26th, 2022, to October 31st, 2022 the wait time for patient access decreased from 47 days to 24 days and in December, 2022 decreased again to 16 days for in-person appointments and 9 days for virtual visits.

Conclusion

The physician and team introduced new appointment times on the schedule that resulted in a significant decrease in the next available appointment enhancing patient access over a three-month period. Moving forward there are opportunities to continue to explore ways to increase access and continue to sustain patient access to care at this clinic.

P25 The Kudos Project, East Kootenay Regional Hospital

Speakers: **Jill Bain**, EKRH Medical Staff Society
Lori Wik, EKRH Medical Staff Society
Stephanie Nolan, EKRH Medical Staff Society
Sophia Bianchi, EKRH Medical Staff Society
Laura Swaney, EKRH Medical Staff Society

Physicians struggle daily to improve patients' care but often don't put much emphasis on their own wellness which can lead to increased burnout.

At EKRH we wanted to hear what our physicians view as most important as it relates to wellness. A brief survey was conducted at a Medical Staff AGM which told us loud and clear: appreciation.

Initially we explored developing an appreciation 'app' but wrestled with questions such as anonymity and how to build interest in an app, especially when most of us are already bombarded with technology. Meanwhile, we had sent thank you cards to colleauges who had stepped down from our FEI working group and were surprised how much these meant to each of them (to quote one "when I received that unexpected card in my mail slot, it put an extra spring in my step"). This was an "ah ha" moment and sprung the Kudos project: a simple and old-school idea whereby physicians send paper notes of appreciation to each other.

The Kudos are printed on colorful pads of paper similar to prescription pads, with check boxes and a comment section where one colleague can appreciate another and tell them why. These slips are then placed in the receiving colleauges' mailbox; recipients can then redeem it at our hospital café for a free treat.

In 3 months, 108 kudos have been distributed. Feedback has been extremely positive, and we needed to print more as each department wanted notepads for their teams. The Kudos have also gone viral, being provided to other facility staff such as security personnel. We plan to conduct a post-survey in May at our next MSA meeting. This simple, cost-effective project is easily spreadable to other sites and we look to forward to sharing more about our results.

P26 Our Journey: Retaining IMG ROS Physicians in Surrey-North Delta

Speaker: **Megan Shymanski**, Surrey-North Delta Division of Family Practice

Since 2015, Surrey-North Delta has welcomed between 2 and 8 International Medical Graduate (IMG) Return of Service (ROS) physicians each year. While our population is growing, our older physicians are retiring and many of our younger physicians are not entering full-time longitudinal

family practice. IMG ROS physicians are therefore crucial to our community's ability to maintain patient care, and to relieve some of the burden that is being shouldered by our hardworking Family Physicians (most of whom have reported experiencing some level of burnout). To encourage long-term commitment to our community, we have evolved our ROS placement process to become more flexible and more attuned to IMG and host clinic input.

Mismatched expectations between IMGs and host clinics, cultural differences in the provision of care and IMGs feeling unheard and unsupported are all roadblocks that we have encountered on our journey.

Our Recruitment, Retention & Wellness committee, comprised of local physicians, has led the way in developing new approaches and evolving our process which now includes:

- an application process (in the last few years we have used a quantitative grading system as well as a qualitative one)
- additional questions in the application reflective of feedback received from our clinics and applicants
- an invitation to ROS Residents to tour and provide feedback on potential clinics, and on the process overall (this feedback is considered by the committee when selecting the clinics that will receive an ROS)

These strategies have been designed to offer our IMGs options in order to facilitate a best fit situation for both IMG and host clinic, and to increase the likelihood that IMGs will remain in Surrey-North Delta at the end of their return of service.

Implementing these solutions has strengthened our IMG ROS program and contributed to our community's 77% retention rate.

P27 A Data-Driven HA-MSA Collaboration: Tackling the Physician Wellness Crisis at the Organizational Level

Speakers: **Fahreen Dossa**, UBC/VGH
Andrew Pinfold, Vancouver Physician Staff

AssociationPhysician wellness is an established quality metric highlighted in the IHI Quintuple Aim. In order to address the current physician wellness crisis, the Vancouver Physician Staff Association (VPSA) and the Vancouver Coastal Health Authority (VCH) partnered to design a survey that assessed local levels of burnout alongside specific drivers. This interdepartmental survey was launched to 1949 physicians in Vancouver in October of 2020 and revealed an average burnout rate of 51.4% (range 10-80% depending on department/division). VPSA and VCH are now collaborating with department and division leaders to support data-driven wellness initiatives. Challenges exist in supporting our leaders and wellness champions in the roadmap of systemic and organizational change.

We were able to meet the challenge of securing funding and buy-in from senior leadership by showcasing survey results and developing a transparent funding application process to support the design, implementation, and evaluation of systemic wellness initiatives. We have also initiated interdepartmental physician peer support/ commensality groups which allow colleagues to come together in a safe, non judgemental environment.

This project has the potential to impact a large number of providers and thousands of patients in terms of safety, quality of experience, and care provided. It is unique as it offers metrics around burnout and its local drivers within a large Canadian medical institution. Moreover, it exemplifies a singular, collaborative, and fruitful partnership between a regional health authority and physicians and offers a distinctive model for improving physician health and both provider and patient experience in Canada.

P28 Medical Scribe in Primary Care Practice

Speakers: **Meg Cybak**, Doctors of BC
Willem Prinsloo, Dogwood Medical Clinic
Rachel Myerscough, Dogwood Medical Clinic

Charting is a burden and not being completed in an efficient way, which can take too much time outside of office hours, and cause the schedule to fall behind. Would like a new process that improves this burden in a way that benefits the experience for the physician and patients. Aim is to trial the implementation of a medical scribe into practice, who will be utilized 2 days per week for most of the patient encounters, over the next 6 months.

Key Factors of Success

- Physician will remain more on time throughout the day
- Physician can focus on patient versus needing to chart through the appointment
- Patients feel more connected to physician
- Lowered risk of missed tasks; requisitions, referrals, follow up recommendations

Measures

- # of scribe supported encounters (approximating time per encounter spent charting)
- # of patients declining scribes' presence (to gauge comfort and acceptance level from patients)

Outcome

After one month of using the medical scribe in practice it is felt that there has been a huge benefit to the physician. Most patients have been very receptive to the scribe's presence. There is a mutual understanding between the physician and the scribe with regards to visits that the scribe should not be present for (without having to ask patient), for example, physical examinations, mental health counselling sessions, or more confidential matters. The overall benefit of using a scribe in practice is felt to outweigh the cost. It is felt that the success of this project is also related to the existing trusted relationship between patients, MOA, and physician.

Implementation Plan

Internal processes will be documented via; confidentiality forms signed by medical scribe, patient EMR documentation notated with authors name and sign off by physician, and a documented job description, and manual for office processes.

P29 The 4 Cs of Emergency Medicine & Family Practice

Speakers: **April Bonise**, Surrey-North Delta Division of Family Practice
Tomas Reyes, Surrey-North Delta Division of Family Practice

In November 2022, the SND Division hosted an engagement event between Family Physicians (FPs), ER physicians from Surrey Memorial Hospital (SMH) and SMH hospitalists.

This event came about as an identified action item in the very early stages of our Admission and Discharge Communication Shared Care project. It was originally envisioned as a small group setting to foster early relationship building, with an attendance goal of 50 attendees. The event focused on the 4 Cs: Connection, Communications, Care and Collegiality and included focused presentations and guided facilitation breakout rooms for small-group discussion.

However, due to an unanticipated ER surge in the community in the weeks leading up to the scheduled event, coupled with a significant FP shortage, local FPs and ER physicians were straining to meet patient demands.

This strain was leading to a heightened sense of tension and stress between the separate provider groups.

The ER crisis led to 111 physicians registering for the event and the project team deciding to adjust their original agenda format to instead focus on providing opportunities for attendees to share their experiences and frustrations and then to brainstorm possible solutions together.

Event goals included:

- Improving communication and collegiality between acute care physicians and community doctors.
- A solutions-oriented and positive atmosphere
- Emphasizing engagement with different peer groups
- Providing opportunities for attendees to brainstorm: "How do we take ownership and responsibility for our sphere of influence?"

Results

The feedback from participants was overwhelmingly positive. While discussions were passionate, evaluation survey results indicated that the majority of participants felt that discussions were balanced and solutions-focused. Following the event, 92% of participants felt more connected to their colleagues and 100% said they place a high value on discussions such as these. The Division is now working on implementing a number of the ideas proposed during the session.

V30 Virtual Psychiatry Consultations (VPC)

Speakers: **Claire Doherty**, Providence Health Care (PHC)
Karl Torbicki, Providence Health Care (PHC)

In Vancouver City Centre, 11% of residents have a mood or anxiety disorder. Family physicians (FPs) are key partners in patients' mental health journeys. This partnership is most effective when a psychiatrist can assist with clarifying diagnoses or adjusting medications. Unfortunately, access to outpatient psychiatry is limited. In response, our team developed the Virtual Psychiatry Consultations (VPC) program, based on input from patients, FPs, psychiatrists, nurses, clerks and others.

Participating psychiatrists see 1-2 VPC patients per week and continue their pre-existing work. Participating FPs can refer patients to VPC if they are aged 19-64, likely to benefit from short-term psychiatric care, and not already working with a psychiatrist or mental health team. A nurse case coordinator reviews all referrals and completes an intake assessment with eligible patients. Next, a psychiatrist meets with the patient virtually 1-3 times. After completing a debrief call with the psychiatrist and receiving consult notes, the FP continues to care for the patient.

VPC launched in October 2020. As of December 2022, VPC involves 4 psychiatrists, 1 case coordinator, 1 clerk, 14 referring providers and 1 clinical nurse specialist. VPC has enabled >200 psychiatry visits for >100 patients who might otherwise not have had access to specialized mental health care. Survey results show >90% of discharged patients agreed that their VPC psychiatrist understood and addressed their concerns and questions. The majority of patients responded they would not have been able to see a psychiatrist for their current concerns without VPC, and the majority agreed they had a good understanding of their medications and care plan.

VPC is primarily funded by Shared Care, a partnership of Doctors of BC and the BC government. We also received in-kind support from the BCPSQC in the form an intern, who played a key role in engaging stakeholders and co-designing VPC.

V31 Rapid Deployment of a Video-Enabled Virtual Health Tool to Support Pediatric Critical Care in BC during the 2022 Pediatric Respiratory Surge

Speakers: **Jonathan Wong**, Office of Virtual Health - PHSA
Adela Matettore, BC Children's Hospital

In British Columbia, pediatric tertiary care is centralized. The increased demand for pediatric consultative, transport, and inpatient services, as a result of the 2022 respiratory illness surge, required fast and innovative solutions to support patient assessment, community providers, and appropriate transfer decisions across a large geographical region. To meet this need, a virtual health solution, GoodSAM Instant.Help, that allowed an instant video connection, was deployed and evaluated.

Objective

The overall objective of the pilot project was to improve clinical decision making and peer-to-peer support services with timely and appropriate video conferencing consultations for pediatric critical care and inter-facility transfer during the respiratory surge.

Methods and Evaluation

The GoodSam web-based application was rapidly implemented over a 3-week period in winter 2022, in partnership with the Pediatric Critical Care Team at BC Children's Hospital, Child Health BC, BC Emergency Health Services/Patient Transfer Network, and the Office of Virtual Health at Provincial Health Services Authority.

The evaluation of this project was conducted using multiple data sources and a mixed-methods design, including both qualitative and quantitative data. Qualitative data was collected using a variety of surveys and interviews of care providers and patients/families, while quantitative data was collected from different clinical systems and metrics available from PTN, PICU, and the GoodSAM solution. Key areas for evaluation included: Adoption and Utilization, Patient/Family and Provider Satisfaction, Efficiency and Effectiveness, and Technical Performance and Data Security. Evaluation is ongoing and further data will be presented at the JCC Forum.

Conclusion

A real-time video enabled virtual health solution was rapidly implemented to improve provider-to provider clinical support and decision-making during a period of overwhelming demand for pediatric critical care. This type of solution is being considered to provide sustainable paediatric outreach services across BC and to support additional clinical areas including neonatology, maternity, and adult critical care.

2023 JCC Pre-Forum
Storyboard Reception & Voting

Display Time

Storyboards will be on display in the Regency Foyer throughout the day.

Storyboard Reception

Join us for the Storyboard Reception from 3:30 - 4:30pm immediately following the final session. Attendees will have the opportunity to interact with the JCC Co-Chairs and storyboard presenters about their work. Hors d'oeuvres will be served and there will be a cash bar.

People's Choice Award

Participants will have the opportunity to cast a vote for their favourite storyboard throughout the day using this QR code. One vote per participant and the winner will be revealed before the end of the Storyboard Reception.

JCC Co-Chair Choice Award

The JCC Co-Chairs acting as Emcees will be voting on their favourite storyboard which will be awarded at the same time as the People's Choice Award.

Notes

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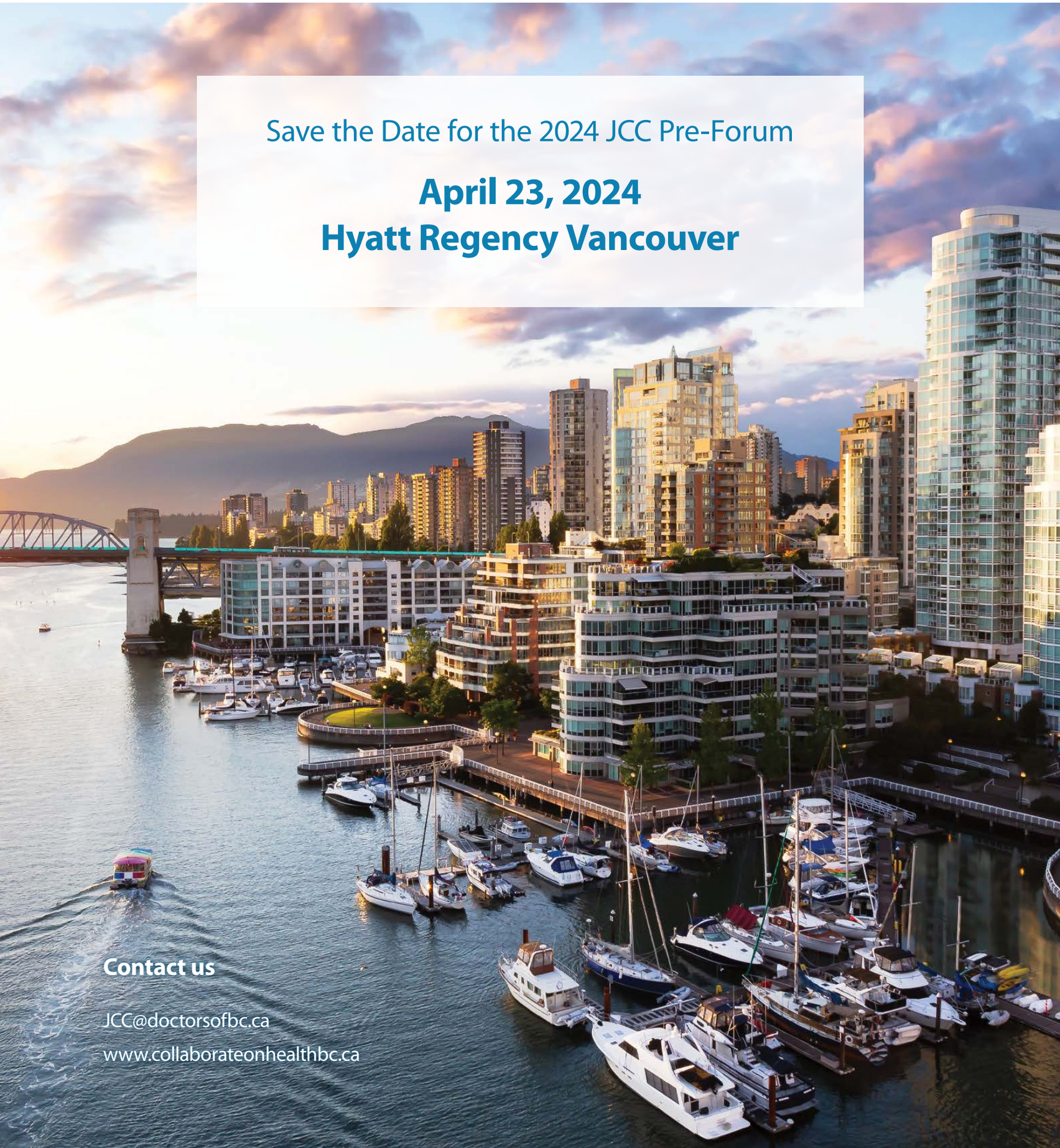
JCC Joint Collaborative Committees

BRITISH COLUMBIA doctors of bc HQBC HEALTH QUALITY BC



Save the Date for the 2024 JCC Pre-Forum

April 23, 2024
Hyatt Regency Vancouver

Contact us

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