RURAL HEALTH MATTERS

British Columbia Rural Health Network January 2022

Letter from the President

Dear members and supporters,

As we say goodbye to 2021 and welcome 2022, it's time to celebrate our accomplishments and to look forward in anticipation of a momentous year ahead.

The past year has been one of change and growth for our Network.

Perhaps the biggest change was in personnel. On August 18, with great regret, the Board of Directors received and accepted Connie Howe's letter of resignation. As our first Administrator, Connie provided outstanding service to our organization for 19 months and the Board wished her well as she accepted a full time position in her community. The process of hiring a new Administrator began in September and after interviews were held with three candidates, on October 2nd, Paul Adams was offered the job. Paul brings a wealth of experience to the position and his commitment and initiative are showing promise for the future.

On the growth front, the Board of Directors continued its work on its strategic plan that included support for the establishment of rural Community Health Centres, improved access to public transportation, improved community involvement in healthcare decision-making through Rural Health Councils, and improved access to mental health and substance use services.

Membership in the BCRHN also had very significant growth. We now have 53 members, adding 12 new members over the past year. The Membership Committee continues to recruit, with a goal of increasing membership in under-represented areas of the province.

In April, the BCRHN formed the Access to Care Committee aimed at addressing the barriers that make access to healthcare difficult for rural BC residents. In recognition of the Network's strategic plan, the Committee has made transportation its primary focus.

Critically important to the work of our Network is the development and maintenance of relationships with government ministries and provincial health care organizations. In this capacity, the BCRHN continues to work closely with the Rural Coordination Centre of BC, the BC Health Coalition, the Centre for Rural Health Research, the BC Association of Community Health Centres, the Stigma Free Society, Let's Ride BC, and others.

Over the past few months, we have continued to develop relationships with government ministries. On November 8th, we met with Ted Patterson, Assistant Deputy Minister, Primary Care Division of the Ministry of Health (MoH). This was an opportunity for our new Administrator to meet ADM Patterson, who has been a long time supporter of the BCRHN. On December 3rd, we met with Thomas Guerrero, Executive Director in the Ministry of Health in charge of communications. This is the beginning of a new and important relationship that opens a two-way conduit of information between the BCRHN and the MoH. And on December 13, we met with the Honourable Sheila Malcolmson, Minister of Mental Health and Addictions, where we shared our mutual concerns and commitments to improve access to services for rural residents.

Recently, the BCRHN Board of Directors completed a visioning exercise (or more precisely, a re-visioning) where we took an optimistic look into the future. The result is a bold and ambitious view of what we expect our organization to look like in the year 2040 (see page 3). It is my hope that this revision of our future will serve as a focus as we continue to develop goals and strategies intended to improve access to healthcare services for all rural British Columbians.

On behalf of the Board of Directors and Staff of the BCRHN, I wish all our members and supporters a Happy and Healthy New Year.

Edward Staples, BCRHN President
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email: bcruralhealthnetwork@gmail.com

From the desk of the Administrator

Happy New Year to all!

2022 brings hope for a year with less suffering globally and a year to create better health outcomes everywhere. BC was hit especially hard with natural/unnatural events that caused so much additional hardship and suffering. I wish everyone a year filled with happiness, less extremes and good health!

Securing funding for operations and growth remain a priority for the BC Rural Health Network. The need for security was explained when I was recruited in October and has been the front burner issue since then. As you may know, the BCRHN was declined charitable status at the same time I was recruited, and we have now completed the appeal process and await the decision from CRA. No matter what the outcome of this appeal, we will continue to seek charitable status as the BCRHN's activities have been and will remain charitable. We received fourteen letters of support to the application, and I would like to thank all of those who have provided supporting letters to date!

In addition to CRA Charitable Status, we have also looked for other sources of support through both government and non-government organizations. We await responses on the requests we have made to government and hope to provide good news soon!

The Rural Coordination Centre of BC (RCCbc) has been a dedicated supporter of the Network and provide a liaison to the Board of Directors; the RCCbc represents the rural doctors of BC and sees the BCRHN as a partner in creating improvements for health outcomes for all. For the past two years the RCCbc has assisted in distributing funds to the BCRHN and have been instrumental in supporting the BCRHN. We are delighted to announce that the RCCbc has committed to additional funding for the 2022 fiscal year and their continued engagement with the BCRHN! A special thanks to Dr. Stuart Johnston (the official RCCbc liaison to the BCRHN) and to Dr. Ray Markham (Executive Director) who have both been instrumental in this needed support.

As mentioned in the message from the President, our work has also been highly active in growing and improving the Network. Meetings at the highest levels have been achieved with government, and networking between likeminded organizations and allies have been ongoing. The BCRHN has great supporters both in government and in non-government organizations, and these relationships will continue to be fostered in 2022.

Andrea Paquette (President) of the Stigma Free Society has been a great asset and has helped me with our CRA Charity appeal and I would like to thank her directly. Her group has excellent resources for rural mental health, and I would encourage you to visit https://ruralmentalwellness.com/. I was recently invited to speak on their YouTube Live, and you can view that here Stigma Free Interview

My first few months on the job have been focused on the future and focused on improving the ability for the BCRHN to be self-sustaining. It is however the past, which has created a platform, which will ensure better health outcomes for rural residents in BC.

I would like to express my thanks to all who created the organization and especially to Ed Staples and Nienke Klaver who have worked tirelessly on the BCRHN for four years and many additional years on protecting community level healthcare here in Princeton. A special thanks to Nienke Klaver especially for all her work on this newsletter, the website and building a network with very few resources but a whole lot of commitment and love!

BC Rural Health Network Vision - Where We Will Be in 2040

The BC Rural Health Network (the BCRHN) is the healthcare voice for all rural residents of British Columbia.

BCRHN's focus is on reaching all rural residents, hearing their needs, celebrating their successes, and assisting them with access to information, programs, and care. The BCRHN is focused on the rural resident and is both located in and connected throughout, rural British Columbia. Through efficient communications, broad provincial reach, volunteer driven community connections, sharing successes and open communications with all governments, it is possible for the BCRHN to reach a specific rural community or the entire province with timely information and responses.

The Network improves:

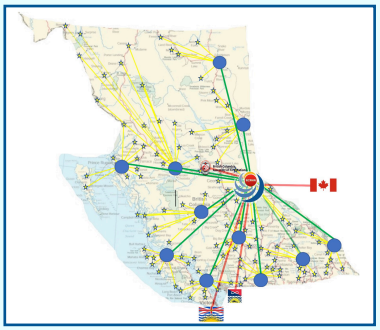
- rural health outcomes in a changing environment through accurate and timely information provision
- general healthcare information access
- senior care information and programming
- creation of community centric care groups
- interagency communications with other NGOs
- mental health awareness and programming access
- access to information from governments and healthcare providers
- access to programs that benefit the rural resident's wellness
- access to science pertinent to the rural resident that is accurate and approved by authorities
- access to the rural resident generally
- access to governments generally
- assistance to scientists and universities in accessing rural residents to identify determinants of rural healthcare impacts on the rural resident
- identification of rural health needs specific to rural life
- support for scholarship and education in rural healthcare fields

The BCRHN inter-connects directly with all member groups and with all governments. Open lines of communication are established and functional within the BCRHN ensuring the resident is receiving accurate information and the governments are aware of the impacts and benefits their decisions have in rural BC.

The BCRHN has community level memberships throughout BC, made up of municipalities and community healthcare organizations. The BCRHN has Network location hubs in each rural Health Service Delivery region allowing for information provision to specific locations with similar population densities and areas. Eventually, there are 12 BCRHN location hubs, all with similar facilities and office spaces. Each of these facilities is capable of being a HQ of operations.

The Board of Directors is a sophisticated, diverse group, who live in and are representative of, rural BC residents. The BCRHN has deep committee representation which includes government representatives, academics, First Nations, medical practitioners, and other community leaders. All committees are active and are included in policy meetings with governments. The BCRHN is the agent for the BC rural residents' healthcare interests.

2040 Vision Map



= BCRHN Operations Hub (any hub can operate as HQ)

= Randomly selected HQ for 2040 example

= Membership groups and communities

= Open lines of communication

= BC First

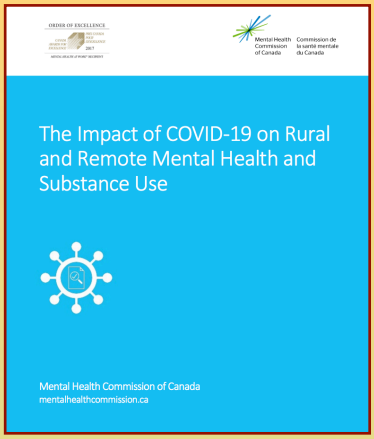
Nations = BC Metis Association

= BC Government

= Canadian Government

NEW ON OUR WEBSITE

The Impact of COVID-19 on Rural and Remote Mental Health and Substance Use



Nelly D. Oelke, PhD, RN, Associate Professor, University of British Columbia School of Nursing, Okanagan; Lauren Airth, MSN, RN, University of British Columbia School of Nursing, Okanagan

[Excerpts] This policy brief provides an overview of the developing issues and unique mental health and substance use challenges that COVID-19 poses for rural and remote communities. It builds on a **preliminary scan** the Mental Health Commission of Canada (MHCC) completed at the outset of the pandemic and on an **evidence brief on best and promising practices** written just before it began. The current brief includes an updated literature review, a section on diverse populations and social determinants of health, domestic and international policy responses, and policy recommendations.

Also included is a case study that highlights the British Columbia (B.C.) community of Princeton, in collaboration with the Princeton Community Health Table. Its primary audience comprises policy makers and organizations across the mental health and substance use sectors that serve rural and remote communities.

Key messages

- The COVID-19 pandemic continues to have a substantial impact on the mental health and substance use needs in rural and remote communities and on a growing lack of access to adequate and timely services and supports.
- The unique context, the influence of the social determinants of health, and health equity considerations play major roles in how COVID-19 affects these communities in terms of mental health and substance use.
- Provinces and territories pivoted quickly to provide innovative virtual mental health and substance use services. However, the lack of access to broadband internet coverage and information and communication technology (ICT) make it harder for people living in rural and remote communities to access services and supports.
- The pandemic has been a challenge on the resources, capacity, and solidarity of rural and remote communities but has reinforced the importance of resilience.
- Given the pandemic's expected long-lasting effects on mental health and substance use, the postpandemic period will be critical. It will also be an opportunity to transform the system and address unique impacts for people living in rural and remote communities.

Background

No single definition of rural or remote exists in Canada. Because each rural and remote community is unique, they are often defined by the experience and perceptions of the individuals who live there. According to Statistics Canada, rural and remote communities include "all areas outside population centres". Canadian research often defines rural as "communities with a core population of less than 10,000 people, where less than 50% of the employed population commutes to larger urban centers for work". In light of these differences, this policy brief uses both the academic definition of rural and remote as well as the lived experience of people in these communities.

Prior to the pandemic, research on rural and remote communities found that problems related to mental health and substance use vary when compared to urban settings. Evidence shows similar overall rates of mental health problems but differences in terms of specific mental illnesses and patterns of substance use.

Rural and remote communities face higher rates of suicide — including suicidal ideation, attempts, and deaths — than urban settings. Some rural and remote communities also report that substance use is a risk factor for suicide attempts and deaths. People in these communities who use drugs also have different patterns of use and access to harm reduction services while facing a greater risk of poisoning, morbidity, and mortality.

Over the course of the pandemic, the distinct risks in rural and remote communities have led to more impactful outbreaks. They have been at higher risk of COVID-19-related harms because, on average, they have a larger

Continued on page 6

Continued from page 5
proportion of people over 65, higher burdens due to chronic illness and underlying medical conditions, and lower degrees of mobility. These communities also face unique challenges across the social determinants of health, which include higher levels of income inequality, a lack of consistent and local employment, a seasonal and rotational way of life, increased levels of food insecurity, more limited access to clean water, and less access to high-speed ICT.

COVID-19 and its resulting public health measures, particularly those involving social distancing, have strained rural economies and social connections. As well, the pandemic has been associated with a drug supply that is becoming increasingly toxic. When combined with a decrease in services and increased stress on people who use drugs, this has resulted in increased drug poisonings across Canada, with disproportionate impacts for rural and remote communities and for First Nations and Métis.

The pandemic has exacerbated pre-existing gaps in access to mental health and substance use services and has added to already persistent shortages in the number of service providers. These access gaps include specialized mental health services, many in-person harm reduction services and supports, and other substance use treatment services, including opioid agonist treatment

Several in-person services and supports (e.g., peer support) have also moved to virtual platforms, which face particular limitations in rural and remote communities.

As an example of the pandemic's impact on mental health and substance use in a rural community, the following case study describes a grassroots initiative undertaken by the community health table in Princeton, B.C.

Case Study: Princeton Community Health Table [PCHT]

Description of the community

Princeton is a beautiful town, situated in the Similkameen Valley and surrounded by mountains, as seen in the pictures below. Among the 4,780 people who live there, the majority are 50 and older. Over 10 per cent of the population identifies as Indigenous. While the mean income is $57,000, eight in 10 residents fall below the poverty line. Mental health and substance use have both been identified as significant concerns. The rates of anxiety, mood disorders, and depression are eight times as high as those in the rest of the province, and like many rural communities in B.C., the community suffers disproportionately from the toxic drug crisis and consistently has one of the highest drug-related death rates per capita. Over the past year, these high rates of mental health and substance use have been further exacerbated by the COVID-19 pandemic.

Development of the PCHT

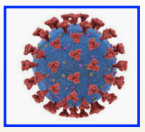
The PCHT was formed in June 2020 as part of the BC Rural and First Nations Health and Wellness Summit, sponsored by the Rural Coordination Centre of BC and the First Nations Health Authority. At the summit, partners came together to discuss and plan for health services delivery in Princeton and surrounding areas. The PCHT identified mental health and substance use as priorities for the health and wellness of the community. The group began with eight members representing various partner groups, including community members, providers, policy makers, and academic partners. It decided to continue to meet after the summit to plan, develop, and implement various community based activities to promote mental health and well-being. The final makeup of the group provided a strong representation of community members who could lead this grassroots initiative to improve services and supports for the community at large.

Goals of the PCHT

- Develop a community-driven package of mental health/substance use improvements.
- Study the implementation of specific enhancements to mental health/substance use service accessibility.
- Evaluate the outcomes attributed to the implementation of mental health/substance use service advancements.
- Sustain progress via new partnerships and existing community partnerships.
- Develop a transferable and adaptable model for implementing improved mental health/substance use services in rural and remote B.C. communities.

https://mentalhealthcommission.ca/resource/the-impact-of-covid-19-on-rural-and-remote-mental-health-and-substance-use/

More from https://mentalhealthcommission.ca/resource/the-impact-of-covid-19-on-rural-and-remote-mental-health-and-substance-use/



Nelly D. Oelke, PhD, RN, Associate Professor, University of British Columbia School of Nursing, Okanagan; Lauren Airth, MSN, RN, University of British Columbia School of Nursing, Okanagan

[Excerpt] COVID-19 has had far-reaching impacts for rural and remote communities. As a result, international efforts have sought to bring together best practices in terms of policy responses to some of the considerations and issues outlined in this report. The following points highlight such responses.

- WHO has advocated for placing more health-care workers in rural and remote communities, while psychiatrists internationally have recommended greater telepsychiatry training and the development of local guidelines to support practitioners during the pandemic.
- The Centre for Rural and Remote Mental Health in Australia has developed The Orange Declaration on Rural and Remote Mental Health, which provides an opportunity for dialogue about improving mental health in these communities through research, service design, and delivery. The declaration identifies 10 key problems and offers solutions that identify new and coordinated approaches at an international level.
- In B.C., the Northern Health Authority has advanced a strategy for rural and remote areas. In June 2020, it published the Northern BC Rural and Remote and First Nations COVID-19 Response Framework "to surface and co-create innovative solutions to these challenges by bringing together policy makers, educators, health care administrators, researchers, and health professionals/service providers". This operational framework provides guidance on how to better meet the urgent, unique, and local health and mental health needs of First Nations and rural and remote communities.

Policy Recommendations

Prioritize rural and remote communities and strengthen partnerships

1. Develop post-pandemic policies that recognize the unique mental health and substance use impacts of COVID-19 in rural and remote communities, in partnership with diverse community members.
2. Strengthen partnerships between the mental health and substance use sectors and policy makers serving rural and remote communities.

Recognize unique strengths and vulnerabilities

1. Build on the strong foundation of community resilience in rural and remote communities to address the long-term impacts of COVID-19.
2. Address the twin pandemics of opioid poisonings and COVID-19 in post-pandemic policies for rural and remote communities.
3. Invest in innovative harm reduction initiatives that address rural and remote communities' unique characteristics, including the provision of more accessible substance use services.

Support virtual care, internet communications technology, and accessibility

1. Provide all rural and remote residents with adequate access to broadband internet coverage and internet communication devices to access virtual mental health and substance use services.
2. Tailor virtual care solutions to the unique features of life in rural and remote communities.
3. Train rural and remote service providers and service users (including families) on the use of virtual technology, including its use as a tool to support their collaboration.

To read more, click on: **DOWNLOAD THE PDF**

Stigma Free Society: Interview with Paul Adams, Administrator, BC Rural Health Network

Click on: **https://bcrhn.ca/interview-with-paul-adams-administrator-bcrhn/**

Community engagement in public health emergency preparedness

EUROPEAN JOURNAL OF PUBLIC HEALTH

J Takacs, M Ciotti, S Tsolova, E Wiltshire, A Baka, J Kinsman, D de Vries, L Cremers, M Rios, J Angrén

[Excerpt] **Background:** Communities that could be affected by infectious disease outbreaks are increasingly recognised as resources that may be effectively utilized by the authorities during public health emergencies.

Conclusions: An over-riding principle emerging from this study is that an informed, at-risk community understands the challenges to adopting effective preventive practices for themselves better than anyone. Additional good practices included the utilisation of pre-existing stakeholder networks for information dissemination; and of monitoring community perceptions of any public health incident, including through social media, in order to identify and manage misperceptions. Efforts to build on the community engagement activities that are already in place in the four countries could contribute to better preparedness planning and more efficient and timely responses in future outbreaks.

Key messages:

- Recognise the community as a real partner in outbreak preparedness, response, and recovery.
- Optimise communications with communities who may be affected by outbreaks.

From: https://academic.oup.com/eurpub/article/29/Supplement_4/ckz186.514/5623431

Canadian-developed screening test aims to detect early-stage cancer using blood samples

CTV NEWS

Tom Yun CTV News.ca writer November 28, 2021

TORONTO — [Excerpts] The COVID-19 pandemic led to a surge in late-stage cancer diagnoses, with restrictions preventing or discouraging many from getting screened early.

But a new screening technology developed by a Canadian company could make it easier to detect cancers earlier.

StageZero Life Sciences is a Richmond Hill, Ont.-based health care company that has developed a way to simultaneously screen for a wide variety of cancers using a single blood sample. Some of the cancers that StageZero can detect include breast, cervical, endometrial, prostate, liver, stomach, bladder and colorectal.

"We'll take a sample of your blood and we then measure it to see whether it matches. Clearly, if it does that, we're going to say with very high probability that you have (cancer)," said Howard-Tripp. The test uses mRNA technology to analyze gene signatures in the patient's blood sample and cross-reference them with genetic profiles of individuals who have had cancer.

If mRNA sounds familiar, that's because it's the same technology that's been used to develop the COVID-19 vaccines made by Pfizer and Moderna.

Howard-Tripp says the blood tests can detect cancers with 98 to 99 per cent accuracy at any stage, even in very early stages. If the blood test comes up as positive for a cancer, the patient would be advised to see a pathologist for a traditional lab test to confirm the diagnosis.

"We will always tell you that we're not the definitive test. The definitive test is always a piece of tissue in front of the pathologist," Howard-Tripp said.

Cancer is the leading cause of death in Canada. According to the Canadian Cancer Society, an estimated 229,200 new cancer cases and 84,600 cancer deaths are expected in 2021.

But being able to detect cancers in the earlier stages can significantly increase the likelihood of survival. For example, patients with colorectal cancers detected in stage one or two have a five-year survival rate of around 90 per cent, Howard-Tripp says.

Howard-Tripp says the pandemic has resulted in a "tsunami" of late-stage cancer diagnoses.

[Click on the title to read the entire article.]

NEW ON OUR WEBSITE

Overdose prevention sites provide wide range of health benefits: new research

[Excerpts] Published on December 2, 2021.

The scaling-up of overdose prevention sites (OPS) in Vancouver beginning in December 2016 was associated with a range of health benefits, including an increase in engagement in addiction treatment, as well decreases in public injection and syringe sharing.

The findings from researchers with the BC Centre on Substance Use (BCCSU) and University of British Columbia (UBC) were published today [December 2, 2021] in the peer-reviewed journal Addiction.

They found that following the establishment and expansion of OPS:

- Use of supervised consumption services immediately increased by more than 6% (from about 41% to 47%)
- Addiction treatment participation immediately increased by nearly 5% (from about 65% to 70%)
- Public injection immediately decreased by approximately 6% (from about 36% to 30%)
- Syringe sharing immediately decreased by nearly 3% (from about 5% to 2%)

The findings build upon evidence that has shown that OPS and supervised consumption sites can reduce fatal overdose, reduce other causes of premature death, reduce transmission of infectious diseases like HIV and hepatitis C, support access to other health services, and improve the well-being of neighbourhoods by reducing public disorder.

“Overdose prevention sites are low-barrier settings that not only prevent overdose deaths, but also have the added benefit of bringing people into a supportive environment where they can get the help they need,” says lead author Dr. Mary Clare Kennedy, research scientist at the BCCSU. “Given the worsening of the drug poisoning crisis across the country, access to these services should be expanded.”

OPS provide access to a clean, safe space where drug consumption is witnessed and overdoses are responded to by teams of trained staff and peers.

“This research shows exactly what we are seeing on the frontline – that OPS save lives in so many ways,” says Sarah Blyth, a co-founder of the Overdose Prevention Society. “I hope this information helps guide government officials.”

The need for these services can be especially acute in more rural and remote communities, which lack many substance use services but still experience high rates of overdose.

Read more: [text in blue are hot links]

Study: **“Health impacts of a scale-up of supervised injection services in a Canadian setting: an interrupted time series analysis”**

- Study: **“Supervised injection facilities reduce all causes of premature death among people who inject drugs, new research finds”**
- Study: **“Overdose deaths would be at least twice as high without emergency harm reduction and treatment response”**
- Resource: **Why SCS** [Supervised Consumption Services]

Source: **https://www.bccsu.ca/blog/news-release/overdose-prevention-sites-provide-wide-range-of-health-benefits-new-research/**

NEW ON OUR WEBSITE

Duncan ER Team Puts Teamwork at Heart of Their Care

November 29, 2021 - Rural Coordination Centre of BC [Excerpt] During a year in British Columbia in which we've experienced a continuation of the COVID-19 pandemic, the ongoing climate crisis leading to fires and floods, and news of the discovery of 215 Indigenous children buried on Tk'emlúps te Secwépemc territory, for many, the mental load can be overwhelming.

And if you're a healthcare worker, on top of record low staffing levels, you may also be dealing with backlash to vaccination and mask mandates, and the urgent need to respond to the *In Plain Sight* report on anti-Indigenous racism in healthcare.

So it would be understandable for healthcare workers to simply want to hunker down and go into survival mode.

But one Emergency Department team on Vancouver Island decided to do whatever it took to ensure the care they provided the community could continue—and that the team at the centre of it was functioning at its best. To help with this, they accessed Quality Team Coaching for Rural BC (QTC4RBC), a pilot program run by the Rural Coordination Centre of BC, and the results have been remarkable. Since starting the program, the team has reported feeling less stressed, having better communication, and working with each other at another level that they haven't before.

Dr. Ava Butler, an Emergency doctor in Duncan who was instrumental in bringing the program to the team, said: "What we're trying to ignite is a sense of empowerment."

"One way that you make people feel loved and respected is you listen to them."

She said they had a great team, but that it wasn't always simple for individuals to make positive changes in the system and that can lead to low morale and feelings of helplessness. "Sometimes we get so frustrated that we stop trying to make change," she said.

"There are people who have worked in this environment for decades. They know what needs changing, but it could be that no one has asked them."

"When you present them with the ability to make change, they make change."

Dr. Butler added: "The ultimate goal is this is going to improve how we function, and then it's going to affect how we give care, and the end goal is it will improve how we provide culturally safe care."

And that's just what the program is designed for, says physician lead Dr. Rahul Gupta, who coached the group.

"There's a huge emphasis on creating spaces and carving out styles of communication that foster support and belonging so that people could feel that this was a safe place to not only share their challenges but also work together to design a way forward," he said.

While the program was originally envisioned as a one-day, in-person coaching workshop, due to COVID, it pivoted to being six online, two-hour modules. The modules are facilitated by one of two certified physician coaches—Dr. Gupta and Dr. Cecile Andreas—to lay the foundation for highly effective teams.

Nurse Terra Lee said the program came along at an important time. She said: "The project has been super important for us and the feedback has been very positive. We've seen a change in the way we are functioning. I'm so grateful that we have this opportunity to do this in a time of crisis. It's providing safer care when we are working under such challenging circumstances."

While the QTC4RBC is still a pilot program, there are plans to open another intake for the program in 2022. [QTC4RBC information sheet]

From: https://enews.rccbc.ca/2021/11/29/duncan-team-puts-teamwork-at-the-heart-of-their-care/

NEW ON OUR WEBSITE

Leading in Changing Times: SFU Program Tackles Systemic Inequities

THE TYEE

The Leadership Essentials Certificate program aims to decolonize traditional leadership approaches.

Kim Mah December 13, 2021 | TheTyee.ca

SFU's leadership essentials program is designed for new and aspiring leaders.

[Excerpt] From the Black Lives Matter movement to growing calls for reconciliation, Canada is facing a racial reckoning like never before. But how equipped are today's leaders to address systemic inequities in their workplace culture?

A new leadership development program at SFU Continuing Studies aims to fill that gap in skills and knowledge. Launched earlier this year, the Leadership Essentials Certificate program consists of four online courses created for new and aspiring leaders.

"For decades, there has been much research, academic work and activism in anti-racism, anti-oppression and social justice," says instructor Indy Batth, a leadership coach and consultant who helped design the program. "And then there's the field of leadership development. But the two areas have long been separate.

"What we've done is bring them together in one unique program where we can expose students to the next iteration of leadership for a changing society."

Rather than focus only on skills taught in other leadership training, like conflict or communication, explains Batth, the SFU program approaches such topics through an unwavering lens of decolonization and social justice.

"What are the dominant ways of working that no longer serve, that actually exclude some and benefit others?" says Batth. "How do we unknowingly (and sometimes knowingly) maintain those systems? This program reveals and helps name those systems."

As a senior program advisor with the federal government, Vancouver's Lupe Sibrian initially enrolled in the program to gain leadership skills that would enhance her ability to navigate the various systems within the public service. To her surprise, what she learned was essentially the opposite: how to shift away from colonial systems that lead to inequitable treatment.

"It's been such an emotional journey of self-discovery," she says. "As a person of colour, I felt validated in the frustration I had been feeling within these systems. It felt liberating to share and engage in topics that placed my lived experiences at the centre of the very topics we were discussing."

In the program, says Sibrian, she felt safe, supported — and prepared to speak up: "Through this journey, I'm so proud that I've been able to push myself out of my comfort zone. I now feel better equipped to acknowledge the things that need to be acknowledged."

"I knew Indigenous groups were underrepresented at work," she explains. "Since taking this program, I can now better identify the systems that hinder the success of individuals and reinforce it with all that I'm learning."

Click on: **Leading in Changing Times: SFU Program Tackles Systemic Inequities** to access.

NEW ON OUR WEBSITE

Following shocking heat wave death toll, long wait times for 911, here's what's changing about emergency care in B.C.

CTV NEWS

Kendra Mangione
CTV News Vancouver.ca Reporter and Producer
Updated Dec. 3, 2021

[Excerpt] In an update addressing recent issues involving access to emergency health care in B.C., the health minister outlined some changes the province is making that aren't popular with everyone.

Minister Adrian Dix confirmed in more detail Friday what was already reported by CTV News in November.

The province is expanding the scope of care paramedics and others are able to provide.

"When you call 911 and it's an emergency, you need to know that first responders can help you with every health intervention they are trained, licensed and able to deliver," the minister said at a news conference.

He said discussions have been going on for years, and this is the culmination of those talks.

"Once the changes are implemented, paramedics and first responders will increasingly be able to help patients on scene. For paramedics, this means the ability to provide more life-saving interventions, which at various licensing levels can include needle decompression for major chest trauma to support breathing, using portable ultrasound to better assess patients and inform care decisions, enhancing airway management skills and providing life-supporting or sustaining medications during transport," Dix listed.

Firefighters and other first responders will also see a broader scope of care, he said, including diagnostic testing, dealing with life-threatening allergic reactions and "administering care supporting the preparation and packaging of patients for transport by paramedics."

Additionally, Dix pledged further mental health supports members of B.C. Emergency Health Services, including increased clinical resources.

While some, including members of the B.C. Professional Firefighters Association (BCPFA), say the change is something they've been advocating for for years, others are less on board with the plan.

"They don't want our job, we don't want their job," the president of Ambulance Paramedics and Dispatchers of B.C. said last month.

The union's Troy Clifford called it a "duplication of services that goes on to municipal taxpayers."

Instead, the union is pushing for mass hiring, with Clifford saying up to 40 per cent of ambulances are not staffed because there aren't enough paramedics.

To read more, click on: **Following shocking heat wave death toll, long wait times for 911, here's what's changing about emergency care in B.C.**

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- B.C. paramedics understaffed by up to 40 per cent daily due to burnout, injuries, vacancies
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- More ambulance-fire integration? B.C. officials poised to make announcement

NEW ON OUR WEBSITE

Addressing rural and Indigenous health inequities in Canada through socially accountable health partnerships

BMJ Open

Ray Markham, Megan Hunt, Robert Woollard, Nelly Oelke, David Snadden, Roger Strasser, Georgia Betkus, Scott Graham, Correspondence to Dr David Snadden; david.snadden@ubc.ca

[Please note that references have been omitted in this excerpt.] **Background** There are few examples of the practical application of the concepts of social accountability, as defined by the World Bank and WHO, to health system change. This paper describes a robust approach led by First Nations Health Authority and the Rural Coordination Centre of British Columbia.

This was achieved using partnerships in British Columbia, Canada, where the health system features inequities in service and outcomes for rural and Indigenous populations.

Social accountability is achieved when all stakeholders come together simultaneously as partners and agree on a path forward. This approach has enabled socially accountable healthcare, effecting change in the healthcare system by addressing the needs of the population.

There are persistent health and wellness inequities across multiple domains including rural, remote and Indigenous communities in Canada.

One unique factor in British Columbia (BC) is the establishment of the First Nations Health Authority (FNHA) taking over the remit of First Nations Health from the Federal Government.

The negative variance in population health between rural and urban populations is present throughout our world. These disparities are more prevalent in remote, resource-based and isolated First Nations communities as seen in BC, Canada.

Their genesis is multifactorial, generally not from malice but from forces like economies of scale, system bias (eg, negative assumptions about rural), structural racism and historical and current day colonial systems of possession and control of Indigenous lands and services as well as critical mass perceptions to maintain service—all of which have created persistent inequities for decades.

These forces can be seen as a gravitational pull to urban centres in health systems, including deliberate centralisation of services. We have demonstrated that it is possible to embed counter forces in community relationships and healthcare systems that mitigate this pull, moving towards a more socially accountable equitable, and just health system.

Boelen and colleagues developed a framework for social accountability in health professions education using an approach that identifies and engages equitably five distinct health partners (policymakers, health administrators, health professionals, academics and community members). These partners were described visually as a Partnership Pentagram. We (Rural Coordination Centre of British Columbia (RCCbc)) modified the Pentagram partners framework, adapted and applied it to rural health system change using the World Bank definition of social accountability: ‘an approach toward building accountability that relies on civic engagement, in which citizens participate directly or indirectly in demanding accountability from service providers and public officials’. A sixth partner of Linked Sectors, industry and not-for-profit organisations, was added and the framework is referred to as the Partnership Pentagram Plus (PPP)

Connecting as human beings

Following the lead of our Indigenous partners, the importance of healthy relationships and recognising the intrinsic value of connecting as human beings (connection before action) is emphasised. Pragmatically, this results in us recognising that connecting is a part of any ‘work’ and needs to be valued as such.

We start most of our small group work by checking in, recognising we are Human Beings not just Human Doings. Each person introduces themselves, shares something about who they are as a human being as well as what they do (their work ‘hats’). In larger events, this can also be supported, by recognising First Nations Culture (eg, Elder openings, storytelling, traditional healers, cultural activities), grounding in community, environment and the people we serve.

For the full document, click on: **Addressing rural and Indigenous health inequities in Canada through socially accountable health partnerships**

NEW ON OUR WEBSITE

By Charlotte Lamb
November 22, 2021

[Excerpts from New Philanthropy Capital (NPC)] As we explore building back better after the pandemic, we are thinking a lot about readdressing power imbalances and about diversity, equity, and inclusion. If we are to do this well, centring the voices of those with lived experience in our work is vital.

1. Lived expertise and professional expertise are valued equally and are used alongside impact data and information about the wider system to inform strategic and operational decisions, at all levels.
2. Genuine co-creation and co-production is facilitated by true power sharing within and between organisations and supported by effective decision-making and governance processes.
3. There is a good understanding of the purpose and benefits of including those with lived experience in decision-making, and consequently, there is a desire to do this well across charities and funders.
4. Organisations have a strong understanding of what good involvement practice looks like for their organisation and are committed to implementing this to a high standard.
5. Boards take an evidence-led approach to decision-making—which includes lived experience, alongside professional expertise, impact data and information about the external environment.

We know that it can be hard to picture what genuine influence should look like in your organisation and the practicalities of it, and so it's easy to feel stuck on how to take it forward. Often power imbalances and unclear accountability prevent meaningful user involvement—this is where it's easy to fall into the practice of involving people in a tokenistic way. What's more, having an outcome fixed before beginning the involvement process prevents any decision-making power from genuinely being shared. Re-balancing decision-making power requires a deep culture shift.

Good co-production requires relationships and trust building, and this take time.

Good involvement practices are reinforced by better evidence of their efficacy and impact.

[…..] for the voices of people with lived experience to be truly reflected, they must have a genuine influence on decisions and not just be giving feedback on your choices.

Read more at: **https://www.thinknpc.org/blog/genuine-involvement-requires-a-re-balance-of-decision-making-power/**

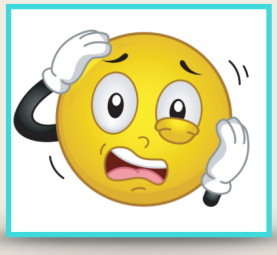
Implementing and evaluating co-design. A step-by-step toolkit

Co-design is when an organisation and its stakeholders work together to design or rethink a service. As an approach it sits midway between consultation and fully user-led projects.

We [New Philantropy Capital] are pleased to offer this toolkit, in which we explore what co-design is and why it matters. Our five-stage process offers a roadmap for planning and implementing your co-design, with tips and tools for each of the five stages. We also explore how you can assess the outcomes of your co-design and the quality of your processes, and how to review and learn from the data.

We have written this with service delivery organisations in mind, but you can apply these principles to any organisation looking to start or improve its co-design.

To access the toolkit, click on: Implementing and evaluating co-design DOWNLOAD



Wondering about the various acronyms and abbreviations?
Are you confused???
Don't worry, help is on the way.
Number 14 in our series *'acronyms explained'* (AE)

CIHI = Canadian Institutes of Health Research

The Canadian Institutes of Health Research (CIHR) is Canada's federal funding agency for health research. Composed of 13 Institutes, they collaborate with partners and researchers to support the discoveries and innovations that improve our health and strengthen our health care system. Visit the website by clicking on: **Learn more about us**

Canadian Institutes of Health Research

NEW ON OUR WEBSITE

What Does Synthetic Data Mean In Healthcare's Artificial Intelligence [A.I.] Revolution?

TMF The Medical Futurist

[Excerpts] Dec. 9, 2021 Data is the foundation of artificial intelligence. As the importance of A.I. grows in modern medicine, there's a huge need for data (as well as data annotation) – the latter being one of the most important aspects of the work in building an algorithm. In healthcare, collecting data means utilising existing databases and using images, radiology results, samples, CT or MR scans, patient records and more. The more data you feed the system, the better the results can become.

It's easy to guess that this data includes your own health-related data: EMRs, smartwatches, genetic reports, wearables and so on are all means to feed the A.I. with datasets. **But what if we would never be able to obtain enough data to contribute to the progress of A.I. in healthcare?**

Why is data important in healthcare A.I.?
The biggest obstacle to A.I. is the inadequacy of the available data. Without patient data, there is no A.I. in healthcare. On one hand, the amount of data needed for effective algorithms in healthcare is crucial as a huge amount of data is needed to feed the algorithms. On the other hand, data needs to be annotated, drawing lines around tumours, pinpointing cells or designating ECG rhythm strips – that's why the altruistic role of data annotators is so important.

Above all that, privacy concerns limit the amount of available data in medicine. Working with sensitive patient data is a tricky issue. It seems we cannot keep our privacy intact AND also benefit from A.I.'s advantages in our care. We saw in many cases how sensitive information can get leaked even unintentionally – and we are not even talking about hacking or privacy, just a poorly protected database. New methods like federated learning might make it possible to do this without breaching patients' privacy, but its scope is limited.

That is where synthetic data could be of help. It can fill in the missing data, making it possible to produce entirely fabricated patient datasets that are just as useful for training A.I. as the real thing, while keeping patient data protected.

Hands-on use
Synthetic data already has a number of practical use cases. A group of researchers in Michigan have developed a computer vision model to help improve pathologist decision support to more accurately diagnose brain tumours. Their challenge was that if they wanted to use brain scans from other institutions, the algorithm's efficiency dropped as it could not compare the different types of scans.

Click on **Synthetic Data** if you want to read more about privacy, quality and bias.

Some of Our Latest Twitter Followers

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BC SUPPORT Unit - Vancouver Island Centre
We support #patientorientedresearch in the Island Health region as part of Canada's Strategy for Patient-Oriented Research (SPOR) led by the CIHR [Canadian Institutes for Health Research]
islandhealth.ca/research-capac…

Pharmacists have an integral role in the team-based primary care strategy being introduced by the BC government.

The Pharmacists in Primary Care Network (PCN) Program (the Program), which officially started in the Fall of 2020, will see up to 50 Primary Care Clinical Pharmacists (PCCP) integrated into PCNs across British Columbia.This Program is also mobilizing and connecting existing pharmacists within communities to enable and support shared patient care.

"Embedding a clinical pharmacist in a patient's primary-care team reduces the risk of adverse drug reactions, which rises with the complexity of the condition, a patient's frailty, age and the number of medications prescribed. " Adrian Dix

Read about PCNs **here.**
Read about the first PCCP hire **here.**
Read the government announcement **here**.

For immediate help, call 1-800-SUICIDE
To book an appointment, call 1-833-308-6379
For hours of operation click on: foundrybc.ca/virtual

HEALTH CANADA HAS APPROVED ITS FIRST CANADIAN-MADE 3D PRINTED MEDICAL IMPLANT

Kubi Sertoglu - December 9, 2021.
[Excerpt] Health Canada, the government arm that deals with national health, has approved its first Canadian-made 3D printed medical implant.

The 3D printed device is a customizable mandibular (lower jaw) plate for use in facial reconstruction surgery, predominantly for patients with oral cancer. It can also be used in conjunction with surgical guides for cutting and drilling operations.

Health Canada issued the Specifit 3D mandibular plate approval in September 2021, enabling surgeons to use the implant, together with two surgical cutting and drilling guides, to treat patients.

Since the device is designed to be customizable, treatments will benefit from being patient-specific. The implant can be 3D printed according to the anatomy of the patient, which will help improve surgery success rates, as well as reduce both surgery and recovery times.

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