How the Medical Transfer Summary Works in Practice: Community Pediatrician - Nurse Practitioner Interview

— Dr. Francine Ling and Elaine Clark, NP

This article is part of an on-going series introducing the newly developed BC Pediatric Society Medical Transfer Form found [here](#).

New tools supporting BC’s community pediatricians in the transfer of adolescent patients into the adult system are winning praise from both pediatricians and the adult-care physicians who participated in the pilot of the tools earlier this year.

The tools were all developed with extensive consultation with community pediatricians around the province and included input from family physicians and adult specialists. Building on the transfer form created by the ON TRAC program at BC Children’s Hospital, the project created a custom version of that form specifically to address the needs identified by community pediatricians, family physicians and adult specialists.

Dr. Francine Ling used the new BCPS form in the transfer of a young woman of 18 with an eating disorder. Dr. Ling found the form very useful for bringing to mind the vital information needed for a smooth transfer.

“Oftentimes those pieces of information get lost in the transfer,” says Dr. Ling. “If you’re relying on patients to share it, they may have a limited understanding of some of it, or get mixed up. Having the form helps to address that, and helps to standardize the approach. There’s a lot of practice variation in how each community pediatrician transfers care, and the ideal case would be to have everyone transferring the information that’s on the form.”

Overall, the concept of having a transfer form is a great one. It really highlights the importance of the information being transferred.

Dr. Ling says she has always aimed to include the same information listed on the form in her consult letters for transfer up until now, but the form “serves as a way to flag it” and as a result brings about more comprehensive information-sharing.

“I’d probably be sharing much of the same information that I did whether I had the form or not, but if I was super-busy, I might forget or overlook something in my consult letter. Using the form, that didn’t happen,” she says.

“I think it’s especially nice to name the adult specialists so that information gets transferred over accurately to the primary caregiver, reducing the chances that you do a double-referral, or the patient gets mixed up between urology and neurology or something like that! Sharing that information in the form is a good supplement to add to what the patient shares.”

Elaine Clark, a nurse-practitioner who received the form from Dr. Ling, really liked how the form provided ideas for the consult note, commenting “The pediatrician sent me the best consult note I’d seen in a long time.”

The BC Pediatric Society has been working with community pediatricians, family physicians and adult specialists on a quality improvement project with the goal of supporting the transition process.

The BCPS Medical Transfer Summary (MTS) is one of the tools developed through several consultations with physicians throughout the past year. In spring 2017 the MTS and other resources were piloted in practices of 7 BC community pediatricians, and the family physicians and adult specialists their patients were transferred to.

This article shares how the MTS worked in practice for one community pediatrician and a nurse-practitioner in a clinic environment.

Continued on next page
Clark appreciated that the form listed all the team members who were supporting the young woman, “so I could quickly see who was connected to this person.” The section on supports and benefits was also very useful to help Clark see at a glance what benefits the young woman was eligible for.

“The detail was wonderful,” she says, noting how important it is when working with a young patient with an eating disorder to have historical information documenting the patient’s lowest weight on record and fluctuations over the years.

“When I’m working with a new patient, I appreciate that baseline information, as well as what current measures the community pediatrician has been taking, the patient’s functional abilities, the activities of daily living,” says Clark.

The new BCPS tools include the form; an online list of community resources grouped by health authority that can be shared with family members or adult caregivers; online information about family doctors and adult specialists accepting new patients; and a series of articles like this one to support CPs in learning about and testing the tools in their own practices.

Both professionals had a few suggestions for improvements to the form and these were reviewed along with other suggestions received from pilot participants. They both hope the new tools end up being well-used.

“The transfer form is a useful guide, and it would definitely be worthwhile for Community Pediatricians to take a look at it,” says Dr. Ling. “Overall, the concept of having a transfer form is a great one. It really highlights the importance of the information being transferred.”

“Transitioning Patients from Community Pediatricians into Adult Care” is a project supported by the Specialist Services Committee (SSC) a partnership of Doctors of BC and the BC government.
Dr. Judith Hall 2017 Award Winner

Dr. Aven Poynter, President, BC Pediatric Society, Dr. Judy Hall and Dr. Kirk Schultz, 2017 Award Winner

The BCPS Announces the 2017 Winner of the Dr. Judy Hall Award - Dr. Kirk Schultz!

Each year the BC Pediatric Society presents the Dr. Judith Hall Award, which recognizes excellence in research, policy development, community involvement and improving the status of or empowering pediatricians.

Here is what Dr. Schultz’s nominator said about him:

Dr. Schultz is internationally known in the areas of research involving pediatric cancer and BMT with over 150 peer reviewed articles. His work has led to significant national and international practice changes, especially in the areas of leukemia and graft-versus-host diseases. He has organized the first adolescent and young adult meetings and clinical trials in ALL and helped establish a national patient partnership group in BMT. His work as the Department of Pediatric AFP working group chair moved toward practice changes in pediatrics across the province.

Congratulations Dr. Schultz!
Dr. Parminder Singh 2017 Award Winner

Dr. Lori Tucker, 2017 Award Winner, Dr. Aven Poynter, President, BC Pediatric Society and Dr. Harpreet Chauhan (representing her father, the late Dr. Parminder Singh)

The BCPS Announces the 2017 Winner of the Dr. Parminder Singh Award - Dr. Lori Tucker!

The relationship between community and hospital-based pediatricians and sub-specialists plays a significant role in the health outcomes of BC children and youth.

Each year, the BC Pediatric Society (BCPS), in co-operation with the BC Children’s Hospital Foundation (BCCHF), is pleased to present the Dr. Parminder Singh Award of Distinction to recognize the value of this interrelationship.

Here’s what Dr. Tucker’s nominator said about her:

Dr. Tucker offers outreach services to our community (Prince George) and has done so faithfully and reliably for about a decade, perhaps longer. The paediatric rheumatology patients in our region (Northern Health Region), which is geographically very distant from BC Children’s Hospital, are extremely well served by Dr. Tucker and her colleagues. Not only that, but the communication the general paediatricians in our community receive from Dr. Tucker is stellar; I always feel that she keeps me abreast of how our mutual patients are doing and she is readily available any time I have questions. She works with us collaboratively and collegially, always demonstrating that she values the contribution that the general paediatricians play in the care of the sometimes complex paediatric rheumatology patients’ care. In addition, she was instrumental at helping our paediatric group and paediatric hospital clinic in establishing our current practice of administering IV biologic infusions for paediatric rheumatology patients here in Prince George. Enabling these children to receive their regular IV medications, such as infliximab, either in their home community or very close to their home has saved dozens of children (maybe more than 100 in our region by now) countless days of time away from friends, activities and school and has saved their parents innumerable amounts of money lost due to missed work and travel. Lastly, Dr. Tucker has been proactive at teaching UBC Northern Medical Program medical students during her outreach clinics here; the students feedback about the time they spend with Dr. Tucker and the visiting Paediatric Rheumatology team is overwhelmingly positive. Dr. Tucker has also provided grand rounds presentations to the Prince George medical community during her time here. Her passion for her clinical work is apparent, her communication with her colleagues ‘in the community’ is exceptional and her enthusiasm for teaching is admirable. She is a great role model for physicians new to practice and I strongly endorse her as a candidate for the Dr. Parminder Singh award.

Congratulations Dr. Tucker!
Clinical Faculty Award for Excellence in Clinical Teaching

Dr. Kristin Houghton has been Postgraduate Program Director for the Division of Rheumatology, Department of Pediatrics, for the past 10 years, and has been extraordinarily effective in transforming the training program during her tenure. She has developed a new interactive online case-based academic half-day teaching program together with a mentored postgraduate trainee, and this program is now used internationally. Her teaching evaluations demonstrate excellence in teaching methods, and most importantly, learners find her an approachable, thoughtful, and compassionate educator and role model.

This award recognizes excellence in teaching by Clinical Faculty members at a Clinical Academic Campus, namely BC Cancer Agency, BC Children’s Hospital, BC Women’s Hospital & Health Centre, Kelowna General Hospital, Royal Columbian Hospital, Royal Jubilee Hospital, St. Paul’s Hospital, Surrey Memorial Hospital, Vancouver General Hospital, Victoria General Hospital, University Hospital of Northern BC.

And here’s another BCPS member award winner!

Pediatricians say that the Medical Transfer Summary reduces the need for supplemental phone calls or correspondence when transferring a patient into adult care.

Click here for the Medical Transfer Summary.
Missing Pieces: Joshua’s Story

*Missing Pieces: Joshua’s Story* investigated the life of a 17-year-old Lower Mainland youth who died of suicide on the grounds of BC Children’s Hospital while on a four-month stay at the Vancouver facility. A more comprehensive child and youth mental health system would have given this boy and his family a better chance in dealing with his debilitating mental illness, it concludes.

The complete report is available online here: 
[http://www.rcybc.ca/joshua](http://www.rcybc.ca/joshua)

Maternal Antidepressant use may Increase Child’s Psychiatric Disorder Risk

Youths whose mothers used antidepressants before pregnancy, during pregnancy, or before and during pregnancy were more likely to develop psychiatric disorders by age 16, compared with those whose mothers weren’t exposed to the drugs, researchers reported in The BMJ. The findings also showed the highest psychiatric disorder risk among those whose mothers took both selective serotonin reuptake inhibitor and non-SSRI antidepressants.

Youths with ADHD may Benefit from Micronutrient Supplements

More children with attention-deficit/hyperactivity disorder who took Daily Essential Nutrients, a micronutrient treatment containing 13 vitamins, 17 minerals and four amino acids, had significantly improved ADHD symptoms, as well as better emotional and aggression control, attention and general functioning after 10 weeks, compared with those who took a placebo, researchers reported in the Journal of Child Psychology and Psychiatry. The findings showed similar hyperactive and impulsive symptoms between the groups.
CYMHSU ER Protocol

The ER Protocol’s working group mandate has been to improve the experience of children, youth and their families with mental health and substance use challenges who arrive at BC ER’s and to care and to create a standardized approach to their care. In the fall of 2016 we started working with Dr. Doan and the HEARTSMAP team from BCCH who had developed an assessment tool. Together we have been working with Health Authorities as they are now leading this process to implement this across the province.

Please refer here for a short training video.

CYMHSU ER Protocol Training Video

ER Protocol Training

A short training video has been created to introduce you to the Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative ER protocol. The video has been designed to clearly outline the Protocol’s five steps, and how each step works to form part of a consistent supportive response for children, youth and families seeking help for a MHSU crisis in the ER.

The five steps are:

1. A ‘WHAT TO EXPECT PAMPHLET’ – given out at triage to parents/youth
2. AN ALGORITHM – to guide the process for physicians and nurses from triage to discharge
3. HEARTSMAP – a psychosocial assessment tool www.heartsmap.ca
4. A ‘COMMUNICATION PLAN AT DISCHARGE’ – replaces all existing referral forms
5. A ‘SAFETY PLAN AT DISCHARGE’ – completed by youth, with a copy going home with them.

All information and forms will be tailored to your Health Authority or hospital, and readily available when needed (on your HA or internal hospital website). Please note that in the video we refer to the ER and ED protocol recognizing that these can be used interchangeably in some hospitals. Some sites will also refer to the ER or ED guideline.

Additional Training Sites:

- HEARTSMAP assessment tool www.heartsmap.ca to register and for additional information
- Learning Links – 15 free on-line modules on MHSU www.learninglinksc.ca
- [CME CREDITS AVAILABLE]

If you would like to provide feedback please forward to michele.blais@outlook.com until 12/31/2017

AS YOU WATCH ...

If you are about to watch the video, you will find it much more effective if you have copies of the supporting forms to review as you watch. We recommend making pre-made kits in the ER with the forms for a more efficient process.

BACKGROUND

Why was the ER protocol developed?

In the past ten years there has been a steady increase in the number of children and youth seeking help in the Emergency Department for a mental health or substance use crisis. To try and address the issue, the Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative (a partnership by Doctors of BC and the BC government) formed the ER Protocol working group.

What are the goals of the protocol?

The protocol was developed to ensure that all BC children, youth and families receive a consistent approach to care in the ER, from staff who are skilled and confident to support them. Also that the need for referrals to community resources are identified, completed and communicated to all parties, including GPs.

Who was the protocol developed for?

All practitioners who see and assess children and youth with mental health and substance use issues in the Emergency Department may be trained to use the protocol: physicians, nurses, psychiatric liaison nurses, social workers, and crisis response teams. The most appropriate team to be trained will be determined by each site.
Study Looks at Cost-Effective Interventions to Curb Child Obesity

Researchers estimated that imposing excise taxes on sugar-sweetened drinks could curb 576,000 child obesity cases and yield savings of $14.2 billion between 2015 and 2025. The findings, presented at the American Academy of Pediatrics annual meeting, also showed that implementation of nutritional standards on children’s school food and removal of tax breaks for junk food ads aimed at youths may prevent 345,000 and 129,000 child obesity cases, respectively, and lead to savings of $792 million and $260 million, respectively, during the same period. Medscape (free registration)

Study Identifies “Critical Windows” During Youth to Prevent Adult Obesity

A January 2018 Pediatrics study that tracked the body mass index (BMI) of more than 2,700 people in Finland over three decades identified key ages when achieving a healthy BMI may prevent obesity during middle age. The study, “Body Mass Index Trajectories Associated with Resolution of Elevated Youth BMI and Incident Adult Obesity,” which will be published online Dec. 19, found that people with a healthy BMI by age 6 were less likely to have obesity by age 49. This finding echoed those of earlier studies linking a healthy early childhood BMI with lower adult obesity rates. However, the researchers also identified a second “critical window,” beginning in adolescence for females and early adulthood for males. BMI levels started to plateau at 16 years for females and 21 years for males among those within normal ranges, while the those who continued to have high BMI levels at those ages did not level off until age 25 (for males) and 27 (for females). The researchers said the findings support focusing efforts to achieve a healthy BMI by age 6, with a second chance to help prevent obesity later in life among teens and young adults.
Most High-Risk Babies Don’t Receive Rotavirus Vaccine in Hospital

Two-thirds of high-risk infants who were age-eligible for routine rotavirus vaccination weren’t immunized before hospital discharge, 42.6% of whom were no longer age-eligible after discharge, researchers reported in Pediatrics. The findings also showed no transmission of vaccine-type rotavirus between vaccinated and unvaccinated babies, and researchers suggested that postponing rotavirus immunization until discharge may result in missed vaccination opportunities.

Medscape (free registration)/Reuters
Adverse Childhood Events Less Likely Among Hispanic Immigrant Youths

Hispanic children in immigrant families were significantly less likely to experience adverse childhood events such as abuse, family dysfunction and violence exposure despite having increased odds of living at or under 20% of the federal poverty level, compared with Hispanic youths in US-native families, according to a study in Pediatrics. The findings also showed lower parent-reported ACE exposure among Hispanics, compared with African-Americans, despite similarly elevated childhood poverty rates.

New Early Years Domestic Violence Toolkit

As part of the Provincial Domestic Violence Plan, the Ministry of Children and Family Development (MCFD) committed to develop an Early Years Toolkit to increase capacity and competency among early years professionals to respond to children who are exposed to domestic violence, and provide their families with appropriate support. The Early Childhood Exposure To Domestic Violence: You Can Help Toolkit is a tool to raise awareness and provide information about how to recognize the signs of exposure to domestic violence for children ages 0-5, and provide tips for how to safely respond.

The toolkit is full of facts about the impacts of domestic violence on children’s health and well-being, how to support children who disclose domestic violence, considerations for working with diverse populations, as well as many links to helping organizations and more information.

Download the toolkit here.

QUICK FACTS ABOUT DOMESTIC VIOLENCE

Rates of domestic abuse related homicide are 4.5 times greater for women than men. 70% of relationship violence is not reported to the police.

Children under the age of five are more likely to live in a home where domestic violence occurs. Children who are exposed to domestic violence are more likely to experience child abuse and neglect. In Canada, almost one third of confirmed child abuses cases involve exposure to domestic violence.

Relationship violence accounts for over 1/4 of all violent offences reported to the police.

Every 4 days a woman is killed by a family member in Canada. In 2015, approximately 18,000 women and children accessed transition houses and safe homes to escape violence or abuse in BC.

Pregnancy increases a woman’s risk of experiencing domestic violence.
Advocacy for Vulnerable Children and Youth: The Child and Youth Legal Centre
— by Suzette Narbonne, Lawyer, Child and Youth Legal Centre

The Problem

Children and youth are impacted daily by legal problems but often have little ability to ensure that their voices are heard. Too often, delays in resolving court cases involving where a child will live can cause enormous stress on the young person. With little ability to affect the process, the child feels powerless.

The United Nations Convention on the Rights of the Child (UNCRC), the world's most ratified human rights treaty, affirms that the child who is capable of forming his or her own views must be assured “the right to express those views freely in all matters affecting the child” (Article 12, UNCRC). In order to ensure this right, Article 12 mandates that the child shall “be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child” either directly or through a representative. The rights are clear; the question, however, is how to give these children that voice.

The Solution

In the fall of 2017, the Child and Youth Legal Centre opened its doors. The Centre, which is based in Vancouver, provides free, province-wide, legal representation and assistance to vulnerable, immigrant, and Indigenous children and youth.

The Child and Youth Legal Centre is an initiative established through the Society for Children and Youth of British Columbia—a unique provincial organization dedicated to improving the well-being of children and youth in BC using the UNCRC as a foundation. The mandate of the Centre is to improve the well-being of children and youth in BC through the advancement of their legal rights.

Young persons in BC can get direct advocacy services from lawyers for a wide range of legal problems including family matters, child protection, and human rights.

The lawyers will advocate for the young person, making sure the child’s voice is heard—that his or her views and preferences are clearly communicated to the judges, the tribunals, and to the many other people who are making legal decisions that will affect the young person.

Legal services range from summary advice to drafting legal documents to appearing on behalf of the child at court or at mediations.

Children and young people can be referred by caregivers, professionals or can call the Centre directly.

For more information about this program, along with a list of frequently asked questions, please go to www.scyofbc.org and visit the Child and Youth Legal Centre page.

The Centre is funded by The Law Foundation of British Columbia, The Law Foundation of Ontario, The Law Society of British Columbia, The Notary Foundation, and Representative for Children and Youth
Safer Infant Sleep: A Practice Support Tool for Healthcare Professionals

From 2013 to 2015, 57 babies younger than one year died during sleep in BC. The Safer Infant Sleep: Practice Support Tool for healthcare professionals is intended to facilitate and encourage an open discussion around safer infant sleep starting in the prenatal period. To learn more and download the resource, please click here.

SAFER INFANT SLEEP
A practice support tool for healthcare professionals

To be used in combination with PSBC’s “Safe Sleep Environment Guideline for Infants 0-12 months of Age” and the companion parent resource “Safer Sleep for my Baby”

About this resource
This resource is intended to facilitate and encourage an open discussion around safer infant sleep starting in the prenatal period. Before you begin, consider asking families the following questions to open the conversation:

• Where will your baby sleep?
• What have you heard about keeping your baby safe while they sleep?
• What would you like to know about keeping your baby safe while they sleep?

Safe sleep principles | Safer sleep for every sleep, day or night

• BACK TO SLEEP. Putting your baby to sleep on his/her back in a crib or bassinet in the same room as you is the safest way for your baby to sleep.
• FIRM MATTRESS FREE OF HAZARDS. To reduce the risk of suffocation, put your baby on a firm mattress with a tight-fitting sheet and no bumper pads, pillows, heavy blankets or toys in the sleep space.
• CRIB OR BASSINET. The safest place for a baby to sleep is in a Health Canada approved crib or bassinet. (If you’re unsure about yours, talk to your health care provider). It is important to supervise your baby if he/she falls asleep in a car seat, stroller, or baby carrier. Once you have arrived at your destination, it is best to move your baby to a crib.
• SHARING YOUR ROOM. Having your baby sleep on a separate sleep surface in the same room as you for the first six months helps keep your baby safe.
• SMOKE-FREE. Avoiding smoking during pregnancy and keeping your home smoke-free before and after the birth helps prevent sleep-related infant death.
• BREASTFEEDING. Breastfeeding helps prevent sleep-related infant death. Any amount of breast milk will give your baby’s immune system a boost and help keep him/her healthy.
• AVOID OVERHEATING. Babies like to be warm but not hot, so for sleeping it is best to keep the room temperature comfortable (around 18º C) and use a light blanket, ‘sleep sack’, or blanket-weight sleeper. There’s no need to swaddle or put a hat on indoors.

BC Statistics

Many of these deaths are preventable and differ from “SIDS”, which are infant deaths during sleep where the cause of death remains unknown after a thorough case investigation. 68% (49) of the infants who died had more than one of the following risk factors:

- 59% of infants were bedsharing
- 35% Placed or found prone
- 23% Parent incapacitation due to medication, alcohol or substances
- 19% Baby was premature
- 14% exposure to second hand smoke

Every year in BC more than 43,000 babies are born.

From 2013-2015, 57 babies younger than one year died during sleep in BC.
Health Care Compared
— by Ian Austen

Aaron E. Carroll, a professor of pediatrics at Indiana University School of Medicine, and Austin Frakt, a health economist with several governmental and academic affiliations, frequently analyze health care policy for The Upshot. (They also have an excellent blog about health care economics.)

Recently, they gathered two other economists and a physician and held a tournament to pick the world’s best health care system. Canada was knocked out early by Britain. Long wait times delivered the fatal blow. But in this essay for the Canada Letter, Professor Carroll and Dr. Frakt offer a positive take on that result:

One of the most common complaints about the Canadian health care system is the duration of wait times. That was the reason that some judges favored other nations in The Upshot’s tournament-style comparison of various countries’ health systems. Indeed, fear of long wait times is one of the most commonly cited reasons people in the United States reject a single-payer health system.

But these access issues are not necessarily because Canada has a single-payer, or government-run, system. After all, Britain has a much more socialized system, and performs much better than many other countries with respect to wait times.

Further, many of the wait time comparisons made between the United States and Canada focus on elective procedures like hip replacements and cataract removals, which predominantly affect older people. Older Americans are covered by Medicare, which is a single-payer system.

The reason for longer wait times in Canada is not because of the system’s design. It’s because of the system’s spending. Canada spends, on average, about half of what the United States does for health care. Spending so much less has to have consequences, either decreased access or decreased quality.

We can quibble about various metrics, but the same Commonwealth Fund study that faulted Canada for access issues didn’t find huge differences in outcomes. Canada beats the United States on population metrics, while the United States wins with respect to hospital-based ones. The United States also does well in cancer survival rates, but we’ve discussed why survival rates are flawed before. Canada may have longer wait times, but it’s hard to see how they are negatively affecting Canadians in comparison with Americans.

The bottom line is that while Canada does have longer wait times compared with other countries, it seems to have made the decision to accept this as a trade-off for significantly reduced spending. We can choose to value different things, but those wait times are most likely an economic decision, not one inherent to single-payer.

The Best Health Care System in the World: Which One Would You Pick?
**King of Children: The Life and Death of Janusz Korczak**

This is the tragic story of Janusz Korczak (as featured in the major motion picture The Zookeeper’s Wife) who chose to perish in Treblinka rather than abandon the Jewish orphans in his care.

Korczak comes alive in this acclaimed biography by Betty Jean Lifton as the first known advocate of children’s rights in Poland, and the man known as a savior of hundreds of orphans in the Warsaw ghetto.

To order a copy of this inspiring book, please [click here](#).

**Review Examines Benefits of Pediatric Medical Marijuana**

Tetrahydrocannabinol in medical marijuana was significantly better in reducing chemotherapy-related nausea and vomiting than anti-nausea medicines among children and adolescents with cancer, while another cannabis compound, cannabidiol, led to lower seizure frequency without intoxication in youths with epilepsy, according to a review in Pediatrics. However, researchers found inadequate studies supporting the benefits of medical marijuana for youths with post-traumatic stress disorder, neuropathic pain or Tourette's syndrome.

HealthDay News (10/23), Healthline (10/23)
The BCPS established a service to provide a central source of information for those pediatricians requiring and those providing locum service. Please find our current Locum postings below. Help us keep this list current by sending us your “Available for Locums” or “Opening for Locums” listing. Just email your vacancies to the BC Pediatric Society and we will publish it in the member section of our website and in the next issue of The Prescription Pad.

<table>
<thead>
<tr>
<th>Name</th>
<th>Place</th>
<th>Availability</th>
<th>Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dr. Nina-Karen Bansal</strong></td>
<td>Burnaby, BC</td>
<td>Anytime between June 2017 - February 2018 Full or Part Time</td>
<td>Consultant pediatrician in office-based practice. No call. 70/30 split of all MSP-paid billings.</td>
</tr>
<tr>
<td>604.553.7787</td>
<td></td>
<td>Prefer longer locum duration if possible (ie. few months rather than few weeks), but any coverage is welcome.</td>
<td></td>
</tr>
</tbody>
</table>

| Dr. Melissa Paquette        | Kamloops, BC     | July 2017 onward                                  | The Kamloops team of Pediatricians is recruiting another pediatrician but will happily accept any locum work as well. We are a very collegial group of 6 pediatricians looking for a seventh. We have office space available for an interested pediatrician to walk in to a full and busy practice. In addition to our office work, we cover call at the hospital one week at a time which includes managing our busy level 2B SCN, our 8 bed Pediatric ward and consulting work from the ER and community. We are actively involved with the UBC Pediatric and Family medicine residency programs and the UBC Southern Medical Program. |
| melis.paquette@gmail.com    |                  |                                                  |                                                                         |
| 250-319-0752                |                  |                                                  |                                                                         |

| Dr. Antoinette van den Brekel| Vancouver, BC    | long term starting December 2017                  | This position is to cover night calls (6 pm to 8 am on weekdays) and weekend shifts (24 hours). Coverage is for neonatal call and to ER. St Paul's Hospital has a 9 bed level 2 NICU with approximately 1700 deliveries per year. There are no inpatient pediatric beds but we have a urgent referral pediatric clinic which allows you to see ER referrals in a timely manner. We would like someone to take 3 to 4 weekdays and two weekend days per month. Teaching of 3rd year medical students is included and compensated on weekends. |
| avandenbrekel@telus.net     |                  |                                                  |                                                                         |

| Dr. Monica McKay            | Williams Lake    | January-March 2018                                | Approximately 7-10 days a month mainly for on call MOCAP coverage. January 5th-15th is looking critical at the moment, but any help will be appreciated. Office time is flexible and optional, and the locum will be reimbursed through the Rural Locums for BC Program. |
| dmimckay@gmail.com           |                  |                                                  |                                                                         |
| Dr. Kate Runkle  
karunkle@gmail.com | Kelowna, BC  
August 1, 2017 to May 25, 2018 | We are looking for short or long term locum with ongoing employment opportunities available with the Kelowna General Hospital Paediatrics Team. This is mostly a hospital-based locum with NICU and CTU weeks and call coverage. We have a brand new, busy, level 2B NICU with 12+ beds. We attend deliveries and keep newborns above 30 weeks gestation. We also cover emergency consults and have a 12+ bed paediatrics ward. An urgent care clinic is run out of the paediatrics ward. We are actively involved with teaching medical students, family medicine residents and year 4 paediatric residents, and are affiliated with UBC Southern Medical Program. Clinic time is also available for consultant paediatric consults at a brand new paediatric office overlooking Okanagan Lake.
Our team is friendly, supporting, and very welcoming. Kelowna is a gorgeous city with plenty to do all year round! |
| Dr. Kathy Gross  
kgross@shaw.ca  
250-809-0035 | Penticton  
March 5-14, 2018 | Penticton Regional Hospital: Short term locum between March 5th and March 14th, flexible as to dates: could be Thursday March 7th, Friday to Sunday March 9th, 10th and 11th plus Tuesday March 13th but another combination would work too. Looking for 4-7 days total. No overhead charge and the payment is level 1 MOCAP, expenses will be covered for travel and accommodation.
There is a hospital clinic that can be used and outpatient consults can be booked to supplement the on call work, usual income approx $1400 per day. The call is not usually onerous. We have a level 1 nursery, so we transfer out infants <36 weeks and anyone needing ventilation for more than 24 hrs. The ER docs are very good and supportive. Skiing is great at Apex on days off! |
| Dr. Laura Swaney  
laura.swaney@gmail.com  
250-421-8367 | Cranbrook  
January 1 - April 30, 2018 | East Kootenay Regional Hospital, Cranbrook, BC: Short or longer term locum ANYTIME between Jan 1 - April 30, 2018. We have 35 days of additional RLSP (Rural Locum program) which provides travel expenses, accommodation and a daily minimum stipend ($1200/day + top up if bill more). Call is 1/4, not usually very busy, and is covered by MOCAP. No overhead expenses. We have no funded nursery but keep babies 36+ weeks, or until transport to Kamloops/Kelowna/BCCH can be arranged if ventilated. ER docs are great.
We are within a 2 hour driving radius of 7 ski hills, with Kimberley the closest at 20min!
We specifically could use coverage during the following dates:
• Jan 25th - Feb 7th, 2018  
• March 9 - 30th  
• April 20 - 27th |
### AVAILABLE FOR LOCUMS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Place</th>
<th>Availability</th>
<th>Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Gelpke</td>
<td>Victoria, BC</td>
<td>Experienced locum available for most of the year.</td>
<td>Communities not eligible for RLSP, would prefer to house/animal sit.</td>
</tr>
<tr>
<td>250-598-6863</td>
<td></td>
<td>Two weeks or so at a time ideal. Office and on call.</td>
<td>Provides portable echocardiography service.</td>
</tr>
</tbody>
</table>

---

**Important Information:**

The Rural Locum Specialist Program provides great incentives to help provide services to rural areas. The daily rate is dependent on the location. In the West Kootenay's a locum will receive $1200.00/day for all days they work, plus $600.00 MOCAP if they are on call. They can recover billings if the average exceeds the daily rate quoted above. Billings would also include the additional funds added for the Rural retention program. The program also covers travel expenses, and a $1000.00 travel honorarium to cover for the travel time. The Health Authority will pay for lodging.

Details are available on the website: [http://www.health.gov.bc.ca pcb/rural_specialist.html](http://www.health.gov.bc.ca pcb/rural_specialist.html)