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If you have story ideas for future issues, please e-mail: IHAcommunications@interiorhealth.ca

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As retirement approaches and my age creeps up, along with new aches and pains, I’ve been thinking it might be a good time to consider investing in a virtual buddy.

“Alexa, remind me to take my medicine at 8 a.m. every day.”

Once I tell Alexa, the virtual buddy, to do this, she will remind me daily about any pills I need to take, as well as a host of other things from letting me know the weather forecast, to getting news and reports of interest, to making lists and telling me what I’m supposed to be doing and where.

The power of artificial intelligence (AI) and the digital wave is a hot topic in many industries and health care is no exception.

I describe technology as the new health-care disruptor. For that reason, it has been an area of particular interest for me and one that I’ve been researching as I think about its potential and how we prepare for it in Interior Health.

New apps are being developed every day to help us with a health condition or a medical diagnosis.

One app currently being tested allows me to check a spot on my skin and assess within five seconds if it is cancerous or not. I lost my older brother, at age 42, to skin cancer, so technology like this is extremely valuable if it actually offers an accurate diagnosis and I can get to treatment that much faster.

Another one related to surgery appeals to me because it’s one of our key strategies in IH as we look to improve that journey for our patients. The app tells you how to prepare for your surgery, provides follow-up information, and allows you to connect with your physician afterwards as needed for ongoing advice.

These kinds of apps, which are hooked into trusted medical sources, offer immense advantages for accessibility of information.

But they also give you control as a patient because you know more about what’s happening, you’re not as anxious, and you feel supported.

And then there’s robotics – where sales worldwide are projected to reach $13 billion by 2021. These are the early stage robots, some of which have already been able to pass medical exams. They can learn and teach themselves, and they are also showing a higher level of accuracy when reading reports in areas like radiology and pathology. The potential is immense, particularly in the area of quality improvement.

What’s becoming clear is that every organization, in health care and beyond, needs to figure out their part in this new world. So, how do we keep up?

MyHealthPortal is a good example of work we’ve done in IH to give patients tools to be better informed and engaged in their own care. To date, lab and medical imaging results and reports are available to more than 43,000 patients who have enrolled in the portal and we’re hearing patients want more, so we’re continuing to expand. Starting with Vernon Jubilee Hospital on June 18, patients will be able to access physician notes via the portal (with some exceptions) and there will also be access for Mature Minors. All other IH hospitals will follow within a few months.

I’d like to see this lens in all of our work – what are the technologies and innovations that can help us better meet the needs of our health-care clients? The implementation of a Clinical Research Department in IH is definitely a step in the right direction (read more on p. 6), as is the real-time, interactive drinking water advisory map that was released in late May, enabling people to search the entire IH region for current advisories (see p. 8).

Most importantly, we need to start learning how to be flexible and look for areas where we can try small things that we can fast track when they work. Finding the “fast wins” will help build credibility and confidence.

I have presented on this topic to a number of groups inside and outside of IH over the last several months, and I’m pleased to see the reactions. People are thinking about how AI and digital technologies are changing our patterns of behaviour and how we think, and they are interested and eager to know more.

There are possibilities for phenomenal outcomes if we do this right. Exciting times are ahead – I hope everyone will ask themselves how they will participate.
A question is a powerful thing. Questions spark imagination and innovation. In health care, questions lead to new treatments, enhanced care delivery models and, ultimately, better patient care.

The Interior Health Research Department is in the business of asking questions every day. But it was a few well-timed questions asked about a year ago that resulted in its most recent achievement – an ever-expanding Clinical Research Department that is putting IH on the map for highly competitive clinical trials.

“There was limited clinical research being performed in Interior Health. It wasn’t a big focus,” says Dr. Devin Harris, Executive Medical Director for Quality and Patient Safety, and until recently the Associate Scientific Director for the IH Research Department. “Physicians didn’t have the infrastructure to do clinical research within IH – the support staff and logistics. Many physicians want to be involved in clinical research but it’s impossible to do off the side of their desks.”

So a question was put to Dee Taylor, Corporate Director for IH Research: Will you build it? Because we will come.

“There was limited clinical research being performed in Interior Health. It wasn’t a big focus,” says Dr. Devin Harris, Executive Medical Director for Quality and Patient Safety, and until recently the Associate Scientific Director for the IH Research Department. “Physicians didn’t have the infrastructure to do clinical research within IH – the support staff and logistics. Many physicians want to be involved in clinical research but it’s impossible to do off the side of their desks.”

“Somebody asked the question: Is this possible? I said yes,” says Dee. “As soon as people found out we were building the program and the infrastructure, it grew quickly. There was untapped potential.

“The biggest realization for me was there are people walking around with brilliant research minds, asking meaningful questions. Now we have the infrastructure, and they can explore those questions.”

Dee says clinical research focuses on therapeutic improvements – how we deliver care in a best-practice way, such as a new surgery technique, a new medication, or innovations such as home monitoring for cardiac health. This differs from applied research, which focuses on processes or systems such as quality improvement in residential care, or how a health-care worker’s environment helps their confidence and competence in practice.
Clinical research is among the most highly regulated industries, says Coleen Adderley, manager of the Clinical Research Department. That means a robust infrastructure is needed to support clinical trials. In Interior Health, the Clinical Research Department is self-supported through grants and sponsored studies.

Since it launched a year ago, Devin says clinical research at IH “has absolutely taken off.” As a result, Coleen now manages 11 clinical research coordinators, and she says there is potential to hire more.

The coordinators ensure all research is carried out according to Canadian, U.S., and European regulations, follow site operating procedures, prepare ethics submissions (this alone can take more than 20 hours per trial), recruit patient participants, arrange study and monitoring visits, provide ongoing staff education, and are responsible for data entry. In short, the coordinators support all study aspects from start to the close of the trial.

In addition, physicians no longer need to worry about contract and budget negotiations or study invoicing and accountability. Coleen takes care of that.

“The goal is to make sure physicians have the support they need to run the trials they want. The coordinators take the administrative work from the side of physicians’ desks, and allow them to focus on their clinical work,” says Coleen.

Dr. Joslyn Conley loves having the chance to do clinical research. The Kamloops nephrologist is planning on participating in three international clinical trials, ranging from looking at new forms of anticoagulants for high-risk populations like dialysis patients, to testing a potentially life-prolonging medication on patients with renal failure, to examining better treatment for IgA nephropathy.

Joslyn says clinical research offers patients treatments they may not access otherwise, and gives them an opportunity to be involved in improving care. It also makes IH clinicians active participants in exploring potential changes to the care delivery model. And, it harnesses the collective knowledge of care givers, with the common goal of advancing practice and the satisfaction of being a part of the solution.

But by far the biggest benefit, she says, is in physician recruitment and retention. Clinical research allows doctors to ask tough questions and have the tools to find the answers, which improves their practice and provides job satisfaction. Moreover, it creates an academic environment usually found only in larger centres, which is attractive to new physicians.

“Having a research unit and a research hub like this can draw people in,” she says. “There are just so many opportunities. Being in an environment and a part of a community that does research to improve health, and that is dedicated to health improvements, it makes me super excited. It’s so inspiring.”

Indeed, says Devin, the addition of clinical research is helping IH become an Academic Health Science enterprise. IH is now viewed as a driver of quality improvement and innovation, and is garnering support and recognition on the national and international stage. That brings in research funding, including from foundations who want to assist in building research and development (the RIH Foundation, for instance, was instrumental recently in helping establish a new research hub at Royal Inland Hospital, joining those already at Kelowna General and Penticton Regional hospitals). Not to mention that the Ministry of Health has made research a priority for all health authorities.

“It’s a powerful recruitment tool. A lot of doctors are now bringing their work under the IH umbrella. It makes it that much easier for recruitment of highly trained people,” says Devin, a Kelowna emergency department physician.

“However, the most important benefit is improved health care to Interior patients and families, because of the people we recruit and the innovations to health-care delivery that research brings. Our vision is a world class Academic Health Sciences Centre, and it’s completely achievable.”

To learn more about Clinical Research in IH, contact Coleen Adderley.
In a first-of-its-kind project in Canada, Interior Health has launched a real-time, interactive drinking water advisory map, enabling people to search the entire Interior Health region for current drinking water advisories. Map users can also learn more about their local water suppliers, types of advisories, and the reasons for these advisories.

Given the recent flooding in the region and the potential dangers this presents to the safety of water supplies, the launch of the map is especially timely in providing a valuable resource to help protect residents from waterborne illnesses.

“Not everyone across IH has peace of mind that the water that comes out of their tap is safe. With this map, individuals are provided accessible and up-to-date information on their water quality,” says IH Chief Medical Health Officer Dr. Trevor Corneil. “If there’s an advisory on their system, they can make informed decisions related to possible health risks. This level of understanding is also important as local communities discuss future investments in their public and private water systems.”

The Water Advisory Map is now live and accessible at drinkingwaterforeveryone.ca.

In order to create this map, IH consulted a wide range of people in the region regarding their water supply and carefully studied the region’s drinking water systems. The findings from this outreach and research were initially presented by IH in its June 2017 report, Drinking Water in Interior Health. This report identified risks to public health and made recommendations for improving drinking water safety.

One of the report’s key recommendations was to develop and implement a more collaborative engagement process with water operators and other members of the community in order to determine how to communicate more effectively about water.

IH addressed this recommendation by talking to a wide range of stakeholders, and hiring a third-party firm to reach out, listen, and report on the needs of water operators and communities using the following methods:

- Interviews with Environmental Health officers, water suppliers/operators, and representatives from organizations supporting water suppliers, municipalities, and other health authorities;
- Focus groups with small water suppliers that explored roles, challenges, successes, and participants’ recommendations for messaging and resources;
- Visits to seven sites throughout the region that include small and large water systems from each IH region and represent different types of ownership structure.

In response to requests from IH communities for an awareness campaign to provide information about their water and drinking water systems, in June 2017, the Drinking Water For Everyone campaign began.

In the first phase, the website was launched, introducing resources that include a series of educational videos that provide information on how water systems work and how water is treated, as well as safety issues about which communities should be aware.

The second phase saw the development of the water advisory map, built for and with the community, to give the public information about water supply systems and help every water operator to communicate with their communities.

Once the map was built, the team returned to our communities throughout the region to gather feedback from local residents and water operators to ensure that the map reflects their needs and how they want to receive information.

IH is encouraging all residents to look for their community on the map and get to know what’s happening with their water. If anyone has questions about their water or their water system, it’s best to contact their water supplier or their local IH Health Protection office.
Cousin
Student
Drug User
Friend

People who use drugs are real people.

StopOverdoseBC.ca
Since the death of his wife one year ago, 76-year-old Moshe Yarosky has struggled with severe anxiety.

Prior to that, he was used to life’s challenges. When he was 18, he left the family farm in Montreal and moved to Israel where he bought his own farm and stayed for 38 years. He lived through one divorce, raised four children – two of whom still live in Israel – and managed the unpredictability of farm economics.

But the loss of Anna knocked him off his centre.

“We had a very warm, close relationship and since her passing I have found it very hard to cope with the anxiety that began to overwhelm me,” says Moshe.

In 1997, he and Anna moved to Kelowna where their two daughters and one grandchild also live. Their life was beautiful until Anna was diagnosed with pancreatic cancer and they faced a battle they couldn’t win.

“I loved her so deeply. She shared my life so completely and I shared hers.”

He told his family physician, Dr. Jennifer Parsons, what was happening to him and that is how Moshe arrived at Cedar Sage Health & Wellness.

The newly opened mental health and substance use (MHSU) service was developed in partnership between Interior Health and the Central Okanagan Division of Family Practice to help people such as Moshe.

“This is my fifth visit to this fantastic facility and I feel so privileged to have this service available to me.”

Moshe adds that he is grateful to Dr. Parsons for referring him to Cedar Sage and to his counsellor there, Jason McCarty, who helped him deal with his depression-based anxiety.

Cedar Sage is one of Interior Health’s first forays into transforming the way health care is delivered so clients are supported through team-based care.

At the clinic, an interdisciplinary team of MHSU clinicians and physicians provide team-based care to higher functioning individuals experiencing a mental health and/or substance use illness.

“The clinic is designed for people living with mental health conditions or substance use who are facing new challenges and are struggling to cope,” IH Board Chair Doug Cochrane said at a grand opening event on April 27. “The clinic’s goal is to support the client so that she/he can effectively address the challenge before it impairs their health.”

For Moshe, that immediate intervention made all the difference.

“The way Jason works has been so beneficial in teaching me how to take my destiny into my own hands. He has helped me learn not to be overwhelmed by the negatives and realize the positives available to me.”

Moshe says through the joint efforts of his doctor and his counsellor, he has been able to find the strength to look forward and put the anxiety into the proper perspective.

“I still feel the grief, it will never leave me and I won’t ever lose the anxiety, but Jason has given me techniques that really work for me.”

Cedar Sage Team Lead Seija Emond says the story of Moshe indicates the clinic is responding to the need identified by family physicians.

“One of the primary purposes is to support family doctors and nurse practitioners who have patients who don’t need long-term management but need to see someone right away for an issue that could cause long-term health issues if left untreated.”

The team includes a care co-ordinator who handles all the intake and links patients to the appropriate service, which won’t always be at Cedar Sage.

“We never send clients back to physicians and just decline services. We link the client to the right service and send a letter to the physician outlining the plan that has been put in place,” says Seija.
Cedar Sage also has a strong component of Aboriginal culture in both the esthetics and the way clinicians practice. All are trained in trauma-informed methodology and Indigenous Cultural Competency.

Okanagan Indian Band Councillor Allan Louis, who is a member of the First Nations Health Council of B.C., says he is really happy that Interior Health reached out to First Nations representatives and accepted their ideas on how to make the clinic welcoming.

“The first step toward healing is getting people through the door and to do that, it has to be a comfortable place,” he says.

He is also optimistic that the counselling services at Cedar Sage will be culturally safe and help people figure out what led them to their current troubles in the first place.

“An elder put it well. He said we keep pulling people out of the river (when they are in crisis) but not [looking at] why they end up in the river in the first place. We need to deal with the issues that put them in the river.”

He believes this will happen at Cedar Sage.

“I take my hat off to Interior Health for how we have worked together. We’re not at the finish line yet, but we are starting to build a relationship so we understand each other – and this is how people will be helped.”

The full team at Cedar Sage will include physicians, two counsellors, a nurse, a social worker, the care co-ordinator and team lead, and medical office assistants.

Seija says depending on the supports they need, some clients might see a counsellor and a social worker, others may see a counsellor and a nurse, and some will also see the physician.

Early feedback indicates referrals from physicians and NPs are strong, clients are getting seen quickly and they, along with the providers, are reporting a good experience.

The clinic is located on the second floor of the Community Health Services Centre in Kelowna and is currently open Monday to Friday from 8:30 a.m. to 8 p.m., and Saturday 10 a.m. to 6 p.m., at 505 Doyle Avenue.
Tips for effective allies

- **Learn** about Aboriginal experiences and cultural safety.
- **Include** Aboriginal communities in project planning. IH’s Aboriginal Health team is an excellent resource for identifying Indigenous partners.
- **Acknowledge** the traditional lands of Aboriginal people where you work, meet, and hold events.
- **Display** the Aboriginal Health Symbol, where appropriate.
- **Celebrate** Aboriginal culture during National Indigenous Peoples’ Day and all year round.

Message from
Brad Anderson, Corporate Director, Aboriginal Health

I am pleased to be celebrating National Indigenous Peoples’ Day this month, on June 21, with our Aboriginal partners across the region and with my colleagues and allies in an organization that continues to embrace, promote, and make Aboriginal health a priority.

Leadership from our Nation partners and within Interior Health has allowed a trickle of change to turn into a river of transformation. Relationships have formed between local Interior Health administrators and service providers and First Nations and Métis communities. Cultural awareness has grown into cultural sensitivity and continues to shift into cultural competency and humility. As our team continues to work towards Aboriginal health equity and cultural safety, it is increasingly met with openness across the organization to learning, understanding, and partnering. We have come so far on this journey as a health authority and I look forward to where we will continue to go.

There have been many exciting Aboriginal Health initiatives completed recently across Interior Health, including the successful opening of the Cedar Sage Health and Wellness Clinic in Kelowna, the completion and ongoing implementation of the Aboriginal Mental Health and Wellness Plan, the development of the Interior Region First Nations Elder Care Service Enhancement with First Nation Health Authority, and the advancement of cultural safety education. Across IH portfolios, our team and our Nation partners have been involved in important work such as primary and community care transformation and the overdose response.

I want to encourage everyone, Aboriginal and non-Aboriginal, to take part in National Indigenous Peoples’ Day events in their local community. Beyond this one day, getting to know the Aboriginal communities around you is an important step in personal learning and building relationships. My team is available to answer questions or connect you to events nearby. Learn more on the Aboriginal Health InsideNet page.
**Why terminology matters**

In the history of relationships between Canadian institutions and Aboriginal peoples, terminology has often been deployed in ways that have been damaging to communities. The terminology used in public discourse has rarely been that actually preferred by people, who most often refer to themselves by the traditional name of their specific group. Using the best terminology in any given situation is not just a matter of being “politically correct,” but of being respectful and accurate.

Interior Nation representatives at the Partnership Accord Leadership Table have indicated that Interior Health should continue to use Aboriginal when referring to groups of individual First Nations, Inuit, and Métis as this is protected in the Constitution of Canada. The Métis Nation of British Columbia is also supportive of IH utilizing the term Aboriginal.

The term **Indigenous** is a relational term that has a global context that affects the Canadian context (i.e. **UN Declaration on the Rights of Indigenous Peoples**). We have seen a shift across Canada and organizations to move towards this language.

**Aboriginal** is a term that first appeared in the **1982 Constitution of Canada under Section 35(1)** in reference to First Nations, Inuit, and Métis peoples.

Officially called Indians in the Indian Act, the term **First Nations** refers to the Indigenous peoples of North America located in what is now Canada, and their descendants, who are not Inuit or Métis. “First Nation(s)” is the generally preferred term in place of “Indian.”

**Métis** means a person who self-identifies as Métis, is of historic Métis Nation ancestry, is distinct from other Aboriginal peoples, and is accepted by the Métis Nation.

The **Inuit** are the Aboriginal inhabitants of the North American Arctic. They are united by a common cultural heritage and a common language.

For a more detailed explanation of terminology, please visit the **International Journal for Indigenous Health**.

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**Interior First Nation and Métis communities**

Learn more about the First Nations (**St’at’imc, Nlaka’pamux, Syilx, Ktunaxa, Secwepemc, Tsilhqot’in, Dakelh**) and **Métis** communities in the Interior region. Unsure of Nation pronunciations? Check out the **traditional language map**.
CELEBRATING NATIONAL
INDIGENOUS PEOPLES’ DAY
JUNE 21, 2018

VISIT THE
FNHA WEBSITE
FOR EVENTS NEAR YOU!
PLAY SAFE

Kids under age five should use playground equipment lower than 1.5 metres (5 feet)
Engaging Physicians

CULTURE CHANGE TOWARD BETTER CARE

Hurtling across the prairies in a ’93 Ford Crown Victoria, Dr. Harsh Hundal was driving his son to college in Ontario when his cell phone rang. On the other end was Dr. Mike Ertel, Vice President of Medicine and Quality.

“IH had finished dead last on the 2017 Health Authority Engagement Survey for physicians – just 27 per cent – a bad score in an already poor league,” recalls Dr. Hundal. “So, Mike, asked me if I wanted to come back to Interior Health and be the first Executive Medical Director for Physician Engagement.”

Two months later, and with his wife’s permission, Harsh was back at Interior Health. Previously, Harsh was Executive Medical Director for Residential and Community and was instrumental in the implementation of Medical Assistance in Dying (MAiD). After Harsh returned, consultant Rose Harrison, Harrison Health Collaborative Inc., joined to help launch Interior Health on the new physician engagement journey.

“When we look at the literature about what drives engagement, it is authentic leadership supporting a sense of community, efficacy, and joy in work,” says Harsh.

“People are supported in being innovative in a psychologically safe environment. In health care, we have an aging patient population with increased service needs, combined with shrinking resources, placing more burdens of care on our clinicians.”

Harsh explains that over 40 per cent of B.C. physicians are over the age of 55, the physician suicide rate is two to three times higher than the general population, and one in 10 physicians in Canada takes medication for mental health.

“Clinicians are feeling marginalized, isolated, and distressed, and we can’t fix what we do not acknowledge. If we accept that this is an issue, for not just our physicians, but also our administrators and staff, we begin to see that we are not alone. It becomes imperative to build community and co-create a more empowered culture one relationship at a time.”
Engaged Physicians – Cornerstone of a High-Performing Health System

Using models from world-leading health systems, the intention is to help IH shift from complacency thinking, “we are not as bad as...,” to innovative thinking, “we are as great as...”

Others have been on this journey before and have succeeded. Harsh and Rose are modelling our changes after the Mayo Clinic, Cleveland Clinic, and in particular Intermountain Health, whose history bears striking parallels to our own.

“If we empower clinicians and administrators to drive innovation with the front-line staff, include patient and Aboriginal voices, and incorporate their leadership and decision making into the structure and in the processes, then our people will be engaged and we will improve the quality of our care,” explains Harsh.

Equal partners in decision making

Harsh says that we will see real improvements in system performance when physicians and administrators collaborate to pursue excellence in quality of care supported by data, and effective structures and processes.

To help drive this change, physician leaders have been invited to be a part of IH’s administrative structure in dyad pairings, making them equal partners in decision-making processes.

The physician brings skills in clinical strategy, evidence-based decision making, quality of care, etc. The administrative leader brings skills in areas such as budget management, human resources, and union negotiations. This is a relational response to the complexity of health care where two complementary heads can be better than one.

“Together, they can remove barriers, advocate for funding, and celebrate successes within their teams, clinical programs, sites, and entire regions of care – physicians and administrators will begin to feel empowered to help shape and implement initiatives,” says Rose.

”By working with physicians and clinicians closest to the problem; teaching them skills they are not normally taught in medical school, like systems thinking, change management, project delivery, and managing conflict; and supporting them in solving problems, a culture shift begins to take place, quality increases, and the physician engagement problem disappears.”

An example of one such dyad is shared on p. 18.

Where are We Now?

“We know that engaged physicians improve quality, which improves patient outcomes, decreases costs to the health-care system, and improves patient and staff satisfaction,” says Dr. Mike Ertel.

“I am very passionate about this work. It is key for Interior Health to be a high-performing health-care organization. I couldn’t be more pleased with the progress we’re making and seeing the early successes. The journey has officially begun.”

Mike and his team will be identifying the next 25 high-potential physician leaders throughout the organization and formalizing development plans with mentors for each. Other tactics to develop physician leaders include:

- establishing an in-house coaching program for key roles;
- reviewing and the roles of HAMAC and the LMACs to support leadership and quality; and
- partnering with Doctors of BC to create leadership and quality improvement training.

“We must find a way to develop our administrators and clinicians together,” says Harsh. “When we initially shared our findings and recommendations, administrators said they have the same learning needs. I believe we need to provide opportunities for all members of IH to participate in quality improvement.”

The Next Step

In the end, the focus is not the score on the Doctors of BC Health Authority Engagement Survey – it is to change our culture through open dialogue, supportive systems, and a model of leadership to nurture and build capacity.

Harsh believes health care is a calling for each of us – from housekeeper to physician, to librarian, to health service administrator.

“We need to get back to what brought us into caring for others and align our structures and processes accordingly. We need to really focus beyond ourselves to the people we serve: our patients, families, and communities.

“There is a will to tackle the problems together, and it is a necessity for physicians to lead the charge. We should not expect perfection in the beginning. Be prepared to fail – it’s okay. It’s part of the change process and we will learn and improve along the way.”

If you like what you are hearing and are interested in learning more, email engage@interiorhealth.ca.
Leading together in residential care

Like Batman and Robin, Cindy Kozak-Campbell and Dr. Douglas Smith are a team out to make changes – for the better.

“Our dyad is about more than the work we do and achieving the goals,” says Cindy, Executive Director for Residential Services. “It’s about developing a personal relationship that helps to build the teamwork.”

Doug is the Executive Medical Director for Residential Care, Medical Assistance in Dying, Palliative and End of Life Care. With Cindy, he supports the strategic priorities for residential services, while including the physician voice and perspective.

“Creating a culture of dyad relationships that extend to all levels of our residential care keeps patients, clients, and residents at the centre of all that we do,” says Doug.

Through Doug’s connections, like the Divisions of Family Practice, they have been able to reach a larger group of physicians and move some operational work forward.

“The benefit is that we can spark interest, conversation, and involvement on the front line, and familiarize physicians with our strategic priorities to ensure their day-to-day work aligns with the bigger picture,” says Cindy. “The important part for Doug and I is to have the same key messages to share with our peers and partners.”

Through regular meetings and a collaborative learning approach, Doug and Cindy are able to involve more stakeholders in decision making, communication, and vision building for Residential Services’ priorities and strategic projects in IH.

“Doug and I both tend towards a collaborative leadership style,” says Cindy. “We want to hear others’ perspectives and be clear on what we are trying to do; I think this similarity is a real strength for our partnership.”

This dynamic duo has been a team for more than a year and a half and there are no signs of slowing down.

“One of the largest projects we are working on is the Palliative Approach to Residential Care, which applies aspects of palliative care to help long-term care residents live as long and as well as they can,” says Cindy. “Working with Doug I am more confident that we have included the physician voice to help pave the way ahead.”

Doug says care teams will know they are successful when they are having earlier and more frequent goals of care conversations.

“We will know when we are consistently delivering care aligned with people’s wishes, and when our care teams have the confidence, skills, and tools to embed this approach to care in all of our homes.”

More than 3,000 employees make up the IH Residential Services portfolio. Doug supports more than 500 residential care physicians.
FLEET VEHICLES ARE DISTRACTION-FREE ZONES.

Going hands-free isn’t enough. Pull over to take calls or set your phone to Do Not Disturb while driving.

Learn more about the Hands-free and Distracted Driving guidelines in the IH Fleet Vehicle Responsibility Policy.

The use of cell phones, smart phones, or other electronic devices is not permitted when driving Fleet vehicles – including all hands-free devices.
What is your Foundation’s focus or mission? Why is what you do important?
Our focus is to improve the level of health-care available to people living in the interior of B.C. Our mission is to change the lives of people in need and work to ensure that when people are experiencing some of their most challenging times, the Foundation can play a role to try and support those services and equipment so they are there when needed.

What are some of your past favourite campaigns?
Our campaigns are like children – it’s impossible to pick a favourite. The Not Alone Campaign to support Foundry Kelowna was an important campaign for us in many ways. In six months, over 1,000 young people experiencing mental illness and addictions will have a new place to seek help. Over 600 of those had never received help before. This is deeply impactful to us and we are proud of being able to support this important community service.

Is there a particular donation over the years that stands out in your mind – an unusual situation or donation itself?
We’re proud all the time. All of the staff and directors at the Foundation feel so fortunate to be able to work with incredibly generous people who want to make the world a better and kinder place – for people they don’t know and will never meet. To be able to so positively impact even a small part of the world with your time and energies is truly a gift.

Tell us of one of your Foundation’s proudest moments.
A number of years ago, a woman on disability income who was experiencing mental illness sent us a card. The card described how much she appreciates the care she receives in the KGH Emergency Department when she needs it, along with the expert care from the physicians and nurses. She stated that they were very busy and she hoped her gift would help them get a few more people to help out. She had taped a two dollar coin to the inside of the card. The card still sits in our office. It is a constant reminder that every gift counts.

What is your current campaign or major project? Why is it important?
The Better Together campaign to build and operate JoeAnna’s House is our current focus. Families with loved ones in care often don’t plan their visit to KGH. They are in the most stressful time of their lives. Many people who have to come to KGH for life-saving care do not have the resources to even take a vacation – and certainly to stay in Kelowna in high season for weeks or months at a time. JoeAnna’s House will be there for families who need a safe haven during their most trying moments.

Any parting words?
One of the most remarkable things about working at the Foundation is the support and respect that is evident for the staff at KGH. People give to provide the tools the staff and physicians at our hospital need, so they can do what they do best. Supporters to the Foundation are really the cheerleaders for everyone working at KGH. Their respect for the skill and dedication that is so evident at the hospital is what compels them to provide the support they so generously provide.
Total foundation donations to IH (2016/17) $3.7m

Affiliations with hospital auxiliaries and other charitable groups:
The KGH Foundation has had strong relationships with active auxiliaries for close to 100 years. Currently the Foundation is associated with the Kelowna, Rutland, and Peachland Auxiliaries.

KGH Foundation campaign stories:
• This well-loved video features the story of a girl who was rescued from Apex Mountain after being impaled by a tree. Her harrowing rescue and treatment in the brand new Fipke Trauma Room involved many hands, and she survived to tell the story.
• JoeAnna’s House, KGH Foundation’s current campaign to build and operate a home away from home for visitors to KGH.

Total donations to IH $35.8m
Not Alone campaign $2m
Foundation began 1978

Find more information at www.kghfoundation.com.
Where we live & work.
Visit Facebook to see more of the faces in IH.
In celebration of Mental Health Week, IH went live on Facebook with Canadian Mental Health Association Kelowna to talk strategies for good mental health and well-being.

Mark Tyndall’s TED Talk provides a thorough explanation of harm reduction. Mark is an epidemiologist, executive director of the B.C. Centre for Disease Control, deputy provincial health officer of British Columbia, and professor of medicine at the University of British Columbia.
ARE YOU PREPARED?

Know your site’s emergency response plan, know who to contact in the event of a site evacuation, make an emergency plan, build an emergency kit.

InsideNet > About IH > Emergency Response & Planning