Shuswap North Okanagan
Division of Family Practice
A GPSC initiative

2014 Annual Report

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Message from the Physician Lead

First I offer my heartfelt thanks to Tracey and Peggy. They are truly the engines of this organization. With considerable adroitness and joy, Tracey manages all manner of business for our Division. Peggy supports Tracey and the SNO board with skill and competency. You are most fortunate to have these two dedicated women working on your behalf.

I also offer my gratitude to our Board for their energy, insight and patience. In particular, I would like to acknowledge the wisdom and steadfastness of Ken Perrier and Rick Sherwin. I have appreciated their guidance and advice as I learn the mysteries of collaboration with Interior Health and the importance of Division work.

Many of you will be aware of and some of you will have read the Policy Framework for Primary and Community Care in BC, and the attendant papers on Rural Health Services and Future Directions for Surgical Care in BC. These are dense documents that hold the Ministry of Health's vision for the future of Health Care in BC. These papers must be understood in the context of our Physician Master Agreement that provides a safe and stable relationship with the MOH until 2019. This combination of a stable work agreement and a new vision for Health Care portends that change is coming.

There will be much head scratching and anxious moments as we reconcile this new vision with our day-to-day work. Divisions are positioned to do much of the work in informing and engaging Physicians as we transition to new (and old) ways of working.

The Annual Report will inform you of the impressive amount of work your Division has completed this year. You deserve a "pat on the back" for doing the work you do to guide our citizens towards good health.

We serve in a Province that has provided all of us with a rich and fulfilling life. How privileged we are!

Message from the Executive Director

Over the past few months I have been called upon to help find family physicians for people who are new to our area.

These people are often elderly, have complex health issues; and they are scared. The desperation and urgency in their voices is palpable as they make their pleas, urging me to find them a doctor.

Today I was fortunate enough to hear the relief and gratitude in the voices of an elderly couple when I told them that a physician was willing to accept them as new patients. They could not contain their appreciation and said that they can now "finally stop worrying", as their "prayers have been answered". What a powerful message that speaks to the important role a family physician plays in the lives of patients.

I often tell people that I have the best job in the world and this incident illustrates it so beautifully. I am honored to be working with an amazing group of dedicated professionals who are willing to go above and beyond for their patients, whether they are existing ones or new ones!

Over the past year the Division has continued to support its members in their practices by providing CME opportunities; medical tools such as Up To Date and RxFiles; communication through the Flyer Spyer; billing and MOA support as well as opportunities to engage, build and improve relationships with our specialist colleagues.

In an attempt to connect with more physicians, I embarked on a road trip in the fall and visited our physicians in their clinics. This was a wonderful opportunity for me to gather information and to hear the physician's voice. Based on the positive response, this will become an annual event and I look forward to seeing you in the Fall.

In the community the Division has been very active and has supported local initiatives such as Integrated Primary Community Care (IPCC), Child and Youth Mental Health, Adult Mental Health and Palliative Care.

Inpatient care is supported through the administration of the assigned and unassigned networks. It was a sad but inevitable day for me when the Vernon unassigned network, or DOD program was terminated. This group of physicians is very near and dear to my heart and they fought tirelessly to maintain a critical service to their hospital and community. I would like to thank all the Vernon DOD docs for never giving up and for always being there for me when I needed to fill that last shift!

As we close this chapter on the past year, I look forward to embracing the challenges and opportunities that lie ahead.

"Sometimes in the winds of change, we find our true direction."

We have a sound board and a formidable new Physician Lead, Melany Dyer, to lead us to increased physician satisfaction, improved patient care and community health

The Year in Review

April 2014
- MOA Breakfasts in Vernon with MCFD
- Rx Files renewed for Division members

May 2014
- Residential Care Polypharmacy Education sessions (Vernon and Salmon Arm)
- Therapeutics Collaborative CME
- Walk with your doc (Salmon Arm)
- 4th AGM held in Armstrong
- New Board members: Dr. M. Dyer and Dr. K. Goldberg

June 2014
- Teddy Bear Hospice Function Salmon Arm
- Business consultant hired to develop business plan for the Integrated Palliative and Acute Campus of Care model

July 2014
- MOA Breakfast Vernon

August 2014
- MOA Breakfast Salmon Arm
- MOA Flyer Spyer launched

September 2014
- Physician office visits

October 2014
- Dr. D. Smith accepted position as Board Treasurer

November 2014
- BC College of Family Physicians Fall Roadshow CME
- Meeting with Salmon Arm specialists and family physicians
- Business model for Rural Palliative Care Centre of Excellence finalized
- Initial discussion with Armstrong pharmacists and physicians to explore collaborative opportunities

December 2014
- Submission to the Select Standing Committee: Rural Palliative Care Centre of Excellence
- Collect and distribute specialist wait times with Salmon Arm physicians

January 2015

- Dr. M. Dyer accepts position as Physician Lead
- Follow up meeting with Armstrong Pharmacists
- Discussion with Vernon maternity physicians and IHA re: lease agreement for Vernon Primary Care Clinic

February 2015

- MOA Breakfasts in Vernon and Salmon Arm
- Residential care meetings Vernon and Salmon Arm
- 1st SNO Silver Star CME

March 2015

- Salmon Arm Community Meeting: Advanced Care Directives (Hospice and IHA)
- Telus EMR Utilization and Training proposal accepted
- Discussion with Salmon Arm community stakeholders and IHA: IHA End of Life Strategic Plan
- Financial support for existing SNO initiatives
- Vernon Jubilee Hospital DOD program terminated (Effective Date: 15 May 2015)

2014 Office Visits: What did we learn?

CLINICS VISITED

Salmon Arm:	5 out of the 6 clinics (23 physicians participated)
Enderby:	Enderby Health Unit (2 physicians + 1 NP)
Armstrong:	Haugen Medical Clinic (4 physicians + Physician Lead)
Sicamous:	Sicamous Medical Clinic (2 physicians)
Vernon:	9 clinics visited (26 physicians)
Total:	58 physicians

POSITIVES

- CME's
- Informed via Flyer Spyer
- MOA support and breakfasts
- Uptodate and Rx Files
- GPSC incentives for inpatient care
- Mentorship
- Improved relationships with Internal Medicine (Vernon)
- Communicating wait times for Internal Medicine (Vernon)

WHERE CAN WE PROVIDE SUPPORT?

EMR training / support

Expand wait times to include all specialties (use web page)

Annual ACLS / ATLS dates

3 / 4 big CME events as opposed to smaller events

Lab resources in Salmon Arm

Ambulatory Care in Salmon Arm

Printers at Salmon Arm hospital

1 page information sheet to give to patients re: promotion and prevention, resources

Opportunities for professional / collegial interaction

Palliative Care in the Shuswap North Okanagan Region

Executive Summary

Over the past three decades, palliative care in Canada has progressed from the periphery of medicine to a place where it is gaining recognition as an integral component of comprehensive lifelong health care. This progression, in part, is due to an increased awareness of the value and significance of a good death, for patients, families and health care providers alike. There has been a shift away from the perception that palliative care is synonymous with 'giving up'. This shift has coincided with the acknowledgement that death is an experience common to all people, and that all people deserve to live meaningfully and with dignity, regardless of how close to death they might be.

Palliative care, in its most elementary form, provides palliation for the physical symptoms of dying. However it has become increasingly obvious that palliation of physical symptoms alone does not meet the needs of the dying. Instead, palliative care has progressed to become the aggregate care provided to patients and their loved ones that recognizes the spiritual, psychosocial, physical and financial burdens associated with death.

High-quality palliative care necessitates proper training for health care professionals, so that the unique needs of patients and families are met and symptoms are effectively managed.

Furthermore, it acknowledges psychosocial and spiritual suffering, and ensures that resources and consistency are provided to alleviate this suffering. It includes resources that allow for a multidisciplinary team of care providers, round-the-clock care should it be necessary, and a location for death that is most suitable for the patient. It also allows for initiation of palliative care early in the treatment of a life-limiting illness, leading to more informed end-of-life decisions, better peace of mind, and in some cases, a better prognosis.

In addition to enhancing the patient and caregiver's quality of life, recent evidence has also suggested that providing palliative care may be cost-effective. When compared to similar patients who do not receive hospice care, patients receiving hospice care are less likely to be hospitalized, spend

time in intensive care or receive invasive procedures at the end of life.

Furthermore, it is important to consider the financial burden incurred by caregivers, and how a palliative program might alleviate that strain. A high-quality palliative care program will mitigate the financial impact on caregivers, reducing the need for them to be absent from their paid work to provide care, as well as reducing the emotional burden of grieving so they are able to return to their usual activities more quickly following the death of their loved one.

There are challenges that make palliative care provision inherently difficult in rural areas, namely the lack of resources available for smaller populations and large distances between patients and hospitals and between hospitals and larger urban centres with adequate palliative resources. In order to combat these problems and provide sustainable palliative care outside of Canada's major cities, an innovative and forward-thinking model of care delivery is required.

There are a number of jurisdictions that have addressed this challenge, and designed models of palliative care that can provide quality care to regions with small populations. In particular, Australia has been at the forefront of reinventing palliative care, largely due to the needs of their considerable rural population and the cultural and linguistic diversity that exists within their indigenous populations. Their model of palliative care takes a population-based approach that acknowledges the individual needs within a population, as opposed to the diagnoses or prognoses. The primary care provider has a central role in providing palliative care to their patient; however, formal links with specialized teams provide care, education and consultation as it is needed. This model also acknowledges that the degree to which palliative services are required will vary substantially among patients regardless of prognoses, and within a single patient at any given time.

British Columbia has recently demonstrated a commitment to improve quality palliative care Provision across the province. The Provincial End-of-Life Care Action Plan for British Columbia uses the Australian model as a foundation for this growth, and prioritizes timely delivery, education and resources to those who need it, and strengthening of accountability and efficiency.

Business Model for Rural Palliative Care Centre of Excellence

The Interior Health Authority has embraced the provincial momentum for improving population-focused palliative care. Interior Health is considering the implementation of an Integrated Palliative Campus of Care (IPCC) model for end-of-life care in select communities, in order to increase the capacity for quality palliative care outside of the region's four existing hospices. The proposed rural Salmon Arm IPCC would act as a springboard for the selection and development of two additional remote and urban settings for a trial of expansion and evaluation. Currently, Salmon Arm has no designated palliative beds and end-of-life care is generally provided in the community's long-term care facility at Shuswap Lake General Hospital, or through home health services to support death at home.

The end-of-life services provided through these three avenues are not particularly well integrated.

We estimate that 373 deaths occur annually under the care of a Salmon Arm physician. Using the methods developed by Palliative Care Australia, we estimate that each year, 151 dying patients would require palliative care assessment, 108 would require ongoing consultation and 32 would require direct care. By piloting the IPCC model in Salmon Arm, the intention would be to provide this care and promote integration between acute, home health, residential and physician services through the co-location of services. It is intended that the end result of this pilot project will be the establishment of a comprehensive end-of-life centre with trained staff and resources that address the widespread palliative needs of the community.

In this business plan, we have proposed that the redesign of end-of-life services in the Salmon Arm LHA take place in the following three phases:

Phase I - Reallocate two beds at Shuswap Lake General Hospital to be designated end-of-life care beds and enhance the availability of community-based services

Phase II - Redevelop, re-purpose or replace the McGuire building located on the Shuswap Lake General Hospital, including three community residential palliative care beds

Phase III – Move into the McGuire Lake Centre

Business Model for Rural Palliative Care Centre of Excellence

For planning purposes, we have assumed that Phase I and II will each take 1.5 years.

A high-level estimate of capital resources indicates the need for $3.45 million in capital resources. These resources would largely be required in the first years of the redesign process (see following table).

During Phase I and II, approximately $125,000 in new staffing resources would be required annually to enhance community-based resources and to support the broader provision of end-of-life care. When the McGuire Lake Centre is available for occupancy (Phase III), including access to three community palliative beds, staffing and other ongoing costs will increase to approximately $575,000 per year.

Over a five-year period, total new costs for the redesign of end-of-life services in the Salmon Arm Local Health Area (LHA), including both capital and operating costs, are estimated at $5.0 million. Of this total, $3.45 million would be for capital costs and $1.57 million for operating costs.

An Integrated Palliative Campus of Care Model
For End-of-Life Care in Rural BC
Estimated Net New Resources

	Phase I		Phase II		Phase III		
	Year 1	Year 2a	Year 2b	Year 3	Year 4	Year 5	Total
Capital	***$150,000***		***$3,300,000***		***$0***		***$3,450,000***
Staffing							
Palliative Care Co-ordinator	$123,649	$63,679	$63,679	$131,180	$135,115	$139,169	$656,472
Administrator			Current Resources				$0
Social Worker			Current Resources				$0
Pharmacist			Current Resources				$0
Sub-Total	**$123,649**	**$63,679**	**$63,679**	**$131,180**	**$135,115**	**$139,169**	**$656,472**
Staffing for 3-Bed Unit							
Registered Nurse					$135,115	$139,169	$274,284
Licensed Practical Nurse					$147,036	$151,447	$298,484
Nursing Assistant					$107,037	$110,248	$217,286
Shift and Weekend Premiums					$11,799	$11,799	$23,598
Sub-Total					**$400,988**	**$412,663**	**$813,651**
Supplies	**$12,000**	**$6,000**	**$6,000**	**$12,000**	**$20,000**	**$20,000**	**$76,000**
Ancillary Costs					**$39,420**	**$39,420**	**$78,840**
Revenue					**-$27,944**	**-$27,944**	**-$55,888**
Estimated Net New Resources	**$285,649**		**$3,439,359**		**$567,579**	**$583,308**	**$5,019,074**

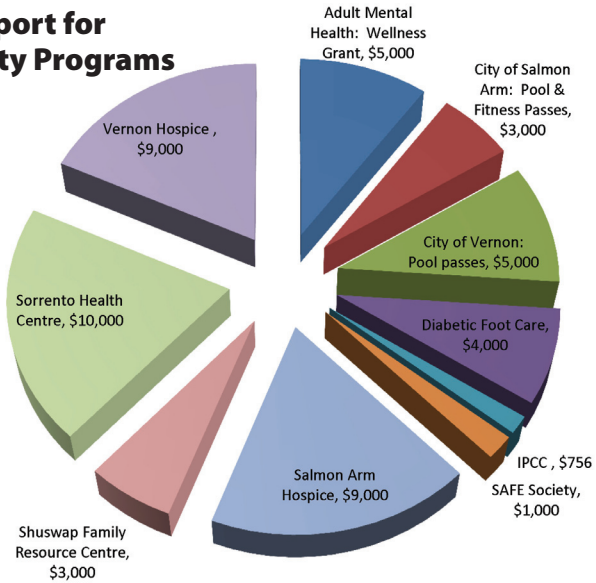
It is intended that the IPCC pilot site also be comprehensively evaluated to facilitate its potential role in future palliative programs across the region. We suggest that this evaluation be undertaken within the context of the Institute for Healthcare Improvement's Triple Aim Framework. As such, we have presented a variety of outcomes that may be used to measure various aspects of the Triple Aim Framework.

The primary goal of the redesign of end-of-life services in the Salmon Arm LHA is to enhance the patient and caregiver's quality of life. There are, however, a number of other benefits that could result from the implementation of this pilot project. These include the opportunity to research and advance knowledge in rural palliative care, the establishment of a centre for rural palliative care education, access to a more coordinated and trained volunteer Workforce and improved support for the generalist family doctor.

Support for our patients and community programs linked to Division Initiatives

Community Program / Partner	Division Initiative	Approx. Number of Patients Benefiting	Financial Support
North Okanagan Hospice Society	Palliative Care	Cost / Resident: $523 / Day = 17 hospice days paid for	$9000
Shuswap Hospice Society	Palliative Care	324 Volunteer Hours	$9000
Sorrento & Area Community Health Centre	Access to Primary Care	Operating Cost $50K / Year = 2.4 months covered 1000 patient files at Centre	$10,000
City of Salmon Arm Pool & Fitness Passes	Integrated Primary Community Care	130 for pool passes 100 for fitness passes	$3000
SAFE Society	Child Youth & Mental Health	10 Families	$1000
Canadian Mental Health	Adult Mental Health	50	$5000
Shuswap Family Resource Centre	Child Youth & Mental Health	36 Families	$3000
Diabetic Foot Care	Integrated Primary Community Care	80	$4000
City of Vernon Pool Passes	Integrated Primary Community Care	434	$5000
Blood Pressure Monitor (6)	Integrated Primary Community Care	N/A	$755.94

2014 Support for Community Programs



Financial Report

This financial statement is based on an unaudited statement for the period of April 1, 2014 to March 31, 2015.

ASSETS

CURRENT ASSETS

TD Canada Trust - 0928	$	65,408.07
Bank Adjustment - As per auditer	$	-7,656.58
Telpay Clearing Account	$	-9,669.97
Accounts Receivable	$	0.00
Overpaid DOD - As per Auditor	$	22,929.52
Prepaid Expenses	$	0.00
TOTAL CURRENT ASSETS	**$**	**71,011.04**

CAPITAL ASSETS

Office Furniture & Equipment	$	8322.08
Accum. Amort - Furniture & Equipment	$	-2644.07
Computer Hardware & Software	$	816.96
Accu. Amort. Computer Equipment & Software	$	0.00
TOTAL CAPITAL ASSETS	**$**	**6494.97**
TOTAL ASSETS	**$**	**77,506.01**

LIABILITY

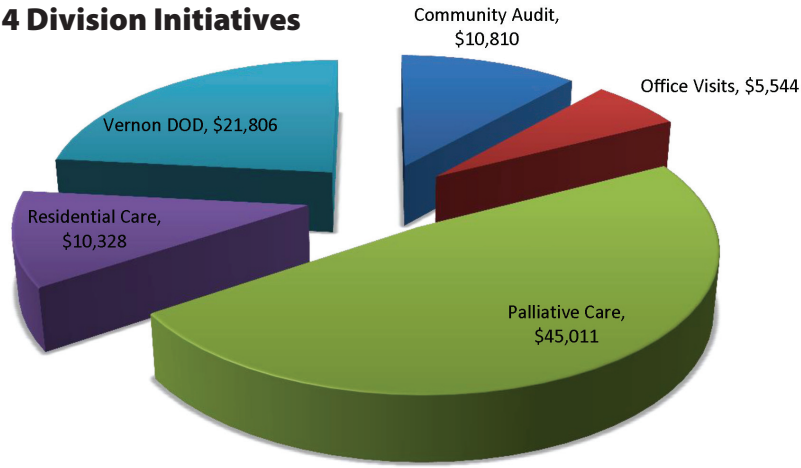
CURRENT LIABILITIES

Accounts Payable	$	20,478.91
Accounts Payable Adjustment-Auditor	$	-18,033.07
Accrued Liabilities -As Per Auditor	$	30,100.96
Accrued DOD - As Per Auditor	$	34,100.00
Deferred Revenue - Infrastructure	$	-70,446.39
Deferred Revenue - Shared Care	$	17,167.39
GST / HST Collected	$	0.00
GST / HST Paid	$	-2657.39
PST Payable	$	0.00
CPP Liability	$	0.00
EI Liability	$	0.00
Tax Liability	$	0.00
Net: Deductions	$	0.00
Vacation Accrued	$	690.93
WCB Payable	$	3.20
TOTAL CURRENT LIABILITIES	**$**	**11,404.54**
TOTAL LIABILITIES	**$**	**11,404.54**

EQUITY		
Retained Earnings	$	145,544.66
Current Earnings	$	-79,443.19
TOTAL EQUITY	**$**	**66,101.47**
LIABILITIES & EQUITY	**$**	**77,506.01**

Expenditure – April 1, 2014 – March 31, 2015		
Board Meetings	$	31,323.54
CSC Meetings	$	5973.09
Physician Lead	$	22,530.00
SNO Events / Sessionals	$	24,076.38
CME	$	26,850.81
Division Initiatives	$	93,498.69*
Support for Community Programs / Division Initiatives	$	49,755.94
Salaries: Support Staff	$	80,957.25
Bookkeeper	$	4081.83
Office Supplies & Printing	$	4155.12
Physician Data Collaborative	$	13,125.00
TOTAL EXPENSES	**$**	**356,327.65**

***2014 Division Initiatives**



SNO Board of Directors

Melany Dyer ~ *Physician Lead*
Don Smith ~ *Treasurer*
Rick Sherwin
Juliann Aitchison
Tanja Redelinghuys
Kevin Goldberg

Staff

Tracey Kirkman ~ *Executive Director*
Peggy Crough ~ *Administrative Assistant*

Shuswap North Okanagan Division of Family Practice

Tel: 250.833.6826
www.divisionsbc.ca

Photographs of the SNO area courtesy of: PictureBC.ca

Cover:	Enderby Cliffs
Page 2:	Salmon Arm Wharf
Page 7:	Salmon Arm & Salmon Arm Bay
Page 15:	Shuswap Lake
Page 17	Lumby