

SHARED CARE

**PROJECT  
SUMMARIES**

**2025/26**



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Shared Care Project Abstract Summary

**PROJECT NAME: Addressing Communication and Language Barriers for the Provision of Culturally Appropriate Medical Care**

**LOCATION: Burnaby Division of Family Practice**

**PHYSICIAN LEAD(s):  
Dr. Ana Pesantez (FP), Dr. Carrie Wong (SP)**

**AIM STATEMENT: By September 2025, this project will enhance and improve communication for Burnaby residents (with a focus on families who experience language barriers, including women, new parents and seniors) and their providers by improving culturally safe access to care, increasing patient understanding and navigation of the healthcare system, and boosting patient and provider confidence and satisfaction related to medical visits.**

**TIMEFRAME: July 20, 2022 – September 30, 2025**

**1. Purpose  
Why did you start?  
Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

The Shared Care Language Project was launched to address significant communication barriers facing Burnaby residents—particularly newcomers, women, new parents, and seniors—when accessing health care. Miscommunication during clinical encounters contributes to delayed care, repeat visits, unnecessary procedures, and compromised safety, while reliance on informal interpreters erodes trust and deepens inequities. With only 26% of surveyed providers reporting confidence using interpretation supports, and 61% of patients relying on family or friends, there was a clear need for new approaches. The project’s aim was to enhance communication, improve culturally safe access, and increase patient and provider confidence and satisfaction by September 2025.

**2. Methods  
What did you do?  
Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The project employed a phased, evidence-driven design beginning with a comprehensive needs assessment (2022–2023) and process mapping (2024) to identify bottlenecks in service provision for patients and providers. Interventions included piloting AI-enabled translation (DeepL Voice) during appointments, launching a multilingual “Accessing Health Care in Canada” webpage on the Burnaby Primary Care Network website using GTranslate (103+ languages), an AI chatbot, translated patient intake forms, resource links, and an educational webinar recording. Engagement was multi-layered: providers participated in training, benchmarking, and pilot testing; patients and caregivers joined multilingual focus groups and conducted online surveys; and community partners such as Immigrant Settlement Services of British Columbia (ISSofBC), Multi-lingual Orientation Service Association for Immigrant Communities (MOSAIC), YWCA Vancouver, Burnaby Intercultural Planning Table, Burnaby Local Immigration Partnership, and Burnaby Together – Coalition Against Racism and Hate supported resource development and dissemination. Data collection followed a mixed-methods framework combining surveys, focus groups, community consultations, website analytics, and Steering Committee reflections.

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### 3. Results

#### **What did you find?**

**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Results demonstrated measurable benefits. In the pilot, 86% of patients found DeepL Voice helpful for understanding diagnoses and care instructions, and post-pilot surveys confirmed improved trust, satisfaction, and communication confidence. Providers reported 71% improved efficiency, though only 43% intended to continue using AI tools due to workflow, cost and accuracy concerns. Benchmarking versus pilot data showed a 9% reduction in extended appointments; history taking (39% in benchmarking vs. 34% in pilot) remained the biggest challenge.

Qualitative findings demonstrated a notable shift among patients from reliance on informal interpreters toward strong enthusiasm for AI-enabled translation tools. Patients described these aids as *“very good,” “great,” “convenient,” “easy to understand,”* and *“better than nothing.”* Health care providers similarly reported enhanced communication, noting *“improved mutual understanding between physician and patient”* and *“reasonable accuracy when functioning correctly; useful when the user has a working knowledge of the language.”* Despite these positive outcomes, providers identified ongoing challenges related to dialect accuracy and ongoing operational costs at the expense of the provider. Reported issues included *“mishearing (e.g., homophones, omissions, repetitions) leading to meaning distortion”* and *“mistranslations—sometimes subtle, sometimes significant.”* The Burnaby PCN webpage also demonstrated engagement, receiving 694 “Health Supports” views and 305 “DocTalks” views across 18 languages from May to September 2025. Final Steering Committee evaluation found 86% agreed the project improved care for people experiencing language challenges, and 100% agreed participation enhanced understanding of issues and opportunities.

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### 4. Conclusion

#### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project met its aim by improving patient-provider communication, increasing awareness of language supports, and producing sustainable digital tools. The Burnaby Primary Care Network will maintain the webpage, translated resources, and patient education materials. While DeepL Voice significantly improved patient experience, provider adoption was tempered by technical and workflow challenges, and it will not be sustained. Nonetheless, spread is feasible across other BC divisions through adaptation of the digital hub, training modules, and engagement strategies.

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### Lessons Learned

From a project management perspective, several enablers were critical. Strong partnerships with community organizations, consistent physician leadership, and regular Steering Committee engagement ensured that diverse perspectives shaped interventions. The phased approach—beginning with the needs assessment and process mapping, followed by piloting and evaluation—allowed flexibility to pivot from video interpretation pilots to AI-enabled solutions. Digital innovations, such as the multilingual Burnaby Primary Care Network’s digital hub and translated resources, were major successes, as was the use of patient and provider surveys to create a robust evidence base.

Challenges also emerged. Time and workflow constraints remained a consistent barrier for providers, and sustainability planning revealed gaps in infrastructure and funding required for long-term adoption of AI tools. Engagement with Indigenous communities was initiated but remained at an early stage, pointing to a need for deeper relationship-building. Patient

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recruitment for surveys and focus groups was sometimes difficult, particularly among seniors and those with limited digital access, which limited the diversity of input.

Looking ahead, if the project were to be repeated, the team would invest earlier in workflow integration strategies for AI tools, dedicate resources for broader Indigenous engagement, and provide enhanced training and communication for providers. Advice for other groups undertaking similar work includes engaging stakeholders early and continuously, balancing innovation with evidence-based practices, and ensuring sustainability planning begins at project inception. Above all, the project demonstrated that addressing language barriers requires a multi-pronged approach—combining technology, professional interpretation, and community partnerships—to meaningfully advance health equity.

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## Tools & Resources

### 1. Educational Resources

- Burnaby Primary Care Network's [Accessing Health Care in Canada](#) multilingual webpage (central hub)
- Translated patient & provider education materials ([posters for clinics](#), [take away cards](#) for patients, and [intake forms](#) in Burnaby's top 10 languages)
- Patient educational webinar - [DocTalks – Accessing Health Care in Canada](#) with subtitled recordings online
- Ongoing training resources such as physician pilot training sessions

### 2. Clinical & Workflow Tools

- Process maps identifying patient and provider bottlenecks
- Benchmarking and pilot data collection templates (for physicians and MOAs)
- Quality improvement and evaluation tools, including survey templates

### 3. Digital Innovations

- Multilingual webpage hub with GTranslate (103+ languages)
- Online menu of links to resources and supports
- Online/print resources translated into multiple languages
- *DocTalks* recordings, subtitled and accessible on the PCN website
- AI chatbot offering immediate, multilingual health information
- DeepL Voice pilot testing AI translation in clinical encounters

### 4. Community & Stakeholder Engagement

- Focus groups in six languages (English, Farsi, Dari, Spanish, Mandarin, Tigrinya)
  - Engagement and training sessions with MOAs, clinic managers, and physicians
  - Partnerships with organizations including ISSofBC, MOSAIC, YWCA Vancouver, Burnaby Together, Umbrella Multicultural Health Co-op, Burnaby Intercultural Planning Table, Burnaby Local Immigration Partnership, and Burnaby Together – Coalition Against Racism and Hate
  - PCN Working Group meetings to build awareness and promotion of resources
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## Shared Care Project Abstract Summary

**PROJECT NAME: Strengthening the Transition from Acute to Primary and Community Care for Burnaby Patients with Substance Use Disorders**

**LOCATION: Burnaby Division**

**PHYSICIAN LEAD(s):**

**Jia, Dr Lingsa  
Tran, Dr Wynn**

**AIM STATEMENT: By Jan, 2026, the project team aims to better support people in Burnaby who use substances through the implementation of a localized, longitudinal, integrated, and holistic model that streamlines the transition from acute care to primary and community care in Burnaby via at least two initiatives, as well as by developing at least two knowledge sharing opportunities to address stigma for both providers and Burnaby community members.**

**TIMEFRAME: 6/1/2023 - 1/31/2026**

### 1. Purpose

**Why did you start? Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

The Burnaby community has been significantly impacted by the ongoing toxic drug and overdose crisis, with substance use closely linked to mental health challenges and broader social determinants such as housing insecurity, poverty, and systemic inequities. Shared Care needs-assessment activities identified substantial gaps in substance-use care across acute, primary, and community settings, including low provider confidence, limited awareness of available supports, fragmented transitions of care, and pervasive stigma. In response, the Burnaby Substance Use Shared Care Project was initiated to strengthen coordination, reduce stigma, and build system readiness to better support people who use substances in Burnaby. The project aimed to implement a localized, integrated Shared Care model that improves transitions from acute care to primary and community care while enhancing provider capacity and community awareness.

### 2. Methods

**What did you do? Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The project used a relationship-based, mixed-methods quality improvement approach. Interventions included provider and community anti-stigma learning events; opioid agonist treatment (OAT) capacity building through a structured education and mentorship pathway; strengthening connections between primary care and peer supports via the Burnaby Community Action Team (BCAT); formative engagement with community pharmacists to identify barriers to OAT distribution; and consolidation of substance-use resource navigation tools, including development of a Burnaby-specific Addictions Care Pathway. The target population included people in Burnaby who use substances, primary care providers, specialists, peers with lived and living experience, pharmacists, and community partners. Data collection methods included pre- and post-event surveys, focus groups, engagement documentation, training participation tracking, environmental scans, and qualitative analysis of feedback and reflections.

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### 3. Results

#### **What did you find?**

**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

The project achieved measurable improvements in provider experience and system readiness. Provider anti-stigma learning events demonstrated significant increases in comfort interacting with people who use substances (29% to 77%), understanding of harm reduction (58% to 97%), and awareness of local substance-use supports (13% to 47%). Sixty percent of participants expressed interest in further OAT training. Twelve physicians expressed interest in OAT education, six enrolled, and three completed the full training pathway by project close. Community anti-stigma activities reached over 100 community members and increased awareness of harm reduction and local resources. System-level outputs included a Burnaby-specific Addictions Care Pathway, strengthened primary care–peer referral connections, and improved alignment of resource navigation tools across platforms. These outcomes indicate improved system readiness and coordination rather than immediate changes in patient utilization.

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### 4. Conclusion

#### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The Burnaby Substance Use Shared Care Project met its aim of strengthening system readiness to support people who use substances by reducing stigma, increasing provider confidence, improving care coordination, and developing sustainable tools and partnerships. While some anticipated outcomes—such as reductions in acute-care utilization—require longer-term follow-up, the project produced strong foundational impacts that support future system-level improvements. Embedding outputs within existing structures enhances sustainability, and the project’s relationship-based, scalable approach offers a transferable model for other communities responding to the toxic drug crisis.

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### Tools & Resources

- [Burnaby Resources on Substance Use](#)
  - [Enhanced Care Pathways: Addiction Care Pathway for Navigating Health Authority and Community Services](#)
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## Shared Care Project Abstract Summary

**PROJECT NAME:** Access to Dermatology

**LOCATION:** Fraser Northwest Division of Family Practice

**PHYSICIAN LEAD(s):**

**Dr. Sabrina Nurmohamed, Dermatologist**

**Dr. Mahsa Mackie, Family Physician**

**TIMEFRAME:** May 1, 2023 - November 30, 2025

**AIM STATEMENT:** The aim was to increase patient access to skin cancer diagnosis and increase dermatologist capacity by piloting a Skin Lesion Photography Clinic, whereby a trained photographer takes high quality dermoscopic photos of a suspicious skin lesion and in lieu of an in person assessment, a dermatologist will review the photos asynchronously to determine if further investigations are needed.

1. Purpose

**Why did you start? Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

In 2023, the average wait time to see a dermatologist was 12-18 months in the Fraser Northwest region. Due to the increasingly high demand, some dermatologists stopped accepting referrals, leading to increased pressures and resource shortages across the lower mainland.

Family physicians and dermatologists were concerned about patients who have been waiting years to have their suspicious spots checked and in some unfortunate cases, these cases turn out to be melanoma or advanced skin cancers which could have been prevented with earlier assessment and treatment.

The aim of the project was to increase timely access to skin cancer diagnosis and increase dermatologist capacity by piloting a Skin Lesion Photography Clinic, whereby a trained photographer takes high quality dermoscopic photos of a suspicious skin lesion. In lieu of an in-person assessment, a dermatologist reviews the photos asynchronously to determine if further investigations are needed.

2. Methods

**What did you do? Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The Skin Lesion Photography Clinic was set up to adopt a team-based care model where a trained photographer, nurse, and dermatologist's scope of care are maximized. This pathway is run in parallel alongside the dermatologist's regular practice so that access to care for other dermatologic issues are not impacted. In the early days of setting up the clinic, a local primary care clinic in Coquitlam was engaged and provided feedback on the referral pathway. Referrals were accepted from across the lower mainland and the eligibility criteria included patients between 16-80 years old with 1 or 2 skin lesions of concern that are not in sensitive or difficult to photograph areas (e.g. the breast, genital or spots covered by tattoos). Clinic days were held once or twice a week depending on demand. Data collection methods included patient and referring satisfaction surveys, committee feedback surveys and EMR data including wait times and patient outcomes.

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### 3. Results

#### **What did you find?**

**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

From January 2024 to January 2025, 18 patients on average were seen each clinic day for a total of 751 patients seen and 885 skin lesions assessed. Of those lesions, 27% were treated for pre-cancerous lesions or skin cancer. The average wait time from referral to appointment was 20 days and the average time from referral to receiving definitive management was 39.9 days. 428 (49%) of lesions were benign and followed up by nurses at the clinic. As a result, the photography clinic saved 107 hours of face-to-face appointments with the dermatologist, which was used to provide other aspects of dermatology care. Results from a patient and referring provider survey showed high levels of satisfaction and timely access to care.

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### 4. Conclusion

#### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The Skin Lesion Photography Clinic represents a significant opportunity to enhance dermatological capacity and has improved access to diagnosis of skin cancers through utilizing a team-based care approach with nurses, dermatologists and a trained professional that can take high quality, standardized dermoscopic photos. The photography clinic is being continued at Inlet Pharmacy in Port Moody and is exploring other potential communities of interest for spread. This pathway has strong scalability potential for communities with reduced access to dermatologists or organizations with existing infrastructure and could minimize the burden on individual practices.

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### Lessons Learned

- Dermatologist participation was constrained by competing clinical priorities and variable practice models, so the project focused on establishing the Skin Lesion Photography Clinic and streamlining communication with family physicians
  - Patient feedback indicated that some patients still expected an in-person dermatologist visit and struggled to understand the new process. As referring providers are the first point of contact, messaging was enhanced and consult notes were updated to clarify the process for future referrals.
  - To improve sustainability and scalability, the project adopted a dermatology-specific Casio camera to lower training barriers and enable cross-coverage, reducing reliance on specialized photographers and individual-level operational support.
  - A robust data collection and evaluation approach was established early, enabling thorough chart-based analysis and ultimately transitioning to ongoing support from the FNW Division's evaluation team. Key contributions to data extraction and analysis were made by medical students Emilie Wang and Adrianna Keeler.
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**Tools & Resources**

- Figure 1: Patient Journey Map
  - Patients and referring providers can visit the [CheckMark website here](#)
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## Shared Care Project Abstract Summary

**PROJECT NAME:** Community pathway of care for suspected Deep Vein Thrombosis (DVT) cases

**LOCATION:** Fraser Northwest Division

**PHYSICIAN LEAD(s):**  
Yun, Dr Jennifer Meng-Sup  
Braunstein, Dr Jonathan Brett  
Wong, Dr Kenneth

**AIM STATEMENT:** By coming to a local agreement on a safe and efficient pathway of care for suspected DVT patients, our project aims to reduce the number of ultrasound workups in the ER by at least 5%, increase awareness of the availability of access to timely ultrasound imaging in the community, and promote guidelines around initiating Novel Oral Anticoagulants (NOACs)/Direct Oral Anticoagulants (DOACs) in the Primary Care Provider's office.

**TIMEFRAME:**  
5/1/2023 - 3/31/2025

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

In the Fraser Northwest, an increasing number of patients present to the emergency for urgent access to blood work and ultrasound imaging. However, high patient volumes at the ED often lead to long wait times and sometimes patients are asked to next day for their ultrasound appointment as appointments are no longer available on the same day, leading to frustrations. The aim of the project is to reduce the number of ultrasound workups in the ER by at least 5% by establishing a safe and efficient care pathway through primary care. This includes increasing awareness of timely ultrasound imaging access and promoting guidelines around initiating Novel Oral Anticoagulants (NOACs)/Direct Oral Anticoagulants (DOACs) in the primary care.

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The project established and created a streamlined algorithm for suspected DVT patients by collaborating with radiologists, emergency (ER) physicians, hematologists and primary care providers (PCPs). Methods to disseminate this algorithm include electronic newsletters, posting on Pathways BC, individual reach outs to PCPs and Medical Office Assistants (MOAs). Educational workshops were held to increase confidence with diagnosing and managing DVT patients and knowledge in how to access timely imaging in the community. To evaluate project outcomes, a mixed-methods design of collecting both qualitative and quantitative data was used.

**3. Results**  
**What did you find?**  
**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

The project improved timely access to imaging, allowing PCPs to have reliable access to imaging to manage suspected DVT patients in the community. Although ED data showed that there was less than 1% change in doppler imaging visits at the ED following the implementation of the DVT algorithm when compared to pre-implementation, standardized decision-making protocols based on patients' anticoagulant status helps to avoid unnecessary ED visits. Changes to imaging reports enhanced communication between PCPs and radiologists. Education sessions increased provider knowledge in diagnosing suspected DVT patients in primary care, greater confidence in initiating anticoagulation therapy and awareness of timely ultrasound imaging options in the community.

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#### 4. Conclusion

##### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

In summary, this project successfully enhanced care for suspected DVT patients by improving PCPs confidence in the work up process and increasing access to timely imaging options in the community. To ensure sustainability, established protocols will remain in place, ongoing communication will be maintained through various mechanisms and future collaboration between PCPs and ER physicians in spring 2025 will foster relationships and address broader challenges at the ED.

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#### **Lessons Learned**

The DVT project successfully established multidisciplinary protocols that ensure patients receive immediate anticoagulation and avoid unnecessary ER visits. However, significant diagnostic delays remain because community lab results often lag behind imaging, disrupting the intended workflow. While the project improved report clarity, it highlighted persistent gaps in after-hours lab access and incomplete imaging requisitions. Moving forward, the goal is to shift toward a “one-stop-shop” model that integrates blood work and imaging into a single visit, reducing the patient burden and streamlining the path to treatment.

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#### **Tools & Resources**

[Pathway of Care for Suspected Deep Vein Thrombosis Cases](#)

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## Shared Care Project Abstract Summary

**PROJECT NAME:** Neurology

**LOCATION:** Ridge Meadows Division

**PHYSICIAN LEAD(s):**  
Lee, Dr Joseph  
Athwal, Dr Gurleen

**AIM STATEMENT:** Over the next 24 months, we will improve access to neurological care by building relationships between family physicians, nurse practitioners, hospitalists, ER physicians, neurologists, psychiatrists with special interest in neurology, and other appropriate specialists; and improve system navigation and access for the complicated neuro-symptoms that remain undiagnosed with a focus on headaches and dizziness.

**TIMEFRAME:**  
3/1/2022 - 8/31/2025

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

Ridge Meadows has had no Neurologist since May 2023, when the specialist providing limited coverage (two half days per month) to support acute care patients at the Rapid Access Clinic resigned. Patients were redirected to hospitals and clinics across the Lower Mainland. Larger hospitals were at full capacity and unable to recruit, while BC's low number of medical school seats per capita worsened province-wide Neurologist shortages. Wait times exceeded 6 months, further delayed by limited local imaging and recruitment challenges. As a result, Ridge Meadows patients faced significant delays in access, diagnosis, and treatment, while providers lacked clear referral options and support for complex cases, reducing quality of care.

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

We implemented strategies to improve timely access, provider knowledge, and system navigation for patients with neurological conditions. Key interventions included a dedicated referral pathway with a neurologist (in-person and virtual), 7 structured education sessions, a customized Neurology Gem Share referral guide, an impact analysis for a local Neurology Clinic, and strengthened collaboration among family physicians, hospitalists, ER physicians, and specialists. The target population, Ridge Meadows providers and specialists, were engaged through education sessions, newsletters, clinic visits, leadership meetings, virtual forums, and partnerships with Fraser Health and the Neurosciences Network. Engagement built relationships, raised awareness of supports, and fostered collaboration. Data collection via polls, surveys, stakeholder discussions, informal feedback, and referral tracking—measured impact on provider confidence, knowledge, care coordination, and system improvements.

**3. Results**  
**What did you find?**  
**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes**

The project enhanced provider knowledge, confidence, and coordination of neurological care. Seven virtual education sessions engaged 230 providers, with 76–78% reported increased confidence;. Satisfaction with patient care improved, with 60–97% of attendees noting enhanced ability to manage conditions, and 80% agreeing coordination between providers improved. The Neurology Gem Share tool initially had strong uptake (81%) but declined to 31% active use by June 2025, mainly due to awareness gaps amongst new to community physicians and nurse practitioners. Qualitative feedback emphasized easier referral pathways, better access, and reduced wait times, though some uncertainty remained regarding the gem shares impact on care coordination.

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**achieved through the project work.**

4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The Neurology Project successfully addressed gaps in specialist access by implementing a dedicated referral pathway, targeted provider education, relationship-building with Neurology specialists, and support for a new Neurology department. Provider knowledge, confidence, and coordination of care, was enhanced, through education sessions. Qualitative feedback highlighted easier referral pathways and reduced wait times. To ensure sustainability, the practice supports lead (Division employee) will monitor utilization of the Neurology Gem Share, referral pathways and resources, to maintain timely access and coordination of neurological care in Ridge Meadows. Development of the Impact Analysis for the Neurology clinic at Ridge Meadows Hospital will continue by Fraser Health executives and the Regional Neurology Director to ensure implementation. The overall project demonstrated clear value in supporting providers, improving system navigation, and enhancing patient care, with opportunities.

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**Lessons Learned**

Challenges and Success Factors:

- Gem Share Tool:
    - o Challenges: Usage of the Neurology Gem Share tool declined from 81% to 31% due to awareness and accessibility challenges.
    - o What we would do differently: Build it into onboarding and strengthen communication to improve awareness and ongoing use.
  - Neurology Specialist Project Participation:
    - o Challenges: Lack of a local Neurologist, specialist shortages, and a mid-project change in Regional Neurology Director, changed strategy direction, slowed relationship building and delayed outcomes.
    - o What we would do differently: Involve Regional Specialist Directors during the EOI stage to support early networking, strategy development, and earlier delivery.
  - Dedicated Referral Pathway:
    - o Challenges: Lower than expected usage due to limited scope of practice, distance and virtual platform not always appropriate.
    - o What we would do differently: Research specialist scope and alignment for broader reach
  - Hospital Neurologist Recruitment & Compensation Barriers:
    - o Challenges: Recruitment hindered by regional shortages and graduates choosing larger hospitals for mentorship.
    - o Successes: Partnering with Fraser health recruitment, supported opportunity for wider reach.
  - Algorithm Development:
    - o Challenges: Complexity, comorbidity and variability of neurological conditions made algorithm design difficult, which resulted in not addressing dizziness that was outlined in the original aim statement.
    - o Successes: Relationship development enabled an education session on the headache/migraine algorithm.
    - o What we would do differently: Conduct thorough research on existing algorithms and complexities to inform EOI strategies.
  - Virtual Neurology Clinic:
    - o Challenges: Whilst a virtual neurology clinic was explored as an interim solution, specialist capacity, burn out and inadequate compensation resulted in a lack of support
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from Neurologists at Royal Columbian Hospital. These challenges would have impacted the long-term sustainability of the clinic.

o What we would do differently: Development of a working group, including regional and Fraser Health representatives and leadership and a thorough risk assessment, to identify challenges earlier in the process.

Advice for Similar projects

- Involve Regional Directors at the EOI phase
- Continuously collect and apply feedback

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**Tools & Resources**

[Neurology Gem Shares](#)

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## Shared Care Project Abstract Summary

**PROJECT NAME:** Strengthening Chronic Fatigue Care in Ridge Meadows

**LOCATION:** Ridge Meadows Division

**PHYSICIAN LEAD(s):**  
Zubek, Dr Liz  
Dmitrieva, Dr Victoria

**AIM STATEMENT:** Over the next 24 months, we will clarify ME/CFS referral pathways, and develop small group learning sessions to increase capacity for Ridge Meadows physicians and nurse practitioners to assess, diagnose and treat ME/CFS. Additionally, we will develop and test a model for group medical visits to support patients and caregivers living with ME/CFS.

**TIMEFRAME:**  
3/1/2022 - 10/31/2025

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) is a complex and often misunderstood illness that presents challenges for both health care providers and patients. Long wait times (2 to 3 years) at the CCDP, limited familiarity among providers with signs and symptoms, difficulty with assessment and diagnosis, and unclear treatment pathways and patient supports leave many patients struggling, impacting mental health and leading to repeated medical visits. Compounding this was the growing number of patients with Long COVID, whose symptoms mimic ME/CFS. With limited alternative regional and local referral options, patients faced significant delays in diagnosis and care. Over the next 24 months, we will clarify ME/CFS referral pathways and develop small group learning sessions to increase capacity for Ridge Meadows physicians and nurse practitioners to assess, diagnose and treat ME/CFS. Additionally, we will develop and test a model for group medical visits to support patients and caregivers living with ME/CFS.

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The Ridge Meadows ME/CFS Project implemented coordinated strategies to improve timely access to diagnosis, treatment and care, provider knowledge, system navigation, and enhanced patient support. Key interventions included a customized ME/CFS provider toolkit, three structured education sessions, a group medical visit program, and a brochure aimed at supporting patients. The target population, Ridge Meadows providers and specialists, were engaged through education sessions, newsletters, clinic visits, leadership meetings, virtual forums, and partnerships with the ME/FM Society of BC. Engagement aimed at building relationships, raising awareness of supports, and fostering collaboration. Data collection via provider polls and surveys, patient surveys, stakeholder discussions, and informal feedback measured impact on provider confidence, knowledge, care coordination, and system-level improvements.

**3. Results**  
**What did you find?**  
**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes**

Overall 100% of Leadership strongly agreed that the project outcomes led to improved population health. enhanced provider knowledge, confidence, and coordination of care for patients with ME/CFS. Three virtual education sessions engaged 71 providers, where 78% reported increased confidence in providing care. The toolkit will require evaluation in 2026/2027 to understand value, however 100% of leadership strongly agreed that the ME/CFS toolkit will improve confidence to provide care. From the sample of patients who participated in the Group Medical Visits, 86% agreed/strongly agreed with improved

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**achieved through the project work.**

satisfaction with care and 72% agreed/strongly agreed with an increased ability to self-manage their condition following the sessions.

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**4. Conclusion**  
**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The Ridge Meadows ME/CFS project successfully addressed gaps in patient care, provider knowledge, improving timely access to diagnosis, treatment, and supports. The average wait time at the Complex Chronic Disease Program (CCDP) for treatment is over 18 months, which has been decreased to 1-2 months with the introduction of the GMV's. Through a toolkit and algorithm, targeted education sessions, Group Medical Visits, and patient-facing resources, the project strengthened provider confidence, streamlined care pathways, and empowered patients in managing their health. While a local diagnostic clinic was not established, expanding primary care resources ensured timely assessment and management. Measurable improvements in provider confidence and patient satisfaction, combined with patient-informed materials, created relevant and supportive care tools. The overall project demonstrated clear value in supporting providers and enhancing patient care. The project provides a replicable model for coordinated patient-centered care in other communities.

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**Lessons Learned**

- **Diagnostic Clinic:**  
Challenges: This strategy was identified after the EOI process. Lengthy wait for APP application approval, limited progress of other strategies and delayed deliverables and evaluation processes.  
What we would do differently: Ensure thorough strategy development at EOI stage and build in funding application to risk assessments.
- **Toolkit and Algorithm:**  
Challenges: Restructuring a strategy late in a project, delayed deliverable, and impacting testing and evaluation.  
What we would do differently: Ensure clarity on strategies at EOI stage, conduct risk assessments on delaying strategies, re-evaluate timelines and work back schedules.  
Successes: Initial qualitative feedback from testing suggests a valuable tool that will help guide informed decision making and improve timely access to care for patients.
- **Contractors:**  
Challenges: Using contractors who are unfamiliar with the work and health condition can result in inaccurate representation of and misalignment of project objectives, delaying strategy completion.  
What we would do differently: Ensure contractors are onboarded and orientated to health conditions, have aligned goals and establish review and check-in processes.
- **Patient Brochure and Poster:**  
Challenges: Complexity of a health condition can impact patient participation and timelines for deliverables, resulting in limited opportunity for evaluation on success.  
Successes: Patient participation ensured patient needs, insights and voice were captured, increasing authenticity of the brochure and empowering patients.  
What we would do differently: Consider complexity of health conditions and ensure strategies are started earlier.

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## Shared Care Project Abstract Summary

**PROJECT NAME:** Transforming Gender-Affirming Care in Surrey-North Delta

**LOCATION:** Surrey-North Delta Division of Family Practice

**PHYSICIAN LEAD(s):**  
Dr. Jagoda Kissock, Endocrinology and Metabolism  
Dr. Alex Yang, Family Practice

**AIM STATEMENT:** The overarching aim of the project was to increase primary care providers' confidence in providing gender-affirming care, knowledge of how to provide gender-affirming care, and knowledge of how to create a safe clinical space for patients to receive gender-affirming care.

**TIMEFRAME:** May 2024 - July 2025

1. Purpose  
**Why did you start? Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

The project was initiated in Surrey-North Delta to address local gaps in access to gender-affirming care for Two-Spirit, trans, and gender diverse patients. Patients reported barriers to timely, culturally safe care, including experiences of stigma and discrimination in clinical encounters (reported by 17 patients), which undermined trust and limited access. Primary care providers and clinic teams also identified challenges in delivering consistent gender-affirming care, with notably 65 of 88 providers (74%) reporting no prior gender-affirming care training, alongside limited practical tools and system navigation supports. To address these gaps, the project aimed to develop targeted resources and delivering continuing medical education (CME) to strengthen provider capacity and enhance system navigation and access for patients.

2. Methods  
**What did you do? Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The evaluation used a mixed-methods approach to assess the implementation and outcomes of the project. Key interventions included the development and delivery of three Continuing Medical Education sessions, development of gender-affirming care resources, including supporting video development and development of Pathways BC resources. The primary target population was primary care providers and clinic team members, including family physicians, nurse practitioners, MOA's, PCN allied health providers, specialist physicians, and other community partners. Engagement was supported through an interdisciplinary working group involving local family physicians, specialist physicians, Fraser Health representatives including Indigenous health representation, Primary Care Network (PCN) staff, a Trans Care BC representative, a Foundry representative, and supported by two Surrey-North Delta Division staff members (the project leads), which provided guidance throughout planning and implementation. Data collection included a document and administrative data review, surveys to gather feedback on project activities, a patient partner focus group, and qualitative video/phone interviews with key partners.

3. Results

**What did you find? Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

The project achieved its objective of increasing primary care providers’ confidence and knowledge to provide gender-affirming care by 50% (result: 72% increase from pre-project baseline, and 51% increase from pre- to post-education sessions), and made progress towards its objective of increasing their knowledge of creating a safe clinical space by 50% (result: 29% increase from pre-project baseline and 30% increase from pre-to post-education sessions).  
The evaluation found that across education sessions, at least 50% of primary care providers (and others who participated) reported increased confidence in creating a gender-affirming space and in providing gender-affirming care.  
As well, education participants reported that they used their learnings to create safer clinical spaces, used the resources the project team shared, and are motivated to continue to learn more. 22 people signed up to hear about future learning opportunities related to gender-affirming care from the Division.

4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project was successful in increasing knowledge of how to create a safe clinical space, knowledge of how to provide gender-affirming care, and confidence to provide this care among primary care providers, MOAs, and allied health providers. Evaluation data also reveal an improvement in appropriate endocrinology referrals, increased awareness of how to navigate care pathways, and an appetite to learn more, which the project has begun to address by connecting providers to a Trans Care BC education course. Going forward, the relationships forged between working group members resulted in ongoing work to integrate gender-affirming practices and services more broadly and sustainably in Surrey-North Delta’s primary care community. This ongoing work can enable the sustainability of the project’s positive impacts, and improve access for Two-Spirit, trans, and gender diverse people to get the care they need

**Lessons Learned**

Successes

- Effective project management and coordination by the project leads
- Engagement with a variety of partners on the working group, who were open to learning
- Working group members and patient partners felt meaningfully engaged, respected, and valued
- It is important to build sustainable capacity within a provider community, which was supported with the project’s approach that aimed to normalize gender-affirming care within primary care
- The format and content of the education sessions enhanced participation and the project’s impact

Challenges

- Societal transphobia and stigma against gender-affirming care
- More clarity on working group roles and responsibilities would have encouraged greater participation. Capacity constraints also posed challenges to keeping a consistent momentum with the project.
- Education sessions included a large amount of information in a short period of time

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**Tools & Resources**

- Guide on how to create safer spaces
  - Guide on inclusive language
  - [Transcare BC public education campaign:](#)
  - [Gender-Affirming Care in SND: A Family Physician's Toolkit:](#)
  - [Gender-Affirming Care in SND: Moving Forward Together:](#) Pathway resource for gender-affirming care
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## Shared Care Project Abstract Summary

**PROJECT NAME:** Curiosity, Frailty and Palliative Care

**LOCATION:** East Kootenay Division

**PHYSICIAN LEAD(s):**  
Andreas, Dr Gregory Stacey  
Wik, Dr Lori Mae

**TIMEFRAME:**  
3/1/2024 - 2/28/2026

**AIM STATEMENT:** The project aims to spread a person-centered approach to care, one that benefits patients, healthcare professionals, and system leaders alike. This is achieved by expanding access to meaningful training opportunities, co-designing and sharing practical tools for both HCPs and patients, and fostering dialogue with partners across the health system to identify opportunities that embed curious and compassionate frailty and EoL care into practice.

1. Purpose  
**Why did you start?**  
Establish the context of the project and its significance. Include the nature of the local problem and aim statement.

As individuals become progressively frail, medical needs evolve and reliance on health care professionals (HCPs) and loved ones increases. End of life (EoL) is not solely a biomechanical process but a human experience that can be fundamentally impacted by compassionate interactions with curious and prepared HCPs. For time-poor HCPs in regional settings characterized by limited EoL resources and ageing populations such as the East Kootenay (EK), it is crucial that HCPs and patients are empowered to approach early and compassionate conversations around frailty and EoL care. The Curiosity, Frailty and Palliative Care (CFPC) Project aims to spread a person-centered approach to EoL and frailty care that benefits patients, HCPs, and system leaders by facilitating access and exposure to training, HCP and patient tools, and encouraging discussion with partners across the health system.

2. Methods  
**What did you do?**  
Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.

The multidisciplinary Steering Committee and three Working Groups led three key interventions: 1) facilitating diverse and accessible training opportunities, 2) co-designing and sharing of HCP and patient tools to empower compassionate care, and 3) integrating EK perspectives into provincial and regional partner discussions. Training consisted of LEAP, Serious Illness Conversation (SIC), and project specific engagements. This was complemented by community engagements with relevant Senior and Hospice partners. HCP tools and patient tools were introduced in the latter engagement sessions and aligned with the needs identified in an EK wide Family Physician Survey. Briefly, the tools included a project-specific and operationalized Frailty Definition, a Frailty Screening Tool, a HCP Resource Sheet, and a MOST Patient Video. The project data consists of cross-sectional surveys (FP Survey, n=79), participant tracking for engagement and training events, and cross-sectional patient acceptability surveys (n=33).

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### 3. Results

**What did you find? Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Over the course of the project, 58 events were held with over 1,200 participants. The positive impact of this training is clearly demonstrated and reported including initiating WMTY and SIC-G conversations more frequently (97%), and earlier (86%), more organically or confidently (96%), and discussing these learnings with colleagues (96%). Seventy-two (72%) of HCPs in the FP Survey indicated the Frailty Definition was 'True' or 'Very true', suggesting that the definition is acceptable and congruent. A PDSA cycle of the 6-item EK Frailty Tool found the screening approach did not provide consistent value across patients with lower consent rates and discordance between results and HCP perceptions of frailty; this cycle highlighted an invaluable opportunity to supplement HCP education with tools that redirect screening efforts towards communication prompts. HCPs and community members perceived the MOST Patient video to be highly acceptable. Approximately 91% of community members would recommend this video to others; similarly, 94% of HCPs would share the video with patients and 100% felt it would support shared decision-making.

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### 4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

This project presents a community of Healthcare Professionals that is engaged and motivated to develop their skills through training opportunities; and provides them with practice-ready tools designed to be used in person-centered conversations. However, shifting the culture towards person-centered frailty care is challenging, and sustained meaningful progress will depend on further structural changes (like electronic medical record integration and strong leadership commitment and prioritization). Even so, the team is optimistic and confident that the foundation and momentum created from this project will continue to drive lasting change.

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### Lessons Learned

Culture change in healthcare is driven by relationships, trust, and empathetic language that focuses on patient function and lived experience rather than administrative paperwork. While the Frailty Working Group identified a clear system-level need for automated data tools to proactively flag disconnected patients, implementation was limited by project constraints and the demanding schedules of busy family physicians. For others undertaking similar work: start with curiosity, prioritize relationships over forms, anchor conversations in function, build coalitions early, and remain adaptable. Ultimately, sustainable change depends less on perfect tools and more on shared mindset and trust across a community of care.

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### Tools & Resources

What Matters to You? : The MOST Form in BC and Advance Care Planning (East Kootenay DoFP)

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## Shared Care Project Abstract Summary

**PROJECT NAME:** EK Encompass Pregnancy Clinic Collaboration

**LOCATION:** East Kootenay Division

**PHYSICIAN LEAD(s):**  
Burch, Dr Tanya  
Sanregret, Dr Alisa

**AIM STATEMENT:** Over the next 24 months the Encompass Pregnancy Care Clinic Project will support the establishment of an interprofessional model of care between EPCC family physicians and midwives working to full scope, to include establishing a sustainable funding model, teamwork flow, resource creation, and strong network development between the EPCC and the local perinatal community in order to meet the needs of both patients and providers.

**TIMEFRAME:**  
4/1/2023 - 11/30/2025

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

With increasing care complexity and a declining number of regional obstetric care providers, maternity services are facing challenges at both the provincial and regional levels. Maternity services in Cranbrook (East Kootenay Health Service Delivery Area) have experienced ongoing vulnerabilities and staffing shortages despite earlier Shared Care project efforts. The first project focused on developing a shared practice between family physicians (FPs) and establishing dedicated space for Encompass Pregnancy Care Cranbrook (EPCC) within the Cranbrook Urgent and Primary Care Centre (UPCC). To further stabilize this vulnerable service, a second project was launched to integrate local registered midwives (RM) and evolve the EPCC into a truly team

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The project focused on three key intervention areas:

1. Developing a collaborative working environment between FPs (providers), RMs (providers), and allied health providers to deliver high-quality team-based care
2. Establishing a multidisciplinary maternity network
3. Advocating and implementing person-centered maternal care

Project activities included the development of clearly defined and ratified team roles with call-sharing agreements, the creation of accessible standardized care processes, and the establishment of a strengthened governance structure. The work also included local and regional engagement, improved patient navigation pathways, and the creation of patient-facing education resources. To evaluate impact, a mixed-methods approach was used, including the EPCC Team Perception Survey and interviews, complemented by the EPCC Patient Perception Survey. Additional data sources included medical record reviews and online content analytics.

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### 3. Results

#### **What did you find?**

**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

From January 2024 to November 2025, the EPCC team completed 16750 appointments for 1370 maternity patients, averaging 12.2 appointments per patient. During this period, 517 newborns transitioned through EPCC representing an increase over previous years. A thematic qualitative analysis of interviews with ten providers highlighted several key advantages of the EPCC model, including trust-based teamwork that fostered a more efficient and resilient practice environment. This in turn created additional capacity for ongoing quality improvement activities such as new appointment models and expanded service offerings (e.g., enhanced postpartum care). The advantages of team-based care were closely tied to the implementation of consistent care standards and a deep respect for clearly defined team roles and scopes of practice. Findings from the EPCC Team Perception Survey supported these themes with team members (n=16) reporting:

- Highly efficient care delivery (average group score = 3.6/5)
- High-quality patient care (3.9/5)
- Strong respect for individuals' roles and experience (4.3/5)
- Overall EPCC providers reported excellent teamwork (4.1/5)

EPCC Patient Perception Survey (n=45) suggested that patient experience remained stable under the new model of care, with opportunities identified for continued quality improvement.

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### 4. Conclusion

#### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The EPCC Project contributed to measurable progress across provider well-being, and system integration. Despite a large shift in care models, the patient experience remained consistent. With the multidisciplinary team now stabilized, additional team capacity is available to pursue ongoing quality improvement activities. Regional services with health human resource challenges should consider tailoring the EPCC team-based care model to provide high-quality, consistent, and team-based maternity care.

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### Lessons Learned

The EPCC Model successfully demonstrated that a team-based, multidisciplinary approach to maternity care can improve provider experiences and stabilize clinic operations through shared workloads and trusted professional relationships. Key lessons learned include the necessity of stabilizing medical teams before attempting quality improvements and the critical need for better communication tools, as current EMR often hinder information sharing. While the project established a replicable blueprint for care, it highlighted that long-term sustainability is threatened by “urban-centered bias” and a reliance on short-term funding. For future recommendations, securing dedicated leadership and transitioning from project-based efforts to a permanent framework are essential to maintaining these gains and addressing the unique needs of rural communities.

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## Shared Care Project Abstract Summary

**PROJECT NAME: EK Pediatric Asthma**

**LOCATION: East Kootenay Division**

**PHYSICIAN LEAD(s):**  
van Zyl, Dr Shaun Peter  
Swaney, Dr Laura Colleen  
Haiduk, Dr. Tasha

**AIM STATEMENT:**  
**The Pediatric Asthma Project aimed to enhance the quality of pediatric asthma care by implementing standardized assessment, strengthening collaboration between acute and community-based HCPS, and improving admission and discharge processes. The project sought to enhance provider, patient, and family education to support consistent, evidence-based asthma management across care settings. Furthermore, the project aimed to align the work with Interior Health’s low-carbon high-quality care practices. This included optimizing inhaler use, thoughtful prescribing, and reducing waste through patient education.**

**TIMEFRAME: 10/1/2023 - 1/31/2026**

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

The Pediatric Asthma Project was initiated in the East Kootenay region to address significant gaps in pediatric asthma management, which is the most common chronic childhood condition in BC but suffers from underdiagnosis and inconsistent clinical practices, particularly in rural areas. Driven by recurring, avoidable emergency department visits and hospital admission at East Kootenay Regional Hospital, the project identified critical systemic issues: a lack of standardized diagnostic and treatment tools, fragmented communication and care pathways between hospital and community providers, and insufficient education for families and healthcare professionals. Supported by Shared Care funding, the project aims to implement evidence-based tools, such as Child Health BC’s Provincial Asthma Care Toolkit, to standardize assessment, streamline admission and discharge workflows, improve inter-provider collaboration, and promote sustainable, low-carbon care practices (like optimized inhaler use) for children aged 0-18 across Cranbrook, Creston, Kimberley, Elk Valley, Invermere, and Golden.

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

We used a multifaceted, collaborative implementation strategy to standardize pediatric asthma care across primary and acute settings: a multidisciplinary team co-developed two evidence-based care pathways (primary care and acute care) and distributed laminated quick-reference copies to clinics and EDs; created accessible education (four pediatric inhaler demonstration videos with QR-code labels and online hosting on Pathways BC/EKDoFP); delivered capacity-building sessions and clinical outreach with refresher training; engaged providers and families via interviews and working groups to iteratively refine tools; incorporated sustainability planning for ongoing updates and staff onboarding; integrated environmental stewardship by aligning prescribing and inhaler practices with provincial low-carbon guidance; and used mixed-methods evaluation (environmental scans, needs assessments, baseline workflow reviews, provider surveys, and qualitative feedback) to identify gaps and measure impact.

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### 3. Results

#### **What did you find?**

**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

The project delivered extensive engagement and resources across the region and produced early quantitative and qualitative signals of impact: two care pathways were developed and widely disseminated (Primary Care pathway was the second-most viewed clinician tool on Pathways locally), four inhaler videos have been viewed over 280 times, and clinic/hospital outreach and events reached numerous providers (see Tables). An East Kootenay survey of 79 family physicians found high self-reported confidence after rollout—90% fairly confident/confident diagnosing and managing asthma in patients ≥12 years, 77% for <12 years, and ~82% confident in knowing when to escalate to a pediatrician—while steering committee members uniformly reported positive impacts on provider experience and care quality. Qualitative feedback reinforced that pathways and educational tools increased consistency, provider confidence, and readiness for standard practice across sites, and stakeholders expect downstream reductions in unnecessary ED visits and admissions. Limitations included selection bias, variable clinic capacity, seasonal confounding, and inability to access hospital-level outcome data for definitive admission/LOS analyses.

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### 4. Conclusion

#### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The Pediatric Inpatient Asthma Project has made significant strides in standardizing pediatric asthma care across the East Kootenay region. Key achievements include the development of evidence-based care pathways, accessible educational tools, and strengthened collaboration between hospital and community providers. Early feedback shows improved provider confidence, more consistent patient education, and enhanced care coordination, positioning the project to achieve its aim of reducing preventable pediatric asthma hospitalizations.

Sustainability is built into the project through integration into Pathways, Shared Care networks, and ongoing provider education, with oversight shared between the EKDoFP, Interior Health partners, and participating clinics. These tools and workflows are highly adaptable, supporting potential spread to other rural and multi-clinic settings.

This work establishes a scalable, data-informed model for pediatric asthma management that improves patient outcomes, supports providers, and aligns with environmentally sustainable care practices.

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### Lessons Learned

The project evolution revealed several important insights regarding successful implementation and collaborative system change. As flagged above, between clinic variability necessitates tailored engagement with some community sites requiring more time and flexibility based on clinic capacity. Additionally, workflows and differences in diagnostic practices were difficult to map and demonstrated more complexity than anticipated. Teams wishing to undertake similar work should anticipate lengthy discovery phases with extensive HCP engagement, regardless of clinic proximity. Finally, we cannot under-emphasize education is central to sustainable and consistent high-quality care.

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### Tools & Resources

- [Pediatric Asthma - A Primary Care Pathway for Diagnosis, Treatment & Management](#)
  - [Pediatric Asthma - Acute Care Pathway for Diagnosis, Treatment & Management](#)
  - [Pediatric Asthma Instructional Video - Metered Dose Inhaler \(MDI\) with Spacer \(East Kootenay DoFP\)](#)
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- [Pediatric Asthma Instructional Video - Metered Dose Inhaler \(MDI\) with Mask \(East Kootenay DoFP\)](#)
  - [Pediatric Asthma Instructional Video - Dry Powder Inhaler \(DPI\) Diskus \(East Kootenay DoFP\)](#)
  - [Pediatric Asthma Instructional Video - Dry Powder Inhaler \(DPI\) Turbuhaler \(East Kootenay DoFP\)](#)
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## Shared Care Project Abstract Summary

**PROJECT NAME: Shared Orthopedic Referral and Triage Project (SORT Project)**

**LOCATION: East Kootenay Division**

**PHYSICIAN LEAD(s):  
Chan, Dr Alex Dart Man  
Ure, Dr. Megan**

**AIM STATEMENT:** In the East Kootenay, there are six orthopedic surgeons that are not co-located, do not share an electronic medical record system, and received over 350 referrals monthly without use of standardized referral form. The primary aim of SORT was to enhance the quality of referrals from family physician and specialist perspectives by implementing a single referral form with imaging guidelines and conservative treatments incorporated in a multidisciplinary care pathway.

**TIMEFRAME:  
8/1/2022 - 3/31/2025**

**1. Purpose  
Why did you start?  
Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

Orthopedic wait-times consistently exceed recommended benchmarks nationally and in the Interior Health Authority. Furthermore, the percentage of British Columbians receiving orthopedic surgery in recommended timeframes has improved by less than 5% since 2016. Re-invigorated approaches are urgently needed to support orthopedic teams particularly in regional settings where there is limited specialist availability. The primary aim of the Shared Orthopedic Referral and Triage (SORT) project was to enhance the quality of referrals from family physician (FP) and orthopedic surgeon (OS) perspectives and incorporate conservative treatment options in a multidisciplinary care pathway.

**2. Methods  
What did you do?  
Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

Baseline data included qualitative engagement sessions, cross-sectional surveys (80% response, 86 physicians), and clinic record extraction. Based on clinical record audit, approximately 330 OS referrals are made monthly. Physician self-reported data suggested the majority of FPs were not using a referral form (63%) and OS thought referrals were missing clinical details or had incomplete imaging (55%). Additionally, OSs reported most patients (67%) would have benefitted from a referral to a FP specializing in Sports Medicine (FP Sports). While FPs report that referrals are typically made after conservative treatment is complete (91%), OS considered only 54% of referrals 'Appropriate'. Less than one-quarter of FPs (23%) provided patient educational materials. Following co-design procedures with OSs, physiotherapists, FPs, and clinic managers, a new SORT referral pathway was introduced in mid-2024 including a 1-page multidisciplinary referral form with 'red-flag' indicators for urgency,

**3. Results  
What did you find?  
Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Following multiple engagement activities and inclusion in MSK Care Pathway and SORT Referral Form, clinic record audit in our first implementation cycle showed an increase of 27% of referrals to FP Sports relative to the same time in the previous year. The SORT Care Pathway was the most viewed Clinician Tool locally. Provincially, Pathways highlighted 11 SORT-selected patient resources as Provincial Picks and the referral form was used by Digital Referral and Orders to develop a provincial e-referral template. Following the first PDSA cycle, support was needed to ensure FP-Sports could action increased referral volumes and limited appointment time was used efficiently. To do this, referrals to FP-Sports receive a newly developed animated video with embedded decisional aid and

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exercise tutorials for osteoarthritis. Since implementation in November 2024, these three videos have been viewed close to 1,200 times.

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#### 4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

SORT engaged with over 100 FPs, 8 OS, and 6 physiotherapists in advisory capacities, feedback activities, or engagement and upskilling events. Project evaluation demonstrated increased referral volumes to FP Sports (a conservative treatment option), community use of patient education resources which also reported high patient acceptability, and an overall improvement in relationships between FPs and OS.

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#### Lessons Learned

The SORT project did not introduce any new service offerings or health professional availability. Furthermore, the project did not introduce central intake and increase surgical capacity. Research demonstrates efforts to reduce only WT1 or WT2 in isolation has limited effects.<sup>10</sup> SORT provides the necessary precursors to support a central intake model by implementing a single referral form with predominately discrete questions. Central intake is supported in other health authorities and demonstrates multiple system, provider, and patient benefits. For example, central intake demonstrated a reduction of 47 business days for referral processing, increased proportions of patients who complete a trial of non-surgical management, reduced WT1 by 55 business days, increased patient and provider satisfaction, and demonstrated health service savings as a result of using less costly conservative options.<sup>11-13</sup> Ongoing advocacy with health authority representatives to facilitate a central intake is essential to realize the full impact of standardized referral pathways.

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#### Tools & Resources

[East Kootenay Musculoskeletal Referral Form: Ortho/Sports Med](#)

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## Shared Care Project Abstract Summary

**PROJECT NAME: Creating regional capacity for child wellness in the Kootenay Boundary**

**LOCATION: Kootenay Boundary Division**

**PHYSICIAN LEAD(s):  
Guillemette, Dr. Chantal**

**AIM STATEMENT: By September 2024 the KB Region will have a sustainable system with clear referral pathways that provides readily accessible, trauma-informed medical and mental health care for children and youth who have experienced or witnessed abuse, assault, neglect, maltreatment and/or violence so that victimized children and youth living in the West Kootenays may access the acute and longitudinal clinical services they need while remaining within the region.**

**TIMEFRAME:  
3/1/2022 - 9/30/2025**

**1. Purpose  
Why did you start?  
Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

In Kootenay Boundary (KB), children who experience maltreatment often have to repeat their stories multiple times, are asked to leave the area for wellness checks and often do not have a primary care practitioner. Providers must also navigate how to coordinate services for their patients, which takes up considerable time. This project aimed to create a sustainable system with clear referral pathways that provides readily accessible, coordinated, trauma-informed medical and mental health care for children and youth who have experienced or witnessed abuse, assault, neglect, maltreatment and/or violence.

**2. Methods  
What did you do?  
Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

Project activities included appointing a project advisory committee and holding regular meetings to advance the work plan, and engaging with partner organizations to discuss educational needs for specialized sessions with KB physicians. Project deliverables included:

- Submitting an SBAR Proposal for establishing a child maltreatment exam clinic in KB to the Interior Health (IH) Authority and continued advocacy
- Developing a child maltreatment referral guideline that outlines how local providers can consult with SCAN for medical decision making, including wellness exams
- Developing a pathway for longitudinal attachment to primary care for children/youth who have experienced maltreatment
- Four practitioner learning events to connect, discuss & map out the support network for children/youth in KB who have experienced maltreatment, as well as relevant clinical topics.

Evaluation data were collected via post-event surveys and through web-analytics.

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### 3. Results

**What did you find? Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Access to medical exams (wellness or forensic) improved due to an increase in Pediatricians who are now available locally to conduct child wellness exams. This process was formalized in the referral guideline. Over 80% of learning event attendees reported improvements in knowledge, confidence and ability to provide care to vulnerable children, and improvements in care coordination. All learning event attendees (100%) increased their awareness of resources and supports, including SKY (local child/youth advocacy centre). The SKY Manager reported seeing an increase in referrals to SKY/new cases as a result of this project.

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### 4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project achieved improved collaboration between physicians and partner agencies/social service stakeholders in developing a referral guideline to clearly identify what a practitioner should do if they receive a disclosure of child maltreatment and what services are available to children and youth. Access to medical exams and to primary care was also enhanced as a result of this project, despite us not achieving our original goal of developing a funded medical team and clinic space. A limitation is that we were unable to measure whether more child and youth victims of maltreatment are being assessed/cared for due to work completed late in the project. The referral guideline is sustainable and available on Pathways. The project could be spread to other rural sites within IH.

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### Lessons Learned

While strong multi-agency collaboration and committed advisory team are essential for success, systemic issues such as high staff turnover, funding gaps from health authorities, and a lack of role clarity among physicians create significant barriers. To improve outcomes, the team learned that they must engage broader organizational networks rather than relying on individuals, clearly define medical responsibilities to reduce practitioner fear, and be prepared to partner with NGOs for private funding when traditional systems are too slow to respond.

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### Tools & Resources

[Suspected Child Abuse or Maltreatment - Guideline for Practitioners](#)

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## Shared Care Project Abstract Summary

**PROJECT NAME: Optimizing Regional Orthopedic Care For Reduced Wait Times**

**LOCATION: Kootenay Boundary Division**

**PHYSICIAN LEAD(s):  
Benzer, Dr. Susan  
Segal, Dr. Samantha  
Bitting, Dr. Seth**

**AIM STATEMENT: By March 2026, we aim to improve clarity and communication of referrals, develop more efficient patient intake pathways, decrease patient wait times to an average of less than two months for initial assessments, improve coordination of treatment plans and collaboration between a multidisciplinary team of Specialists, FPs, Allied Health, and Nursing to ensure patient access to Specialized Orthopedic and Rheumatology care within the KB Region.**

**TIMEFRAME: 10/1/2023 - 2/28/2026**

**1. Purpose  
Why did you start?  
Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

This project was initiated in response to a lack of timely and/or local access to both Orthopedic and Rheumatologic care in the Kootenay Boundary (KB). Orthopedic Specialists (SPs) reported the wait time for non-urgent consults to be two+ years with over 2000 patients waiting. Additionally, KB has no Rheumatologists and access to advanced therapies was very limited for most of the rheumatologic patients unable to travel. The project aimed to ensure timely access to Orthopedic and Rheumatology care within KB by improving clarity and communication of referrals, developing more efficient patient intake pathways, and improving collaboration between a multidisciplinary team of SPs, primary care practitioners (PCPs), Allied Health, and Nursing.

**2. Methods  
What did you do?  
Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The current intake process and solutions to the backlog were explored by the Orthopedic SPs. Automating patient and primary care communications were not feasible due to cost constraints. Instead, an updated “first available surgeon” referral form and 12 referral guides were created, promoted to PCPs through emails and learning events, and posted on Pathways. Two PSDA cycles were completed on the referral form, which included an audit of appropriate referrals. A review of five percent of the wait list backlog encouraged the SP clinic to contact patients to confirm whether they still needed surgery. For the Rheumatology sub-committee, an Internal Medicine SP and a local Sports Medicine FP collaborated on supporting each other’s Rheumatology patients.

**3. Results  
What did you find?  
Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Referral form updates balanced the workload between surgeons and clarified referral requirements. Re-triaging the wait list backlog resulted in a 59% reduction of patients waiting for an initial Orthopedic consult (from 1439 to 590 patients). These actions, in addition to new SPs joining the clinic, resulted in an 84% decrease in patient wait times for non-urgent Orthopedic consults, from a clinic average of 27 months to 4.4 months. PCPs agreed that the learning events improved their ability to write referral letters (n=73/76; 96%) and improved their ability to provide care (n=97/99; 98%). Nearly all who attended learning events agreed that the project improved coordination of care between physicians, and collegiality and collaboration between PCPs and SPs (n=71/74; 96%). Referral quality was low mid-project (n=4/30 or 13% referral scored “appropriate”). More changes were made to the form and the SPs decided to start rejecting referrals missing key information.

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PDSA cycle 2 found referral quality remained low with 23% (n=7/30) of referrals scored “appropriate.”

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#### 4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

Health equity across KB improved with the large reduction in Wait 1 times. Growth of the Orthopedic team highlighted the need for greater coordination with each other so the team could equitably balance patient wait times. This enhanced level of coordination will be sustained through the first available referral form and regular clinic meetings. Sustainability funding will be sought to determine long term impacts of the project deliverables on referral quality. The project work can be spread to other multi-member SP clinics in various disciplines.

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#### Lessons Learned

The project highlighted the complexities of change management, communication, and stakeholder engagement across specialties. Initially, it took six months of deliberation for the Orthopedic clinic to accept responsibility for its waitlist triage, but a subsequent 5% sample review demonstrated a massive 50% backlog reduction, which motivated MOAs and Specialists to adopt new referral guides and PCP redirect processes. Concurrently, while the project executed four highly rated peer-learning events that improved stated referral capabilities, Orthopedic SPs continued to receive a high volume of inappropriate referrals, revealing that standalone educational events and resources have a limited immediate impact on actual primary care provider behavior without systematic EMR enhancements. Finally, the project demonstrated that Expressions of Interest with low engagement should not proceed; a lack of advisory members and the loss of a key physician lead ultimately derailed the Rheumatology stream, which was completely abandoned after the team discovered its virtual consultation goals were already being duplicated by the provincial Real Time Virtual Support program.

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#### Tools & Resources

- [Orthopedic Referral Guides \(Kootenay Boundary\)](#)
  - [Morton’s Neuroma - Non-operative Treatment Modalities \(Orthopedic Toolbox\)](#)
  - [Plantar Fasciopathy - Non-operative Treatment Modalities \(Orthopedic Toolbox\)](#)
  - [Hallux Valgus - Non-operative Treatment Modalities \(Orthopedic Toolbox\)](#)
  - [Ankle Sprain & Instability - Non-operative Treatment Modalities \(Orthopedic Toolbox\)](#)
  - [Achilles Tendinopathy - Non-operative Treatment Modalities \(Orthopedic Toolbox\)](#)
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## Shared Care Project Abstract Summary

**PROJECT NAME:** Emergency Preparedness for Physicians

**LOCATION:** Thompson Region Division

**PHYSICIAN LEAD(s):**  
Dodd, Dr Graham  
Conley, Dr Joslyn  
MacDonald, Dr Meghan Anne

**AIM STATEMENT:** The project aimed to create an emergency preparedness program for primary care providers. While this was to start with the Thompson Division, the hope was that the knowledge could then be shared with all Divisions and healthcare partners throughout the province.

**TIMEFRAME:**  
9/1/2018 - 12/31/2024

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

The Thompson Region Division of Family Practice (Division) secured Shared Care funding in 2019. The major reason for this project came from wildfire occurrences in the Interior and the effect that might have on the provision of primary health care in future wildfires. With the onset of COVID-19 in March 2020, shortly after the funding was received, the Division was able to operationalize its objectives in real time. The Emergency Preparedness for Primary Care Providers project aimed to create an emergency preparedness program for primary care providers that could be shared with Divisions and healthcare partners throughout the province.

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

To meet these challenges, the project had two main objectives. The first objective involved developing a proactive family practice/patient preparedness/continuity program that would support primary care providers and their patients to prepare for an emergency, build networks to enable primary care providers to work together during an emergency, and support primary care providers to recover from an emergency if their practice was the target of an emergency. The second objective focused on building a codesigned healthcare emergency preparedness framework with healthcare and community partners to ensure patient care is provided in a coordinated manner in the event of a disaster.

**3. Results**  
**What did you find?**  
**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

The first objective was categorized into two activities: practice resources and networks. An Emergency Management Guidebook for Health Care Clinics and an accompanying Emergency Management Workbook for Health Care Clinics were developed. Focus groups captured emergency preparedness needs. Providers were supported to implement the resources through one-to-one or group meetings, and tabletop exercises. The COVID-19 pandemic prompted the Division to build networks to support the Division membership. Network supports included: physician wellness; personal protective equipment needs; clinic operations; and transiting to virtual care. Networks were contacted on a regular basis to explore gaps, opportunities and needs. Formalized networking built capacity within the Thompson Region to attend to priority populations during emergencies. COVID-19 also prompted the Division to revise our organizational emergency response plan so that it reflected how the organization would support a member network and work with partners in various emergency scenarios. The Division sought to formalize an emergency preparedness framework with healthcare and

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community partners. At the onset of the COVID- 19 pandemic, the Division advocated to be included in Interior Health's (IH) local incident command structure. Fostering partnerships with IH and other community organizations, and working in lockstep with them, brought to fruition needed supports.

4. Conclusion  
**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project sought to ensure primary care providers were supported to prepare for, manage, and recover from emergencies, and that their voice, and the perspective of primary care in general, was encouraged and valued at local, regional and provincial emergency management forums. The foundational partnership work we conducted provided an opportunity to advocate for all divisions in the interior to be included in IH's emergency management planning tables. The funding facilitated regional collaboration and spread, in partnership with Divisions and the Interior Division Network. The Division was honored and thankful to assume a leadership role in this space and to be recognized at the table as a source of expertise.

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**Lessons Learned**

This project highlights that while disasters are inherently unpredictable, a proactive approach to emergency management is essential for maintaining healthcare delivery. The COVID-19 pandemic served as a critical real-time case study, while revealing that the process of navigating an event, such as through tabletop exercises, is as vital as the EM documents themselves. These exercises identify gaps in planning and personnel that static resources might miss.

However, the pandemic also created challenges, including delayed resource development and limited engagement from primary care providers due to competing priorities. This underscored the need for the Division to advocate more strongly for its role in community emergency activities, including planning and recovery. A major success of this initiative was the partnership between the Thompson and Kootenay Boundary Divisions, demonstrating that inter-division collaboration facilitates essential knowledge sharing and workload distribution. Ultimately, having a formal EM plan in place before a crisis is crucial for optimizing resource availability and supporting staff during unprecedented change.

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## Shared Care Project Abstract Summary

**PROJECT NAME: Palliative Care**

**LOCATION: Thompson Region Division**

**PHYSICIAN LEAD(s):  
Baker, Dr Robert Nelson  
Kusler, Dr Janet Lee**

**AIM STATEMENT: The project aim statement was to improve the palliative care experience for patients and primary care providers through educational opportunities and integrated health services planning over two years.**

**TIMEFRAME:  
3/1/2021 - 3/31/2025**

**1. Purpose  
Why did you start?  
Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

The project proposal was a result of needs identified by key palliative care stakeholders. The physicians involved in palliative care in the Thompson Region are engaged and contributing to an already functioning system but there are areas for improvement. At the time of the project proposal, the following was known: the palliative physician on-call group was anticipating three retirements; not all primary care providers provide palliative care; and that palliative care related education to the public may be beneficial. The project aim statement was broad and involved improving the palliative care experience for patients and primary care providers through educational opportunities and integrated health services planning.

**2. Methods  
What did you do?  
Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

The project had three main objectives: conduct a needs assessment to better understand the current resources available to support palliative patients; provide education to primary care providers, patients, and other health care providers to increase comfort with discussing death and increase awareness of services; and develop solutions to support identified gaps and needs. A needs assessment was conducted to better understand gaps and opportunities as it related to the provision of palliative care in the Thompson Region from the perspective of primary care providers, which built the foundation for the project and influenced project activities.

**3. Results  
What did you find?  
Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Primary care providers overall shared that they were satisfied with the quality of palliative care and noted good coordination, multi-disciplinary team, and continuity of care. However, several challenges were also noted which included: difficulty accessing and coordinating services; difficulty managing the complexity of palliative care, including time and resources; communications amongst colleagues; lack of clarity of roles/responsibilities; and patient related barriers. Over the course of the project, activities included: education to primary care providers and the public; the development of a palliative care and end-of life toolkit for primary care providers; recruitment of four new palliative care physicians to the on-call group; supported regular meetings to discuss opportunities to improve palliative care in the region; developed two outpatient clinics which included the Palliative Care Outpatient Clinic at Marjorie Willoughby Hospice, which provides space to interview, and examine community based palliative care patients possibly needing intervention at Hospice, and the Interior Health owned and operated

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Pain and Symptom Management clinic to help with the symptom burden related to a patients' advanced, progressive, life-limiting illness.

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#### 4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project leveraged the expertise and knowledge of the palliative on-call group who were engaged and already meeting on a regular basis to support operations and the implementation of many of the project activities. On-call group members shared that this helped them establish a solid working relationship, identify priorities for palliative care and set goals as a group. The two clinics are still operational, with the Pain and Symptom Management clinic functioning two half days per week. The Palliative Care Outpatient Clinic at Marjorie Willoughby Hospice has been used less than anticipated and therefore difficult to measure impact, however, providers agree that it is a useful space to sustain. Providers anecdotally report some evidence of earlier palliative care referrals, and improved symptom management by connecting with patients sooner, however, work to enhance this practice shift is still needed.

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#### Lessons Learned

This project demonstrates that leveraging established working groups, such as the IH North Palliative Physician group, significantly enhances engagement and reduces redundant efforts. Continuity in leadership also proved vital for maintaining relationship momentum and consistent information flow. However, challenges arose from differing care philosophies among providers, particularly regarding the timing of palliative care discussions, highlighting the need for ongoing collaboration to drive cultural change. Measuring impact presented further difficulties; broad aim statements made defining the project scope challenging, and accessing health authority data required better initial planning. A key takeaway is that impact is not always quantitative; the perceived value of having service available, like the outpatient clinic, is a qualitative success. Finally, adapting existing tools may not always save time; the team learned that switching directions entirely can be more effective than trying to force an existing algorithm to fit a new context.

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## Shared Care Project Abstract Summary

**PROJECT NAME:** Building a healthcare team with remote First Nation communities      **LOCATION:** Central Island Division

**PHYSICIAN LEAD(s):**  
**Woodley, Dr. Kristine**  
**Warbrick, Dr. Ian**

**AIM STATEMENT:** Over the next 18 months, the project team will engage with remote First Nation communities to identify and implement processes and care plans to foster a team based approach to delivering care for patients with chronic complex conditions. This will address the unique needs of Indigenous rural patients and foster improved coordination of care for them, while collaboration takes place between patients and providers. These include Family Physicians, Internists, Specialists, Pediatricians and allied health.

**TIMEFRAME:**  
**11/1/2022 - 12/31/2025**

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

Our project aim statement included the following: There are 5 Nuu-chah-nulth Nations in and around Port Alberni, as well as 5 Nations on the West Coast surrounding Tofino and Ucluelet. 50% of these Nations are remote with access by boat, plane, or a long dirt road. This project will aim to give support to remote community members with complex chronic conditions via a team based care approach, with an Internist, GPs, and the Nuu-chah-nulth nursing team. The goal is to have in person visits monthly with any follow up in between via tele health. Patients often have complex co-morbidities with little or no access to services to support them. GPs will benefit from access to a specialist and the specialist will benefit from offering care and a care pathway for patients to be followed up on by GP or Nurse.

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

Over the course of this project, we engaged with the remote First Nation communities Ahousath, Hesquiaht, Huu-ay-aht, Ditidaht, to identify and implement processes and care plans to foster a team based approach to delivering care for patients with chronic complex conditions. This, we hope, addressed the unique needs of Indigenous rural patients and fostered improved coordination of care for them, while collaboration took place between patients and providers.

Overall, the approach of the evaluation was to provide formative and summative findings, as well as to provide feedback throughout the project to enable data-informed decision-making. The evaluation was designed to be developmental and participatory, allowing the evaluation to be responsive to the emergent nature of complex projects. This final report provides the evaluation findings after completion of the project (March 2023 to March 2025).

**Method:** Document and data review, key partner interviews, patient surveys/interviews  
The physician lead and project manager gathered six physicians to visit communities. Two of the physicians (including the physician lead) were specialists (internal medicine and pediatrics), and five were FPs.

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### 3. Results

#### **What did you find?**

**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Approximately 38% of Ditidaht First Nation members who live on reserves (62 of 165) saw the physician lead between February 2023 and February 2025 (see Figure 5 below). For Hesquiaht First Nation, the number of patients served by the physician lead represented 31% of registered members who live on reserve lands (36 of 116 people), and this proportion was 23% for Huu-ay-aht First Nation members (22 of 97 people). For Ahousaht First Nation, 6% of members living on reserve saw the physician lead during the project (48 of 758 people).

Because this project took place across four different communities, the impacts below may differ for each community. All interviewees highlighted the need for primary and specialized healthcare in the communities of Ahousaht, Ditidaht, Hesquiaht, and Huu-ay-aht.

Improved Access to Care: Instead of needing to travel to see a specialist, patients can access care when the specialist comes to community. All interviewees highlighted that having physicians visit patients in community prevents a patient from having to travel outside the community to seek care. This is helpful because travel can be:

- expensive,
- logistically challenging (i.e., weather, finding support for childcare or traveling with children, accommodation),
- and time-consuming.

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### 4. Conclusion

#### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project made progress towards its goals of improving coordination of care for Indigenous people living in rural First Nations communities and supporting collaboration between providers. Evaluation data show that a team-based approach, effective project management and communication, and early engagement with First Nations communities supported the project to increase patient access to healthcare in their home communities, improve continuity of care, and build patient-physician relationships. Further, the project team formed stronger relationships with First Nation communities and there was an improved coordination of care between family physicians, nurses, and specialist physicians.

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### Lessons Learned

The project was driven by a highly engaged working group and successfully addressed critical gaps in local elder care through the creation of a specialized resource toolkit. However, the team faced challenges such as limited physician participation due to time constraints and a lack of long-term sustainable funding. To ensure future success, the project recommends establishing clear clinical leads early on, simplifying physician engagement through pre-scheduled meetings, and focusing on integrating resources into existing workflows (such as EMR templates) rather than relying on temporary external supports.

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## Shared Care Project Abstract Summary

**PROJECT NAME:** Social Prescribing

**LOCATION:** Nanaimo Division

**PHYSICIAN LEAD(s):**  
**Hoverman, Dr. Adam**  
**Allison, Dr. Sandra**

**AIM STATEMENT:** The social prescribing project will enable Nanaimo primary care physicians and Nurse Practitioners to connect socially isolated pts with a link worker to provide personal patient support in a community activity, with the goal of decreasing detrimental health outcomes associated with social isolation and loneliness (cognitive decline, depression, frailty, etc).

**TIMEFRAME:**  
**11/1/2022 - 9/30/2025**

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

About 35,000 patients in Nanaimo lack a primary care provider (MOH, 2020). While the Primary Care Network initiative is reducing this number, patients with access still face long wait times for mental health referrals and limited effectiveness of common treatments due to sociocultural factors.

Many clinics and physicians address social determinants of health by recommending activities to reduce social isolation. However, there's a gap in support to ensure patient commitment. Social prescribing studies show that prescriptions for activities and link worker support enhance patient well-being. Some Nanaimo family practice clinics have social workers, but they can't provide direct personal support or link patients with activities.

The social prescribing project will enable Nanaimo primary care physicians, clinicians, and Nurse Practitioners to connect socially isolated patients with a link worker to provide personal patient support, with the goal of decreasing detrimental health outcomes associated with social isolation and loneliness (cognitive decline, depression, frailty, etc.).

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

**Link Worker Position Development:**

- In collaboration with Island Health, project lead spearheaded the creation of a link worker position.

**Social Prescribing Implementation:**

- Established a social prescribing pathway; this was achieved by utilizing an existing Island Health referral form, which was familiar to clinicians.

**Community Connector Integration:**

- Partnered with the Nanaimo Family Life Association (funded by United Way) to introduce a Community Connector. This role provided link worker services to the community.

**Grant Funding and Patient Registration:**

- Secured grant funding that enabled patients to register for city classes and activities at no cost.

**Referral Pathway Optimization:**

- Revamped the referral pathway, ensuring that patients were assessed through the Island Health Access Services system. Based on the complexity of their conditions

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and comorbidities, patients were triaged to either the Island Health Link Worker or the NFLA Community Connector.

Project Expansion:

- Expanded the project to include all Nanaimo acute and community clinicians.

Bi-Weekly Kitchen Socials

Provider Brochures:

- We developed comprehensive provider brochures that included program information, lunch and learns at clinics

Program Presentation:

- Presented the program at various clinician and physician staff meetings, provincial conferences and workshops,

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### 3. Results

#### **What did you find?**

**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Improved Social Connection:

- 91% of participants reported social isolation at intake, and case studies show significant increases in social engagement (e.g., clients attending group activities, volunteering, reconnecting with community services).

Enhanced Well-being:

- Clients experienced improved mental health, reported feelings of joy and laughter, and gained confidence in navigating resources.

Addressed Practical Barriers:

- Many clients received support with transportation, food access, housing assistance, and dental/health services improving quality of life and independence.

Holistic Support:

- The initiative addressed non-medical determinants of health, complementing clinical care with recreation therapy, social activities, and mental wellness supports.

Provider familiarity improved, with a significant increase in “very familiar” (7% → 38%). The number of respondents at least “familiar” increased from 28% to 63%, showing growing understanding over time. While providers initially recognized patient need, the final survey suggests mixed perceptions of how well the initiative addressed those needs. Formal referrals emerged during the project, but adoption remained at 50%, showing room for broader provider engagement and system integration. Where applicable, providers found referrals manageable, but many lacked enough experience to judge, highlighting the need for increased referral activity and clearer workflows.

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### 4. Conclusion

#### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The Social Prescribing Initiative demonstrated meaningful progress in addressing social determinants of health through a collaborative, person-centered approach. Patients experienced improved social connection, enhanced emotional well-being, and tangible benefits in transportation, food security, housing, and access to community resources.

The program successfully built new sustainable pathways between primary care and community services.

For the healthcare system, the initiative increased provider awareness, introduced structured and sustainable referral mechanisms, and strengthened intersectoral collaboration. The program integrated an existing referral form for providers to continue using past project close. Link Workers proved integral to bridging clinical and social supports, laying the groundwork for long-term system efficiencies and anticipated reductions in acute care demand.

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Key outcomes included supporting 408 participants, receiving over 150 healthcare referrals, and connecting clients to vital services. Observed differences from the program's outset include improved provider familiarity with social prescribing, development of standardized processes, and greater integration with community partners. Anticipated outcomes—such as broader adoption, improved population health indicators, and healthcare cost savings—will require sustained investment and continued scaling.

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Shared Care Project Abstract Summary

PROJECT NAME: **CBT Spread Initiative (UBC CPD)**

LOCATION: **University of British Columbia**

PHYSICIAN LEAD(s):  
**Burrell, Dr Erin Colleen**

AIM STATEMENT:  
**Between September 2024 and March 2025, UBC CPD set out to deliver a minimum of eight CBT Skills Physician Wellness Training cohorts across British Columbia, with the goal of engaging at least 75 physicians from both family practice and specialty care. The intent of this aim was to directly improve physician wellness by reducing symptoms of burnout, enhancing resilience, and strengthening professional fulfilment through structured, evidence-based CBT skills training, and second, to indirectly improve patient care by equipping physicians with CBT-informed strategies that can be integrated into routine practice, thereby expanding access to timely, effective mental health support within primary care and specialty settings. The project also sought to foster alignment among groups of physicians, supporting more consistent, team-based approaches to care and advancing system-wide priorities for provider wellness and patient-centred mental health care.**

TIMEFRAME: **6/1/2021 - 3/31/2025**

1. Purpose  
**Why did you start? Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

Physician burnout and rising patient demand for mental health support continue to strain primary care across BC. Supported by the University of British Columbia’s Division of Continuing Professional Development (UBC CPD), the CBT Skills Physician Wellness Training program (a Mind Space Skills for Wellness initiative) was designed to strengthen physician resilience, equip providers with CBT-informed strategies, and ultimately improve patient access to timely, evidence-based mental health care. The program responds to provincial priorities to improve physician wellness and build capacity for early mental health intervention in primary care.

2. Methods  
**What did you do? Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

Between Sept 2024 and Mar 2025, UBC CPD delivered 8 cohorts of the CBT Skills program, delivered to all BC physicians engaged with via emails, and partners. Registered physicians participated in 8 weekly sessions led by trained facilitators (4 family physicians and 1 psychiatrist). Pre- and post-surveys captured physician experience, knowledge uptake, and early indicators of patient impact:

- Pre surveys were administered 1-2 weeks before the start of each cohort. The data collected by UBC CPD and were be communicated to facilitators and used to guide the delivery of the course.
- Post surveys were administered within 1 week of the conclusion of the 8-week training. Self-reported data on perceived knowledge change, CanMEDs competency development and further interest in CBT education was collected.

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- During design, development and implementation, UBC CPD monitored progress and continued to evaluate results using a Plan-Do-Study-Act (PDSA), cycle to foster program improvement.

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### 3. Results

**What did you find? Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

A total of 116 physicians registered for the program between September 2024 and March 2025, with 95 completing at least six of the eight weekly sessions (an 82% completion rate). Participants represented a mix of family physicians and specialists across BC. Response rates for pre- and post- program surveys averaged 85% across cohorts; this data was combined with informal feedback captured by facilitators during closing sessions.

#### Quantitative Findings

- Attendance: 116 registered; 95 completed ( $\geq 6/8$  sessions).
- Completion Rate: 82%, consistent with or exceeding CPD benchmarks.
- Outcomes: Post-program survey results showed statistically significant improvements in physician professional fulfilment, resilience, and reductions in burnout, consistent with Reichert & Associates' 2025 evaluation ( $p \leq .001$ ).

#### Qualitative Findings

- Physicians reported greater confidence in using CBT-informed strategies with patients, describing the tools as practical, efficient, and adaptable to primary care encounters.
- Many highlighted that sharing a common framework improved collegial consultation and reduced stress when managing challenging cases.
- In divisions where multiple physicians participated, providers reported that patients noticed more consistent approaches to care, which improved continuity and trust.

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### 4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project exceeded its target of 75 learners by training 95 physicians across BC, demonstrating that the CBT Skills Physician Wellness Training program is both feasible and highly valued. The program met its aim of improving physician wellness and strengthening patient care by equipping providers with CBT-informed strategies, which translated into more consistent care and earlier intervention for patients.

The overall usefulness of the project lies in its dual impact: improving physician resilience and professional fulfilment while also expanding patient access to evidence-based mental health support. Sustained demand, reflected in ongoing waitlists, underscores the program's relevance and the importance of continued investment.

Sustainability plans include expanding offerings to additional divisions of family practice and health authority partners, prioritizing regions with high unmet mental health needs. Future work will focus on strengthening patient-level outcome measurement.

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## Shared Care Project Abstract Summary

**PROJECT NAME:** Enhancing Patient Flow between LGH Emergency Department and Primary Care on the North Shore

**LOCATION:** North Shore Division

**PHYSICIAN LEAD(s):**  
Brown, Dr Dean  
Lange, Dr Lisa

**AIM STATEMENT:** To improve communication and enhance patient flow processes between North Shore family physicians, Lions Gate Hospital (LGH) Emergency Department (ED) physicians, and LGH Diagnostic Imaging (DI) physicians as a means of reducing the burden on LGH emergency services and improving patient care outcomes in the community.

**TIMEFRAME:**  
1/1/2023 - 7/31/2025

**1. Purpose**  
**Why did you start?**  
**Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

Emergency departments (EDs) across British Columbia are increasingly burdened by rising patient volumes and the growing reliance on EDs as a default point of care. Nearly one-third of BC residents lack a family physician. At Lions Gate Hospital (LGH), one of the busiest EDs in the province, local gaps in communication between emergency, diagnostic imaging (DI), and primary care providers have contributed to unnecessary ED visits, fragmented transitions, and delayed follow-up care. The North Shore Patient Flow project aimed to improve communication and care coordination across these settings to enhance patient flow, reduce unnecessary ED burden, and improve continuity of care.

**2. Methods**  
**What did you do?**  
**Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

From July 2023 to June 2025, the North Shore Division of Family Practice led a physician-driven quality improvement initiative using a co-design approach. Through four working groups, tools were developed, including a standardized ED referral form, an urgent CT and ultrasound (US) referral pathway, and secure messaging (Pathways BC, dr2dr). Using a mixed-method approach, the evaluation incorporated multiple surveys, project team and stakeholder interviews, and administrative data.

**3. Results**  
**What did you find?**  
**Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

The urgent CT and ultrasound referral pathway was used 224 times from February 2024 to January 2025—136 CTs and 88 ultrasounds. Over a nine-month period, the referral pathway prevented an estimated 90 ED visits (about 120 annually). Among family physicians (FPs) who used the pathway, 84% reported better communication with diagnostic imaging. The ED referral form also enhanced coordination with 62% of surveyed FPs indicating it improved communication with the ED.

DI direct messaging was used approximately 66 times in its first 6 months. This tool enabled FPs to connect directly with on-call radiologists for clarification on imaging needs, supporting more appropriate test ordering; and increasing confidence in managing urgent cases.

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The PrevED clinical guide provided FPs with practical tips to manage common urgent presentations in the community. The resource averaged 50 monthly views on Pathways BC and was accessed over 440 times via newsletter links since February 2025.

Dine and Learn events enhanced knowledge sharing and engagement, with 96% of attendees rating the sessions as excellent or very good and 89% indicating they were likely to apply what they learned in their practice. In contrast, uptake of the physician messaging platform stayed low due to usability issues, despite widespread interest in secure communication between providers.

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#### 4. Conclusion

**What does it mean? Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project improved communication, helped reduce unnecessary ED use, and laid the groundwork for future collaboration across care settings.

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#### Lessons Learned

The project's success was driven by strong physician leadership, structured collaboration through committees, and the vital support of the Division of Family Practice. By utilizing the Pathways BC infrastructure and hosting "Dine and Learn" events, the team effectively addressed urgent local issues like ER overcrowding. However, the project faced challenges in communication and logistics, particularly in coordinating schedules between busy family doctors and health authority staff. Ultimately, while the project built a solid foundation, distributing new resources and finding a "one-size-fits-all" communication tool for physicians proved more difficult than expected.

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#### Tools & Resources

[PrevED Emergency Resource - North Shore LGH](#)  
[LGH Emergency Department Referral Guidelines for Family Physicians](#)  
[LGH Urgent CT and US Referral Guidelines for Family Physicians](#)  
[Interventional Radiology Procedures at LGH - Comprehensive Guide](#)  
[Radiology Direct Contact - Lions Gate Hospital \(LGH\) Medical Imaging](#)

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## Shared Care Project Abstract Summary

**PROJECT NAME:** Comprehensive Pregnancy Services for the qathet Region    **LOCATION:** qathet Division

**PHYSICIAN LEAD(s):**  
Glen, Dr Lachlan  
Nwaeze, Dr Felix

**AIM STATEMENT:** The project aims to develop a streamlined, transparent, safe and coordinated pathway in the qathet Region to services for pregnant people, from prevention and perinatal to unintended pregnancy care, and to increase the access to termination services in the region.

**TIMEFRAME:**  
5/1/2023 - 11/30/2025

1. Purpose  
**Why did you start? Establish the context of the project and its significance. Include the nature of the local problem and aim statement.**

Access to timely, equitable pregnancy termination care was limited in the qathet region due to geographic isolation, low visibility of services, unclear referral pathways, socio-economic barriers, and stigma. Patients and providers also faced confidentiality and privacy concerns, contributing to delays, missed clinical windows, and the need to travel out of the community for care, particularly impacting youth and structurally underserved populations.  
The project aimed to develop a streamlined, transparent, safe, and coordinated pathway to pregnancy services in the qathet region, focused on improving access to pregnancy termination within a centralized pregnancy care framework by November 2025.

2. Methods  
**What did you do? Describe what was done and how it was done including interventions, target population, engagement strategy, and data collection methods.**

A multidisciplinary working group used a quality improvement approach informed by environmental scans, journey mapping, and partner input. Interventions included a centralized phone line for self-referrals managed by Public Health, a physician roster, and a digital information hub, modelled after Comox Valley and Campbell River. The targeted population was primarily pregnant people of reproductive age in the qathet region and secondarily health care providers. Engagement included input from physicians, specialists, community partners and patients through working group meetings, interviews, online surveys, and focus groups, alongside collaboration with Public Health, Vancouver Coastal Health, Indigenous health partners, and community organizations. Evaluation used a mixed methods approach, which included website analytics, patient and provider surveys, and available administrative data.

3. Results  
**What did you find? Present the findings of the project, including both quantitative and qualitative data. This section gives readers insight into outcomes achieved through the project work.**

Findings indicate improved clarity and visibility of pregnancy service pathways. In 2025, the website had 1,770 unique visitors, with 95% reporting high satisfaction. Following implementation, 52% of providers reported awareness of the website. Between December 2024 and December 2025, 30 referrals were received through the centralized intake line. Qualitative feedback suggests improved navigation, reduced confusion, and more timely access to care. Limitations included small sample sizes and limited access to administrative datasets.

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#### 4. Conclusion

##### **What does it mean?**

**Summarize the key takeaways from the project and state whether you met the aim. Discuss the overall usefulness or value of the project, plans for sustainability or spread, and implication for future work/next steps.**

The project improved coordination, access, and confidentiality of pregnancy termination services and enhanced system navigation. Although some components, such as a standalone provider education session and local surgical termination services, were not implemented due to capacity constraints, alternative approaches achieved broader reach, and Vancouver Coastal Health has incorporated surgical abortion into its services review. Key components, including the referral pathway, centralized intake, and website, will be sustained through existing regional structures. This model offers a practical approach for rural communities to improve coordinated care.

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#### **Lessons Learned**

The project demonstrated that system-level dependencies and limited rural physician capacity require flexible, phased planning rather than large-scale rollouts. External political factors, such as local elections, also highlighted the need to carefully time the release of sensitive information. Success was driven by centralized access models and dedicated “champions” across disciplines (including midwives, NPs, and Indigenous partners) who ensured the work stayed grounded in community needs. Ultimately, future initiatives should prioritize smaller milestones and lean on existing structures like VCH to maintain long-term momentum.

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#### **Tools & Resources**

- [Pathways | Pregnant in qathet](#)
  - [Pathways | Pregnancy Termination Support](#)
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