Thompson Region
Division of Family Practice
A GPSC initiative

ANNUAL PLAN
2021 – 2022

February 2021

NETWORKING & CALL GROUPS | ENGAGEMENT | PRACTICE SUPPORT PROGRAM | PATHWAYS | PATIENT ATTACHMENT | RESIDENTIAL CARE | RECRUITMENT | SHARED CARE | UP TO DATE

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Contents

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ANNUAL PLAN 2021 – 2022

EXECUTIVE SUMMARY

Our 2021-2022 Annual Plan
STARTS HERE

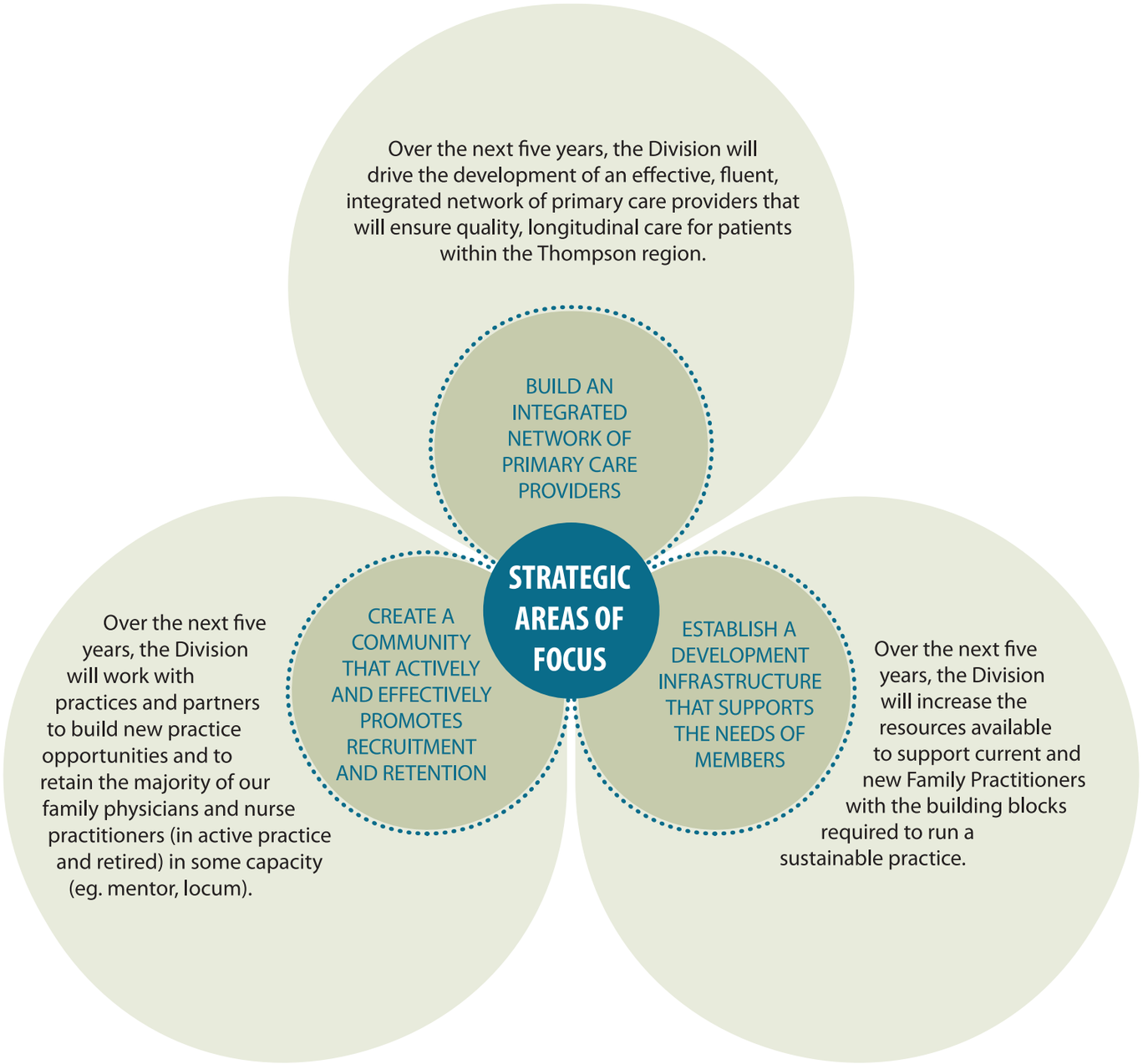
Recent work with the membership and the Thompson Region Division of Family Practice Board of Directors, marks 2021as the start of a new, approved five-year Strategic Plan 2021-2026. Our goal is to answer the call to action, pursuing creative ways of developing practice opportunities with family physicians, nurse practitioners and our partners for longitudinal care.

Our annual plan for 2021-2022 outlines how we at the Thompson Region Division of Family Practice will take steps toward change and the achievement of our vision: *A community of Family Physicians, Nurse Practitioners, and other primary care providers working collaboratively with community partners to develop and support the implementation of primary care focusing on wellness, satisfaction and sustainability for both the patient and providers.*

To maintain our focus and momentum year after year, this annual plan is organized for each body of work to reflect the three strategic areas of focus:

1. Build an Integrated Network of Primary Care providers.
2. Create a community that actively and effectively promotes recruitment and retention.
3. Establish a development infrastructure that supports the needs of members.

Quality
Collaboration
Inspiration
Innovation
Resilience


Over the next five years, the Division will drive the development of an effective, fluent, integrated network of primary care providers that will ensure quality, longitudinal care for patients within the Thompson region.
BUILD AN INTEGRATED NETWORK OF PRIMARY CARE PROVIDERS
STRATEGIC AREAS OF FOCUS
CREATE A COMMUNITY THAT ACTIVELY AND EFFECTIVELY PROMOTES RECRUITMENT AND RETENTION
ESTABLISH A DEVELOPMENT INFRASTRUCTURE THAT SUPPORTS THE NEEDS OF MEMBERS
Over the next five years, the Division will work with practices and partners to build new practice opportunities and to retain the majority of our family physicians and nurse practitioners (in active practice and retired) in some capacity (eg. mentor, locum).
Over the next five years, the Division will increase the resources available to support current and new Family Practitioners with the building blocks required to run a sustainable practice.

1.

Build an Integrated Network of Primary Care Providers

This portfolio is comprised of work that will support the Division, over the next five years, in the development of an effective, fluent, integrated network of primary care providers that will ensure quality, longitudinal care for patients within the Thompson region.

1.1 ADULT MENTAL HEALTH AND SUBSTANCE USE

Goal: To develop initiatives which help provide sustainable, supportive, accessible, and comprehensive mental health care for patients tied to their Patient Medical Home.

Outputs:

- CME event(s)
- Referral algorithm
- Shared diagnostic tools and language
- Improved referral practices
- Patient information
- Central information hub
- Regional collaboration

Impact:

- Access to information and support from mental health specialists tied to the Patient Medical Home.
- A collaborative relationship with Interior Health's Mental Health and Substance Use team as well as community providers.
- Access for patients to timely and effective system of mental health and substance use care.
- Shared knowledge of mental health and substance use practices throughout the Thompson Region.

Physician/Member Lead: Dr. Cynthia Lau/Dr. Nataliya Grishin
Team Lead: S. Breen

1.2 CHRONIC PAIN

Goals: To enhance the spectrum of chronic pain services by engaging and supporting communication and knowledge exchange between family, specialist physicians and other allied health providers. To share patient stories and journey mapping examples. To build community partnerships, document needs, map out current state, advocate, and plan for service redesign. To explore patient support group in partnership with Pain BC.

Impact:

- Patients will experience better management of their pain, more coordinated care and have access to professional and peer support.
- Documentation of services offered by physicians, specialized services, and allied health.
- More opportunities for patients, physicians, and other health professionals to access care.
- Engagement with the provincial Shared Care Chronic Pain Spread Network and share contributions and learning from others engaged in the same work.

Outputs:

- Action plan to Shared Care for gated funds.
- Mapping of chronic pain services
- Patient journey mapping
- Provincial survey

Physician/Member Lead: Dr Baker, Dr Brownlee, and C. Wilson
Team Lead: M. Todd

1.3 COLLABORATIVE SERVICES COMMITTEE

Goals: To maintain a regular partnership table with Interior Health, First Nations Health Authority, Secwepemc Nation, UBC Family Practice Residency, Royal Inland & Hillside Physician Association, General Practice Services Committee, and the Ministry of Health to continue to co-develop solutions across the care continuum. To oversee a model of care in the Thompson Region that prioritises longitudinal care and equitable access to team.

Outputs:

- Memorandums of Understanding and Terms of Reference for partnerships with Local Health Tables, Community Health Centres, and Project/ Initiative groups
- Primary Care Network and Specialized Community Services Program service plan
- Gap Analysis of attachment and access data.
- Change stories documented to demonstrate action and progress due to Division participation.

Impact:

- Ongoing effective channels to engage partners acknowledged and sustained.
- Division members are leaders in the design and implementation of local primary and community care solutions.
- Influencing healthcare policy at the provincial and regional levels.

Physician Lead: Drs. Cornel Barnard, Chip Bantock, and Graham Dodd
Team Lead: M. Walsh

1.4 COMMUNITY AND MEMBER MAPPING

Goals: To geospatially portray data that reflects variations in population characteristics (e.g. demographic, socio-economic) and physical features of primary healthcare resources (e.g. primary care clinics). To inform health service planning and the development of networks through the engagement of the membership and partners. To support the development and implementation of the emergency management plan.

Outputs:

- Maps, story maps, and dashboards
- Regional collaborations for mapping initiatives
- Analysis of trends and patterns

Impact:

- A visual representation of all the primary care, specialized, and allied health services across the region that informs future planning.
- Linkages created within the primary care community that support shared resources, networking and specialized services and the identification and quantification of patterns and relationships.

Physician/Member Lead: Health Leadership Committee
Team Lead: F.Bateman and C. Jones

1.5 HEALTH LEADERSHIP COMMITTEE

Goals: To facilitate the integration of shared physician and primary care provider initiatives in the Thompson Region. To support and link subspecialty networks and working groups into longitudinal care and the broad medical community which will inform and improve provider practice capacity and member wellbeing. To act as a physician and nurse practitioner resource for health service planning and transformation initiatives. To assist in retention efforts by identifying opportunities to bring together members who can find support in one another.

Outputs:

- Member surveys
- Communication content for members and the public
- Action tracker for items to follow up with partners or across programs
- Programmatic direction in initiatives, future projects, and reporting

Impact:

- HLC provides strategic direction for Division programming, communications, and initiatives.
- Decisions and recommendations provide guidance to community primary care providers.
- Building a collegial medical community.

Physician/Member Lead: Drs. Swaart, Bantock and Loland
Team Lead: R. Eden and S. Lissel

1.6 INTERIOR DIVISION NETWORK

Goals: To actively contribute to the regional engagement and system level initiatives with other Interior Divisions. To share learnings, experiences, resources and tools across the region.

Impact:

- Divisions have a collective regional voice when interacting with Interior Health partners, Ministry of Health, or Doctors of BC.
- Shared learnings and resources across the regional Divisions.

Outputs:

- Oversight for the Interior Physician Recruitment and Retention Network, COVID response network, and Primary Care Manager Network
- Executive Director Network
- Briefing Notes, reports, and applications for regional initiatives

Physician Lead: Dr. Graham Dodd and Dr. Cornel Barnard
Team Lead: M. Walsh

1.7 INTEGRATED HEALTH SERVICE PLANNING AND IMPLEMENTATION

Description: A portfolio of partnership work that includes leadership and strategic oversight committees, working groups and operational partnerships, both within healthcare and the broader community. This work spans the broad spectrum of care and includes primary care providers offering both longitudinal and sub-specialty care along with their specialist and allied colleagues. The Division will work with all stakeholders to co-create a model of care that prioritizes longitudinal care and equitable access.

A. Integrated Network of Primary and Community Care Committee: Co-create and co-lead a strategic committee that will contributed to the short- and long-term vision for healthcare in our region. Clear roles, responsibilities, and accountabilities in the implementation and delivery of the plan will be identified. Membership includes Family practice offices privately owned/operated; Interior Health primary care clinics; Community Health Centres; Urgent Primary Care Centres; family practice services with a focused practice (palliative, long term care, chronic pain, obstetrics, mental health); community health service providers that are privately owned; specialist outpatient services; and specialized community services programs within Interior Health.

Outputs:

- Draft a document that outlines common understanding of what is working well in our region for service delivery and the different models that exists.
- To co-develop recommendations around an integrated network of primary and community resources, teams, IT/S, communications data requests. Etc.)
- To co-develop recommendations around supports needed for achieving this integration work (ie. Facilitation tools, communication tools, communities of practice)
- Secure funding and leadership to support identified priorities around access in our region.

B. First Nations Health Directors Committee: To co-create and co-lead a strategic committee with the Secwepemc Health Directors that support communities within the Kamloops, North, Kamloops South and Lower Thompson Community Health Service Areas. Develos a shared vision and comprehensive plan recommendations for healthcare in our region. Clear roles, responsibilities, and accountabilities in the implementation and delivery of the plan will be identified.

Outputs:

- Draft a document that outlines common understanding of what is working well in our region for service delivery and the different models that exist.
- To co-develop recommendations around an integrated network of primary and community resources, teams, IT/S, communications data requests. Etc.)
- To co-develop recommendations around supports needed for achieving this integration work (ie. Facilitation tools, communication tools, communities of practice)
- Secure funding and leadership to support identified priorities around access in our region.

C. Primary Care Network Working Group: To support the creation of a health service plan for submission to the Ministry in pursuit of funding for PCN for both Kamloops and the Lower Thompson. To support the implementation of the PCN and its operations.

Outputs:

- A written PCN service plan
- General PCN operational documents developed – information sharing agreements, change management plan, Human resources for PCN plan, conflict resolution document.

D. Enabling Healthy Communities: To work with communities, including First Nations, to bring the community voice into the development and implementation of the shared vision for healthcare in the region, and enable them to improve their own health outcomes through a partnership between the Division, Interior Health - Healthy Communities, United Way and FNHA.

Outputs:

- Providing access to funding, engagement, education, advocacy, and facilitation
- Leverage collective resources, knowledge, and leadership.
- Act as a conduit between the CSC and the LHTs

E. Local Health Tables: To provide ongoing linkages for community via the Enabling Healthy Communities committee in partnership with the CSC, to collectively work to support and influence appropriate patient care/services and programs, as well as addressing "social determinants of health" in communities, including First Nations, across the Thompson Region.

Outputs:

- Thompson Region healthcare symposium
- First Nations engagement specialist contracted.
- MOU to solidify partnerships with First Nations communities and local health tables.
- Story mapping of health tables and First Nations communities.
- Incorporate identified needs and recommendations into service planning and networks resources.
- Report writing.

F. Evaluation and Data Working Group: To look broadly at data and evaluation information to support integrated health service planning and implementation through partnerships with the Division, PSP, IH Population Health, IMIT, IH Quality Improvement, and Health Link BC. To provide knowledge translation and analysis that informs decisions through the PCN.

Outputs:

- Request and analyse data.
- Identify gaps in data and put forward requests as required.
- Support PCN related data collection and evaluation in a collaborative manner.
- Report writing and submission.

G. Community Redesign: Support the IH led redesign and redeployment of the specialized community service program as interdisciplinary teams (IDT) to support physician and nurse practitioner practices.

Outputs:

- Facilitate the attachment of IDTs to member practices.
- Support Division member engagement in planning and practice development
- Support collaborative evaluation and quality improvement

Impact:

- Primary care providers, partners and communities are contributors in their various roles to the medical system and health outcomes.
- Opportunity for Division membership, the community, and First Nations to be partners in healthcare transformation and ensure the unique rural and Indigenous voices are heard.
- Increased ability to create regional solutions to healthcare challenges and ensure a regional perspective is given to healthcare planning and implementation.
- Innovative ideas for healthcare planning and implementation with the potential to share this with other Divisions and the Ministry of Health

Physician/Member Lead: Drs. Dodd/Loland/Bantock/Sigalet/Mackey
Team Lead: M. Walsh, R. Eden, and S. Lissel

1.8 INTERDIVISIONAL STRATEGIC COUNCIL

Goal: To actively contribute to regional engagement and system level initiatives with Interior Divisions, the Interior Health Authority, and First Nations Health Authority.

Impact:

- Regional partners are able to work together to implement large scale regional initiatives and responses that support local providers and impact provincial directions.

Outputs:

- Oversight of COVID response and Emergency Preparedness and response working groups through ISC.
- Virtual Care Strategy for the region.

Physician Lead: Dr. Graham Dodd, Dr. Chip Bantock, and Dr. Cornel Barnard
Team Lead: M. Walsh

1.9 LONG-TERM CARE INITIATIVE

Goals: To build a local network between physicians, long term care homes, patients and their families, community pharmacies, post-secondary institutions, and the health authority which will improve patient satisfaction and clinical care. To develop opportunities for knowledge exchange between relevant committees and lead quality improvement related priorities that arise from this interaction.

Outputs:

- Quarterly physician invoices, physician self-evaluation, and long-term care home evaluation.
- Oversight of nursing students for the "Overcoming Social Isolation Project" in LTC.
- Develop a LTC provider on-call model.

Impact:

- Support physicians in achieving the five best practices, as per GPSC Long Term Care Initiative criteria, which will contribute to improved patient care.
- Improve geriatric clinical knowledge within the community of providers and health care professionals caring for patients in long term care. Enhance local relationships between providers (NPs & FPs) (including UBC resident physicains), long-term care homes, pharmacies, and the health authority.
- Opportunity to influence the development of best practices at the local level and within the broader context of long-term care through local partnerships. Contribute to long-term sustainability of provider coverage for long-term care patients in Kamloops.
- Reduce unnecessary or inappropriate hospital transfers, improved patient provider experience, and reduce healthcare costs.

Physician/Member Lead: Dr. Janet Bates
Team Lead: M. Todd and S. Lissel

1.10 MATERNITY CARE

Goal: Trial the delivery of group prenatal care. The project will combine teams of physicians and midwives, as an effective prenatal and postpartum care option for low-risk maternity patients accessing care through the Thompson Region Family Obstetrics clinic in Kamloops BC. This innovative model will allow pregnant women and, if desired, their partners to receive prenatal education, routine prenatal care, and the opportunity to network and build a community of support via a collaborative health care team. This is to include ongoing postnatal care delivered virtually across interdisciplinary teams.

Outputs:

- Communication material
- Curriculum and educational material
- Scheduling of interdisciplinary teams
- Virtual post-natal group sessions

Impact:

- Anticipated patient outcomes include improvements in patient centeredness, uptake of prenatal education, continuity of care during the perinatal period, peer support and social networking, time with care providers, antenatal and postpartum preparation. Anticipated provider outcomes include improved retention and recruitment of maternity care providers, opportunities to collaborate more effectively with existing community programs, and greater job satisfaction.
- Implementing the collaborative model as a pilot project allows for the group to examine any challenges and successes on a small scale. The opportunity to upscale later is anticipated to support the sustainability of maternity care for patients accessing care in Thompson Region.

Physician/Member Lead: Dr. Nagu Atmuri, Dr. Ruth Brighouse, Dr. Harpreet Kelly, Rosalynd Curry (RMW), Elaine Barnes (RMW), and Lana Barbir (RMW)

Team Lead: M. Todd

1.11 MEMBER ENGAGEMENT

Goals: To inform and interact with members about the ongoing work of the Division and gather input on strategic direction. To ensure members are aware of the services the Division provides and the supports available. To move towards sustainable, integrated models of care as directed by members.

Outputs:

- Think Tank with members and external partners.
- Briefing note and strategy around roles for the division in the development and sustainability of new models of primary care
- Division member registry
- Engagement tracker
- Member surveys
- Engagement and social events
- Funding applications

Impact:

- For members to build relationships with others members in the community.
- Providers feel supported and connected in the community and are retained.
- Increased opportunities for Division members to lead innovative and sustainable solutions for integrated models of care.
- Funding secured to support members in their pursuit of improving provision of care for the Thompson Region.

Physician/Member Lead: Health Leadership Committee
Team Lead: R. Eden and S. Lissel

1.12 PALLIATIVE CARE

Goals: To complete the palliative care priorities identified in the deliberative dialogue session. To increase education for palliative care providers around essential conversations, critical illness and death discussions. To integrate palliative care into chronic illness. To improve communication between providers, patients, and caregivers.

Outputs:

- Educational material for providers
- Communications material for the public
- Communication tools for providers

Impact:

- Improved patient and provider experience.
- Enhanced palliative care coordination and education will benefit the community.

Physician/Member Lead: Dr. Rob Baker and Dr. Janet Kusler
Team Lead: M. Todd

1.13 RURAL MEMBER NETWORK

Goals: To facilitate the integration of initiatives unique to primary care in rural communities throughout the Thompson Region. To support rural physicians within the medical community which will inform and improve provider practice capacity and member well-being.

Outputs:

- Recommendations as required
- Direction for rural needs identification and co-developed solutions
- Briefing notes

Impact:

- Ensure the rural voice is a focus in Division programming.
- Recommendations provide guidance to rural community primary care.

Physician/Member Lead: Drs. Paul Mackey and Cornel Barnard
Team Lead: R. Eden

2.

Create a Community that Actively and Effectively Supports Recruitment and Retention

This portfolio is comprised of work the Division will continue, over the next five years, with practices and partners. We will build new practice opportunities to retain the majority of our family physicians and nurse practitioners (in active practice and retired).

2.1 ELECTRONIC ACCESS TO SPECIALIST EXPERTISE

Goals: To make specialist care more accessible to the patient and primary care teams in different settings. To bring new and existing communication tools under an umbrella of services enabling communication between patients, specialists and primary care teams using telephone, video and secure texting (with future e-Consult capabilities)within a secure technology environment.

Outputs:

- CME Committee and schedule
- CME events and engagement opportunities
- Communication tools and measurements
- Knowledge sharing across medical community

Impact:

- Members have access to secure technology for communication. Members have access to specialist schedule through RIH switchboard. Members have direct access to specialists.
- More accessibility of specialist care and expertise to the patient and primary care teams in different settings through increased knowledge around telemedicine.

Physician Lead: Shared Care Steering Committee
Project Lead: S. Breen

2.3 MEMBER WELLNESS

Goals: To foster a culture of well-being within the Thompson Region medical community. To support members, personally and professionally, to establish a healthy, connected, and resilient community of family physicians, nurse practitioners and specialist physicians.

Outputs:

- Joint wellness plan between RIHPA and TRDFP
- Wellness committee
- Member network outreach
- Engagement and social events
- Cultural sensitivity and humility

Impact:

- Increased member wellbeing.
- A supportive and collaborative medical community.

Physician/Member Lead: Shared Care Steering Committee
Team Lead: S. Breen

2.4 PUBLIC COMMUNICATIONS

Goals: To communicate how primary care providers are making a difference for practices, patients, and the healthcare system. To build relationships with media, community, and external partners to raise awareness about Division work, shift public perceptions, and support community engagement efforts. To raise the Division profile in the community.

Outputs:

- Communications/media plan
- Regular interaction with media outlets
- Proactive media outreach
- White paper series/research published from Thompson Region
- Media tracker
- Social media strategy
- Website(s) and statistics

Impact:

- Members have a way to communicate successes locally, regionally, and provincially.
- Proactive and positive media stories about health care. Increased awareness of the essential roles of primary care providers.
- Communicate success across social media channels.
- Greater public awareness of and education about the healthcare system thereby empowering the public to be a part of healthcare transformation.
- Create and sustain partnerships to build capacity towards health service planning and Primary Care Networks.

- Gathering information and feedback from Thompson Region communities that can inform provincial healthcare mandates.
- Increased awareness of and traffic to the Division website and use of supported tools.

Physician Lead: Health Leadership Committee
Team Lead: N.Rachynski

2.5 RECRUITMENT

Goals: To increase the awareness of physician practice opportunities in the Thompson Region through marketing and social media practices. To advocate on behalf of the physician community in partnerships to ensure equal consideration at decision-making and health human resource planning tables. To leverage community champions and leaders through local health tables and other partnership tables.

Outputs:

- Physician site visits
- Digital media advertising
- Promotional photo assets
- Promotional video assets
- Practice opportunity postings
- Social media presence (Facebook, Instagram, LinkedIn)
- Recruitment video
- New physician welcome process and program
- Regional locum network (with Interior Physician Recruitment and Retention committee)
- Funding sources secured for recruitment and retention
- Post retirement engagement
- Partnership with UBC Family Medicine residency program
- Partnerships from Local Health Tables around recruitment efforts

Impact:

- New physicians to community and increased access to longitudinal care as well as linkages with other sub-specialities.
- Community that supports recruitment efforts.
- Increased awareness of the Thompson Region as an exceptional place to practice medicine.
- Regional recruitment initiatives created through Interior Physician Recruitment and Retention Network

Physician/Member Lead: Drs. Servaas Swart and Cornel Barnard
Team Lead: S. Breen

2.6 SHARED CARE STEERING COMMITTEE

Goal: To provide strategic leadership for Shared Care funded projects by bringing the Specialist and Family Physician communities together on matters of shared interest such as wellness, CME, social, and engagement activities and recruitment efforts.

Impact:

- Community able to leverage and align Shared Care projects with other strategic initiatives.

Outputs:

- Supported Shared Care projects
- Linkage with the Thompson Medical Alliance
- Regular SCSC meetings that enhance the knowledge sharing and collegiality across the medical community.

Physician/Member Lead: Shared Care Steering Committee
Team Lead: S. Breen

2.7 THOMPSON MEDICAL ALLIANCE

Goals: To synchronizing resources of the Division, RIHPA, PSP, IH Research, IH QI, and IH PQI for physician and medical partners. Building off successful initiatives to plan, communicate and participate in ongoing discussions to better align and strengthen the support provided and effort put into quality improvement initiatives that touch all these entities. Success will maximize clarity for our physicians and other medical partners, who we work to support through these initiatives.

Impact:

- Maximizing clarity for physicians, as well as other professionals sitting on physician-led committees regarding shared opportunities.
- Maximizing funding opportunities to leverage collaborative dollars spent while mitigating duplicate initiatives, energy, resources, or complicating these efforts unnecessarily. Avoiding the creation of a frustrating system for physicians to navigate, where it is difficult to understand where to go, to whom and when
- Work towards better alignment across provincial collaborative committees and provincial initiatives.

Outputs:

- Maintenance of spreadsheet documenting projects and physician leads
- Website promotion of shared work and opportunities
- Shared resources with membership
- Establish process for physician inquiries
- Communication Strategy
- Determine metrics to track and document work

Physician/Member Lead: Shared Care Steering Committee
Team Lead: S. Breen

3.

Establish a Development Infrastructure that Supports the Needs of Members

This portfolio is comprised of work the Division will accomplish over the next five years. The Division will increase the resources available and required to support current and new Family Practitioners to run a sustainable practice.

3.1 COORDINATING CARE FOR OLDER ADULTS

Goals: To bring together primary care providers and specialists to support the design of effective specialist outpatient services for older adults using needs assessments and service planning. To support the development of these services to streamline care.

Outputs:

- Start up support to specialist outpatient clinics.
- Practice support to specialist outpatient clinics
- Specialist participation in integrated service planning.

Impact:

- Enhanced relationships and communication between specialists and family physicians.
- Increased access to effective specialist outpatient services.

Physician/Member Lead: Dr. Alina Cribb and Dr. Kobus Steyn
Team Lead: S. Breen

3.2 EMERGENCY PREPAREDNESS FOR PHYSICIANS

Goals: To create a proactive family practice/patient preparedness/continuity program that will support family physicians and their patients preparing for an emergency. To build networks to enable physicians to work together during an emergency. To support physicians to recover from an emergency if their practice was the target of an emergency. To build a co-designed 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.

Outputs:

- EM Physician working group
- EM Educational Resources (webinar, EM exercises)
- EM symposium

Impact:

- Support practices and create networks that can work together in an emergency.
- Increased ability for patients to access primary healthcare in an emergency.
- Increased ability for better patient care in emergency situations by creating working relationships between family physicians and regional partners.
- Opportunity for integrated care during an emergency with the end result being better patient care.

Physician Lead: Dr. Graham Dodd
Team Lead: R.Eden

3.3 FINANCE, AUDIT, AND PLANNING

Goals: To maintain the finances and fiscal health of the Society in an efficient and cost effect manner. To grow the Society's owned funds, through prudent and effective short-term investments. To have the cleanest audit with the quickest turn around so to get our reporting out to the Board, Members and financial supporters.

Outputs:

- Annual planning
- Annual audit
- Monthly and quarterly financial reporting
- All financial and regulatory deadlines met
- Growth in the society's assets

Impact:

- The assets of the members are safeguarded. Integrity of the accounting system and reporting, while ensuring compliance with guidelines, policies, contract and agreements.
- Resources are brought into the Division to support member-led initiatives.

Physician Lead: Dr. Lennard Pretorius
Team Lead: C. Phillips

3.4 GOVERNANCE

Goals: To provide fiduciary and strategic oversight for the organization. To provide resilient strategic leadership.

Impact:

- All fiduciary, legal and member obligations are met and remain viable.
- Engagement, direction, wellness, and leadership from our membership is maintained.

Outputs:

- Briefing notes
- Strategic plan
- Annual plan
- Annual report
- Annual General Meeting
- Succession planning for Board and Executive Director
- Comprehensive framework for Development branch

Physician Lead: TRDFP Board
Team Lead: M. Walsh

3.5 HUMAN RESOURCES

Goal: To maintain a healthy, effective, and efficient team. To promote a culture that values growth, excellence, balance, relationships, and grace. To grow the team to support the strategic plan.

Impact:

- Team members are well supported and able to deliver on their maximum potential both personally and professionally.
- The Thompson Region Division of Family Practice team is well staffed and prepared to deliver on the Strategic Plan 2021-2026.

Outputs:

- Quarterly On Targets (performance management) for each team member
- Human Resource, policy and procedures manuals
- Framework for hiring, onboarding, training and processes
- Professional Development opportunities for staff
- Knowledge exchange management
- Weekly staff meetings
- Regular team development sessions
- Development branch of the Division

Physician Lead: TRDFP Board
Team Lead: M.Walsh

3.6 INFORMATION TECHNOLOGY

Goals: To increase our availability, accuracy, and security of information for the membership, Board, Committees, project teams, and Division staff. To research, acquire, implement the use of new technology.

Outputs:

- A comprehensive IT strategy that supports growth
- Written procedures on technology use, information storage, and records management.
- Partners and team usage of technology systems in place.
- Management of technology inventory.
- Acquisition of appropriate technology for initiatives.

Impact:

- A comprehensive and integrated infrastructure to support growth and collaboration, ensure data security, and seamless operations; effective tools that are utilized with maximum efficiency and efficacy. Division team, committee members and membership have access to up-to-date information for informed opinions and decisions. Secure access to committee documentation regardless of location.
- Increase involvement of community and networks within information sharing structures. Provide access to teamwork spaces and data specific for that group.
- The membership and the community is supported with technological resources for the delivery of health in collaboration with the Doctors of Technology Office
- The ability to securely share information and include regional representation on committees as required.
- The Division's IT focus aligns with provincial regulations.

Physician/Member Lead: The Board
Team Lead: F. Bateman

3.7 MEMBERSHIP AND CANDIDATE DATABASE

Goals: To maintain a centralized database of all pertinent membership information excluding financial information. It may be used to identify gaps in knowledge of our members and to store information for relationship building. To provide data and anecdotal information on each member in the areas of Division and community engagement. The CRM also serves to house potential recruit information, to be converted over to the main database if they accept a position in the Thompson Region.

Outputs:

- A robust and up to date CRM system (stands for customer relationship management).
- Member profiles
- Profiles for non-members (Specialists, MOA network, Community Partners etc)
- Recruitment profiles for potential new recruits.
- Identifiable projects around the gathering of necessary information.

Impact:

- To keep each member's information current and accessible to all Division staff.
- To provide data on community and division engagement of each of our members to inform ideas around increased engagement. Relationship building as we seek to identify necessary, pertinent information on each of our members.

Physician/Member Lead: Health Leadership Committee
Team Lead: C. Jones

3.8 MEMBER COMMUNICATION

Goals: To improve the communications between Division members, the community, and our partners by developing and maintaining relevant information channels. To keep physicians informed about the work of the Division and other relevant healthcare information.

Impact:

- Improve effective communication with membership. Membership has a better understanding of the Division's services, impacts, and supports.
- Increased communication and collegiality between members and the Division.
- Standardized approach in Division office around communication material.

Outputs:

- Weekly e-letters
- Bi-annual newsletter
- Communications plan
- Discussion papers/Case studies
- Promotional materials
- Social media strategy

Physician Lead: Health Leadership Committee
Team Lead: N. Rachnyski

3.9 OPERATIONS

Goals: To oversee administrative aspects of the Division ensuring the office runs efficiently and contributing to the smooth implementation of initiatives/projects. To ensure a proactive approach to the occupational health and safety of all staff, membership, and guests during their interactions with the Division.

Impact:

- Timely day-today management of offices and the operations of premises.

Outputs:

- Inventory of infrastructure
- Acquisition of infrastructure as required
- Continuity Plan up to date
- Quarterly review of the premises, recording any concerns and either immediate correction where applicable, or review and plan for implementation of correction.
- Availability of OHS Officer to staff, membership and guests to record, review and implement necessary correction of issues as they present.
- Semi-annual unscheduled emergency drills to ensure staff are ready and able to react to situations as they arise.

Physician Lead: TRDFP Board
Team Lead: F. Bateman

3.10 PATHWAYS

Goal: To maintain and enhance the comprehensiveness of the Thompson Region data on the Pathways referral website, while increasing member awareness and usage of Pathways and how it can enhance practice efficiency with current specialist and clinic services, referral mechanisms and wait times.

Outputs:

- Maintenance of Thompson Region data on Pathways website.
- Monthly usage reports
- Educational/promotional material
- Training sessions available to providers and their teams
- Exploration of Pathways Referral Tracker
- Implementation of Pathways Community Services public facing directory

Impact:

- Members and their teams are better informed of specialist and clinic services and associated referral processes. Clinical care is supported by accessibility to physician and patient resources, contributing to improved patient and provider experience.

- Community of specialists and clinics receive more appropriate referrals and less enquires to their offices from the medical community and public concerning services/referrals. The public is aware of and utilizes the Pathways Community Services public facing directory.
- Accessibility to regional and provincial services and resources for members referring outside of the community and likewise for members of other Divisions referring to Kamloops and area.
- Engagement with Pathways working groups at the administration and physician lead level.

Physician/Member Lead: Dr. Stephanie Bourdeau
Team Lead: M. Todd and C. Jones

3.11 PRACTICE DEVELOPMENT SERVICES

Goals: To collaborate with the Division membership to support and enhance the business operations of their practices with a focus on developing tools, best practices, and the sharing of resources. To offer a series of educational and information related seminars based on feedback from the membership (e.g. financial literacy, virtual care, business). To provide one-on-one business and communications supports and needs assessments to enhance practice efficacy. To align these services with specialists' outpatient practices as well. To further develop the MOA network to better enhance network of practices and to support practices.

Outputs:

- Needs assessments and business plans for practices, clinical networks, and specialist outpatient clinics
- Journey Maps
- Services brochures
- Webinars and educational events
- MOA and Clinic Managers network meeting minutes
- MOA and Clinic Managers educational opportunities, evaluation reports, and summary reports
- MOA relief work list
- Communication materials
- Grant proposals

Impact:

- Supports practices and creates efficiencies to optimize member time and ensure balance.
- Increased practice efficiency may mean enhanced access for patients.

Physician/Member Lead: Health Leadership Committee
Team Lead: C. Brookes

Thompson Region
Division of Family Practice
A GPSC initiative

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