RURAL HEALTH MATTERS

British Columbia Rural Health Network March 2022

Letter from the President

Dear members and supporters,

As Paul Adams points out in this month's message from our Administrator, we have taken an important step by establishing monthly meetings between the BCRHN and the Interior Health Authority. We hope to build on this process and use it as a model for future meetings with other provincial health authorities.

In this issue of *Rural Health Matters,* I am very pleased to read about the community of Sicamous and the success of their newly established Community Health Centre (CHC). The promotion of the CHC model is a strategic priority of the BCRHN and we congratulate the District of Sicamous and thank them for their message of inspiration and care.

What is not inspiring and, quite frankly very disturbing, is the article in the February 28 issue of The Tyee*: Is Two-Tier Health Care Growing in BC?* You can read an excerpt from the article on page 4, which also contains a link to the full article.

On a more positive note is the article from the January 4th issue of the Vancouver Sun that outlines the innovations that have resulted from the collaborative efforts of medical professionals, scientists, governments, businesses and citizens. Of particular interest is the work being done by Vancouver Coastal Health and Health Canada to explore the feasibility of training dogs to detect COVID-19, providing a fast, non-invasive and accurate approach to detecting the virus.

There are several other articles that Nienke Klaver, the editor of our newsletter, has included in this issue. She reads dozens of healthcare articles and research documents from a variety sources and hopes that her selections provide something of interest to all our members and supporters. Your comments and suggestions for future issues are welcome.

I'd like to end by borrowing the words of Alex Silas, organizer of the Community Solidarity Ottawa movement, who stated in a webinar that I recently attended, "Love is stronger than hate." The fight for peace "is won with love in our hearts, love for our community, and love for each other."

Edward Staples, BCRHN President
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From the desk of the Administrator

March is upon us and although the end of February has been a reminder of the winter, the weather today is feeling like spring here in the Similkameen. The global events leading the news have been a sober reminder to me about how fortunate we are to live where we live and have all we have. It reminds me also of the importance of communication and solutions-based approaches being the only way to improving our domestic affairs and to improving humanity generally.

On the domestic front, and in continuation of the work that commenced upon the reduction of services in the Interior Health region in January, the BCRHN discussions and BCRHN inclusion in the conversation have continued. These discussions have been happening directly between senior executives at the IHA and both the Administration and Executive of the BCRHN. The BCRHN was informed and included in pre-press announcements of partial service resumption, and to staff recruitment achieved in several rural communities. This inclusion has given the BCRHN an improved ability to respond to members and individuals.

A meeting with IHA occurred on Friday February 25th when the BCRHN met (for what was the first of now a monthly engagement) with Diane Shendruk (VP.) As two communities still remain in reduced service mode following the January reductions and both these communities are impacted due to staffing levels, recruitment and retention was the main focus of our discussions. A full report will be provided to the Board of Directors with discussion at our March meeting. In addition, we initiated some discussion on developing better models for community centric care and resident involvement in their healthcare. The time taken and the exchange of information has been a welcome exercise and one I believe will create a better approach and system for all involved. Action from these discussions will hopefully create models that can be duplicated for better rural health throughout BC.

The BCRHN Board of Directors has also been busy on the Provincial front and received a lengthy response to questions posed by the Board of Directors to the Ministry of Health. This communication dates back to December and due to the pandemic and pressures on the MoH the response took longer than anticipated. Volunteers from the BCRHN Board of Directors have now met and discussed the document at length and a formal response will be sent later this week. The BCRHN is aware of the generic nature of some responses that government makes and hopes this connection directly with MoH allows us improve the information flow back to the rural resident and that mutually beneficial exchanges with a rural focus will continue.

The BCRHN was pleased to see an investment in additional nurse capacity and has acknowledged this as being a much-needed investment for the future. The BCRHN has also emphasised a need to see rural placement of nursing staff and requests priority be placed on ensuring full service and equity in care in rural BC. More investment in rural health and rural student scholarships are certainly needed! This however is a positive step for bringing nursing levels to appropriate levels.

The website build is ongoing and I look forward to getting our beta model up and running in March, we will then be seeking additional input from volunteer beta testers before making a full launch. The changes will significantly improve our website and provide a great tool to for the public on rural health and rural healthcare. I look forward to sharing!

My thoughts are with the people of Ukraine and I wish peace to all!

Yours in health and wellness,

Paul

Member of the Month - Sicamous Community Health Centre

Sicamous is a lively community nestled between Shuswap and Mara lakes midway between Calgary and Vancouver at the intersection of the Trans-Canada Highway and Highway 97A. As the Ancestral Home of the Splatsin, Sicamous is part of the Secwépemc Nation which consists of 17 Campfires. The 2021 Census from Statistics Canada reflects the community is growing with a 7.6 per cent population increase from 2,429 in 2016 to 2,613 in 2021. Sicamous also accommodates a large seasonal population during the peak summer and winter tourist seasons, which at times triples the population of the community.

In June 2021, the District acquired the Sicamous Medical Clinic from retiring physician, Dr. Jack Beech, who tirelessly served Sicamous and the surrounding area for over 40 years. With the acquisition, the Clinic was established as the Sicamous Community Health Centre and shifted from a private practice to a Community Health Centre (CHC). This transition aided in the recruitment of three physicians who are providing quality patient care to Sicamous and area residents.

The CHC model not only aids in the recruitment of health-care providers but supports a collaborative environment for health-care professionals to work together and deliver health and wellness services based on community needs. One of the unique features of the model is its strong focus on the **social determinants of health** and preventing acute illness among groups who are more likely to experience poor health and suffer from chronic conditions, including low-income people, ethno-cultural communities, Indigenous Peoples, and seniors.

In less than six months, the number of patients at the Sicamous Community Health Centre increased from 1,800 to 2,310, and while not a walk-in facility, has been able to accommodate hundreds of patients who required medical care. Currently, there is a patient waitlist of over 200 residents which is attributable to recent population growth as well as a desire to access healthcare locally. The District is excited to be in the final planning stages of a new regional health and wellness centre—the Shuswap Healing Centre—which will become the new home of the Sicamous Community Health Centre and provide space for allied health professionals to offer their services in the community.

Engagement with the larger community as well as the Interagency Committee has been essential during the planning stages of this project. Sicamous is fortunate to have the Interagency Committee, a group of dedicated individuals who work in the non-profit sector that meet once a month to network, share information, provide updates on their work, support one another, and find solutions to better serve their communities.

The Shuswap Healing Centre is inspired by Sicamous' *Live More Live Well Strategy* which was developed in 2018 to foster a strong and healthy community where all individuals can reach their full potential. As our community encompasses Tk'emlups te Secwépemc, we are honored to be in partnership and collaboration with Splatsin to provide regional health and wellness services based on inclusivity and accessibility. In addition, the Shuswap Healing Centre addresses Truth & Reconciliation Calls to Action 21, 22 and 23.

"The greatest distance a human being will ever travel is the distance from their head to their heart. It is only when we can speak heart to heart will we find our way forward together."

Tsewanooek [Elder Dr. Bob George (Hon.) Tsleil Waututh]

Moving from our heads to our hearts requires acknowledging, knowing, and understanding our history as the foundation for taking action to make concrete and lasting change. As Canadians set out on a journey of reconciliation it is incumbent on us to create space to learn about our shared history. For Indigenous Peoples, the colonial past is a painful story, one that not only silences a rich history of deep family values, culture, and land stewardship but one of stolen lands, Residential Schools, and the *Indian Act*.

Before there can be genuine reconciliation, Canadians must know the hard truth about the past. The Shuswap Healing Centre aspires to create new stories of reconciliation based on relationships of mutual understanding, empathy, and respect.

[Submitted by Earen Eastand, Manager Sicamous Community Health Centre]

[https://www.sicamous.ca/live-here/community-health-centre]

NEW ON OUR WEBSITE

Is Two-Tier Health Care Growing in BC?

THE TYEE

Two seniors were told they would need to pay $4,600 each to keep seeing their family doctor after he moved to a Telus clinic. [Note: text in blue are hot links]

Andrew MacLeod February 28 - 2022 / TheTyee.ca Andrew MacLeod is The Tyee's Legislative Bureau Chief in Victoria and the author of *All Together Healthy* (Douglas & McIntyre, 2018). Find him on Twitter or reach him at amacleod@thetyee.ca.

[Excerpt] At 84, Lieta Robinson had a tough choice to make after receiving a letter from her doctor.

Health Minister Adrian Dix says the ministry has asked the Medical Services Commission to review the annual fees being charged by private clinics. Photo via BC government.

She and her 88-year-old husband could start looking for another doctor, joining the roughly 760,000 British Columbians who aren't attached to any primary care provider. Or they could each pay an annual fee to stay with him when he moved to a Vancouver clinic owned by the telecommunications company Telus.

"We are really upset," said Robinson. "We're seniors, and we've had good health care, but this has kind of upset us."

She and her husband had been with Dr. Geoffrey Edwards for some 36 years, staying with him as he moved from clinic to clinic, from Burnaby to Kerrisdale. They are in "pretty good health," but at an age where they need care from time to time.

According to the letter the couple received from Edwards, the fee for each of them would be $4,600 for the first year, then $3,600 for each year after that.

While Robinson and her husband could afford the fees, she said, the wider implications bothered them.

"This is most disturbing if doctors are going to give up their general practice and go into something like this," she said. "If everybody did this, then what happens to our health care?"

Edwards didn't return calls by publication time. The clinic he is moving to operates using a model that has been described as being in "a legal grey area." The model has long been contentious.
Under the Medicare Protection Act, doctors who receive payments under the public Medical Services Plan may not charge a patient directly for any service normally paid for through public insurance.

Telus has spent more than $2.5 billion expanding into health care, seeing it as a way to differentiate itself from its telecommunications competitors and grow revenues.

It bought clinics operating under the brands Medisys, Copeman Healthcare and Horizon Occupational Health Solutions in 2018.

Telus said the annual fees patients like Lieta Robinson face if they want to stay with their doctors are not for necessary services covered by the provincial Medical Services Plan. They are for services that the public system doesn't cover, Telus said in an email.

Telus said most of the doctors working in its clinics "continue to work in the public sector seeing patients for MSP-covered primary care services." In fact, the company argued, by focusing on wellness the clinics help "alleviate the burden on our overall health-care system" by keeping people healthy.

The Copeman clinic, now owned by Telus, made the same argument in 2006 when the Medical Services Commission began an 18-month investigation that eventually concluded the clinic was operating legally.

One person who didn't buy the argument was Adrian Dix, then opposition health critic, now health minister. He said the private clinics were undermining the basic principles of public health care.

Read more at: **Is Two-Tier Health Care Growing in BC?**

NEW ON OUR WEBSITE

Pandemic has driven homegrown health-care innovation. How do we maintain the momentum?

VANCOUVER SUN

Opinion/Op Ed - Jan 04, 2022 Author of the article: Dr. Dean Chittock
Dr. Dean Chittock is vice-president, medicine, quality and safety at Vancouver Coastal Health.

[Excerpt] There's nothing quite like adversity to ignite creative problem solving and foster resilience, and the COVID-19 pandemic is no exception

The past 21 months have taken a devastating toll on individuals, families and communities around the world. Yet, the pandemic has also spurred tremendous innovation in the health-care sector as medical professionals, scientists, governments, businesses and citizens unite to slow the spread of COVID-19.

As we chart out a new normal, Vancouver Coastal Health has been working closely with others to enhance public health and restore public confidence in the safety of our shared spaces.

For example, VCH has joined with Teck Resources Limited, TransLink and the Toronto Transit Commission on a pilot to test copper's effectiveness on high-touch transit surfaces. Phase I of the project confirmed copper could kill 99.9 per cent of bacteria on transit surfaces, consistent with VCH's previous findings in laboratory and hospital settings. Phase II, which started in September, further explores how copper — a visible, tangible infection prevention measure — can enhance public safety.

This collaboration between public and private sectors advances health-care innovation by providing funding and expanding opportunities for real world trials and applications.

At the onset of the pandemic, there was increased global demand for personal protective equipment, or PPE, and severely disrupted supply chains. B.C. faced challenges acquiring PPE, particularly N95 respirators, due to limited global supplies and protracted waiting times for testing and validating of new PPE at labs in North America.

To address this, VCH established Western Canada's first accredited PPE testing lab in just a few short months, working with the B.C. Ministry of Health, Lions Gate Hospital Foundation, VGH & UBC Hospital Foundation and the Provincial Health Services Authority to ensure the new PPE supplies met Canadian and international standards. This lab is also a sustainable resource with economic benefits for the province and country, as Canadian manufacturers can now use this service to evaluate and validate PPE products and materials, fostering the local industry and bolstering the domestic PPE supply.

Detection dog Finn trains with a scent stand to detect the smell of COVID-19. PHOTO BY JASON PAYNE /PNG

In 2016, VCH became the first health-care organization in the world to use C. difficile-detecting dogs to reduce infection in the health-care environment. This summer, VCH joined Health Canada to explore the feasibility of training these super sniffers to detect COVID-19 and find a fast, non-invasive and accurate approach to detecting the virus.

VCH was uniquely positioned to pivot this program to meet pandemic needs, with its extensive experience and team of medical professionals, dog handlers and infection prevention practitioners. Recently, three dogs were externally validated for COVID-19 scent detection with 100 per cent sensitivity and 93 per cent specificity in a laboratory setting.

To read the entire article, click on: **Dr. Dean Chittock: Pandemic has driven homegrown health-care innovation. How do we maintain the momentum?**

NEW ON OUR WEBSITE

How to encourage more family doctors

TIMES COLONIST

A commentary by a family doctor in Saanich: Never, in my 20 years of practice in B.C., have I seen family medicine in crisis as it is now. Trust me, it is not a new issue.

Dr. Jennifer Lush - Feb 7, 2022 5:03 AM

[Exerpt] I am a family doctor, and unless there is major primary care reform in this province, I may be one of a dying breed. Never, in my 20 years of practice in B.C., have I seen family medicine in crisis as it is now. Trust me, it is not a new issue.

The writing has been on the wall for a long time, but we have been so busy working 70 hours a week, caring for patients, and trying to keep our small businesses afloat that we have stood by and watched government after government allow further erosion of primary care with no meaningful change.

I know many physicians who, themselves, do not have a family doctor and little hope of finding one; when my family doctor retires, I have no doubt my family and I will join the 700,000 (and steadily increasing) people in this province with no family physician.

I have watched valued and respected colleagues agonize over how they can continue to offer care to their patients but finally walk away from their practices, thoroughly burnt out and utterly demoralized.

The trouble is it feels like no one with the power to make effective change is listening. Here are a few ideas I would offer up, if I could sit down and have a chat with the health minister over a cup of coffee:

Pay us a wage commensurate to our training and professional status. Family physicians in B.C. are the second-lowest paid in the country, and as we all know, B.C. has the highest cost of living.

The fees paid to doctors have not increased in pace with the cost of living. Most have of us have paid for at least eight to 10 years of university on our journey to becoming a doctor, which translates to massive student loan debt.

Before we can even bill a dollar for patient care, we have to spend upwards of $7,000 annually on professional licensing fees, memberships and malpractice insurance.

Fair compensation for family doctors would still be good value for health care dollars invested. One study showed that people with a family doctor are 35 per cent less likely to be admitted to hospital. It has been proven over and over that a patient with a family doctor costs the health-care system thousands of dollars less annually than a similar unattached patient.

Unlike other small businesses, which can increase their fees to cover increased overhead, our income is limited by the government. Trust me, we would all much rather be practising medicine, which is what we were trained to do, than worrying about purchasing supplies, paying staff, etc.

The average family doctor visit pays about $32, and for most of us, 30-35 per cent of that will go to overhead. From the remaining $21, we have to put aside money to save for our retirement, pay our own medical expenses or plan for future illness, because community family doctors do not have a pension plan, extended health benefits, paid holiday or sick leave.

I have to buy all the equipment I use to offer patient care. That flu vaccine I gave you? I bought the syringe and needle out of the visit fee I will get paid to see you.

The $3,000 autoclave I use to sterilize the metal instruments I use for removing your cancerous mole also came out of my paycheque, as did the instruments, the dressing, the suture material … I think you see where this is going.

Stop with the paperwork! I didn't spend 11 years in university after high school training to write sick notes or fill out insurance forms. Let me diagnose and treat disease, and then maybe, have an hour or two to spend with my family in the evening.

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While I appreciate the Urgent Primary Care Centres are shiny and new, please understand they are not a replacement for the longitudinal care of family doctors.

They have actually driven our walk-in clinics out of business, as a solo physician working fee-for-service can never compete with a Health Authority contract, even though the private walk-in clinics see many more patients annually than the UPCCs do.

The government might proudly declare that UBC is graduating about 170 doctors from family medicine training programs each year. But the vast majority will become hospitalists or subspecialize, do surgical assisting or work in private clinics, work for corporate virtual clinics like Babylon and Maple, or move to other provinces or the U.S. where they are more respected and fairly compensated.

There are so many other fields of medicine that will offer up to twice the income, without the overhead, paperwork, and hours of unpaid (and posthumous) work.
Until we make family medicine the MOST attractive field for young graduates, we will continue to see the family medicine crisis worsen. I sincerely hope this government makes lasting reforms now that will stop the extinction of family medicine in B.C. before it is too late.

Now, Mr. Dix, about that cup of coffee…

From: Times Colonist - Dr. Jennifer Lush **How to encourage more family doctors**

NEW ON OUR WEBSITE

Alone and in Pain, This ER Patient Was Left at a Bus Stop

THE TYEE

Advocates say stigma and mistreatment are ‘rampant’ in hospitals across British Columbia for people who use substances.

Moira Wyton 18 Feb 2022 I TheTyee.ca

Pierce Sharelove: ‘I can’t even express how humiliated and destroyed I was.’ Photo by Lillie Louise Major.

[Excerpts] It was just after 4:30 a.m. Pierce Sharelove was at a bus stop outside Victoria’s Royal Jubilee Hospital emergency room, wracked by back pain, grief-stricken by the recent death of his brother and barely able to move on his own.

But the 61-year-old was not making his way into the Victoria hospital on the morning of Aug. 6. He was trying to get home.

Still holding a prescription for the painkiller hydromorphone a hospital doctor had written minutes earlier, Sharelove had been asked to leave by nurses at the triage desk while he tried to phone friends to get a ride home. None had answered. It was the middle of the night.

He made it a few metres outside the entrance, where he collapsed in pain. Security was called, and when he explained, the security guard put Sharelove in a wheelchair and pushed him about 150 metres to the bus stop outside the hospital.

But the buses wouldn’t run for almost two hours.

A cab had been called by the emergency department, but the driver refused to take him home because he didn’t have his wallet with him or a taxi voucher from the hospital. Sharelove spent at least an hour sobbing and cold at the bus stop he had been wheeled to before a police officer was called and drove him the few minutes home.

Continued on page 7

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Sharelove says he was abandoned by staff at Royal Jubilee Hospital after he was discharged and traumatized by their failure to secure him a ride home that morning, despite not being violent or disruptive.

'It's so dehumanizing'

Advocates say stigma, dismissal and mistreatment are "rampant" in hospitals across British Columbia for people like Sharelove who use substances.

The allegations from Sharelove, who suspects he was stigmatized as a substance user who has required emergency care in recent months, add to growing concerns and accounts of mistreatment and physical harm against other marginalized people at the hospital.

Sharelove's provincial disability assistance due to chronic depression provides a living stipend far below the poverty line, which means he didn't have coverage for sufficient physical therapy to address the pain. He could barely do laundry on his own or walk around, and his support system of friends and family in town was limited.

So Sharelove reluctantly turned to the only relief he had at his disposal, one he knew would work. He began using meth almost daily to manage the pain.

Just a few days after his most recent hospital visit, Sharelove called 911 in pain again on Aug. 6 and shuffled out of his apartment, without his keys or wallet. He was wearing only thin pants and a long-sleeved shirt as he was helped into the ambulance.

Sharelove waited in the emergency department for nearly five hours in physical pain and emotional distress. Two days earlier, he had learned his brother, Steve Bowes, had died by suicide in Nelson and the grief was overwhelming as he sat alone.

The doctor who eventually saw Sharelove that day prescribed him 15 hydromorphone tablets, an opioid stronger than morphine, for sciatic pain. Sharelove says the doctor seemed sympathetic to his grief and was patient with him as he sobbed during the assessment, but the visit ended quickly and there was no followup plan.

"He didn't finish his job. He gave me a prescription, but where was the continuity of care? And was some judgment factored into that? I don't fully know," Sharelove said. "The judgment I can only assume was because I was in the emergency many times before and I told them the truth, that I was using meth and yes, I had injected."

Hospital security wheeled him to a nearby bus stop on Richmond Street.

Security left him lying on the bus stop bench, Sharelove says.

To read the entire article, please click on: **Alone and in Pain, This ER Patient Was Left at a Bus Stop**

Michael Smith Health Research BC

BC AHSN British Columbia Academic Health Science Network

COVID-19 Inventories and Resources

Together with the *BC Ministry of Health*, the *Michael Smith Foundation for Health Research*, *BC Centre for Disease Control* and additional partners, we [the *BC Academic Health Science* Network] are working to ensure that researchers/research teams based in BC are offered diverse resources and supports so that our research impacts are recognized within BC, nationally and internationally.

https://bcrhn.ca/bc-ahsn-covid-19-research-inventory/

NEW ON OUR WEBSITE

B.C. government adding 602 nursing seats in a move to address skills gap

CANADIAN PRESS

Retirements, combined with an aging population that will need more care, are creating new pressures on the system alongside the pandemic, health minister Adrian Dix said.

The Canadian Press – Amy Smart – Feb 20, 2022

[Excerpt] The B.C. government is adding 602 new nursing seats to public post-secondary institutions in a move the B.C. Nurses' Union calls a "promising step" toward addressing a staffing crisis in health-care. The new seats bring the total seats for nurse training in B.C. to about 2,600.

First-term nursing students at BCIT learning health assessment skills the Burnaby campus on May 13, 2021. PHOTO BY JASON PAYNE /PNG

The added funding will create 362 new seats for registered nurses, 40 for registered psychiatric nurses, 20 for nurse practitioners and 180 for licensed practical nurses.

Health Minister Adrian Dix said the spending is about building B.C.'s future health-care workforce, while Jobs Minister Ravi Kahlon said it will help close a skills gap.

The government also announced funding to boost training of graduate nurses — those who will end up in supervisory roles or train new nurses.

Aman Grewal, president of the B.C. Nurses' Union, says staffing levels were already critical before the COVID-19 pandemic and now B.C.'s 40,000 nurses nurses are tired, burned-out and need more support.

In a survey last month, 76 per cent of union members said their workloads have risen since the COVID-19 pandemic began.

The survey found 51 per cent of those working in emergency departments and intensive care units said the pandemic has made them more likely to leave the profession in the next two years.

"This investment is a promising step toward addressing the staffing crisis that is currently crippling our health-care system," Grewal said.

Since 2017-2018, Dix said the number of licensed practical nurses in B.C. has risen 12 per cent and registered nurses are up six per cent. A number of new seats were also added in the fall of 2021 at UBC and Thompson Rivers University, which are among the universities and colleges that will be adding the new seats announced Saturday.

But while the overall number of nurses has risen in recent years, so has demand. Retirements, combined with an aging population that will need more care, are creating new pressures on the system alongside the pandemic, he said.

"The number of nurse increases in B.C. is faster than anywhere else but the demands on nurses are increasing, I think it's fair to say, even more. And so (there's) a need to invest in the future," Dix said.

Grewal said in addition to adding more seats to training programs, retention incentives and finding ways to employ internationally-trained nurses will be key to addressing the problem.

The expansion of nursing programs is part of the NDP's economic plan, which aims to close the skills gap with a generational commitment to hurry talent development and skills training for British Columbians.

Funding comes from $96 million committed over three years as part of last year's budget to expand post-secondary education and training capacity for health professionals.

https://bcrhn.ca/b-c-government-adding-602-nursing-seats-in-a-move-to-address-skills-gap/

NEW ON OUR WEBSITE

Three countries provide lessons for improving health and promoting happiness

Denmark, Costa Rica and New Zealand stand out as three countries that are getting something right when it comes to maintaining the health and happiness of their citizens.

[Excerpt] Case studies show that effectively delivering services at the community level, cultivating social trust, and accounting for well-being at the highest policy level all play an important role.

Living amid the despair caused by a global pandemic has taught us that happiness, as we know it in its many forms, is important for the functioning of societies.

"I'm with Aristotle on this one. Happiness, or a thriving life—or as the ancient Greeks called it, eudaimonia—is the summum bonum, the highest good," says Columbia University economist Jeffrey Sachs, who coauthors the annual World Happiness Report, which ranks countries based on life evaluation surveys.

Denmark: It's a matter of trust

By her own count, Cordelia Chesnutt has taken at least 32 COVID tests. A negative test was a requirement each time she wanted to pursue her side passion of playing badminton once Denmark lifted its lockdowns.

The tests, free and easy to schedule, were a small price to pay, she said, for ensuring the safety of others and, especially, maintaining a bit of happiness during the pandemic. It was also, to a large extent, an example of how many people in Denmark see their actions as a part of a collective effort.

Whether it's based in enlightened self-interest or pure altruism, social trust is paramount in Denmark. Citizens trust that the government will enact policies in the public's interest. Government trusts that citizens will maintain the social fabric. People trust that their fellow Danes will do what is required for the greater good. This social phenomenon played out during the pandemic, leading to a remarkably successful effort at stemming the virus at a relatively low human cost.

Researchers often point to trust as the most important cultural trait when explaining Denmark's consistent top rankings on various measures of happiness and contentment. Rooted within society's trust is the country's robust social welfare system, providing generous unemployment, free health care and higher education, and heavily subsidized childcare.

Bjørnskov, who recently published a book called Happiness in the Nordic World, said the cultural trait of trust is almost unique to Danish and other Nordic societies. But he argues that it's not necessarily the extensive social welfare that makes Danes content or happy but rather a combination of trust, tolerance, strong institutions, a long history of economic development, and a resilient democracy.

From: https://www.imf.org/external/pubs/ft/fandd/2021/12/Countries-lessons-life-well-lived-Bala-Behsudi-Jaquiery.htm?utm_medium=email&utm_source=govdelivery

Extreme heat linked to increases in mental health ER visits: study

BY SHARON UDASIN – 02/23/22

[Excerpt] Waves of extreme heat, which are on the rise due to climate change, are linked to an uptick in emergency room visits for mental health conditions, a new study has determined.

On such hotter-than-normal days over the past decade, emergency department check-ins for any mental health condition surged by 8 percent in comparison to days of optimal temperature, according to the scientists, who shared their results on Wednesday in the journal JAMA Psychiatry.

Read more at: **https://bcrhn.ca/extreme-heat-linked-to-increases-in-mental-health-er-visits-study-3/**

Wondering about the various acronyms and abbreviations?
Are you confused???
Don't worry, help is on the way.
Number 16 in our series *'acronyms explained'* (AE)

PMA = Physician Master Agreement

From: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/negotiated-agreements-with-the-doctors-of-bc:

Negotiated Agreements with the Doctors of BC

There are a number of agreements that set out the relationship between the Government of British Columbia and the Doctors of BC. These agreements acknowledge that the parties wish to work collaboratively in the health care system and recognize their shared obligation and responsibility to meet population and patient medical needs.

2019 Physician Master Agreement

The Physician Master Agreement covers the relationship and economic arrangements between the Government of British Columbia and the Doctors of BC. The agreement is in effect to March 31, 2022.

To download, click on: **https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/consolidated-pma-2019.pdf**

RCCbc's "Rural Patient Health Record" Project Puts Patients at Centre of Health Journeys

In British Columbia's complex healthcare system, rural patients often access disparate services from multiple providers, making it difficult to access or manage their own medical information.

To enable patients to easily access and manage their medical records, the Rural Coordination Centre of BC (RCCbc) launched a new Rural Personal Health Record (rPHR) project in 2020. Find out how the rPHR project could hep rural patients to more easily access and manage their medical records.

Project Manager, Jess Rothenburger, tells us all about it. [Excerpt of an interview]

Q: How could the implementation of a PHR improve health outcomes for rural British Columbians?

A: By having easy access to their own information, a person could better manage and take greater interest in managing their health; the patient can become the protagonist of their own health journey. A patient could be better positioned to access care, understand risks, interact with their health providers, improve their health literacy, and more. By granting access to their information to family members, caregivers and providers, a patient can use a PHR to facilitate partnerships and create a team of care. And, as rural patients travel long distances to access care, having their information travel with them can prevent errors and gaps when information may not seamlessly flow between different providers and health authorities.

Jess Rothenburger (far left) poses with participants in a "Provider Workshop" in Valemount

To read more, click on: **https://enews.rccbc.ca/2021/11/29/rccbcs-new-rural-patient-health-record-project-puts-patients-at-centre-of-health-journeys/**

Some of Our Latest Twitter Followers

My Health CRM

@MyHealthCRM Health and Wellness Contact Record Management transformed into a Information Database of Health Professionals. Including Mental Health and Addictions. Worldwide myhealthcrm.com https://myhealthcrm.com/2020/06/my-experience-with-the-addiction-crisis-in-british-columbia

Redpress Network

Advocacy network for #HarmReduction in ON, Canada by Alex McVean. Journalist, AUD Team at @BCCSU, Social Media @CenterforEBMgt, SEO @drugsandmehub

Adenike Adelakun

@PharmAdenike MSc Student @UBCPharmacy

Pharmacist Vancouver, British Columbia

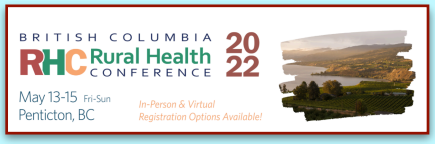
PATIENT VOICES NETWORK

Are you a resident of **LILLOOET, LYTTON, ASHCROFT, MERRITT, or CLEARWATER** and interested in joining the **Collaborate Services Committee,** where primary care planning occurs for the region?
Share your perspectives on the primary care needs in this region!
Deadline: March 8 Click here to: **Read more about the opportunity and RSVP**

TRANSPORTATION SURVEY FOR RURAL RESIDENTS IN THE INTERIOR HEALTH REGION

Deadline: March 7 Four participants will receive a $50 gift certificate or cash prize through random draws. Complete the survey for your chance of winning one!
https://bcrhn.ca/rural-transportation-survey-deadline-march-7/

BC RURAL HEALTH CONFERENCE



Date: May 13-15, 2022
Location: Penticton, British Columbia/Virtual Sessions
Join - in person - for this highly-anticipated rural health event, with rural-relevant CME plenaries and breakout sessions, hands-on skills workshops, and wellness breaks to keep you moving.Virtual sessions will also be offered.
For more information, click on: **BC Rural Health Conference**

WELCOME TO OUR NEW MEMBERS

• **MARCY CHOHEN**, a research associate with the Canadian Centre for Policy Alternatives and an adjunct faculty member in Health Sciences at Simon Fraser University. Marcy has co-authored a number of research and policy studies looking at public solutions to the current challenges in our health care system.

To read some of Marcy's work, click on: **https://bcrhn.ca/a-higher-standard-in-ltc-homes/** and/or: **https://bcrhn.ca/rising-to-the-challenge-how-bcs-community-based-seniors-service-agencies-stepped-up-during-covid-19/**

• **CENTRAL OKANAGAN HOSPICE ASSOCIATION**

The Central Okanagan Hospice Association (COHA) serves the Central Okanagan from Peachland to Oyama.

In partnership with the Central Okanagan Hospice Palliative Care Program of Interior Health, COHA is committed to "Helping people with a serious illness live to the fullest until they die, and to help their loved one to be supported in their grief."
https://hospicecoha.org/

About Us

SOCIAL MEDIA

website: https://bcrhn.ca

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twitter.com/bcrhnetwork

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