# RURAL HEALTH MATTERS

British Columbia Rural Health Network February 2022

## Letter from the President

Dear members and supporters,

This past weekend, I joined 14 other members of my community to take a Mental Health First Aid (MHFA) course offered through the Mental Health Commission of Canada.

I first learned of MHFA from the Salt Spring Island Community Health Society (SSICHS), one of our member organizations, when they included information about the course in the Summer 2020 issue of their newsletter. Through grants, the SSICHS was able to offer the training sessions to 46 community members on August 24/25 and August 27/28. Since then, interest in the course has grown and according to one of the trainers who offered the course, there are now over 100 Salt Spring Island residents who are now certified mental health first aiders.

According to the MHFA Canada website, “Mental Health First Aid is the help provided to a person developing a mental health problem, experiencing the worsening of an existing mental health problem or in a mental health crisis. Just like physical first aid is provided until medical treatment can be obtained, MHFA is given until appropriate support is found or until the crisis is resolved.”

Princeton, my home town, is one of many BC communities that has experienced hardship and suffering over the past several months. In addition to the adverse effects of the COVID-19 pandemic, we have endured a heat dome, wildfires, and a catastrophic flood that has left our community reeling.

In response to these catastrophic events, our community has pulled together, first addressing the immediate physical needs and now responding to the long term mental health needs of those affected. And this scenario is being repeated in many other communities across our province.

One of the values of the BC Rural Health Network is our ability to share our challenges and our success stories. As we continue our efforts to improve access to care in rural BC, I encourage our members and supporters to draw on the inspiration and initiative that is provided by other BCRHN members.

For more information on the Mental Health First Aid course, please visit https://www.mhfa.ca.

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# From the desk of the Administrator

With so much happening with Covid-19 impacts in all aspects of our society, we have been focused on ensuring that cuts being made to healthcare provisions due to staffing are not being made solely at the expense of the rural resident. Our main concern has been in ensuring that cuts made will not result in permanent reductions in rural service or in service reductions that will cost rural residents lives in favour of saving our urban neighbours. This is not an easy task as cuts have impacted everyone.

Upon receiving complaints from member groups and individuals within the Interior Health Authority, we followed up with our entire membership and asked for impacts happening in their jurisdiction. We remain interested when impacts are being felt that seem imbalanced or dangerous to the rural resident. To date, the main concerns have been voiced in the Interior Health Authority and we are ensuring that the information we gather in the Interior is shared out with all our members and with all our contacts in the BC Government.

We are currently setting a meeting with all senior management of the Interior Health Authority and this meeting will hopefully be held this week but certainly as soon as a mutually available time is available. This meeting will be the beginning of a conversation and not the end. The BCRHN will be seeking an ongoing and open dialogue between the IHA and BCRHN. We will ensure that the membership's concerns forwarded are raised if they are related to current cuts and current communication problems. From my experience there is often a desire to vent all issues at a meeting at this level and it is also my experience that this is ineffective. We will remain focused on the issues presented with Covid-19 cuts and hopefully create a platform that will ensure ongoing dialogue.

Everywhere I look there are concerns and disconnect between authorities and the rural residents. We are seeking a meeting with Minister Dix in this regard. It is apparent to the BCRHN that investment in rural outreach is both missing and missing the mark. Rural residents do not receive information that is relevant or based in science. Rural residents are receiving lots of misinformation and becoming increasingly dislocated from the system. This is not new and not specific to the current government(s). It is however becoming a real health concern during a pandemic, and a time when increasing natural disasters are significantly impacting rural lives. These events require clear communication and connection with residents who need crucial information, and that is simply not happening.

Good news on the communication front! We have received money from the Rural Citizen Partnership Group funds to redevelop our website to enhance rural outreach to BC residents. The website has been a huge undertaking by Nienke Klaver who has dedicated thousands of hours to it over the years. It has been done with 100% volunteer time, extremely limited tools, but with lots of love. We now have a little bit of money to take all that work and convert it into a visually appealing platform. The new website will provide better access to tools for members, communities and anyone interested in rural health. Thank you, Nienke! To our members: let us know what you would like to see to improve our site and items that would help your organization.

I was reminded of the following during the weekend's protests: **A convoy of nurses, doctors and healthcare workers are going to work and have been everyday. Support that!**

Yours in health and wellness,

Paul

# Member of the Month
# Sunshine Coast Resource Centre

***Sunshine Coast Resource Centre: Connecting the community to the help they need***

The Sunshine Coast Resource Centre is a drop-in space nestled into downtown Sechelt, on the Sunshine Coast. We started out as a women's resource centre exactly thirty years ago. Since then, we've become a key non-profit for locals, leading community work initiatives and offering services & programs for all.

When it comes to our front-line work, our goal is to help our clients move forward with their lives, by acting as a connector to programs and services that can help. While many of our clients are seniors or those with modest incomes, we are here to help folks regardless of gender, age, income, ability, sexual orientation, or background.

**Our Legal Advocate Ken Carson sits with a client, behind plexiglass.**

Every situation is unique, and we are here to help clients navigate barriers in their way. Some are facing homelessness due to our local housing crisis, others are trying to navigate the legal or government system. We are here to help no matter the situation. Barriers we commonly see include: limited access to information; a lack of confidence with technology or paperwork; overwhelm due to extreme stress or trauma; and simply a lack of resources to navigate any given situation alone.

Sometimes we refer or connect clients to programs & services in the community or beyond (ie. food banks, emergency funding sources, women's outreach services, mental health supports or housing subsidy providers), and other times we refer folks to our in-house programs & services.

Our key programs include our service as an Information Hub, our Legal Advocacy program, our Legal Aid & Information Program, the Caregiver Support Network, and the Community Volunteer Income Tax Program.

The community work we oversee is ongoing. In 2020 we published a report on LGBTQ2+ Seniors on the coast. In 2020-21, we led a community scan and engagement project called the Poverty Reduction Strategy. We continue to coordinate a Sunshine Coast advocacy group for seniors called the Seniors Planning Table.

On any given day our staff and volunteers may be: advocating for clients around tenancy issues; working with clients on applications for disability designations; connecting clients to legal information & free legal aid; offering folks free income tax help; helping clients fill out forms on paper or online, and so much more.

It is common for our clients to take advantage of many of our programs at once.

Future goals for our organization include obtaining charitable status, and setting up a core team of front-line volunteers. In the meantime, our little Resource Centre team continues to offer a helping hand, a compassionate ear, and a strong voice to our community members in need.

If you want to know more about us: [www.resourcecentre.ca](http://www.resourcecentre.ca)

Sunshine Coast Resource Centre

NEW ON OUR WEBSITE

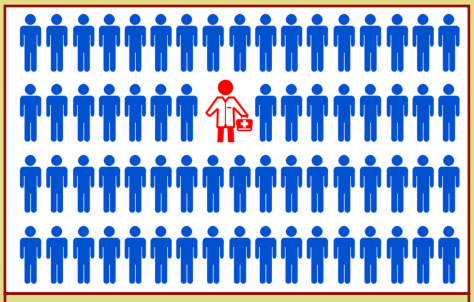
# My Doctor Dumped Me. Here's Why That's So Common.

THE TYEE

Forced to search for a scarce primary care physician or nurse, I joined 700,000 British Columbians without one.

Mark L Winston 5 Jan 2022 | TheTyee.ca

Mark L. Winston is a professor and senior fellow at Simon Fraser University's Morris J. Wosk Centre for Dialogue. His writing awards include the Governor General's Literary Award for his book *Bee Time: Lessons From the Hive.*



Fewer to go around. As part of a project the author interviewed primary care physicians to understand why they were leaving their practices and what would make them stay. Image via Shutterstock.

[Excerpts - text in blue are hot links] I was cut loose by my primary care doctor a few months ago. My struggle to find a new one made personal a widely shared problem. For many years now, there have not been nearly enough family doctors and nurse practitioners to meet demand. Nor have the models of how they practice delivered the quality and timeliness of primary health care we hope for.

When Dr. G. (I'll call him) closed his practice, he moved to Telus Health, a private option that offers patients a LifePlus program for $4,650 a year.

With that tacked on to the medical services plan fees they bill the government, Telus provides premium care to those willing and able to pay, including fast access to your personal primary care physician or nurse practitioner, 30-minute appointments, a soup-to-nuts annual checkup, rapid access to specialists and associated dieticians, kinesiologists, nurses, psychologists and other professionals.

His [Dr. G.'s] farewell letter to patients noted that he was attracted to Telus by their supportive care model, preventative health program, low patient-to-physician ratio and administrative support. His previous clinic is not replacing him, which placed me in good company. According to the Canadian Medical Association, five million Canadians don't have primary care. For B.C., a little over 700,000 British Columbians have no family doctor or nurse practitioner providing primary care.

**Two root causes**

The crisis in primary care is pretty easy to understand, based in two factors, both of which our provincial government is aware of and has committed to change. Number one is not enough family doctors and nurse practitioners to serve our population, while the second root cause is a system of primary care delivery that has increasingly come to depend on walk-in clinics.

As a senior fellow at Simon Fraser University's Morris J. Wosk Centre for Dialogue, I'm often asked to facilitate workshops and strategic conversations. A few years ago I had the opportunity to explore with family doctors how they practised their craft, and what they might prefer in the future.

This deep dive into primary care was sponsored by a non-profit health care think tank, the Institute for Health System Transformation and Sustainability, and resulted in a report, **Physician Heal Thyself,** that uncovered the physician's perspective that walk-in clinics had decimated British Columbia's primary care ecosystem. But my interviews and focus groups also revealed a love-hate dynamic with walk-ins; many doctors prefer them to the traditional office model that represents primary care's past, while at the same time bemoaning walk-in shortcomings.

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In addition to their high-end fee model, Telus **established** a virtual walk-in clinic called Babylon in 2018 that made it even easier for family doctors to practise the walk-in model through a call-in system. Over a million patients are enrolled across Canada. Like a physical walk-in, they see a random physician, and their virtual visits are paid for by provincial governments with no additional fees to patients.

Few of the doctors we talked with found practising in a walk-in model to be professionally or personally satisfying. They pointed to lack of continuity in patient care as a serious deficiency in the walk-in model, and lack of health records a real barrier to providing adequate care for one-off patients. They also pointed to pressure to see large numbers of patients, and an oversimplified approach to the health care of patients with complex problems. In short, our report noted: "Walk-ins can be profitable for the physician and clinic owner, but do not provide good primary care for patients."

Why do family doctors, and more recently nurse practitioners, work in walk-in models at all? They are trading off quality of care for no overhead costs, more rapid payback of student loan debts, and reduction of the massive amount of paperwork associated with the fee-for-service models ubiquitous in Canadian health care.

Read more at: **My Doctor Dumped Me. Here's Why That's So Common**

NEW ON OUR WEBSITE

## Fee-for-service model is deterring aspiring family doctors from setting up practice: report

CBC

[Excerpt] Model incentivizing high volume of patients is also contributing to B.C.'s family doctor shortage, report says - CBC News · Nov 12, 2021

The payment model for family doctors in B.C. is deterring aspiring physicians from pursuing the work and contributing to the ongoing family doctor shortage in the province, according to a report released Friday.

Under the payment model, doctors and hospitals are paid by the province for each office visit, test or operation. To stay afloat, they need to continuously work through a high-volume of patients and run a business at the same time.

"The problem with this type of payment is that it requires the family doctor to do everything related to the patient's care — the medical care, the nursing care and the administrative work," said Dr. Goldis Mitra, a family physician and assistant professor who co-authored the report.

"As patients have become increasingly complex, it's becoming clear that it's not working for patients or for providers."

Under the fee-for-service model, doctors and hospitals are paid by the province for each office visit, test or operation. To stay afloat, doctors need to continuously work through a high-volume of patients and run a business at the same time. (Cryptographer/Shutterstock)

Most family doctors in B.C. are paid about $30 per patient visit — whether they're treating a straightforward common cold or a complex chronic health problem.

Physicians run their practice as a business, paying out overhead costs like staff and office space at an average rate of about $60 per hour or more.

In May 2020, the College of Family Physicians of Canada also called for alternative funding models to replace the fee-for-service method to better support continuity of care and stop family doctors from leaving their jobs.
Listen to the following clip where Dr. Goldis Mitra explains the fee-for-service model and its shortcomings

Click on: **https://www.cbc.ca/listen/live-radio/1-91-the-early-edition/clip/15878060-why-b.c.s-fee-for-service-payment-system-failing-health-care**

NEW ON OUR WEBSITE

# Alternative payment models
# A path forward

CFP·MFC Official Publication of The College of Family Physicians of Canada

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*Ironically, at the very time definitive data are confirming primary care's essential contributions to health care … practicing primary care physicians are demoralized, retiring early, and advising others not to go into the field.* Allan H. Goroll et al

2021 Nov; 67 [Excerpts] Most Canadian FPs [Family Physicians] would suggest that little has changed in the 15 years since the above statement appeared in a journal article calling for reforms to primary care remuneration. Canada has a higher than ever ratio of FPs to the population, yet Canadians continue to struggle to access comprehensive primary care. New-to-practice FPs are choosing hospital-based work and focused practice rather than comprehensive family medicine (FM), which we define as longitudinal primary care for a defined population of patients across the life cycle that addresses a spectrum of clinical presentations. Many of these new FPs never venture into comprehensive FM and those who do often leave, citing the long-standing problems associated with fee-for-service (FFS) remuneration. Most recently, the coronavirus disease 2019 pandemic has exposed additional problems with the FFS payment model.

Increasing evidence suggests that the availability of remuneration models influences newly graduated FPs' decisions about future practice. Payment model reform alone will not be enough to reinvigorate comprehensive FM, which requires other pillars such as engaged leadership, incentives for innovation, and continuous quality improvement. However, it is one part of the solution that can enable team-based care and help address deterrents such as mounting administrative tasks and paperwork. Governments and provincial and territorial medical associations would be wise to adapt payment systems accordingly.

Here we discuss the threat posed to longitudinal primary care by continued reliance on FFS payment models, and the payment reforms needed to maintain and expand the practice of comprehensive FM.

**The remuneration issue in context**

For more than 50 years, Canadian FPs have been primarily remunerated through FFS [Fee For Service], wherein they are paid a predetermined amount for each service rendered for a patient. Fee-for-service remuneration has fallen out of favour as a preferred form of payment, particularly for those early in their careers. Reasons include concerns about the quality of care provided to patients under this model, the negative impact of "one problem per visit" and time limitations commonly associated with FFS, and difficulties in serving marginalized or less advantaged patients. While there are examples of interdisciplinary team–based primary care models that are funded through FFS, they tend to be the exception rather than the rule.

The coronavirus disease 2019 pandemic has highlighted further problems with the FFS payment model, such as income instability and the need for rapid practice change that often outpaces fee schedule cycles. As a result, the College of Family Physicians of Canada has renewed its call for the introduction of more alternative funding models.

Taken together, these issues have led to heightened physician interest in alternatives to FFS such as salaried, capitation, and blended compensation models, collectively termed alternative payment plans (APPs). Alternative payment plans have been implemented in a patchwork fashion in several Canadian provinces.

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Capitated payment models pay physicians a fixed amount per patient per year for delivery of a primary care “basket” of services, with payment adjusted for factors such as age and patient complexity. Successful risk-adjusted capitated models have been piloted in British Columbia (BC) and have been in widespread use internationally for decades. Blended payment models often combine elements of both capitation and FFS.

Payment reform is an essential element of successful transition to a Patient’s Medical Home [PMH] model of care.19 The shift to APPs allows increased ability to fund and support collaborative, team-based care because funding can flow independently from direct physician-patient interaction. Teams can be funded directly in a clinic managed by a health authority or community-governed not-for-profit organization. Alternatively, they can be funded in physician-owned practices through increased flexibility in delegation of patient care to nurses, pharmacists, and allied health care providers. Alternative payment plans also allow increased flexibility for FPs to spend more time with patients, when needed, to address increasingly complex health and social needs.

Across Canada, the limited introduction of APPs and innovations in team-based care have already helped recruit and retain FPs in longitudinal care.8 Physicians remunerated through salary and capitation models report higher levels of satisfaction compared with those working in FFS settings.20,21 Patient care delivered through an APP-funded Patient’s Medical Home is also associated with a higher likelihood of preventive screening for diabetes and malignancy.

**The path forward**

While we continue to graduate large numbers of FPs, we will not solve the problem of dwindling comprehensive FM practices without introducing more alternatives to FFS. Even when FM residents are trained in interprofessional teams and under APPs, upon graduation they have few options to enter similar models of practice.

There have been recent positive changes to remuneration models that will alter the landscape. The 2019 Nova Scotia Master Agreement includes a commitment to develop a blended capitation funding model, adding to existing FFS and APP options.28 In BC, a process was outlined in the 2019 Physician Master Agreement for consultation with physicians around the development of APPs.31

Provincial governments and provincial and territorial medical associations across Canada need to carefully adapt how they fund primary care. There are existing Canadian models for viable and attractive APPs that do not substantially increase per-patient primary care costs compared with FFS. British Columbia has an ongoing pilot project for such a capitation model that adjusts for patient age and medical complexity, with per-patient payment indexed to FFS billing costs for patients with a similar health profile.15 In addition, across the country there are physician contract and other salaried options that can allow for predictability in yearly income for FPs, with fewer administrative burdens.

**To read more, click on: Alternative payment models – A path forward**

* Mythbusters. Myth: most physicians prefer fee-for-service payment. Ottawa, ON: Canadian Health Services Research Foundation; 2010. Available from: **https://www.hhr-rhs.ca/fr/outils/bibliotheque/english-french/myth-most-physicians-prefer-fee-for-service-payments-mythe-la-plupart-des-medecins-preferent-etre-remuneres-a-l-acte.html.** Accessed 2021 Sep 23. [Google Scholar] [Ref list]

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NEW ON OUR WEBSITE

# The Urgent Obligation to Stabilize Canada's Health Care System

Policy Canadian Politics and Public Policy

Paul-Émile Cloutier

picture by *Reuters*

Jan.5, 2022 - [Excerpts] When the COVID-19 epidemic was declared a pandemic by the World Health Organization on March 11th, 2020, Canadians – along with human beings across the world – processed the news within a frame of reference based on history. Our expectations were informed by our most recent experiences with the concept of contagion. Those included the 2003 SARS epidemic, which infected 8,000 people and killed 774 worldwide, 44 of them Canadian; and the Ebola outbreak centred in West Africa that peaked in 2014 before killing a total of 11,000 people. No Canadians were among them.

Based on our confidence in 21st-century reporting, diagnostic, treatment, containment and public education systems vastly more sophisticated than those available during the last deadly global pandemic – the influenza outbreak of 1918-20 that killed 50 million people, including 50,000 Canadians – none of us could have anticipated the narrative trajectory of COVID-19.

"We have never before seen a pandemic sparked by a coronavirus," WHO Director General Dr. Tedros Adhanom Ghebreyesus said when he first declared the pandemic that day in Geneva. "This is the first pandemic caused by a coronavirus."

Nearly two years later, vaccines have mitigated the impact of this unprecedented coronavirus pandemic in terms of containment and mortality, but vaccine denial and mismanagement have kept the contagion alive. Those factors have enabled variants including Delta and Omicron to rationalize ongoing socioeconomic impacts with successive waves of isolation, quarantine and lockdown.

In tabling her annual report on December 13th, Dr. Theresa Tam, Chief Public Health Officer of the Public Health Agency of Canada, said: "There is a lack of a coherent public health system in Canada…Indeed, our publicly funded health care system is composed of a series of disjointed parts, separated by jurisdiction divides and plagued by 'boom and bust' cycles of public health spending where resources are scaled back."

The next day, the federal government's fiscal update was tabled. It included additional measures to help Canada respond to the Omicron variant, but the short-term focus of the spending meant that many of the health system vulnerabilities exposed by the pandemic have yet to be addressed. Canada's health care system and those who work in it are in desperate need, as I pointed out in my response to the fiscal update as president of the group representing health care organizations and hospitals across Canada, adding: "Our political leaders must urgently come together to implement solutions to the challenges facing health care and health research."

HealthCareCAN exhorts on behalf of Canadians our federal and provincial political leaders to urgently address the following, ideally and most practically with a First Ministers Conference in the first quarter of 2022. [HealthCareCAN is the national voice of healthcare organizations and hospitals across Canada, delivering high-quality products and services to members in support of health system innovation and transformation. [https://www.healthcarecan.ca/]

**A pan-Canadian health workforce planning strategy:** The federal government must collaborate with the provinces and territories to identify, prioritize and establish a national strategy to address systemic health workforce shortages. This includes data gathering, benchmarking, research, interprovincial coordination of education and licensing, and so on to ensure Canada's health workforce aligns with the needs of Canadians, addresses factors that contribute to stress, anxiety and burnout among health care workers, and improves diversity, representation and equity in the health system. continued on page 9

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**Strengthening health research and innovation:** Canada's health researchers and health research organizations have been invaluable in the fight against COVID-19. The important innovations and discoveries that have helped us get through the pandemic were built on decades of research.

**Improving access and availability of mental health supports:** The rising rate of burnout among Canadians and health care workers demands federal, provincial and territorial leadership and coordination. In addition to implementing a national health workforce planning strategy to better support our health care workers, governments must also develop a comprehensive approach to improve the availability and access to mental health services for all Canadians.

**Sufficient health transfers:** We have learned that the Canada Health Transfer (CHT) will be $45.2 billion in 2022-23, far less than the approximately $70 billion sought by the provinces.

**National standards for pandemic health policy:** Increased health transfers to provinces and territories are urgently needed to ensure consistent, long-term funding for public health and to eliminate inequities and gaps in our health care system. This investment must keep pace with costs, and ensure standardized, timely, and reliable data collection by developing a set of guiding principles across provincial/territorial jurisdictions, to help Canada respond to outbreaks now and in the future.

For months, HealthCareCAN has been stressing the importance of establishing a true national dialogue that would lead to fundamental reform of the health care system. After five successive waves of the pandemic, we can no longer accept the improvisation that continues to destabilize the health care system across the country. Canadians deserve better, and we have an obligation to deliver it.

For the full article, click on: **The Urgent Obligation to Stabilize Canada's Health Care System**

*Paul-Émile Cloutier is President and CEO of HealthCareCAN, the national voice of healthcare organizations and hospitals across Canada.*

HealthCareCAN Leading. Innovation. Together. SoinsSantéCAN Leadership. Innovation. Collaboration.

**Local lack of doctors and walk-ins gets worse with View Royal clinic closure**

Capital Daily

[Excerpt] View Royal's Eagle Creek Medical walk-in [in Victoria] announced it will be closing its doors on April 15, due to the departure of family doctors George Zabakolas and Chelsie Velikovsky.

While the clinic says it has put out job postings for the vacant positions, they don't expect them to be filled in time for the April 15 closure date, when roughly 3,000 people will be left without a family doctor.

In a statement to their patients, Zabakolas and Velikovsky said they will be ending their practices in Victoria and will no longer be the family doctor for any of their existing patients. They will still be living in Victoria but working remotely to provide care for US patients. The husband and wife duo told Global News that the strain of looking after 1,500 patients each while raising their 2 children was too much to handle.

Zabakolas told CHEK the current pay-for-service model is unsustainable. On average, he's paid $30 per visit while having to also factor in rent and staffing. Zabakolas says many doctors take on more patients than they can handle just to pay the bills.

Eagle Creek says costs to lease space have grown substantially over the last several years and that the high cost of living in Greater Victoria has forced a rise in staffing costs. This is in addition to supply chain issues driving up the cost of supplies. Eagle Creek says that the rate of pay for physicians has not kept pace with these rising costs.

The closure of Eagle Creek exacerbates the longstanding primary-physician shortage in Greater Victoria. In 2021, 2 new UPCCs and a PCN opened locally, but wait lists for primary doctors are still long due to closures and staff leaving the James Bay UPCC.

NEW ON OUR WEBSITE

# Four Ways to Fix Canada's Long-Term Care System

THE CONVERSATION
Academic rigour, journalistic flair

From cohousing to dementia villages, here's how we can put humanity back at the centre of senior care.

Sarah Tranum January 23 - Sarah Tranum is an associate professor of social innovation design in the faculty of design at OCAD University. **[Note: text in blue are hot links]**


Shutterstock

[Excerpt] COVID-19 has amplified existing cracks in the long-term care system in Canada. We need socially innovative solutions to help seniors age safely and with dignity.

From cohousing to community paramedicine programs, from home-based primary care to publicly funded dementia villages, there is hope on the horizon.

As a social innovation designer, I study complex challenges with the aim to find the common approaches needed to solve these issues and not just manage the symptoms.

To better understand the challenges of the long-term care system in Canada, I interviewed stakeholders involved in approaches attuned to individuals' needs at different stages of aging — all of which are socially innovative.

Here are some solutions that can help when it comes to redesigning the long-term care system.

**Senior cohousing**

One of the goals outlined in the National Institute on Ageing's National Seniors Strategy is to help seniors stay active, engaged and maintain their independence. But many seniors struggle to find suitable housing — especially affordable housing. While retirement homes exist, for many the costs are out of reach — so some are choosing cohousing.

Louise Bardswich is a retired college dean and co-owns a home in Port Perry, Ontario. She and three other women pooled their resources to build a shared home. Their home features design elements that will allow them to age in place — like wheelchair accessible bathrooms, a spacious kitchen and a guest room that can be used for a live-in caretaker. The housemates pool their resources to cover costs; Bardswich estimates her monthly costs at $1,100.

**Community paramedicine programs**

An integral part of supporting older adults to continue living safely in their homes is ensuring that they have access to the services they need. One innovative example is community paramedicine programs. These programs use existing trained emergency medical personnel to provide primary health care to people who may have a difficult time leaving the home to see a doctor.

**Home-based primary care**

House Calls is a primary health care practice for home-bound seniors living in Toronto, led by Dr. Mark Nowaczynski and SPRINT Senior Care.

**Dementia villages**

Dementia villages are communities of care designed to give their residents freedom and choice within a safe and supporting environment. The first dementia village in the world opened in 2009 in the Netherlands. The Hogeweyk is an intentionally designed village with 23 houses for 152 seniors living with dementia. The village has a bar, restaurant, theatre, grocery store, streets and gardens for residents to use and enjoy. It is publicly funded and runs on a budget comparable to conventional nursing homes.

Providence Living, in partnership with Island Health, will open Canada's first publicly funded dementia village care model in Comox, B.C. With construction starting this year, it will feature smaller households that support freedom of movement, access to nature and connection with the community.

NEW ON OUR WEBSITE

# An Upgraded Hippocratic Oath Is Needed In The Digital And A.I. Era

The Medical Futurist

[Excerpts] The Hippocratic Oath is the most famous text in Western medicine. It constitutes the ethical basis of the medical profession. For centuries, it has provided an overview of the principles of this noble mission and doctors' professional behaviour. At the dawn of a new era in medicine, it is high time to rewrite the Oath so that it would reflect the state of technological development, changes in social structures and in general, the requirements of the 21st century. These are our [The Medical Futurist] suggestions.

1) **Patient inclusion** - The scientific community does not only consist of physicians: medical researchers, nurses and patients must be included – also symbolically. Doctors are not the sole repositories of medical knowledge, and the ivory tower of medicine is crumbling under the weight of the digital sphere, social media, empowered patients or the DIY movement. The Hippocratic Oath should reflect that.

2) **Healthcare must shift from treatment to prevention** - With the recent advances in precision medicine as well as the appearance of preventive and lifestyle health, healthcare should have responses for the ill and the healthy alike. Advising on how to stay fit and well for the healthy is just as important as recommending treatments for the sick. The appearance of health sensors, wearables, and health apps results in new ways of prevention. It also results in a massive chunk of data medical professionals should be able to use. This data will help analyse as well as predict trends in the health of individuals and populations, so the Oath should change accordingly.

3) **Acknowledgment for technologies** - Technologies also need to be reflected in such a pledge. Physicians need to acknowledge the raison d'etre of technologies in healing, and one of the means to assume its rightful place in medicine starts with its inclusion into the Hippocratic Oath. It has to acknowledge the transformative impact that medical technologies have on healthcare – traditional as well as digital solutions.

4) **Recognition of life-long learning** - Besides mentioning technologies, it's also critical to use the latest innovations. That requires openness towards new concepts, ideas or medical devices, which seems to be evident for many physicians, but is not practised in the medical community as often as it should be. Maybe a kind reminder in the oath could give at least a symbolic boost to life-long learning.

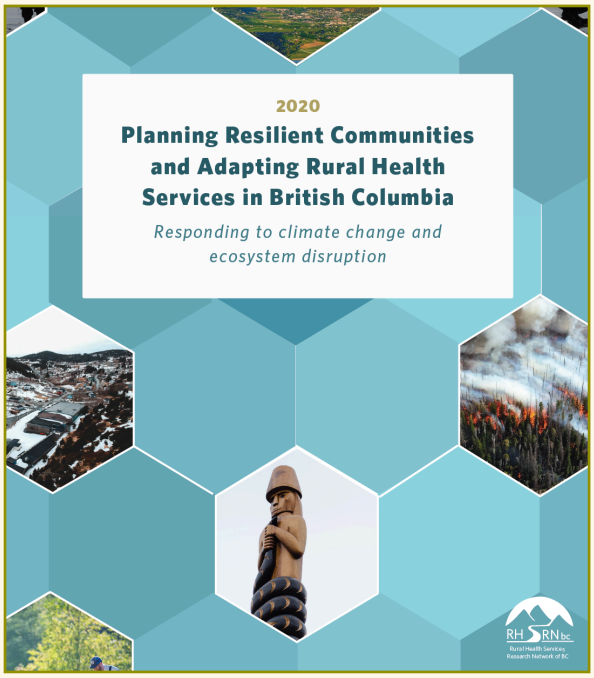
5) **The inclusion of equal-level partnership** - Access to information and technologies is not a privilege of physicians sitting in the ivory tower anymore. Patients also have access to information about drugs, cures, methods online, and with a pinch of digital literacy, anyone can find curated and credible medical data online. This started to shift the hierarchical patient-doctor relationship into a collaborative partnership in the future.

6) **Addressing privacy concerns** - Respecting patients' privacy is a primary passage in the Oath. However, there is no indication of data privacy anywhere. Sure, there was no need for it 2,000 years ago as Odysseus did not check in to Facebook day after day when heading home to Ithaca, but that's not the case today.According to Statista, in 2018, about 2,314 exabytes of new data could be generated worldwide in 2020. The need for safeguarding that amount of information is paramount, so we need to include it in the Oath.

7) **Artificial Intelligence In Medicine** - A.I. has a vast potential to automate processes in healthcare. We can expect dramatic changes in care, with A.I. systems to excel at a specific task and healthcare professionals to increasingly interact with them. But what we always highlight is that A.I. will never replace medical professionals. But those physicians who use and embrace A.I. will replace those that do not.

Read more at: **An Upgraded Hippocratic Oath Is Needed In The Digital And A.I. Era**

**NEW ON OUR WEBSITE**




From: **Rural Health Services Research Network** Chapter 1: an overview of the background and contextual factors underpinning the complex problems of climate change and ecosystem disruption in rural and remote BC based on a review of the literature supplemented by input from rural people.

Corresponding author, Dr. Stefan Grzybowski: sgrzybow@mail.ubc.ca

*Identifying at-risk populations in rural communities*
Though climate change is anticipated to have health consequences for all BC communities, some rural areas may face disproportionately high health impacts as a result of climate change. Rural communities my be more exposed to extreme weather events with lower access to resources that help to protect residents.
Additionally, residence in a rural community ca be a risk factor for heat-related morbidity and mortality, with rural Indigenous populations at an even higher risk.

In rural regions where livelihoods are closely tied to natural resources, climate change may contribute to economic decline, social disruption, and population displacement. As social and economic conditions have strong implications for health, such regions are at a greater risk for health challenges as a result of climate change.

*Health effects of climate change*
Rural communities especially those that are socioeconomically disadvantaged will experience disproportionate health impacts due to climate change.

*Mental health in rural areas*
There are large disparities in the socio-economic and health status of rural and urban residents of BC. Rural residents in B.C. are disproportionately impacted by the negative impacts of climate change due to socio-economic (lower income, lack of higher education) and environmental vulnerability (environmental destruction, pine infestations etc.)

There are some global examples of programs addressing mental health and wellbeing impacted by changing and uncertain environmental conditions in rural area. For example, The Rural Adversity Mental Health Program of Australia has implemented local initiatives to support mental health during extreme drought and forest fires.

Excerpt from Chapter 5:
Rural and Indigenous populations are particularly vulnerable to the adverse health impacts of climate change and ecosystem disruption due to their heavy reliance on the natural environment and climate-dependent industries (e.g. agriculture, fishing, etc.). Furthermore, these communities are often disadvantaged by health inequities stemming from various historical, social, political, and economic factors that further amplify the harmful effects of climate change and lead to disproportionate consequences to their health and access to resources.

**To read more, click on:**

**chapter_1_assessing_impact_climate_change_british_columbia-1Download**

**chapter_2_climate_mitigation_prevention_strategies-1Download**

**chapter_3_climate_adaptation_strategies-1Download**

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**chapter_5_behavioural_determinants_of_climate_actionDownload**

NEW ON OUR WEBSITE

Vol. 16 No. 4 (2021): COVID-19 and Rural Canada: Rural Impacts and Resilience


**The COVID-19 Vulnerability Landscape: Susceptibility to COVID-19 Across Rural Versus Urban Health Regions of Canada**

## Abstract

Rural communities are often portrayed in the research literature and popular media as being disadvantaged and 'vulnerable'. This paper examines the extent to which rural health regions in Canada are more vulnerable than other health regions in terms of contracting COVID-19 and developing serious illness from this virus that leads to death. Data include published numbers of cases of and deaths from COVID-19 in each health region across Canada. Other data from Statistics Canada's Canadian Community Health Survey (CCHS) documents the higher rates of 'vulnerability' in rural health regions, according to (a) their socio-demographic conditions (income, education, age), and (b) the rates of 'underlying health conditions' which would make individuals more susceptible to serious illness from COVID-19. Despite these vulnerabilities, which are consistent with other research on rural areas in Canada, COVID-19 rates are found to be higher in metropolitan areas—although there is some variation in this pattern by province. In no provinces is the rate of death per case of COVID-19 highest in rural areas. Overall, in Canada, deaths per case from COVID-19 are higher in metropolitan than in rural health regions, challenging the notion of rural areas being only and always disadvantaged.

[Excerpt] While acknowledging the importance of rural variety, if we adopt a broad rural development perspective on the conditions in rural communities and regions in Canada, several specific challenges and assets emerge, relative to pandemic impacts. Challenges include ageing population levels; lower overall health outcomes; limited health care capacity; distance to services; variable internet, broadband access;lower levels of education; lower income levels; and a high level of essential service designations associated with rural employment, particularly in the resource and food production sectors.

Rural communities and regions are, however, endowed with considerable assets that have proven important in responding to the pandemic crisis. Most notably, high levels of social capital commonly noted in rural areas have spurred innovative support responses. The strong presence and role of the voluntary sector have also clearly risen to the challenge of dynamic, flexible, and tailored interventions in communities. Aside from the immediate impacts, it is also clear—although not yet fully understood—that the comparative affordability of rural housing(when compared with urban metropolitan regions), combined with high quality of life dynamics, have spurred an in-migration of urban residents into select rural communities(although not all rural regions, as evidence to support the importance of not assuming a homogenous interpretation of rural).

**The COVID-19 Vulnerability Landscape: Susceptibility to COVID-19 Across Rural Versus Urban Health Regions of Canada** E. Dianne Looker

To access, click on: **pdf**

NEW ON OUR WEBSITE

# Two-Eyed Seeing: Current approaches, and discussion of medical applications

BCMJ BC Medical Journal

Issue: BCMJ, vol. 63 , No. 8 , October 2021 By: Tristan Jeffery, BScDonna L.M. Kurtz, RN, PhDCharlotte Ann Jones, PhD, MD, FRCPC

**ABSTRACT: Two-Eyed Seeing is an approach of inquiry and solutions in which people come together to view the world through an Indigenous lens with one eye (perspective), while the other eye sees through a Western lens. It has been used in a variety of Indigenous-partnered research projects, but little information exists about Two-Eyed Seeing approaches in medical research. A focused narrative review of peer-reviewed Western literature was conducted to identify principles of Two-Eyed Seeing applications. Medline, Web of Science, and CAB Direct were searched and papers that described Two-Eyed Seeing approaches in Indigenous-partnered research projects were selected for review. Relationship building, community control, collaborative data analysis, and results that fostered change were recognized as common principles for successful application of Two-Eyed Seeing. Medical researchers must be aware of relational and community-involved processes while conducting research with Indigenous communities.**

A review of which Indigenous health care themes are present in Western medical literature.

**Background**

[Excerpt - without notes] Indigenous knowledge is shaped by the environment and land. Emotional, spiritual, and physical relationships with the natural world influence traditions and customs.[1] Ties to the natural world also influence perspectives on research. There are multiple Indigenous perspectives on research, often relational, being inclusive of people's experiences, spirituality, and culture. Western perspectives about research focus on interpretation of concrete facts and understanding the world, with little attention to emotional or spiritual realms.

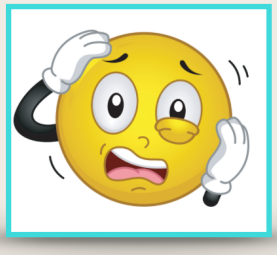
Two-Eyed Seeing developed from the teachings of Chief Charles Labrador of Acadia First Nation, but Mi'kmaw Elder Albert Marshall of the Eskasoni First Nation was the first to apply the concept of Two-Eyed Seeing in a Western setting. Specifically, Two-Eyed Seeing "refers to learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing, and to use both of these eyes together for the benefit of all." Elder Albert Marshall emphasizes that Two-Eyed Seeing requires groups to weave between each respective way of knowing, as Indigenous knowledge may be more applicable than Western in certain situations and vice versa.[2] It brings together two ways of knowing to allow a diverse group of people to use all understandings to improve the world.

Originally developed as a grassroots program to encourage Mi'kmaq postsecondary students to pursue science education,[2] Two-Eyed Seeing has since been used in research projects with Indigenous people across a variety of disciplines, but applications vary between groups. Further, there is little information about Two-Eyed Seeing approaches in medical research. The aim of this article is to discover and review which Indigenous health care themes are present in Western medical literature.

Eight themes were identified from the literature:

- The need to declare author positionality.
- Communication of group interpretations and guiding principles.
- Relationship building.
- Inclusion of Indigenous advisory committees and Knowledge Holders.
- Continued community guidance.
- Use of traditional knowledge gathering techniques.
- Collaborative community-involved data analysis and interpretation.
- Making meaningful and lasting relationships.

To read more, click on: Two-Eyed Seeing: Current approaches, and discussion of medical applications



**Wondering about the various acronyms and abbreviations?**
**Are you confused???**
**Don't worry, help is on the way.**
**Number 15 in our series *'acronyms explained'* (AE)**

**SCC = Specialist Services Committee**

**The Specialist Services Committee (SSC) is one of four joint collaborative committees that represent a partnership of the Government of BC and Doctors of BC, and includes regular representation from health authorities.**

**SSC formed in 2006 under the Physician Master Agreement to help Doctors of BC, BC government and health authorities collaborate on the delivery of specialist services and support improvement of the specialist care system in BC.**

**NEW VIDEOS ON OUR WEBSITE**

## Best Evidence Webinar: The Logic and Politics of National Pharmacare

Steve Morgan is a professor of health policy at the University of British Columbia. An economist by training, Dr. Morgan's research focuses on policies to provide universal access to appropriately prescribed, affordably priced, and equitably financed prescription drugs. He has published over 150 peer-reviewed research papers, received more than $4 million in peer-reviewed research grants, and provided policy advice to governments across Canada and around the world. Dr. Morgan has won many awards for his work and is an Emmett Hall Laureate (awarded in 2019) for career-long contributions to health system equity, fairness, justice and efficiency in Canada.

**LEARNING OBJECTIVES**

By the end of this session, participants should be able to identify and describe:

National drug coverage, and how we got here: Canada's unique position in the world, a country with a universal public health system with no accompanying national drug program.

The logic of national Pharmacare: The advantages it would bring and why it makes sense to provide drug coverage nationally in Canada.

Politics of national Pharmacare: What is preventing us from getting there and where are we heading?

**To listen, click on: https://www.ti.ubc.ca/2021/12/08/jan-12-best-evidence-webinar-the-logic-and-politics-of-national-pharmacare/**

## Physican Assistants - #BCNeedsPAs

To watch, click on: https://www.youtube.com/watch?v=YKauS6b45DA

For more information about PAs, visit https://capa-acam.ca/about-pas/

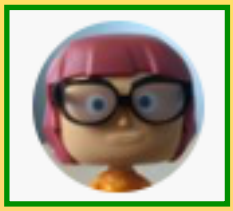
## Some of Our Latest Twitter Followers

**BC NEIHR [BRITISH COLUMBIA NETWORK ENVIRONMENT FOR INDIGENOUS HEALTH RESEARCH]**
**A supportive environment for Indigenous-led research that is woven from the values, knowledge, priorities and leadership of Indigenous communities and peoples**

### Jessica Harris

**@wordsbyjess Evidence-based healthcare. Medical writer. PhD.**

**Worimi country**



### Omobolade Osinowo

**@MobolaOsinowo Public Health enthusiast. MPH candidate @sfu_fhs passionate about Women's health, health equity and social justice #BlackLivesMatter Vancouver, British Columbia linkedin.com/in/omobolade-o…**

## Check out the petitions on our website

- Commit to fair and equitable **COVID-19 vaccine** access for all people in all countries (Doctors Without Borders) at: **https://bcrhn.ca/covid-19-vaccine-commit-to-fair-and-equitable-vaccine-access-for-all-people-in-all-countries/**
- Sign the Open Letter in Support of **Healthcare Workers** (LeadNow) at: **https://bcrhn.ca/leadnow-ca-sign-the-open-letter-in-support-of-healthcare-workers/**
- Take Action for **Pharmacare** (Council of Canadians) at: **https://bcrhn.ca/take-action-for-pharmacare/**

### Long Term Care

- Forward Together - A Canadian Plan at: **https://bcrhn.ca/forward-together-a-canadian-plan/**
- Action for Reform in Residential Care at: **https://bcrhn.ca/action-for-reform-in-residential-care/**
- Make Seniors Care part of our Public Healthcare System (LeadNow) at: **https://bcrhn.ca/make-seniors-care-part-of-our-public-healthcare-system/**
- Fix Long Term Care (CUPE) at: **https://bcrhn.ca/fix-long-term-care-cupe/**
- Support Our Elderly in LTC and Seniors' Care Homes at: **https://bcrhn.ca/support-our-elderly-in-ltc-and-seniors-care-homes/**
- Seniors Deserve Better (BC-GEU) at: **https://bcrhn.ca/seniors-eserve-better-bcgeu/**

### Transportation

The latest transportation petition is by Let's Ride! A National Petition for a Canada-wide Public Bus System which you can find here: **https://wordpress.com/page/bcrhn.ca/13557**

## Surveys currently on our website

**Bereavement Survey** at: **https://bcrhn.ca/bereavement-survey-bc-centre-for-palliative-care-survey-runs-until-march-25-2022/**
or click on the Download: **bereavement-surveyDownload**
The findings of the study will inform the development of priority actions and strategies to make effective supports accessible to more British Columbians with bereavement experiences. This survey runs until March 25, 2022

**Long Term Care Standards** at: **https://bcrhn.ca/long-term-care-standards/**
Have your voice heard: new National LTC Standards are being developed. Your responses will help shape what an optimal future state of LTC ought to look like in Canada.

**Rural Transportation Survey for Rural Residents living within the Interior Health Region** at: **https://bcrhn.ca/transportation-needs-interior-health-region/**
By completing this survey, you will assist in understanding transportation needs of individuals living in rural communities within the Interior Health region. Results will provide information to Interior Health on how to deliver services that best meet the needs of rural communities. Four participants will receive a $50 gift certificate or cash prize through random draws. This survey runs until February 15, 2022.

## About Us

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**Jude Kornelsen** - liaison with the Centre for Rural Health Research at UBC
**Teresa Murphy** - liaison with the BC Health Coalition

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