Shuswap North Okanagan
Division of Family Practice
A GPSC initiative

2015 Annual Report

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"May you have the wisdom to read time clearly and know when the seed of change will flourish."

I often look to John O'Donahue's writings when day to day happenings seem at odds with the world I long to inhabit! Many of you will have other ways that calm your soul, ease your worried mind, reignite your passion for the healing work that is your life. After meetings/teleconferences, it is the patient encounter that lifts and sustains me. I hope that tending to your patients is a happy place for you too.

This past year fulfilled all the clichés; 'went by in a flash', 'is all a blur', seems like it was just yesterday...! Tracey and Peggy continue to work diligently, with professionalism and grace. Physician Leads, Board Chairs, Board Members come and go. Tracey and Peggy remain, holding all of the work, all of the successes and all of the frustrations that is the work of SNO. This is the time and place to thank Tracey and Peggy for their 'quiet miracles that seek no attention'.

Last year I spoke of upcoming changes in Health Care. This week the MOH and the GPSC unveiled their new model of Health Care called the Patient Medical Home/Primary Care Home. We are waiting delivery of the operating manual!

The attributes of a Patient's Medical Home should look familiar to all of you. This is simply good old fashioned Family Practice in 2016. And I use the words old fashioned with intent. But, let us take a look at this "new model" of care.

1. Patient focused care/empowering patients to achieve good health is the Holy Grail of Family Practice in Canada. Tick

2. Most of you in Family Practice have a defined panel of patients to whom you are responsible. Tick
3. Longitudinal, generalist care is another foundational piece of the 'new' model. That is what Family Physicians do everyday, year after year. Tick.
4. You have always played the role of coordinator of services for your patients. That is what Family Docs do. Tick
5. There is an abundance of support to help those Physicians who have difficulty providing same day access for patients. Please ask if you need help. Often there is a simple solution that reaps huge rewards for patients and Physicians. Perhaps one of the more challenging demands on Family Practice is 24/7 coverage. You all have arrangements that work for your patients and your community. Health Authorities want to reduce after hours visits to the ER. Improving 24/7 coverage by Family Physicians in the community is upheld as one solution. We all know the complexities of providing safe, after hours coverage. We also know that the services we need for our patients after hours and on weekends are only available through the ER. Simple yet oh so complex! To Tick or not to tick??
6. Evidence tells us that team based care does lead to improved health outcomes. If you have had the opportunity to work in a team that co-habits, you know that the experience for both provider and patient is richer, more robust. You work in teams everyday with allied care providers, colleagues and staff. Tick
7. Educating students is a time honoured privilege. Many of you have done this for years. Tick
8. How each of your practices operates, how your business model supports team based care etc. is, I think, a private matter.
9. Engaging in continuous QI, at a practice, community and systems level is a lovely idea but I am not sure how much time, skill and energy most Family Physicians will have for this attribute! However, Data

Collaboratives, Family Practice Research, and the high level use of EMR are all evolving with the help of our Physician Champions in these areas. Tick

10. Use of an EMR. Tick. Having IT connectivity is a laudable goal. Good luck with that one!
11. Cross coverage, GP referrals to colleagues with special interest competencies are all operational! Tick
12. Integrating your practices with an IHA Primary Care Home is perhaps futuristic.

Your practices will already fulfill some or most of the attributes of a Patient Medical Home. Integrating with a Primary Care Home remains elusive until we see IH plans for this entity.

In an ideal world we would have robust connectivity with our Health Authority on all levels. Meanwhile, I am confident that you will arise tomorrow morning and set out to be solid Family Physicians providing, accessible, comprehensive, patient-focused care. Your SNO staff and Board will continue to advocate for you, provide those valuable services you love and, God willing, understand how we might come to partner with IHA in a meaningful way.

Thank you for allowing me to act as your Physician Lead.

As I reflect on what stood out for me over the past year, a few things come to mind:

- **The autonomy given to Divisions to design local solutions for the Residential Care Initiative, along with the willingness of physicians to step forward to help guide this process.**
  The orphaned cousin of the health care system, residential care, finally received additional funding from the Ministry to support family physicians providing residential care. This funding comes with 5 best practice expectations, evaluation and the desired outcome of improved patient care. Local physicians were involved in developing the Memorandum of Understanding which was accepted by the GPSC in the Fall 2015.

- **Our AGM where Dr. Brian Goldman delivered a powerful message which reinforced that family medicine is an integral component of our health system with the relationship between patient and family physician being the foundational piece.**
  Our work as the Division is to support this relationship through CME events, EMR support and physician wellness. The Division echoes and champions the physician's voice at Health Authority and Ministry level interactions to ensure that the integrity of family practice is strengthened as we move towards the building of patient medical homes / primary care homes.

- **Our collaboration with Telus and Osler to provide enhanced EMR support to our physicians.**
  EMR training and support has been a consistent ask from our membership. During the year Telus and Osler provided data driven training, focusing on the management of diabetic patients. Physicians and MOA staff valued this training and onsite visits. A detailed report can be found on pages 10 -16.
  This exercise was our first attempt to harness the potential within EMRs. Our hope is that future EMR training strategies will link EMR data to help identify training needs as well as family practice driven research within our local communities. The Board is very excited about this

opportunity and Dr. B. Poulin will take a leadership role in this initiative.

- **Progress with the Salmon Arm Palliative Care project.**
  The Salmon Arm Palliative Care project has been around for almost as long as the Division and has endured similar ups and downs. Dr. Joan Bratty deserves special mention for her dedication and commitment to this project.
  In January 2016 the working group hit an impasse with Interior Health. It was feared that this project would become yet another victim of the system. However, after the Board sent a letter advocating for our physicians, our patients and our community to the Ministry of Health and Interior Health CEO, Chris Mazurkewich, the project is back on track with new faces at the table and real, tangible results. See the detailed report on page 17.

- **The development and strength of the Board under the leadership of Dr. Melany Dyer.**
  Our organization has come a long way since its inception in 2010 when we faced this world of "Divisions" with a sense of excitement, apprehension and little trust in the process, our funding partners and Health Authority.
  In this ever-changing, ever-challenging world of politics and social challenges I believe our organization and Board are well positioned to continue our work of improving physician satisfaction and patient care. Without physician leadership, our organization would cease to exist. I want to take this time to thank our Physician Lead, Dr. Melany Dyer, and our Board for their continued commitment, input, energy and effort. I am truly humbled and blessed to be on this journey alongside you.

Every year I get to tell people that I have the best job in the world. The reason for this is that despite the challenges of the larger health care system, I have the privilege of working with dedicated, caring physicians who work tirelessly to improve the health of their patients and communities. I am truly grateful to be associated with the physicians of the Shuswap North Okanagan.

My final thank you is to my amazing left hand, right hand, and sometimes even my brain – Peggy. Thank you for keeping everything together so efficiently and with a sense of humour. You may be behind the scenes but you are never ever behind! Thank you!

April 2015
- Telus EMR Training Salmon Arm and Vernon: Data Driven Management of Diabetes – Session 1
- Residential Care Working Group meeting (Vernon)
- MOA meeting (Vernon)
- Provincial Round Table

May 2015
- EMR Training Salmon Arm and Vernon – Session 2
- Residential Care Working Group meetings (Vernon and Salmon Arm)

June 2015
- "It's More than Just a Bruise" presentation: Dr. Chapple (Salmon Arm)
- 5th AGM - New Board members: Dr. Richard Harper and Dr. Brett Poulin
- GPSC Residential Care Memorandum of Understanding submitted
- Vernon and Salmon Arm MOA Breakfast
- Access to SGP locum website for Division members
- ISC Meeting

July 2015
- Residential Care Working Group meeting (Vernon)
- GPSC Visioning Teleconference

August 2015
- MOA Breakfast Salmon Arm
- SNO Board Teambuilding session

September 2015
- Evening with General Surgery (Vernon)
- Shuswap Community Palliative Care Advisory Group meeting
- Residential Care Working Group meeting (Salmon Arm)
- Lease agreement signed with IH for maternity space
- Shuswap Community Palliative Care Advisory Group meeting: Kirstine Hill hired as Project Lead

October 2015
- Residential Care Meeting with facility managers (Vernon)
- TELUS Data Driven Management of Diabetes report presented
- Osler Training (Vernon)
- Provincial Round Table – SNO Division presentation on GPSC Residential Care Initiative

- MOA First Aid Recertification (Vernon and Salmon Arm)

November 2015
- BC College of Family Physicians Fall Roadshow CME
- Residential Care Meeting with facility managers (Salmon Arm): Physician leads for each facility identified
- Osler site visits – 1st visit
- Residential Care meeting with Vernon Family Physicians
- Shuswap Community Palliative Care Advisory Group meeting
- First Nations Tele-health Conference

December 2015
- Potential physician recruit tour: Vernon
- Shuswap Community Palliative Care Advisory Group meeting

January 2016
- Residential Care Lead for Vernon identified: Dr. Marcus Trayer
- Shuswap Community Palliative Care Advisory Group meeting
- Initial discussions re: FETCH *For Everything That's Community Heath*
- Letter to Ministry of Health and IH re: The Role of SNO in the Shuswap Community Palliative Care Advisory Group

February 2016
- MOA Breakfasts in Vernon and Salmon Arm: MOST presentation
- Residential care meeting (Vernon): Care conferences
- 2nd SNO Silver Star CME
- SNO Board meeting with IH CEO to discuss letter
- Osler site visits – 2nd visit
- Potential physician recruit tour: Vernon and Salmon Arm

March 2016
- Facility Based Division meeting: Vernon
- Future Funding model for Divisions: Teleconference
- Residential Care Meeting (Salmon Arm): Care conferences
- GPSC QI survey on Residential Care Initiative
- Update on GPSC Strategic Planning: Teleconference
- IH / MoH meeting to Patient Medical Home: Teleconference
- Shuswap Community Palliative Care Advisory Group meeting
- Potential physician recruit tour: Salmon Arm and Vernon
- FETCH Website proposal accepted

Data-Driven Diabetes Program

Identifying Diabetic Population

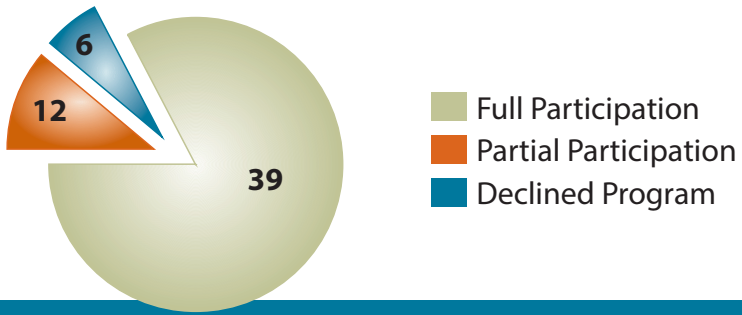
Integrating Goals & Alerts for Diabetic Care

Monitoring Trends & Recall Methods

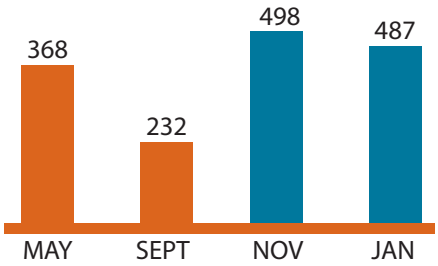
Reflective:	Opportunistic:	Proactive:
Data Cleanup	Alerts (CDS Triggers)	Diabetic Dashboard
Updated Diabetic Populations	Diabetic Goals	Recall Methods

Physician Participation

Of 57 Approached Physicians



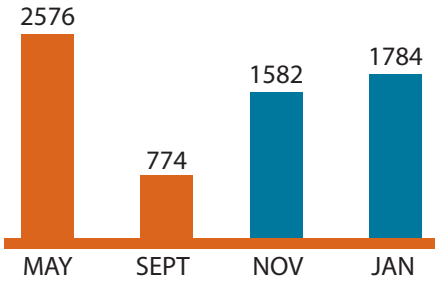
Suspected Diabetics by A1c or Glucose Fasting >7



This represents patients with high A1c or Glucose Fasting that have not been diagnosed with Diabetes.

We can see that the amount of suspected patients has risen since the close of the program in September.

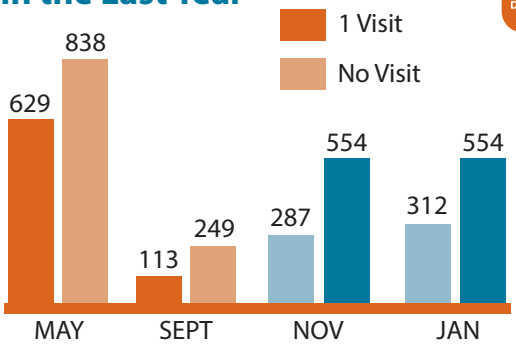
Diabetic Patients with Outdated A1c (>6 months)



A total of **1,802** Diabetic patients with an outdated or non-existent A1c result had their A1c done between May and September.

We can see that the number of outdated A1c results is trending upwards.

Diabetic Patient Visits in the Last Year



586 Diabetic Patients with no visit in the last year were seen for Diabetes and **516** Diabetic Patients received their 2nd Diabetic Visit in the last year (as of September).

Managing Diabetic Patients Efficiently & Effectively

The Shuswap North Okanagan Division of Family Practice contracted Osler Systems and Mary Thurber to work with Physicians in Vernon. The goal of the project was to improve the use of the tools in the Practice Manager EMR and provide physicians and their staff tools to manage their diabetic patients effectively.

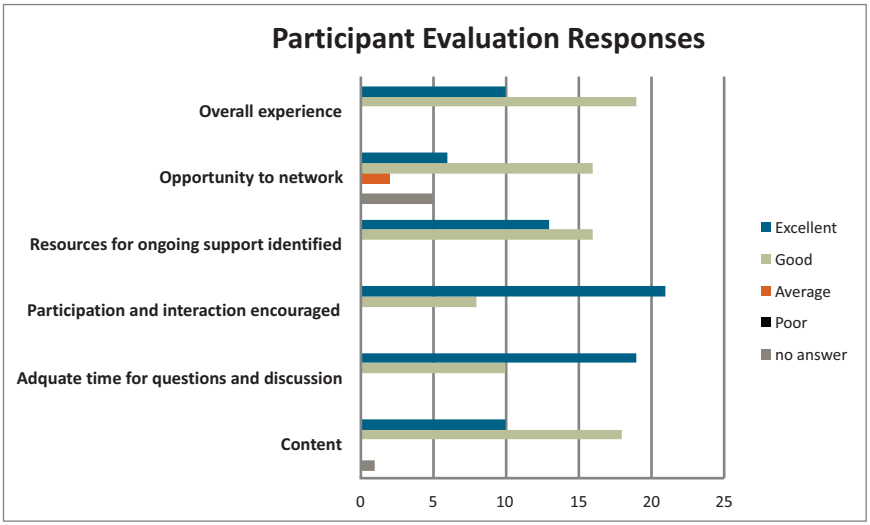
Background

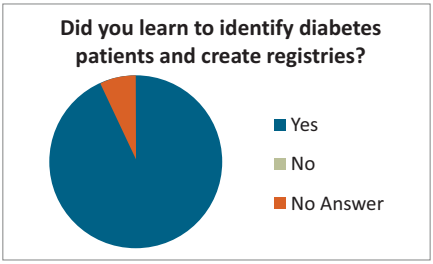
The division was interested in offering some EMR education to Osler users. There are twenty physicians in the Division who use the Osler Practice Manager EMR. Eleven physicians participated in the initiative.

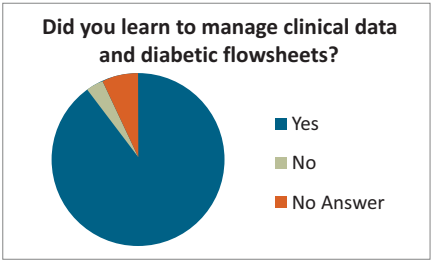
Initial Training Sessions

The initial training sessions for physicians and MOAs were held in mid-October. David Trottier from Osler was the main presenter.

The event was attended by eight physicians, 16 MOAs and three office managers. Evaluations completed by participants in the physician session gave either a good or excellent rating in all categories. The chart below combines the evaluations from both sessions.







Office Visits ~ Round One

At the initial clinic visits we collected some statistics. The findings to the right indicate the percentage of patients in a practice identified as diabetic.

As part of the project Osler designed a report to scan a physician's patient list looking for patients who may be diabetic even though they had not be diagnosed as such. The report searched for patients who met the following criteria:

- On a medication normally used to treat diabetes
- Had an A1C result of > 6.5
- Had an uncoded condition in their condition list that appeared to be diabetes related
- Had been billed more than two times for diabetes visits

This report was run at each clinic and the results shared with the physicians and MOAs. In many cases the results of the report identified issues with data quality in the EMR. We found many deceased patients still in the active list, uncoded conditions, and temporary patients included in the regular patient list. MOAs took on clean-up work to improve data quality.

Some of the first visits were with the nurses who have regular meetings with diabetic patients at physicians' offices. In some cases the clinic thought to invite these nurses to the presentation, others did not. The IHA nurses have indicated that they would like to know about any and all presentations on EMR use as they would like to improve their system use. We should make a point to collect their email addresses and add them to distribution lists as they are part of the care team.

Through discussions with clinics we have been able to identify issues and potential solutions with the Diabetes Flowsheet. It is essential that this custom encounter template be used if you want to take advantage of the system reports and alerts around following diabetics. Osler is considering working on changes to the flowsheet and building a new, shorter customized diabetes encounter to be used in between annual visits. Osler has to manage competing priorities so these requests have not reached the top of the list at this time.

Another advantage to visiting the clinics is being able to assist with system customization and be a conduit to Osler for general concerns. Over the course of the clinic visits many requests for changes or reports were addressed. For a full list see Appendix 1

Not all the Osler users in the division chose to participate in the office visits. Eleven physicians participated in the full process.

Office Visits ~ Round Two

Starting in February Mary returned to clinics to see how they were progressing with the tools for monitoring diabetic patients and to collect new statistics.

To give more value to the visits we also included installation of Mental Health Templates, documents and reports. These items support the PSP Mental Health Module. Each physician received a printed handout and instructions on how to use these new tools. Eleven physicians participated in this process.

Most clients will be given a folder called Mental Health in their New Document drop down, within which there can be subfolders for Adult and Child/Youth. There are 14 new documents in the Adult folder and 21 new forms in the Child folder.

Osler has created documents called **AMH Core Tools and Resources** and **CYMH Core Tools and Resources** (under the Mental Health Adult and Children and Youth tabs) which has the algorithm developed for treating Mental Health issues as well as links to the forms built into PRACTICE MANAGER and links to other resources outside of PRACTICE MANAGER.

In addition to the new documents and encounter templates there are reports to aid in the tracking of Mental Health patients.

Project Results

Data Cleanup – Patient Registry

The results of the data collected show that some progress was made with the help of the reports, education and MOA, Nurse and Physician effort.

Data Cleanup – Condition Lists

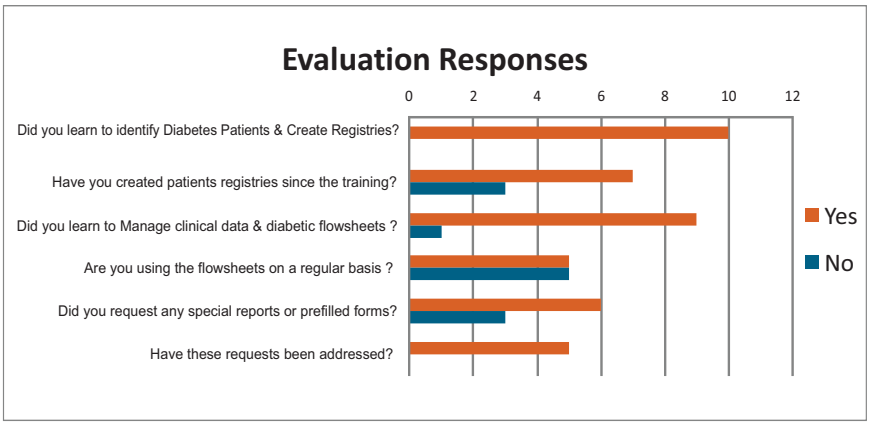
In order to make the best use of the tools available in the EMR the patients should have their diagnosis identified with an ICD9 code in their condition list. In many practices we found patients who could be identified as diabetic via their billing history or an uncoded condition in their list. Throughout the project an effort was made to ensure that all diabetics were coded as recommended.

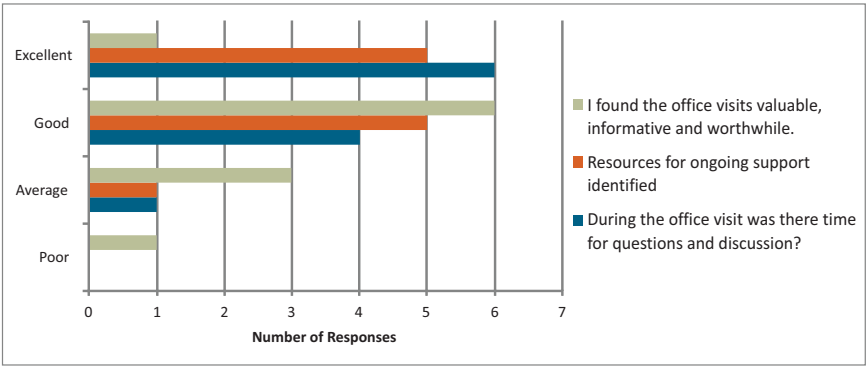
Identification of Possible Uncoded Diabetics

Using the Osler designed report to scan a physician's patient list looking for patients who might be diabetic though they had not be diagnosed as such led to the data cleanup alluded to above and in some cases to the identification of a patient recently diagnosed as diabetic.

Evaluations of Office Visits

Participants were asked to complete evaluation forms after the second office visit. The numerical results are summarized here:





Comments:

1. What did you learn from this visit?

- The mental health folder/encounters
- Need to use the diabetes template to auto populate the diabetes reports
- PHQ9 on computer and template mental health
- Use of mental health forms
- To create specific templates. New mental health plan tagging. Learned that we are very effectively managing chronic patients
- New templates for mental health care planning

2. What was least useful?

- The MOCHA MMSE tools
- Diabetes – old news
- OK Pretty unusual we'd be missing this the way I track

3. Any suggestions for other support topics

- Bring Osler again to Vernon
- Information on using the meds aspect of the program. For example when I send info to consultants and make a list of their meds it comes up with all of the regular and short term meds and it is hard to tell what meds the patient is taking.

4. Other comments

- I found the visit by Osler very helpful
- Well-intentioned but not very useful
- Thank You

The GPSC Residential Care Initiative was launched in April 2015. The aim of this initiative is to support family physicians to deliver care according to five best practice expectations and promote three system level outcomes:

Best practice expectations:

- 24/7 availability and on-site attendance, when deemed necessary by the on-call physician
- Proactive visits to residents
- Meaningful medication reviews
- Completed documentation
- Attendance at case conferences

System level outcomes:

- Reduced unnecessary or inappropriate hospital transfers
- Improved patient-provider experience
- Reduced cost/patient as a result of a higher quality of care

We would like to thank the following physicians who have supported this initiative during the planning and "roll-out" phase.

Vernon:
Dr. Rick Sherwin
Dr. David Screen
Dr. Elizabeth Jolly
Dr. Elaine French
Dr. Chris Cunningham
Dr. Louis Boucher
Dr. Marcus Trayer - Lead

Salmon Arm:
Dr. James Levins
Dr. Cindy Malinowski
Dr. Barb McKinnon
Dr. Juliann Aitchison
Dr. Attie Heunis

General Practice Services Committee

Residential Care Initiative Quality Improvement Report (January - March 2016)

1. 24/7 Availability and On-Site Attendance, When Required

Table 1. Proportion of time facilities can reach physicians in a timely manner during office (8:00am - 5:00pm) and non-office hours (evenings and weekends)[1] and facilities' reported satisfaction with the system in place to contact physicians in a timely manner for 24/7 availability[1,2]

Location	Facilities	Q1 (2015/16)			Q2 (2015/16)			Q3 (2015/16)			Q4 (2015/16)		
		Office hours	Non-office hours	Satis-faction rating	Office hours	Non-office hours	Satis-faction rating	Office hours	Non-office hours	Satis-faction rating	Office hours	Non-office hours	Satis-faction rating
Armstrong	Pleasant Valley Manor	-	-	-	-	-	-	-	-	-	3	1	
Enderby	Parkview Pl.	-	-	-	-	-	-	-	-	-	4	3	
Salmon Arm	Bastion Pl.	-	-	-	-	-	-	-	-	-	3	2	
	Hillside Vlg.	-	-	-	-	-	-	-	-	-	3	3	
	Mount Ida Mews	-	-	-	-	-	-	-	-	-	4	3	
	Piccadilly Care Ctr.	-	-	-	-	-	-	-	-	-	3	3	
Vernon	Creekside Landing	-	-	-	-	-	-	-	-	-	3	3	
	Hearthstone Manor	-	-	-	-	-	-	-	-	-	-	-	-
	Heron Grove	-	-	-	-	-	-	-	-	-	3	2	
	Heritage Square	-	-	-	-	-	-	-	-	-	3	3	
	Noric House	-	-	-	-	-	-	-	-	-	3	1	
	Polson Extended	-	-	-	-	-	-	-	-	-	3	4	
	Polson Special	-	-	-	-	-	-	-	-	-	3	3	
	The Gateby	-	-	-	-	-	-	-	-	-	4	3	Not Sure
IHA overall		-	-	-	-	-	-	-	-	-	3	3	
NHA overall		-	-	-	-	-	-	-	-	-	3	3	
VCHA overall		-	-	-	-	-	-	-	-	-	3	3	
VIHA overall		-	-	-	-	-	-	-	-	-	3	2	
FHA overall		-	-	-	-	-	-	-	-	-	3	3	
BC overall		-	-	-	-	-	-	-	-	-	3	3	

2. Proactive Visits to Residents

Table 2. Facilities' reported satisfaction with physicians making proactive visits to residents before issues arise[1]

Location	Facilities	Q1 (2015/16)	Q2 (2015/16)	Q3 (2015/16)	Q4 (2015/16)
Armstrong	Pleasant Valley Manor	-	-	-	
Enderby	Parkview Pl.	-	-	-	
Salmon Arm	Bastion Pl.	-	-	-	
	HIllside Vlg.	-	-	-	
	Mount Ida Mews	-	-	-	
	Piccadilly Care Ctr.	-	-	-	
Vernon	Creekside Landing	-	-	-	
	Hearthstone Manor	-	-	-	-
	Heron Grove	-	-	-	
	Heritage Square	-	-	-	
	Noric House	-	-	-	
	Polson Extended	-	-	-	
	Polson Special	-	-	-	
	The Gateby	-	-	-	
IHA overall		-	-	-	
NHA overall		-	-	-	
VCHA overall		-	-	-	
VIHA overall		-	-	-	
FHA overall		-	-	-	
BC overall		-	-	-	

3. Meaningful Medication Reviews

To be assessed with administrative data when available.

4. Completed Documentation

Table 3. Proportion of time physicians complete documentation for each resident, including: (i) advanced care plan to include DNR; (ii) MOST intention plan; (iii) patient summary - medical summary and progress notes]

Location	Facilities	Q1 (2015/16)	Q2 (2015/16)	Q3 (2015/16)	Q4 (2015/16)
Armstrong	Pleasant Valley Manor	-	-	-	3
Enderby	Parkview Pl.	-	-	-	4
Salmon Arm	Bastion Pl.	-	-	-	3
	HIllside Vlg.	-	-	-	3
	Mount Ida Mews	-	-	-	4
	Piccadilly Care Ctr.	-	-	-	3
Vernon	Creekside Landing	-	-	-	3
	Hearthstone Manor	-	-	-	-
	Heron Grove	-	-	-	2
	Heritage Square	-	-	-	3
	Noric House	-	-	-	3
	Polson Extended	-	-	-	1
	Polson Special	-	-	-	Other[3]
	The Gateby	-	-	-	3
IHA overall		-	-	-	3
NHA overall		-	-	-	2
VCHA overall		-	-	-	3
VIHA overall		-	-	-	3
FHA overall		-	-	-	3
BC overall		-	-	-	3

LEGEND & NOTES

3. "We perform weekly rounds on the unit with geriatric psychiatrist".

5. Participation in Case Conferences

Table 4. Facilities' reported satisfaction with physician participation in case conferences[1]

Location	Facilities	Q1 (2015/16)	Q2 (2015/16)	Q3 (2015/16)	Q4 (2015/16)
Armstrong	Pleasant Valley Manor	-	-	-	
Enderby	Parkview Pl.	-	-	-	
Salmon Arm	Bastion Pl.	-	-	-	
	HIllside Vlg.	-	-	-	
	Mount Ida Mews	-	-	-	
	Piccadilly Care Ctr.	-	-	-	
Vernon	Creekside Landing	-	-	-	
	Hearthstone Manor	-	-	-	-
	Heron Grove	-	-	-	
	Heritage Square	-	-	-	
	Noric House	-	-	-	
	Polson Extended	-	-	-	
	Polson Special	-	-	-	Not Sure
	The Gateby	-	-	-	
IHA overall		-	-	-	
NHA overall		-	-	-	
VCHA overall		-	-	-	
VIHA overall		-	-	-	
FHA overall		-	-	-	
BC overall		-	-	-	

System Level Outcomes

1. Reduced Unnecessary or Inappropriate Emergency Room Transfers

To be assessed with administrative data when available.

2. Improved Patient and Provider Experience

Table 3. Facilities' reported satisfaction of physicians' working relationships with facility clinical staff[1]

Location	Facilities	Q1 (2015/16)	Q2 (2015/16)	Q3 (2015/16)	Q4 (2015/16)
Armstrong	Pleasant Valley Manor	-	-	-	
Enderby	Parkview Pl.	-	-	-	
Salmon Arm	Bastion Pl.	-	-	-	
	HIllside Vlg.	-	-	-	
	Mount Ida Mews	-	-	-	
	Piccadilly Care Ctr.	-	-	-	
Vernon	Creekside Landing	-	-	-	
	Heron Grove	-	-	-	
	Hearthstone Manor	-	-	-	-
	Heritage Square	-	-	-	
	Noric House	-	-	-	
	Polson Extended	-	-	-	
	Polson Special	-	-	-	
	The Gateby	-	-	-	
IHA overall		-	-	-	
NHA overall		-	-	-	
VCHA overall		-	-	-	
VIHA overall		-	-	-	
FHA overall		-	-	-	
BC overall		-	-	-	

3. Reduced Cost per Patient as a Result of Higher Quality Care

Note: Data for this outcome will be gathered in future evaluation work.

Feedback on the GPSC Residential Care Initiative or Family Physician Services

Other comments from residential care facilities about the Residential Care Initiative or the delivery of family physician services within their facilities.

- One facility described the need for another physician in their community.
- Local physicians described as involved in a facility located in a small community.
- Facilities reported seeing recent improvements in Residential Care Initiative best practices, as well as improved awareness of the physician role in residential care. On the other hand, other facilities noted need for improvement with best practices.
- Safety concerns due to lack of support/resources when dealing with responsive behaviours.
- Need for improved process for after hours call (i.e. which physicians are available to be contacted and availability of accurate contact information).
- Challenges scheduling case conferences with all key players.

Shuswap Community Palliative Care Advisory Group

In September 2015, Kirstine Hill was hired by the Division as the Project Lead to support the work of the Shuswap Community Palliative Care Advisory group.

The purpose of the project is:

- To establish strong local community engagement focused on the improvement of quality palliative care in the Shuswap
- To provide a forum for collaboration and leadership that will advance the proposed Palliative Care Resource Centre
- To gain commitment and support in order to achieve the desired outcomes of the proposed Palliative Care Resource Centre

Successes to date:

- 2 designated palliative care beds within the existing bed complement at Shuswap Lake General Hospital.
- Continued funding for the Palliative Care Co-ordinator position.
- Approval to launch a fundraising campaign in conjunction with the Shuswap Hospital Foundation to raise funds for the renovation and construction of the 2 designated palliative care rooms.
- Community support and collaboration with Shuswap Hospice Society to develop a Hospice / Palliative Care Resource Centre with the following features:
  - Hospice Office
  - Multi-purpose space with teleconferencing capabilities
  - Reflective, quiet space for family and patients
  - Loan library for resources
  - Assessment and treatment room for use by family physicians and nurses
  - Landscaped and accessible outside space
  - Kitchenette
  - Bathrooms

Fetch

Fetch is an online resource that helps patients and health care providers find information on social and health resources within their own community, including counseling, crisis intervention, employment assistance, and agencies that provide support for various medical conditions.

FETCH will be launched in the Shuswap North Okanagan in the Fall.

Screenshot of Fetch Demo Website

Sneak a Peek at:
www.divisionsbc.ca/provincial/fetch

Community Program / Partner	Division Initiative	Financial Support
Canadian Mental Health	Community Wellness	$10,000
Alive Inside Music & Memory *Pleasant Valley, Parkview, Noric House, Mt. Ida*	Residential Care	$13,000
Good Food Box	Community Wellness	$2,000
Seniors Resource Centre Salmon Arm	Seniors / Community Wellness	$5,525
NONA: Build a Clubhouse	Child / Youth Mental Health	$15,000
FETCH: Community Resource Databse	Physician / Community Resource	$10,000
Syrian Refugee Support	Community Wellness	$14,000

2015 Support for Community Programs

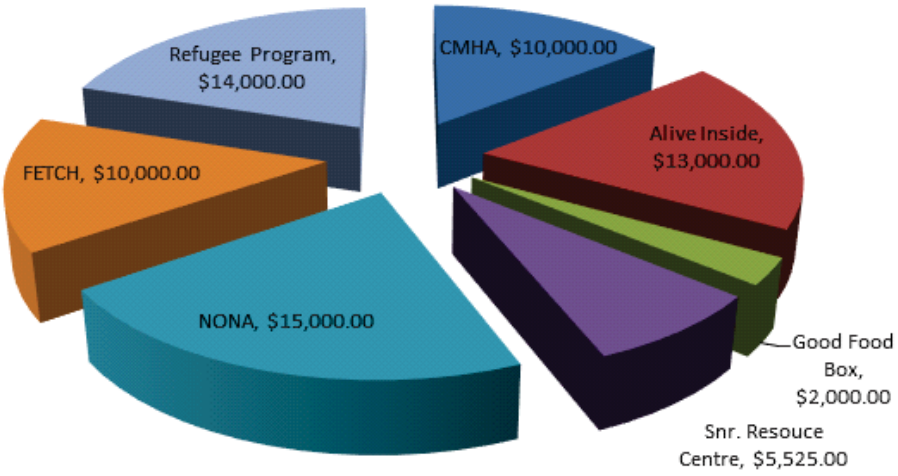


Photo Courtesy of the City of Armstrong

This financial statement is based on an unaudited statement for the period of April 1, 2015 to March 31, 2016.

ASSETS

CURRENT ASSETS

TD Canada Trust - 0928	$	81,899.28
Bank Adjustment - As per auditer	$	-7,656.58
Telpay Clearing Account	$	-10,639.25
Accounts Receivable	$	0.00
Overpaid DOD - As per Auditor	$	22,929.52
Prepaid Expenses	$	0.00
TOTAL CURRENT ASSETS	**$**	**86,532.97**

CAPITAL ASSETS

Office Furniture & Equipment	$	8,322.08
Accum. Amort - Furniture & Equipment	$	-2,644.07
Computer Hardware & Software	$	3,432.28
Accu. Amort. Computer Equipment & Software	$	0.00
TOTAL CAPITAL ASSETS	**$**	**9,110.29**
TOTAL ASSETS	**$**	**95,643.26**

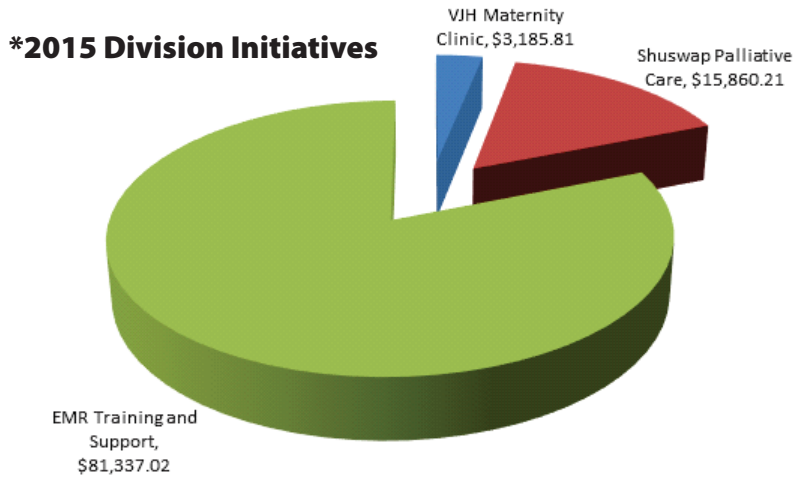
LIABILITY

CURRENT LIABILITIES

Accounts Payable	$	6,747.45
Accounts Payable Adjustment-Auditor	$	0.00
Accrued Liabilities -As Per Auditor	$	11,138.46
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	$	-6,821.98
PST Payable	$	0.00
CPP Liability	$	0.00
EI Liability	$	0.00
Tax Liability	$	0.00
Net: Deductions	$	0.00
Vacation Accrued	$	4,721.04
WCB Payable	$	4.00
TOTAL CURRENT LIABILITIES	**$**	**-3,390.03**
TOTAL LIABILITIES	**$**	**-3,390.03**

EQUITY		
Retained Earnings	$	85,080.97
Current Earnings	$	13,952.32
TOTAL EQUITY	**$**	**99,033.29**
LIABILITIES & EQUITY	**$**	**99,033.29**

Expenditure – April 1, 2015 – March 31, 2016		
Board Meetings	$	39,406.13
CSC Meetings	$	1,784.02
Physician Lead	$	31,275.00
SNO Events / AGM	$	38,526.08
CME	$	51,625.69
Mentorship	$	2,618.38
Division Initiatives	$	101,611.26*
FETCH	$	10,000.00
Support for Community Programs	$	59,525.00
Salaries: Support Staff	$	100,752.75
Physician Data Collaborative	$	13,000.00
TOTAL EXPENSES	**$**	**450,124.31**

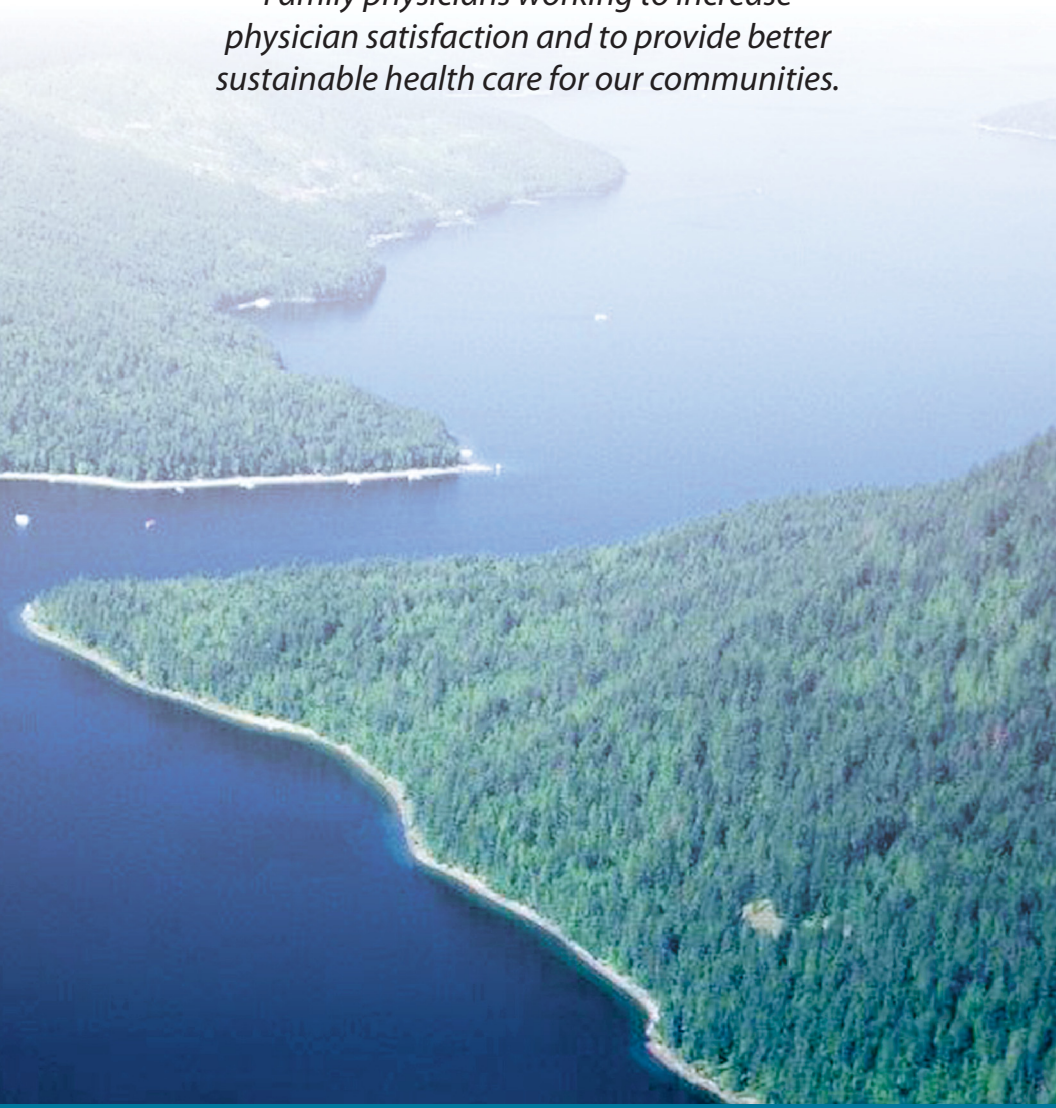


Our Vision

Healthy physicians, patients and communities.

Our Mission

Family physicians working to increase physician satisfaction and to provide better sustainable health care for our communities.



SNO Board of Directors

Melany Dyer ~ *Physician Lead*
Don Smith ~ *Treasurer*
Rick Sherwin
Juliann Aitchison
Kevin Goldberg
Brett Poulin
Richard Harper

Staff

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

Shuswap North Okanagan Division of Family Practice

Tel: 250.833.6826
www.divisionsbc.ca/SNO

Shuswap North Okanagan Division of Family Practice
A GPSC initiative

British Columbia

GPSC General Practice Services Committee

doctors of bc
British Columbia Medical Association