Fraser Northwest Division

Annual Report

Table of Contents

Our Vision

Vision

Fraser Northwest Division of Family Practice strives to be a leader in supporting a healthy and sustainable community of:

- **Doctors committed to continuity of care**
- **Patients participating in managing their health**
- **Primary care which is accessible, and relationship based**

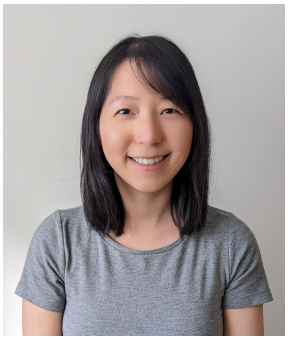
Mission

1. **Being the nucleus for primary care improvement in our region**
2. **Improving access to care through increasing the number of Family Physicians**
3. **Supporting Family Physicians to improve their capacity to provide care**
4. **Providing a voice for our Family Physicians through grassroots engagement, dialogue, idea gathering, and participation**
5. **Engagement with our patients to understand their expectations and needs**

Values

- **Establishing a network for collaboration between Family Physicians and other healthcare partners and community stakeholders**
- **We prioritize key projects in accordance with our vision and mission and only after consultation with our members**
- **We appreciated the strengths and diversity of all our members**
- **We approach the work of the division in the spirit of collaboration, transparency, authenticity, integrity, and accountability**
- **We aim to adapt quickly and respond to our members and their patients' needs**
- **We strive to be fiscally responsible**
- **We recognize the importance of the patient voice**

Co-Chairs' Message



Dear friends and colleagues,

As co-chairs of the Fraser Northwest Division, we are delighted to address you in this year's message. We take great pride in reflecting on the past year's accomplishments, challenges, and milestones, and we are grateful for the progress we have achieved together.

First and foremost, we would like to express our deepest gratitude to our members, Physician Leaders, Division staff, partners, and stakeholders. Without your unwavering dedication, hard work, and commitment, none of our achievements would have been possible. Together, we have overcome obstacles, embraced change, and emerged stronger than ever.

A key priority for us has been to recognize and elevate the value of Family Physicians in our community. We are dedicated to creating a better future for ourselves and future generations of Family Doctors.

Looking ahead, we are filled with optimism and excitement. While celebrating our achievements, we also recognize the immense potential that lies ahead. As we embark on the next chapter of our journey, we remain committed to driving sustainable primary care, delivering exceptional value to our members, and making a positive impact on our community.

In closing, we want to express our heartfelt appreciation to each and every one of you. Your unwavering commitment, passion, and expertise have been crucial to our success. We are confident that by staying true to our values, embracing change, and working together, we will continue to reach new heights and create a better future.

Warmest regards,

Dr. Jennifer Yun, Dr. Gina Zheng
Co-Chairs, Fraser Northwest Division

Executive Director's Report

Dear Members,

I am pleased to present this year's annual report for the Fraser Northwest Division of Family Practice Society.

Over the past year, We have made significant strides in fulfilling our mission:

- the nucleus for primary care improvement in our community by listening to your frustrations and finding ways to alleviate through partnerships.
- improving access to primary care through increasing the number of family physicians, and our recruitment efforts. We have finally turned a corner and we are no longer in a deficit with the retirements; however, we now need to catch up to the population growth and practice style changes.
- supporting family physicians to increase their capacity through the continued integration of allied health team members to support you and your patients.
- establishing a network for collaboration between family doctors and other health care partners and community stakeholders through our ongoing efforts with the Ask the Expert series and increased number of Shared Care projects. There has been tremendous time spent with our partners considering the sustainability of the primary care "system" and we hope to see this work come to fruition soon as we find partnerships to support the increasing operational costs for Patient Medical Homes.
- sharing your successes, concerns, frustrations, and overall voice to ensure that the Family Doctors from Fraser Northwest are heard.
- furthering our engagement with patients to understand their expectations and needs through community wide survey and soon to launch, a community and patient advisory committee.

Despite challenges, we have thrived, thanks to the dedication and resilience of our members and our team. None of our achievements would have been possible without the unwavering support and trust of our members, you are the sole purpose of our work.

In closing, I would like to express my heartfelt appreciation to our dedicated Board of Directors, Physician Leaders and Division Staff Team, whose passion and expertise have been the driving force behind our success. I would also like to extend my gratitude to our partners, funders, and community stakeholders for their unwavering support. Our work together will ensure that Fraser Northwest is the best community to practice as a Family Doctor.

Continuous improvement is better than delayed perfection ~ Mark Twain

All my gratitude,

Kristan Ash
Executive Director

Treasurer's Report

Dear Members,

It is my pleasure to write to you as the Treasurer for the Board for the past 1 year, and a Director of the Board for the last 2 years. As an early career family physician, it has been an absolute pleasure to serve my local community in the Tri-cities from a clinical and non-clinical lens.

As I have quickly learned, our Division has been a pioneer since the inception of Divisions of Family Practice and one that has constantly strived to be astute stewards of the financial resources we have been provided. The Finance and Governance committee has played an important role in reviewing our financial well being as an non-profit entity, and with the guidance of our Executive Director and Controller, ensuring we update policies based on best practices that work towards serving our members and the community at large.

This past year has had major financial changes across different health care levels, some that have caused much conversation of varying emotions. Fortunately, our institutionalized process's have allowed the Division to remain in excellent financial health to be able to continue to provide a high level of return and value for our membership. As with any unexpected changes that may come, we hope to continue to strive towards fiscal responsibility with our spending while leaving ample room for innovation in our services that promote the well being of those in all settings of Family Practice.

Dr. Ravi Parhar

Patient and Community-Focused Initiatives

Primary Care Network

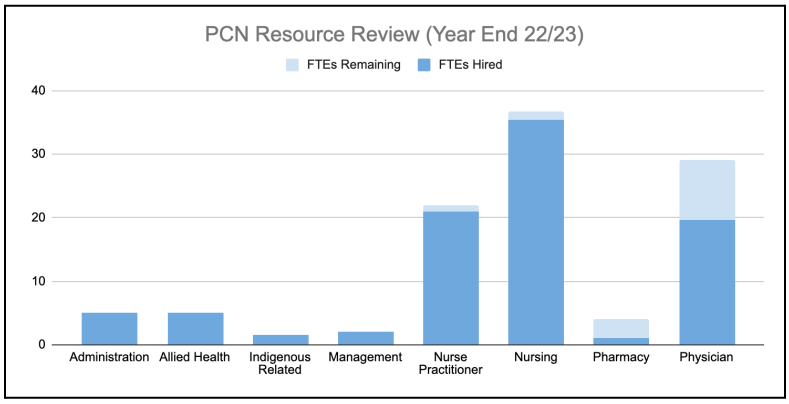
Aim

The Fraser Northwest (FNW) Primary Care Network's (PCN) goals and outcomes are:

- To create a quality, integrated and coordinated delivery system for primary care that is patient-centred, effective in meeting population and patient needs and delivers a quality service experience for patients
- To create the structures necessary to enable all members of the community to receive the primary care they require, by bringing together health authorities, physicians, nurse practitioners, nurses, allied health and other community providers in partnership
- To support family physicians who provide longitudinal care through the support of teams, allied health care providers, and easily-accessed health authority services

Year in Review Overview

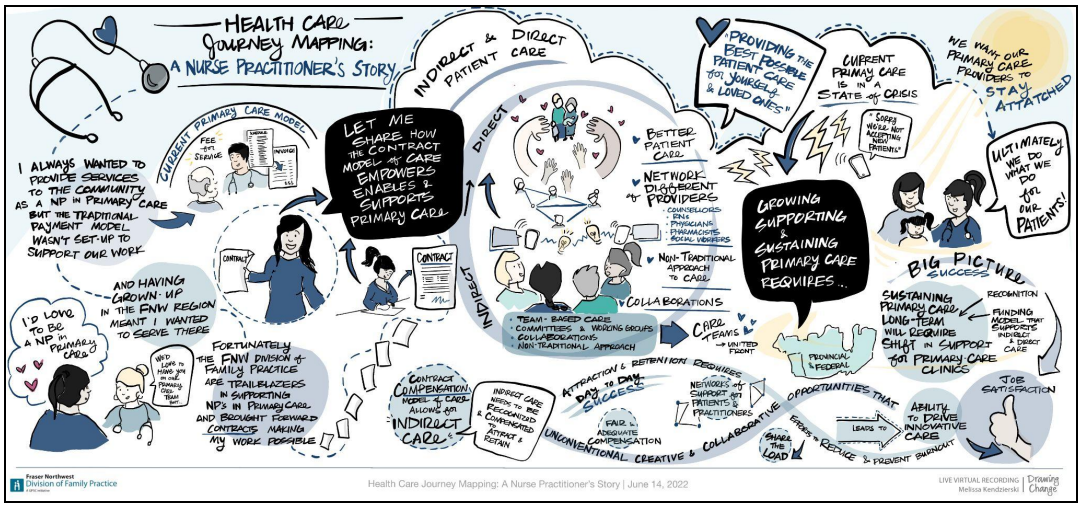
The fourth year of the FNW PCN funding continued with increased resource utilization with the addition of contracted Family Physicians (FP), Nurse Practitioners (NP), Registered Nurses (RN), Indigenous Supports and a Primary Care Clinical Pharmacist (PCCP). The graph reflects the successful recruitment of a number of Primary Care Providers (PCPs).



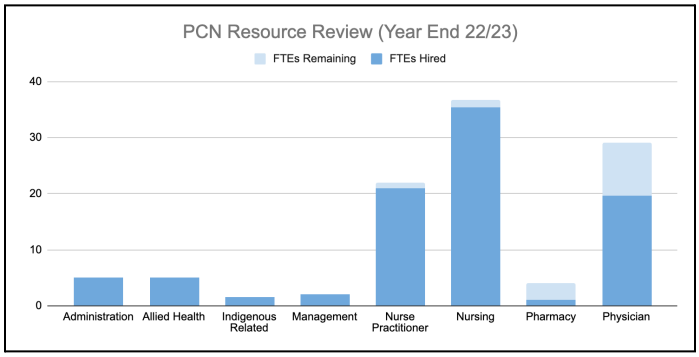
Early in 2023, the PCN provider net loss/gain observed the first time since PCN inception that the community had hit a break even point for provider gains/losses. Providers who have left the community noted the increasing costs of overhead, ongoing burnout and overall health system structural support as being contributors to moving away, retiring early, or moving into a different type of practice away from longitudinal primary care.

	2019	2020	2021	2022	2023	Total
Provider Adds	12	18	18	27	7	**No net loss/gain since PCN inception**
Provider Losses	27	13	16	24	2	
Net Loss/Gain	-15	+5	+2	+3	+5	

A Nurse Practitioner shared their experience supporting patients in the community and a journey map session captured a snapshot of their story (shared below).



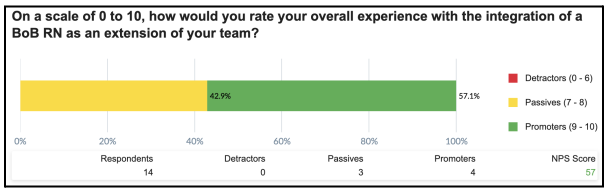
Below are the yearly recaps of PCN funded initiatives. It's important to note that this list does not fully encompass the breadth and reach that the FNW PCN has had on the communities, but rather provides a snapshot of the community impacts.



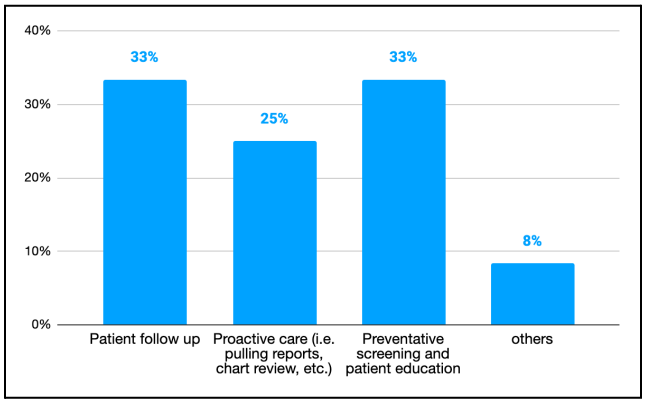
Registered Nurse in Practice Initiative: At the end of this year, 35.37 FTE RN positions have been utilized supporting 24 PMHs across the communities and additional relief coverage. At the beginning of the year, hiring efforts were undertaken to hire much of the remaining FTEs to provide interim Quality Improvement support to PMHs. Types of QI work that these relief RNs have completed include:

- Complex Care Planning and Management
- Mental Health Referrals
- Emergency Preparedness
- Vaccination Reviews

Feedback collected from providers regarding the support they've received from this QI work notes:



Providers also noticed the following improvements since the integration of the RN into the team:



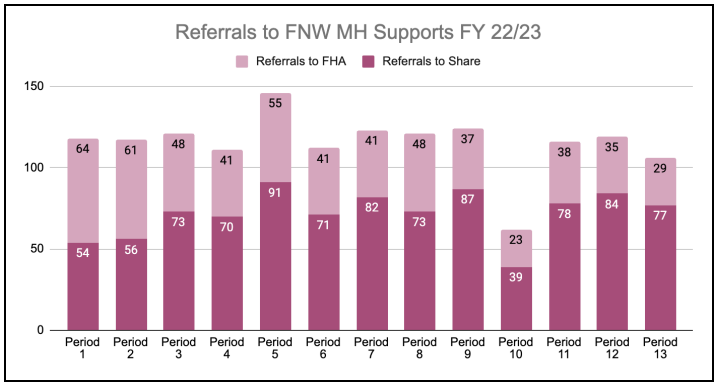
Challenges experienced in this role include:

"How to integrate them as they are here and gone, how they won't step on the toes of our regular nurse, and how to explain that to the team so they don't ask them to do normal RNiP work."

Valuable takeaways

"I am thankful for the support that is given to us. As you are stating, this is just the questionnaire and you are asking me what I think of how we could maximize their help, do not take my answers as a criticism in a negative fashion. I am extremely grateful for the way that the division has helped us. The RN IP program has helped so much. But the Bob RN program is highly specialized and the clinic is also specialized in those sessions that concord with the Bob RN, I think it would be to the maximum benefit if Bob can help your clinic like all the other RN IP's if they can learn the full scope of RNIP practice."

Rapid Access Mental Health Supports: Over the last year, the mental health supports funded by the PCN at SHARE Family and Community Services worked in tandem with the FHA funded Primary Care Network Mental Health Clinicians team. These teams have a total of 9 (4 -5 each) clinicians designated to support patients in the FNW communities seeking rapid access for mild-moderate mental health support.



Indigenous Supports: As one of the partner organizations in the Fraser Northwest Primary Care Network, Kwikwetlem First Nation has worked to identify the resources needed in their First Nation Community. These resources will work to support increased attachment and access to primary care services for the Nation, as well as surrounding urban and away from home Indigenous population.

The community leaders have identified interest in having the doctors move towards doing outreach in the community. The health clinic continues to work on relationships with other partners in the Tri-Cities communities.

Attachment

Aim

Active attachment mechanisms for patients across the New Westminster and Tri-Cities communities enable attachment to longitudinal Primary Care Providers within the communities.

Attachment Hub

This year, the FNW Division Attachment Hub continued to support the attachment between the public seeking a Primary Care

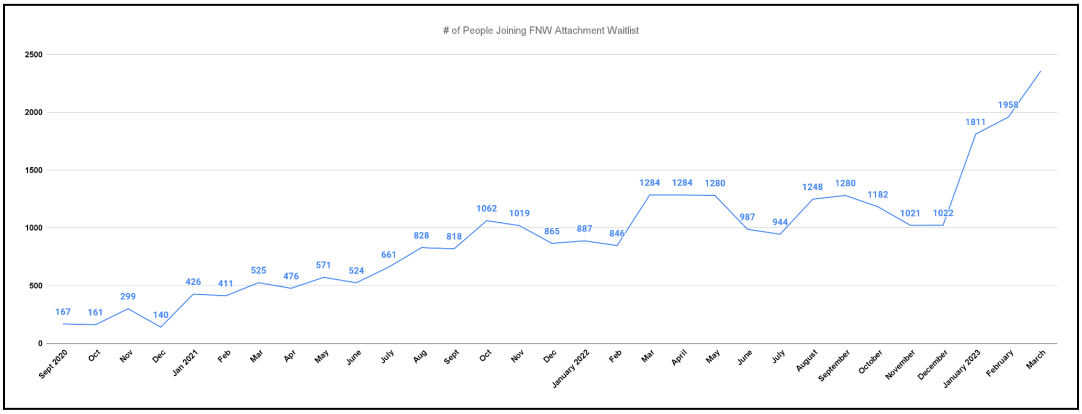
Provider with Family Physicians and Nurse Practitioners accepting new patients for longitudinal primary care. Since the launch of this dedicated service in summer 2019, there have been nearly 14,000 attachments recorded by the end of March 2023.

	FY 19/20	FY 20/21	FY 21/22	FY22/23	Total
New Westminster	323	826	2559	1191	**4899**
Coquitlam	323	1376	2117	771	**4587**
Port Coquitlam	325	947	1194	1098	**3564**
Port Moody,	324	116	384	46	**870**
Total	**1295**	**3265**	**6254**	**3106**	**13920**

The waitlist for patients continues to grow and recent data provides an indication of the average wait time of those who have been attached broken down by community:

Community	**Average Wait Time since inception**	**Average wait time *(last 6 months)***
New Westminster	200	431
Port Moody	261	350
Coquitlam	193	501
Port Coquitlam	97	218

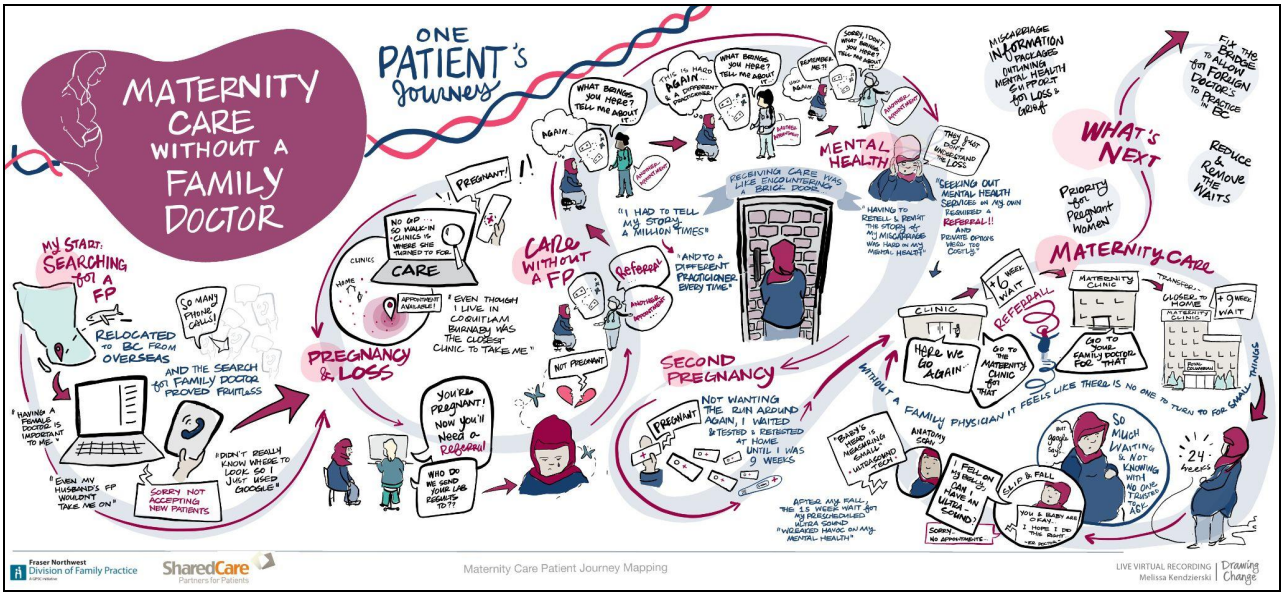
Month over month, the demand to find a longitudinal primary care provider by members of the FNW communities continues to grow.
The table here reflects the ongoing need and high demand for primary care providers. In March 2023, the number of people joining the waitlist grew by 2359 people. This is the largest increase this waitlist has ever seen.

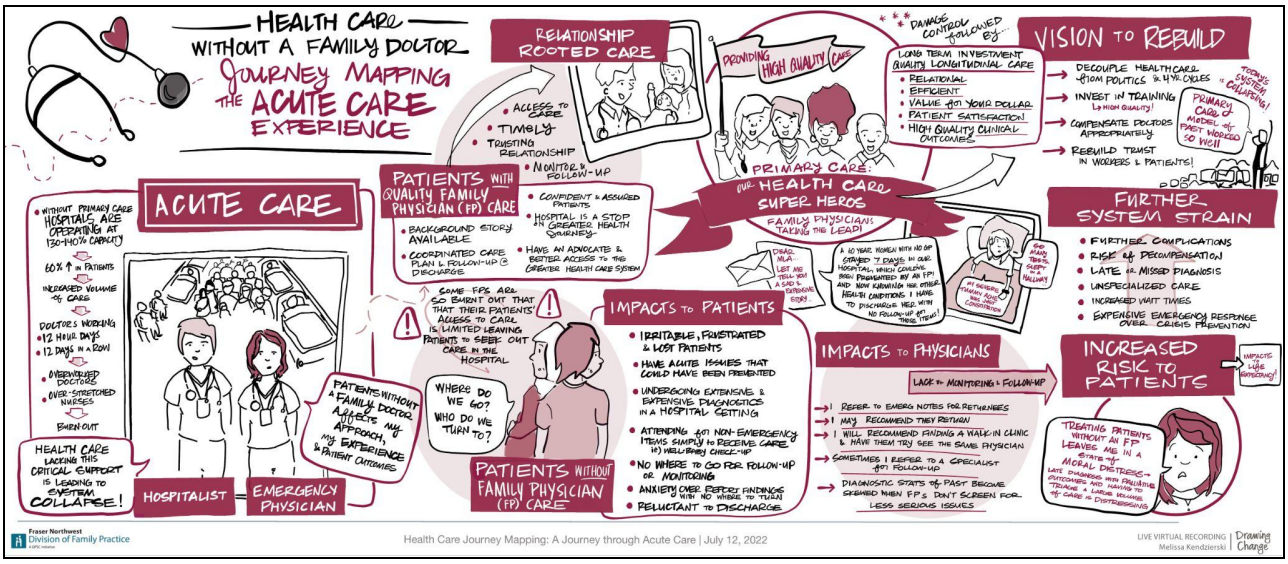


Impacts of unattachment

The Journey maps shared in the images below reflect the impacts of unattachment from a patient and provider perspective. The patient story shared reflects a journey from a patient who was seeking prenatal and postnatal care, but they did not have a primary care provider.

The provider journey map reflects the impacts that providers in the acute system see when patients do not have primary care providers in the community resulting in fragmented follow up care and a higher potential for acute care system.

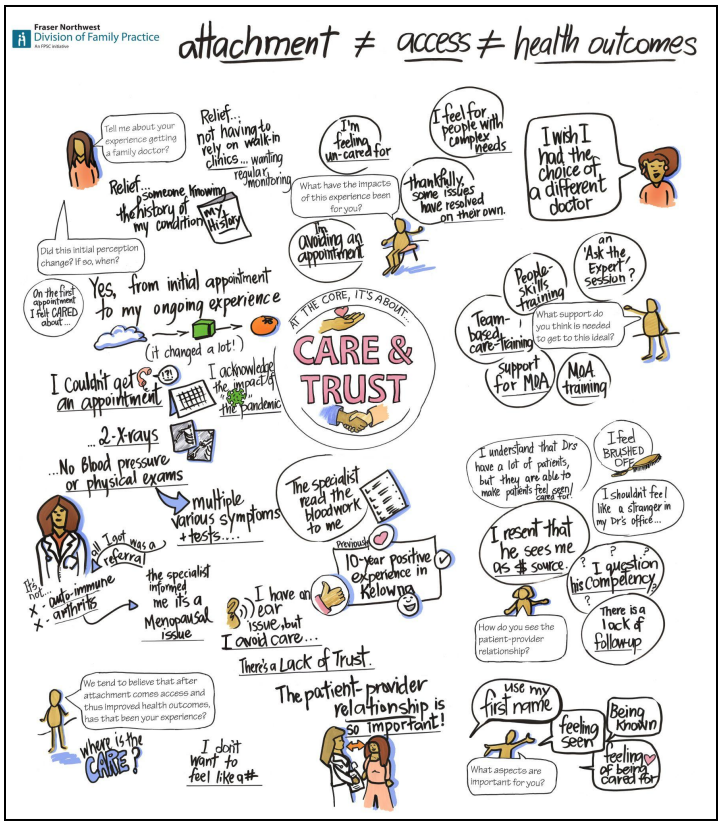




PCN Future Sustainment

The sustainability of the PCN model in the FNW communities requires ongoing commitment to implementing Quality Improvement initiatives, seeking feedback from partners, and ensuring a coordinated and supportive effort is demonstrated by leadership organizations. In the FNW community, recognizing the demographic distribution of the existing primary care providers, and their projected retirements, coupled with the larger than average panel size, complexity of patients, and high overhead, are factors that require attention in order to recruit new providers and retain existing providers. In order to meet the FNW PCN goals and outcomes, continued

partnership between health authorities, physicians, nurse practitioners, nurses, allied health and other community providers is necessary in order to attain a patient-centred quality, integrated and coordinated delivery system for primary care. It is also acknowledged that having a primary care provider does not equate to access nor improved health outcomes for all people. A patient story reflects the complexities in having a longitudinal relationship with their primary care provider:



PCN PHYSICIAN LEAD

Dr. Paras Mehta

PERINATAL COMMUNITY OF PRACTICE

As part of the Primary Care Network, it was announced that support would be provided to develop a Perinatal Community of Practice to implement an environmental scan of the maternity and perinatal services in the Fraser Northwest communities.

Through previous work with the community to develop and enhance access to maternity care for new moms and babies, the FNW Maternity Shared Care Project (2019-2022), lay foundational work with regards to relationship development amongst providers, health authority and community organizations to identify successes, gaps and challenges in supporting this population group. The community relationships that were developed through this project enabled a clear understanding of what community services were currently available within the New Westminster and Tri-Cities and served as a starting point to engage partners in these Community of Practice discussions.

Once this current opportunity for engagement arose, momentum continued forward and through the existing relationships with stakeholders supporting maternity care in the New Westminster and Tri-Cities. In November 2022, these groups

joined each other to share a meal, and identify challenges/gaps. A second session was hosted in February 2023 whereby participants were asked to identify top priorities from the list of gaps identified in the first session and propose solutions.

Collaborative work will continue throughout the next year to identify strategies for incorporating community driven solutions to support a seamless integration and sustainability of maternal and infant resources and supports in the communities.

Long Term Care Initiative

AIM

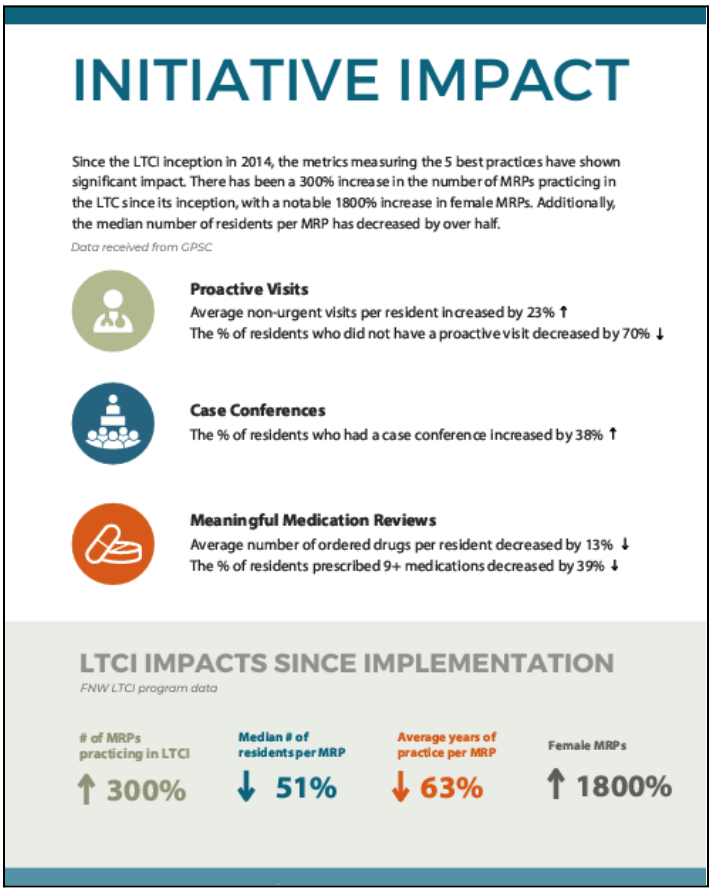
To improve upon the 5 best practices of care for seniors in long term care (meaningful medication reviews, completed documentation, 24/7 availability supported by the after hours call network, , care conferences and proactive visits).

The Long Term Care Initiative's (LCTI) goals for this last year were to

- Continue to enhance facility and practitioner relationships by focusing on improving the communication between our stakeholders.
- Improve the on-boarding of new LTCI physicians into long term care sites by streamlining the process and making sure mentors are in place.

Initiative impact

The FNW LTCI continues to be a stable program for the Division. An initiative impact report was completed in the summer of 2022 and a snapshot of the of the fullscope impact to the long term care community is shared below:



Over the last year, highlights have included:

- Improved recruitment processes to track candidates and available placements
- Streamlined process for suture kit supplies ordering and distribution
- Development of a FNW Standards of Care resource
- Emergency Department Physicians and LTC Physicians relationship

building and identification of quality improvement projects to strengthen the communication.

Within any quality improvement work, the identification of opportunities or challenges enables the continued opportunities for initiative enhancement:

- Facility staff turnover impacted physician satisfaction and had the potential lead to increased burnout
- The introduction of new payment models impacted recruitment and retention challenges with 47% of current LTCI Physicians reporting they were considering discontinuing LTC work in November 2022.
- Concerns around recently unattached patients in care homes due to retirement and resignations.

Continuing Medical Education & Events

- May 2022: MAC - Point Click Care
- June 2022: CareConnect Enrolment Session
- September 2022: MAC - Development of FNW LTCI Standards of Care
- November 2022: MAC - Covid-19 PPO & Treatment in LTC; FHA Transfer From Acute to Alternate Level of Care (ALC)
- November 2022: New to Long Term Care Meeting
- February 2022: MAC - Emergency Department Communication and Transfers

Physician Leads

Dr. Amber Jarvie
Dr. Lalji Halai

Community Centred Engagement & Communications

AIM

The FNW Division is committed to ensuring health care services are delivered with a patient-centred approach. Primary Care Providers are an essential part of identifying opportunities for continuous improvement. In the last year, there has been opportunity for patients and community members to become involved in FNW program implementation and delivery.

Patient/Public Partnership

Patient partners joined the PCN Steering Committee and a number of Shared Care Working groups. In addition to this leadership, understanding how patients navigate the healthcare system is inherent to ensuring the Community Primary Care Providers and partners work to ensure continued coordination and quality of care.

Patient Journey Maps have provided snapshots of the impacts on how the system sets patients up to effectively - and ineffectively - navigate for their healthcare needs. Patient experience surveys continue to provide input around program, project and service delivery. Patients have shared their experience with regards to:

- Impacts of Unattachment during Pregnancy (shared in the above section)

- Caregivers perspective of supporting a loved one through Palliative Care (shared in a latter section)
- Attachment Doesn't Equal Access (shared in the above section)

Communications

Each quarter, a newsletter is distributed to patients in the communities who have signed up to receive newsletters from the Division. This resource continues to connect patients in the community with available health services and supports. Feedback mechanisms have recently been incorporated to allow for two-way information sharing between the Division and newsletter subscribers.

	# Subscribers	# Opens	% Opened	Year Over Year Change
May 2020	170	63	38.20%	
May 2021	3745	2203	59.10%	**2101%** ↑
February 2022	3473	1942	56%	**7%** ↓
February 2023	7676	4858	63%	**121%** ↑

The sharp increase in subscribers over the last year is likely a reflection of the ongoing interconnectedness of division activities - specifically linking those who joined the FNW Attachment Hub to the newsletter to help inform the public about available community resources. The team launched resources related to public engagement through various FNW Division social media strategies where the division's communication team is utilizing multiple social media platforms. Ongoing changes in public engagement through social media platforms such as Facebook, Twitter, Instagram and Youtube have also contributed to increased utilization.

Pathways

Over this last year, Pathways continued to expand its platform to support patients and community members to access healthcare supports, services and resources within their communities. The Community Service Directory and the Medical Care Directory both continue to provide resources for community members to access. The Medical Care Directory is a 'one-stop' online directory for the public to find clinic and booking information for their own primary care provider or to identify primary care providers accepting new patients.

Physician Lead

Dr. Herb Chang

Physician-Focused Initiatives

Patient Medical Home (PMH) Sustainability Program

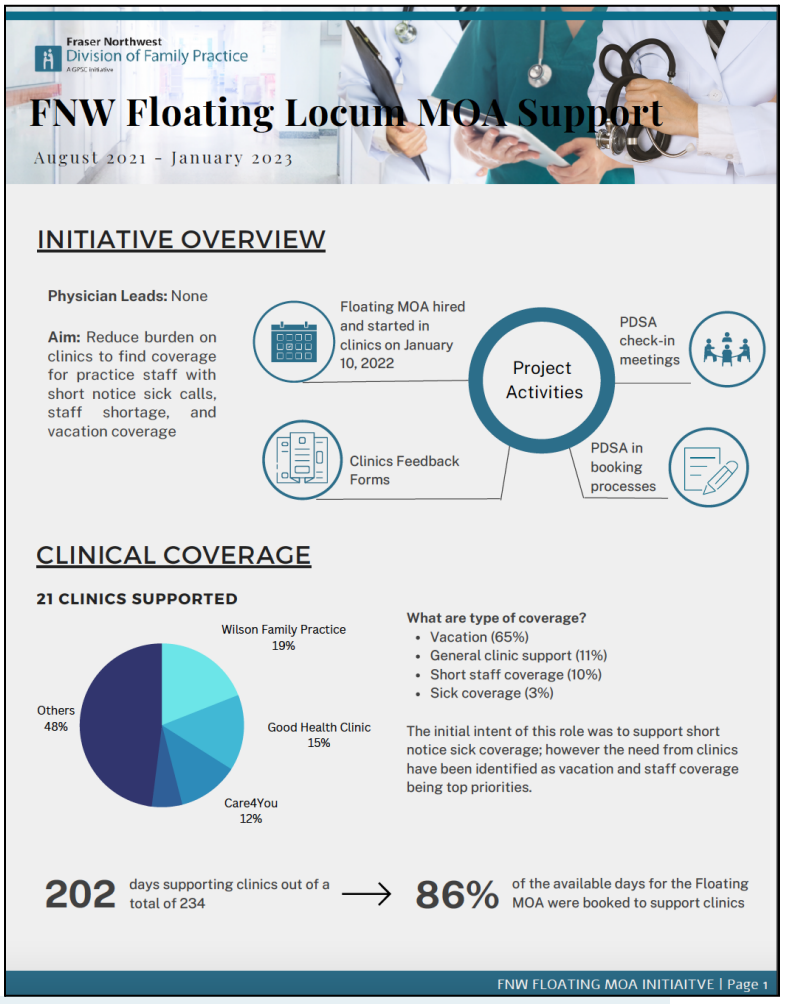
Overview

FNW's PMH program aims to provide in-practice resources and support to Division members and their clinic teams to reduce administrative burdens on providers, foster innovation within the practice setting, and ultimately strengthen the sustainability of primary care in our community. Through direct member feedback and consultation, FNW Division has worked to identify and respond to the challenges and opportunities inherent within the constantly shifting primary care landscape. Challenges such as cost of practice increases, reduced medical office staff resources, and system infrastructure challenges like access to medical imaging, have all contributed to increased provider burnout and reduced capacity to address practice issues outside of direct patient care.

This last fiscal year, the program transitioned to focus on strengthening partnerships and cross-organization collaborative quality improvement work to support the recruitment and retention of family physicians providing longitudinal primary care within the communities. Work pivoted away from specific role focused networks and transitioned its focus on strengthening the PMH teams working within the clinics.

Floating MOA Initiative

The Floating MOA Initiative continued throughout much of the year and a Year in Review report was created to reflect the work of this initiative and a snapshot of the overview of this initiative is included below:



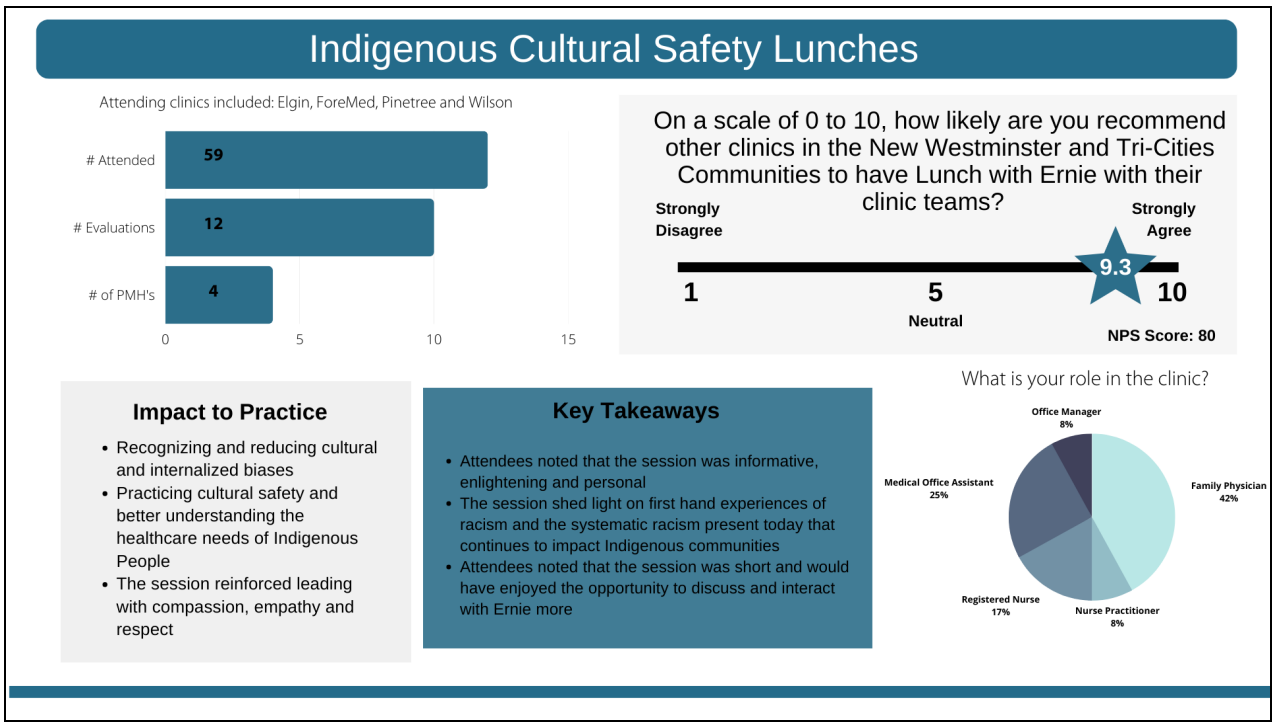
21 PMHs were supported through this initiative with the majority of coverage being attributed to vacation coverage. Although recruitment efforts were underway to expand this resource in Winter 2022/23, it became increasingly difficult to recruit successful candidates that would meet the needs of the clinic, maintain office efficiency in coverage, and provide sustainable support in meeting individual clinic needs. Additionally, the high no show rate consistent throughout the recruitment stage indicated concerns around sustainability and loyalty of any new resources hired and the anticipated impacts to clinics with regards to short notice cancellations of coverage on already short-staffed clinics.

The existing resource that was in this position for much of 2022 and early 2023 provided 86% of coverage to clinics, which is approximately 10% lower than normal averages (taking into consideration 15 business days/year of vacation for staff). These factors indicated a significant risk to continuing this initiative into FY 2023/2024 and it was identified that the risk involved for the FNW PMHs was significant enough to pause on moving forward with this initiative.

PMH Team Enhancement

The Division has created an **MOA Toolkit** and a **Clinic Procedural Manual**, policy templates and more recently, supported the creation of a centralized **PMH HR Policy Manual** which outlines and builds upon the pre-established resources. This manual provides clinics with standardized policy templates which can be adapted to their individual needs. The policy manual also outlines guidance for new staff onboarding and orientation processes, as well as quick links to Division and community-specific resources. While the policy manual provides helpful tools for managing clinic HR, the true value lies in the Division's ability to be responsive to the needs of its members by providing hands-on direct implementation support where needed. Proactive engagement with clinics has resulted in the development, distribution and implementation of HR policy manuals at 4 PMHs as well as additional practice staff recruitment resource creation and implementation.

Enhancing the PMH Team continues to be a focus going into this next year with significant focus pivoting to focusing on enhancing the care team within the clinic as opposed to previous, more role specific, enhancement. Over this last year, focused education and engagement sessions were hosted with PMH teams including cultural safety and humility lunches with a local partner from Spirit of The Children. 4 FNW PMHs have had this opportunity so far with work underway to reach out to the remaining clinics that are interested. A recap of the impact of these lunches is shared below:



With regards to practice staff recruitment, this work pivoted in December 2022 to create a more standardized recruitment effort ensuring candidates that meet the clinic- identified requirements are shared with the clinics. The job descriptions are tailored to the needs of the clinics; experience-level, availability, number of positions needing to be filled are just a few examples. The process then involves screening applicants to ensure they meet the minimum requirements. Once completed, successfully screened candidates are passed along to the clinics who then reach out for interviews if deemed a good-fit.

To ensure the clinics are able to handle the capacity of their workflows and meet their patients' needs, the Division has also placed an emphasis on the opportunity for hosting practicum students while MOA recruitment is in process. This allows for clinics to fill the gaps in terms of support while searching for long-term support. Over the last year, the breakdown of postings, both successfully recruited through the division and those that were unsuccessful are shown in the table below:

Outcome	# of PMHs involved	# of postings
Successful postings	9	14
Unsuccessful postings	9	10
Practicum Student placements	1	1

MOA Network

Strengthening team-based care is a priority for the FNW Division and it's recognized that ensuring practice staff are provided opportunities to engage, learn, and share experiences is a key measure of success in a

PMH. By having Division program staff reach out and engage with PMHs and practice staff, learning opportunities emerge that were brought back to community engagement events. Engagement mechanisms shifted over the last year to ensure events are tailored to the immediate and shifting needs of practice staff. Over this last year, event engagement has focused on:

- April/June/August 2022:Intercultural Mindset with Marla & Lesley
- May 2022: Pathways, Medical Directory and Attachment Hub
- July 2022: Demystifying the Specialist Referral Process

The MOA Advisory Committee was established in the previous FY with the goals of informing and guiding present and future engagement work with practice staff; however, low retention and quality of engagement resulted in pausing on this support moving forward.
Always with a quality improvement and PDSA lens, the MOA monthly survey concluded in October 2022 given the consistently low response rate and a pivoting priority to focus on the PMH teams instead of role specific supports.

Workflow & IT Practice Support

Member specific workflow innovation reimbursements and support are ongoing through the FNW Division. **Clinic website** and online booking development and implementation continue to support over 50% of FNW PMHs.

IT support over this last year focused heavily on increasing providers and PMHs access to platforms and tools that enable increased communication and coordination of care for patients. Much of the focus was on enabling PMHs to access platforms such as CareConnect. Additional work did centre on reaching out to the remaining PMHs around the IT inventory checklist and supporting the clinics with incorporating recommendations. Proactive support and engagement with all clinics continued to ensure PMHs knew this resource was available and strengthened the relationships.

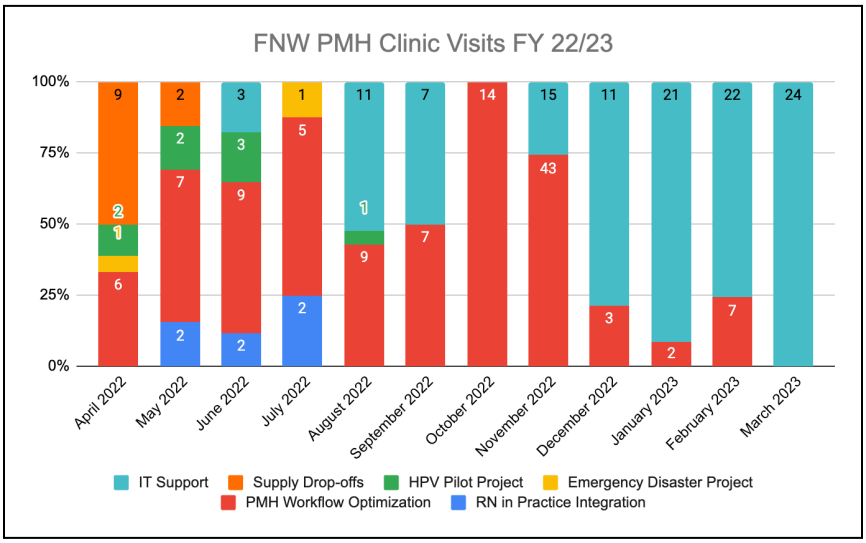
Unfortunately, funding for this internal Division resource was not able to carry forward into the following year; however, given the strong partnership between the Division and Doctors Technology Office (DTO), it is anticipated that PMH IT needs can carry forward through DTO resources.

Emergency Preparedness

In Spring 2022, the Division took on the responsibility of supporting the FNW PMHs to be prepared as a clinic group in the event of a major disaster. By putting together disaster relief plans and kits, the hope was that this would reduce workload on physicians and MOAs and bring a sense of relief when this is completed for clinics. Division staff delivered disaster relief kits to all PMHs and work was underway by Division staff to develop comprehensive relief plans for clinics.

Building on the work that the Division supported in Spring 2022 to put together and deliver disaster relief kits to the PMHs,

in Spring 2023, the Division developed and distributed emergency management plans to clinics who identified wanting one. The primary goal of an emergency management plan is to minimize the impact of emergencies or disasters by preparing and coordinating the necessary resources and activities. The plan outlines the steps to take during an emergency, including how to respond, who to contact, and what actions to take. It also provides guidance on how to recover from the disaster and resume normal operations. By the end of this year, 4 PMHs have had emergency management plans developed, distributed and implemented into their practice.



FNW PMH Visits

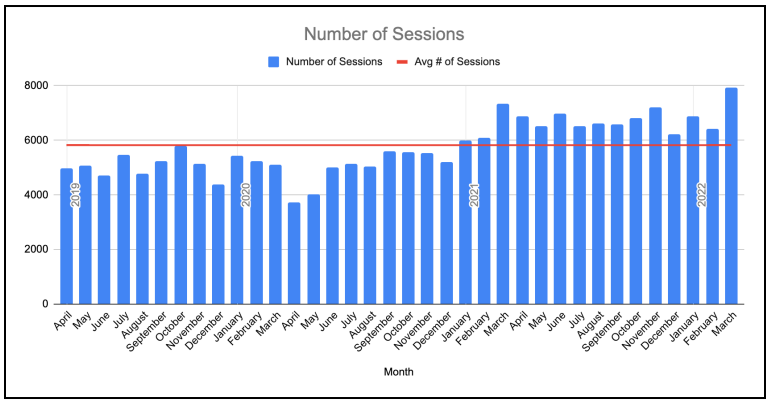
Division staff ensure ongoing reach outs and support is provided to PMHs both virtually and in-person. Over the last 2 years, much of this support has had to transition to virtual; however, over the last 8 months there has been a shift back towards providing support to PMHs in-person. PMH visits include:

- Supply Drop-Offs
- Emergency Preparedness
- Workflow Optimization & Team Member Enhancement
- IT supports
- HPV Pilot Project
- *and* RN in Practice Integration

Pathways

Pathways continues to work to produce features within its platform to better support Primary Care Providers in the community. Currently, at the local context, there are:

- 173 FNW Family Physicians with profiles in Pathways
- 131 FNW clinics listed
- 299 Specialists listed
- 1 Urgent & Primary Care Centre
- 2 hospitals



There has been alignment with FNW engagement events by incorporating how Pathways can support integration of subject matter covered at these events into daily practice. There has been a 24% increase in the number of users logging into Pathways over this last year and a 27% increase in the number of sessions.

	Number of Sessions	Average Number of Users Logged in
FY 21/22	81533	266
FY 22/23	89949	336
% Change	**10% ↑**	**26% ↑**

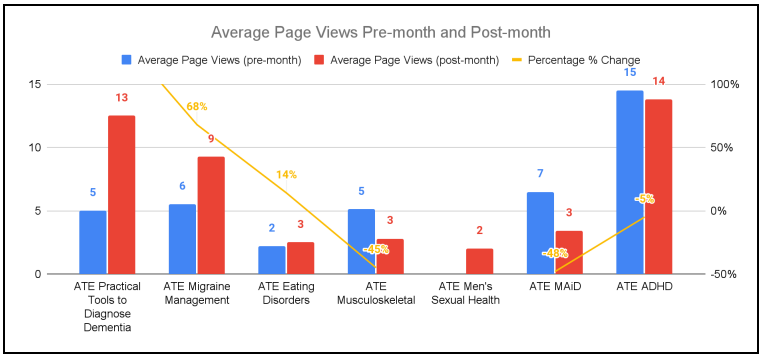
Pathways Integration at Ask The Expert (ATE) Events

The FNW conducted Pathways resource demonstrations for a total of 8 ATE events. During these Pathways demonstrations, Primary Care Providers were exposed to resources aimed at educating themselves, in addition to providing support to their patients across various health-related topics and speciality areas.

The types of resources provided on Pathways include and are not limited to:

- Physician Resources
- Patient Information
- Community & HA Services
- Forms

To showcase the impact of these demonstrations, data was pulled from the Pathways website. Specifically, the average number of page views one month prior to the event, and the page views one month following the event were used. As a result, there was an 22% average increase in the number of page views across the highlighted resources for each event.



Partnership Supports

Practice Support Program (PSP): PSP continues to support Family Physicians in panel management and EMR support. The Division continues to work collaboratively with the region's PSP team to develop and launch further sessions to support FNW PMHs.

Doctors of BC (DoBC): Ongoing partnerships between DoBC and the Division continue to focus on supporting primary care providers in the FNW. Collaborative work between DoBC, provincial and local PSP and the Division is underway to support the implementation of the Patient Experience Tool into PMHs.

Doctors Technology Office (DTO): DTO continues to offer toolkits for support in implementing IT and privacy and security guides into PMHs. A fulsome PMH IT Checklist has been developed in partnership with DTO to support FNW PMHs in understanding IT related needs and assess opportunities for further risk

reduction/mitigation within practices. Building a stronger partnership with DTO over the past year has also led to more opportunities for information sharing based on member feedback related to IT and privacy & security concerns.

Health Data Coalition (HDC): The Health Data Coalition "*is a physician-led data sharing network that encourages self-reflect and practice improvement in patient care. HDC provides access to a secure, core set of anonymized aggregate data"* for physicians and practices. HDC representatives have worked alongside FNW Division staff and Physician leadership to identify opportunities for integration into FNW led engagement events for members. At the end of FY 22/23 there were over 30 FNW PMHs enrolled with HDC.

Physician Leads

PCN/PMH Dr. Paras Mehta
Pathways Dr. Herb Chang
HDC Dr. Herb Chang

Shared Care

Aim

The relationship between family physicians and specialists is fundamental to the delivery of effective health care. Gaps in communication between health care providers can impede the flow of care, resulting in a fragmented experience for patients, caregivers, and families. The overall goal of Shared Care is to provide a coordinated and seamless health care experience for patients.

Shared Care is one of four Joint Collaborative Committees (JCCs) representing a partnership between the government of BC and Doctors of BC. Funding from Shared Care supports family physicians, family physicians with a focused practice, and specialist collaboration on quality improvement projects.

The Shared Care Steering Committee oversees all FNW Shared Care projects and provides advice and input to the development, progression and alignment of Shared Care projects to address the community gaps in care.

Maternity

Project Phase: Project Closed
Description: The Maternity Shared Care project has successfully concluded in Fall 2022, achieving its goal of improving primary maternity care experiences in the Tri-Cities and New Westminster. Please see the final report.
Community Family Physicians, Nurse Practitioners, Maternity providers, OBGYNs, RNs, and service delivery practitioners have recognized the opportunity to establish a Perinatal Community of Practice in the FNW region. This initiative aims to further strengthen maternal and infant care within the FNW Patient Medical Homes and Primary Care Networks, ensuring ongoing improvements in care provision.

Please visit the FNW member website to access the prenatal and postpartum event recordings!

Physician Leads

Dr. Dayna Mudie (Family Physician Lead)
Dr. Natasha Simula, as of October 2021 (Specialist Lead)
Dina Davidson (Registered Midwife Lead)
Dr. Aude Beauchamp, ended as of October 2021 (Specialist Lead)

Older Adult/Medically Complex

Project Phase: Sustain and Spread
Description: As the Older Adult/Medically Complex project enters its final phase, there has been progress made in improving care coordination for older adult patients with multiple comorbidities. Through comprehensive needs assessment activities, including patient and provider surveys, focus group sessions, as well as an engaging event featuring multiple specialties, valuable insights were gathered to guide the project's focus. The primary goal has been to enhance care planning and coordination by increasing the education and understanding of family physicians and specialists regarding available resources and services. The project has successfully developed a Geriatric Rounds series, fostering a virtual learning community that utilizes case-based learning to enhance competence in caring for older adult and medically complex patients.

This final phase of the project will measure the impact of the interventions and identify areas for further improvement. This project wouldn't have been successful without the participation and collaboration of all stakeholders involved in this project. In conclusion, the aim is to share findings and recommendations to ensure ongoing enhancements in care delivery for older adults with complex health concerns. Stay tuned for the final report, which will be made available once completed.

Please visit the FNW member website to access the Geriatric Rounds recording! As well, wallet sized resource cards for seniors are available to FNW clinics.

Physician Leads

Dr. Kathy Kiani (Family Physician Lead)
Dr. Simon Woo (Specialist Lead)

Adult Mental Health and Substance Use

Project Phase: Sustain and Spread
Description: Patient and provider surveys revealed that challenges exist with referrals, resources available, specialist wait-times, and family physician time required to diagnose and treat patients. The goal of the

Adult Mental Health and Substance Use Shared Care project is to foster relationship-building, learning, communication, and capacity for communication between family physicians, nurse practitioners, psychiatrists, and mental health teams across the FNW region.

This project evaluated sustainable ways to communicate about patient cases between psychiatrists and primary care providers, hosted provider education sessions and developed a clinical tool on depression with information about services and supports.

This project is expected to close in the summer of 2023 where learnings will be shared and opportunities for further partnerships and next steps which expand outside of this project due to the complexities of the challenges and system will be documented.

Physician Leads

Dr. Carllin Man (Family Physician Lead)
Dr. Stephanie Aung (Family Physician Lead)
Dr. Stephen Ogunremi (Specialist Lead)
Dr. Angelo Wijeyesinghe (Specialist Lead)

Chronic Pain

Project Phase: Sustain and Spread

Description: The intent of this project is to increase the confidence and satisfaction of the FNW family physicians managing chronic pain patients by ensuring they have the rapid access programs to refer patients to and a team to treat these patients.

Through this Shared Care project, physicians, allied health providers, and health authority leadership will work together to implement functional and consistent referral and communication pathways. This year, the group hosted an MOA and allied health education session in October 2022 to increase awareness of services available to support patients. The committee is also developing a comprehensive resource with the most common chronic pain conditions for primary care providers to reference and use. The next steps of the project include ensuring sustainability of the resource created.

As well, due to the increased need, a new project around opioid prescribing branched out of this project to help patients on high doses of opioids get connected to a family physician. Please read more about this project in the Opioid Prescribing section below. As the Chronic Pain project approaches closure, it's recognized that there are a number of opportunities that are yet to be explored beyond the project's intended scope due to the complexities of chronic pain. The final report will contain these future opportunities, an evaluation of the project activities and will be shared out widely.

Physician Leads

Dr. Huy Nguyen (Family Physician Lead)
Dr. Alyssa Hodgson (Specialist Lead)

Palliative

Project Phase: Project Closed

Description: The goal of the Palliative Shared Care project is to build capacity, enhance communication between

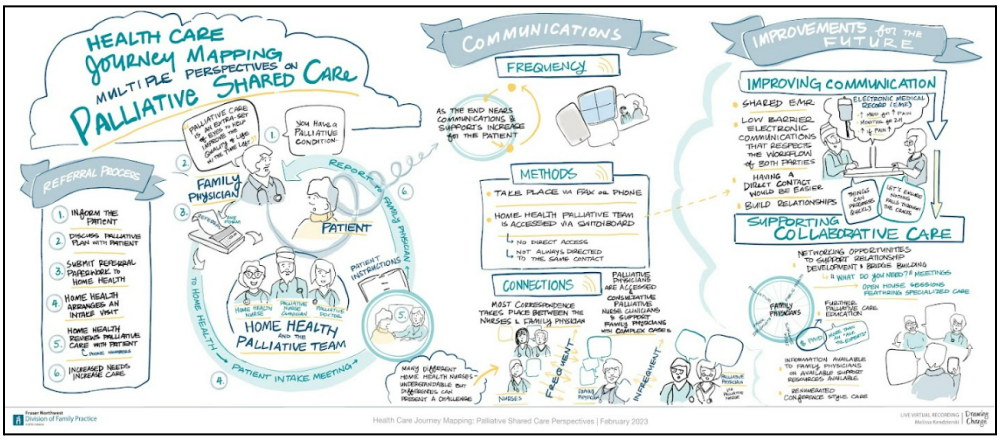
providers, streamline the referral process, resolve prescribing gaps, and to improve the patient and caregiver experience in the palliative care journey. The committee hosted a four-part learning series for family physicians which focused on fostering relationships and education using case based examples. The following learning sessions have been completed:

1. pain management
2. opioid and symptom management,
3. advance care planning
4. panel style engagement session with palliative community services and practitioners to improve understanding of palliative services and referral criteria.

Please visit the FNW member website to access the previous learning series recordings.

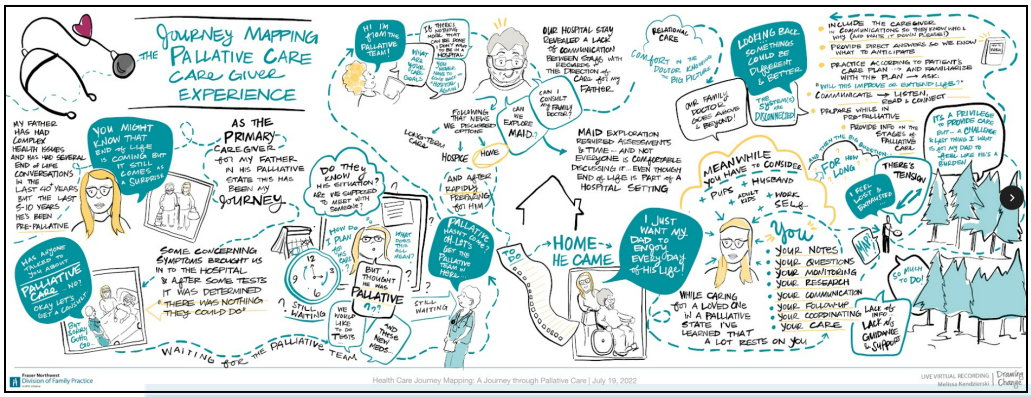
Aa patient journey map from a caregiver's perspective was conducted to better understand the palliative care journey. The full graphic can be found here.

Interviews with family physicians were conducted at the end of the project to identify further opportunities for improvement and the responses were aggregated into a provider journey map. The full graphic can be found here.



The project closed February 2023 and the final report will be submitted in May 2023. Once available, a copy of the final report will be posted on the Division website.

Resources completed from last fiscal year include the Palliative Resource Sheet and the Advance Care Planning resource which are both available to primary care providers on Pathways.



Physician Leads

Dr. Ali Sanei-Moghaddam (Family Physician Lead)
Dr. Wai Phan (Palliative Physician Lead)
Dr. Fify Soeyonggo (Palliative Physician Lead)

Dr. Elizabeth Wu, from March 2022 - May 2023 (Palliative Physician Lead)

Geriatric Psychiatry

Project Phase: Proposal Implementation
Description: Mental health needs of older adult patients who are 65+ differ from those of younger patients, and thus services specific to this population are available. However, this is not reflected in the current referral process, which triages adults and older adults through the same pathways, resulting in delays and excessive times spent on waitlists. The Geriatric Psychiatry Shared Care initiative focuses on streamlining the referral and communication process for Geriatric Psychiatry services, in order to 1) expedite patient access to specialist care and 2) improve communication channels between family physicians and psychiatrists to enable better coordination of care.

The group hosted a two part dementia workshop in April 2022 about practical tools to diagnose dementia patients, and in October 2022 about depression and anxiety in dementia patients. At both of these sessions, the referral algorithm was shown to primary care providers to improve understanding of how to navigate geriatric MHSU services. As well, the dementia care pathway was demonstrated to provide suggestions on workflow when diagnosing a patient with dementia.

Physician Leads

Dr. Carllin Man (Family Physician Lead)
Dr. Simon Woo (Specialist Lead)

Acute Discharge

Project Phase: Sustain and Spread
Description: The Acute Discharge Program was developed to ensure patients being discharged from Eagle Ridge Hospital and Royal Columbian Hospital are followed-up within a timely manner, in hopes of reducing the number of hospital readmissions and repeat emergency room visits. This year, the committee continued to advocate for timely follow up in the community and smooth transition in care processes, especially for unattached patients without a primary care provider.

A concern was voiced from a family physician about not receiving Speech Language Pathology (SLP) reports for patients in the hospital. The group is now actively working to ensure the transition and referral process from acute to the community is efficient.

In order to better understand both the family physician and hospitalist physician perspective, two journey maps were conducted to visualize the complexities of what happens when a patient is admitted in the emergency department, the care provided in the hospital, to the discharge process and the follow up care needed in the community by the primary care provider. The full hospitalist provider journey map is available here and the full family physician journey map is available here.

In partnership with the emergency departments at Royal Columbian Hospital and Eagle Ridge Hospital, and the Port Moody UPCC, an ongoing patient survey is being conducted. The aim of the survey is to understand patients' experiences as they transition from the hospital back into the community where they receive the follow up care needed.

As this project nears completion, the division will continue actively sharing the patient feedback received with the partners and stakeholders involved and is committed to improving patient care in this area.

Physician Leads

Dr. Jennifer Yun (Family Physician Lead)

Dr. Jerusha Millar, from November 2022-Present (Specialist Lead)

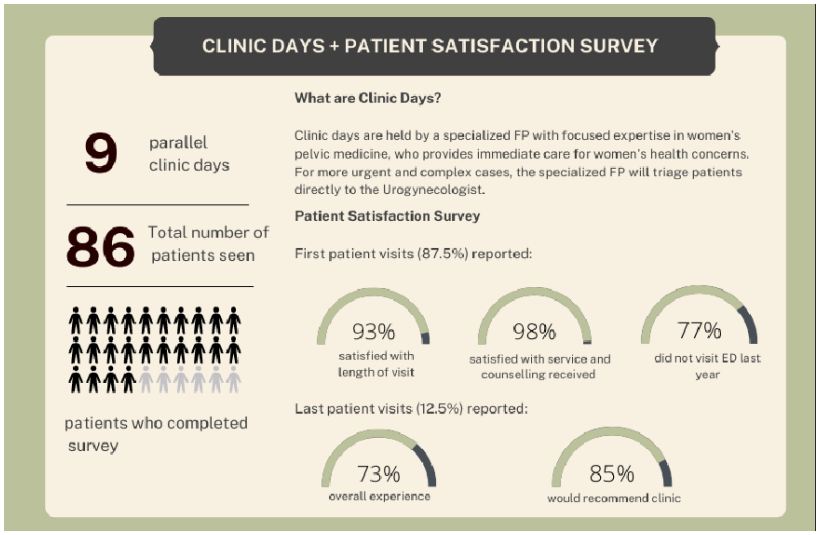
Dr. Joseph Ip, from April 2020 to November 2022 (Specialist Lead)

Women's Health

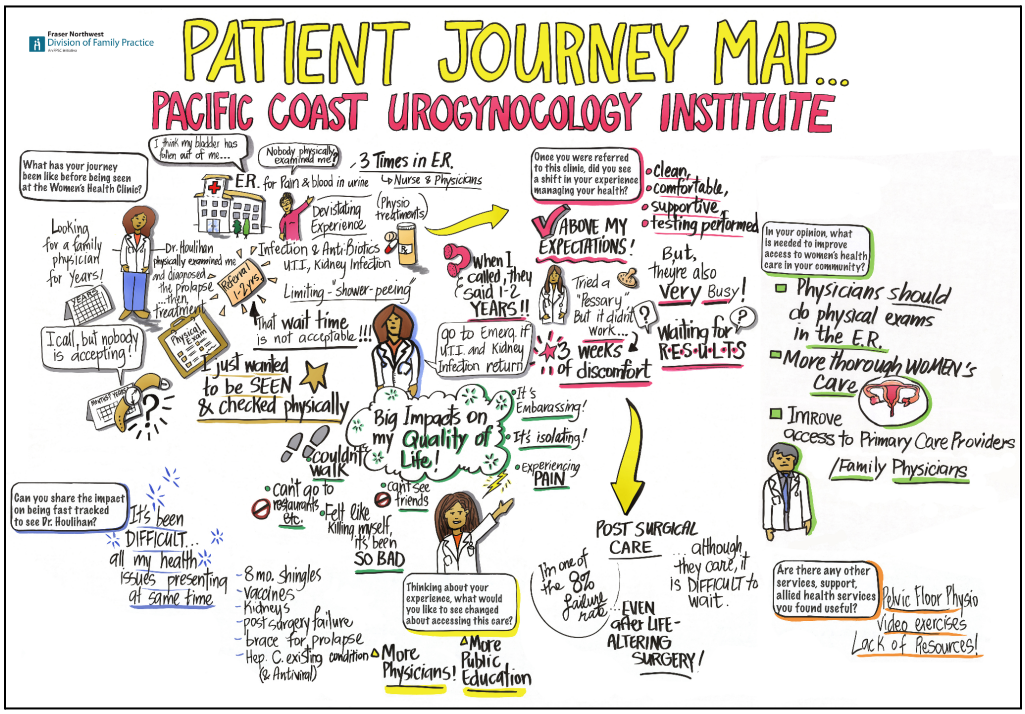
Project Phase: Sustain and Spread
Description: The Women's Health Shared Care Project has made significant progress in improving care for patients awaiting surgery for pelvic organ prolapse and incontinence. Previously, patients experienced long wait times of up to 1.5 years from family physician referral to surgical procedure, resulting in a significant impact on their quality of life.
To address this issue, the project team successfully established a urogynecology clinic model. Through patient surveys, we received 260 responses, highlighting the urgent need for improved access to care. As a result of the clinic model, more than 100 patients have received care, and patient satisfaction surveys were administered after each of the 12 clinic days to assess the patient experience. The following visual summarizes the feedback received and highlights the ongoing efforts for continuous quality improvement through PDSA cycles.

To ensure seamless implementation, a comprehensive Clinic Binder has been created, documenting the model's implementation and clinic flow.
Additionally, an in-person family physician education workshop was conducted to enhance understanding and expertise in women's health.
As the project enters the sustain and spread phase, our focus is on expanding the successful clinic model to reach more patients and further reduce wait times. We remain committed to improving the quality of life for women experiencing pelvic organ prolapse and incontinence, and will continue to collaborate with healthcare providers to achieve this goal.

The below visual depicts the story of a woman navigating healthcare for women's health issues without a family doctor. Her journey unfolds through multiple visits to the emergency room and walk-in clinics, where she faced the challenge of not receiving a thorough physical examination, leading to adverse impacts on her quality of life and mental well-being. With a waitlist of 1-2 years to see a Urogynecologist, the patient eventually experiences a complete prolapse, prompting



an urgent referral to the Pacific Coast Urogynecology Institute. Here, she is fast-tracked to see the specialist and considered as a surgical candidate. The patient expresses her satisfaction with the expedited process, which exceeded her expectations.



Physician Leads

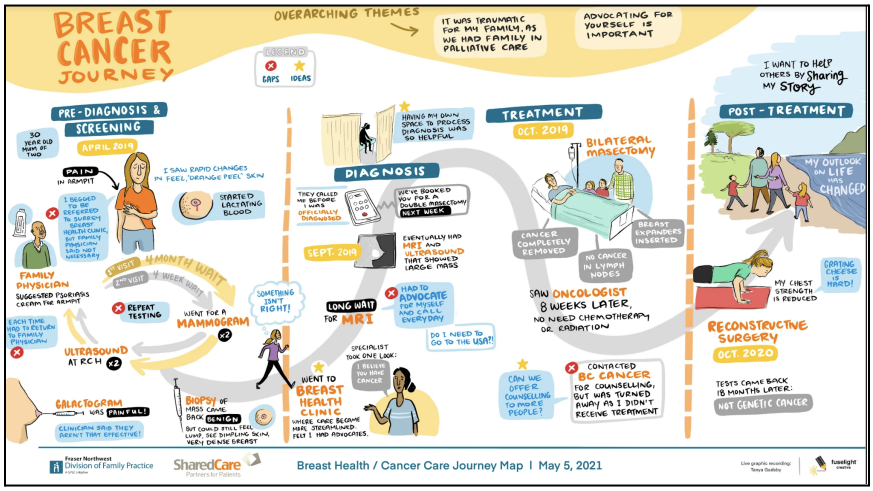
Dr. Sanja Matic (Family Physician Lead)
Dr. Sara Houlihan (Specialist Lead)

Breast Health

Project Phase: Sustain and Spread
Description: The Cancer Care (Breast Health) Shared Care project in the Fraser Northwest region has reached its final phase. The project focused on the delivery of high-quality cancer prevention, preventative screening, and diagnostic services to residents. A MOA engagement event was conducted to disseminate learnings and improve referral processes. As part of our approach, the project team is finalizing a public education campaign aimed at increasing awareness of cancer risk and the importance of screening. This campaign will target hard-to-reach populations, including recent immigrants, the indigenous population, and unattached patients. While obtaining accurate data for the Breast Health Clinic proved challenging, we acknowledge the operational challenges, data processes, and communication issues that contributed to this difficulty. As a result, specific clinic data was not included in this report. These experiences have provided valuable lessons, emphasizing the importance of improved communication protocols, clear referral guidelines and expectations, and collaborative efforts to ensure accurate and reliable data in order to enhance clinical operations for patient-centered care.

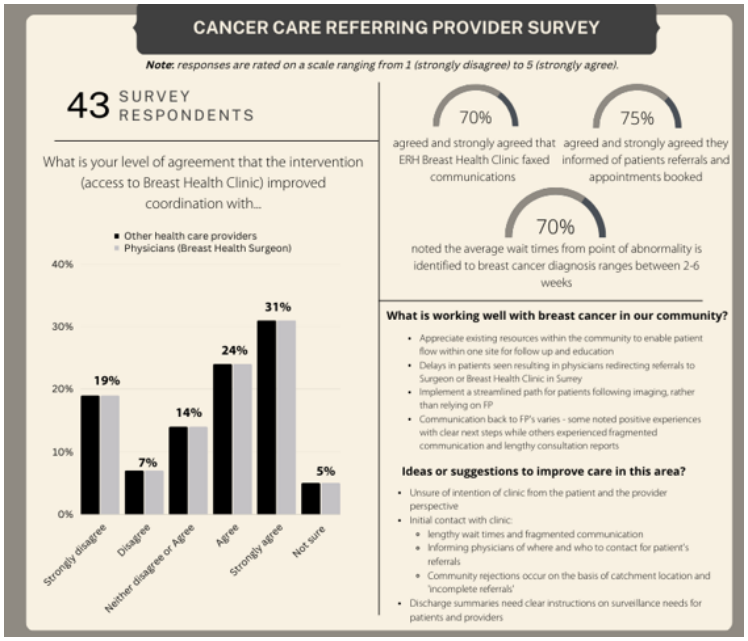
Led by Dr. Jennifer Yun, the patient journey map helped to inform the development of

the Breast Health Shared Care project. We asked a local patient partner to walk us through their cancer care journey from: screening & pre-diagnosis, abnormal test result to breast cancer diagnosis and treatment, and post-treatment.



While reviewing the service delivery model, it's important to note that the Breast Health Clinic has ceased operations. As a result, new referrals are being deferred to other clinics. For existing referrals, care discharge plans are being communicated to primary care providers, ensuring continuity of care.

As this project concludes, the final report and evaluation will document the lessons learned and future recommendations, aiming to improve outcomes and support community well-being.



Physician Leads

Dr. Cathy Clelland (Family Physician Lead) Dr. Michelle Goecke (Specialist Lead)

Respiratory/Pulmonary Function

Project Phase: Project Implementation

Description: The Respiratory/Pulmonary Function project is currently in the implementation phase. The primary goal is to update family physicians' knowledge of diagnostic testing in Respirology, focusing on selecting the appropriate tests for patients and providing guidance on decision-making. Additionally, aiming to enhance community management of Chronic Obstructive Pulmonary Disease (COPD) and address the impact of COVID-19 on respiratory health. To foster member engagement, learning events are being planned for Fall 2023. These events will provide an opportunity for collaboration, knowledge sharing, and discussions to further advance our goals in respiratory care.

Physician Leads

Dr. John Yap (Family Physician Lead)
Dr. Samir Malhotra (Specialist Lead)

Opioid Prescribing

Project Phase: Expression of Interest
Description: The Opioid Prescribing project is currently in the Expression of Interest phase, addressing the complex issue of unattached patients on high-dose opioids for chronic non-cancer pain. Many of these patients struggle to connect with a longitudinal family physician, leading to barriers in accessing care. Extensive discussions and needs assessment activities, including patient journey mapping, surveys, and shared experiences from both patients and physicians, have shaped the project's direction. The project objectives focus on reducing opioid dosages within college guidelines while improving patient function and pain management. By implementing a collaborative model for opioid prescribing, the aim is to increase attachment rates to longitudinal primary care providers, enhance confidence in opioid prescribing for new providers, and improve patient satisfaction and coordination of healthcare services. As the project progresses, future work will involve further needs assessment, structuring project activities, and addressing challenges through a quality improvement lens. Through a collaborative and patient-centered approach, the project strives to empower patients with self-management skills, increase provider confidence, and foster a model of care that yields satisfaction and improved outcomes.

Physician Leads

Dr. Stephan Barron (Family Physician Lead)
Dr. Alyssa Hodgson (Specialist Lead)

Alcohol Use Disorder

Project Phase: Proposal Implementation
Description: The purpose of this project is to reduce the stigma associated with alcohol use through educating the public about the importance of having conversations about their alcohol use with their healthcare provider, improve communication between primary care providers and addiction medicine physicians and increase primary care providers' awareness of resources to support their patients. The group conducted patient and provider surveys and hosted a provider focus group session which was used to tailor the project activities towards the feedback and needs identified.

Marginalized populations such as Indigenous people are impacted by alcohol use disproportionately so it was important to incorporate learnings on harm reduction from an Indigenous perspective. A two part workshop is being planned for Summer 2023 to destigmatize and improve understanding of the root causes of addiction in this patient population. Further provider education will focus on the clinical management and treatment of alcohol use disorder.

Physician Leads

Dr. William Mak (Family Physician and Addiction Medicine Lead)
Dr. Karen Shklanka (Addiction Medicine Lead

Deep Vein Thrombosis

Project Phase: Expression of Interest Planning
Description: The Deep Vein Thrombosis (DVT) Project aims to address concerns related to the management of DVT cases in the Emergency Department. It has been identified that patients presenting with suspected DVT in the ED may experience long wait times due to the unavailability of urgent diagnostic imaging. By establishing a safe and efficient pathway of care for DVT patients within the community, we seek to reduce emergency room visits. Through collaborative efforts and local agreement, we aim to empower family physicians to manage suspected DVT cases in their offices, utilizing Novel Oral Anticoagulants (NOACs)/Direct Oral Anticoagulants (DOACs) while awaiting timely ultrasounds in the community. Preliminary work for the Expression of Interest submission has involved gathering patient stories, conducting member surveys, and process mapping to gain insights into the current state and identify opportunities for improvement.

Physician Leads

Dr. Jennifer Yun (Family Physician Lead)
Dr. Jon Braunstein (Specialist Lead)

Dermatology

Project Phase: Expression of Interest Planning
Description: The Dermatology project aims to address the issue of long wait times for patients seeking medical dermatology services. Patients are experiencing extended waiting periods of 12-18 months. This has led to concerns from family physicians regarding rejected referrals and closed waitlists, resulting in patients presenting to the Emergency Room with dermatological concerns. The FNW Dermatology Shared Care project aims to improve patient access to dermatology by fostering collaborative relationships between local family physicians, dermatologists, and emergency room physicians. Through co-creation and implementation of local solutions, we aim to develop strategies that address these challenges. Preliminary work has involved engaging with specialists, journey mapping, planning relevant events, and gathering valuable feedback from physicians.

Physician Leads

TBD (Family Physician Lead)
Dr. Aaron Wong (Specialist Lead)

Attention-Deficit/Hyperactivity Disorder

Project Phase: Expression of Interest Planning

Description: The ADHD project aims to address the challenges faced by patients and providers in managing adult-ADHD. This project aims to support family physicians by providing education, resources, and reliable psychiatry referrals. An education series will be developed to reduce stigma and equip physicians with tools for diagnosis and management. The goal is to enhance care and support for individuals with ADHD through collaboration with health authorities and mental health partners. Preliminary work involved collecting patient stories and obtaining physician feedback.

Physician Leads

Dr. Amber Jarvie (Family Physician Lead)
Dr. Varinder Parmar (Specialist Lead)

Dizzy/vertigo ENT

Project Phase: Expression of Interest Planning

Description: The Dizzy/Vertigo ENT (Ear, Nose, Threat) project aims to improve access to care for patients with dizzy/vertigo concerns. Wait times can be as long as 12-18 months to see an ENT specialist due to the limited number of providers who accept referrals for this concern. Additionally, patients may get bounced around to other ENTs and other disciplines, leading to further delays in care. During this time, patients' quality of life decreases and their condition worsens.

The goal of the Dizzy Shared Care project is to understand the gaps from all perspectives and develop a solution collaboratively with local ENTs, primary care providers and neurologists to improve access to timely care for dizzy patients. A focus group with family physicians voiced challenges around the wait times, managing patient frustrations and history taking when the symptoms can be unclear. The next steps will be to engage and gather the specialist and patient perspectives to help inform the next steps of the project.

Physician Leads

Dr. Ravi Parhar (Family Physician Lead)
Dr. Margaret Aron (Specialist Lead)

Member Engagement

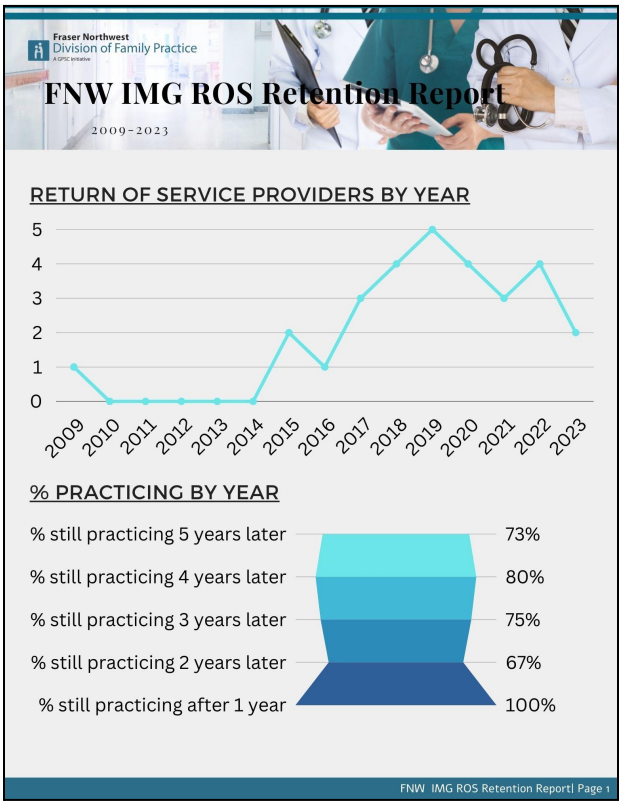
Recruitment/Membership

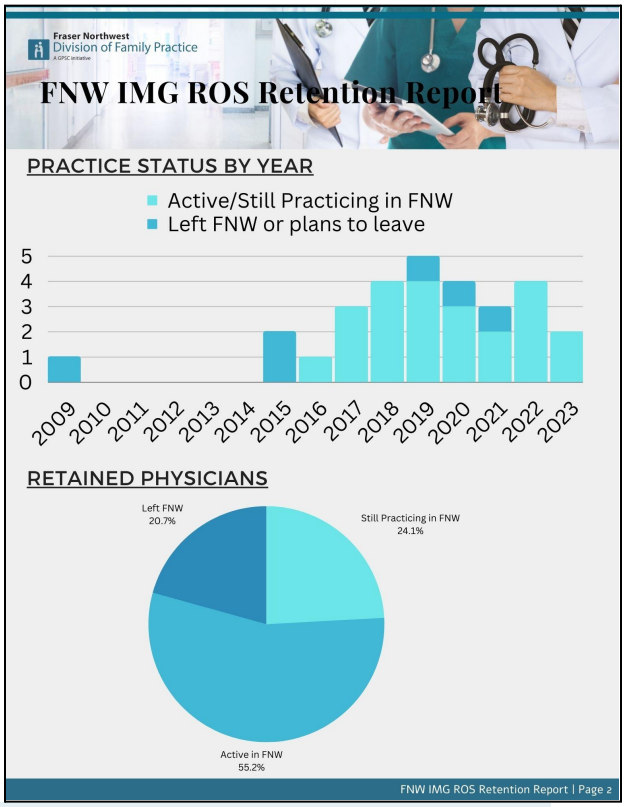
Overview

At the end of this year, the Fraser Northwest Region had 469 members. This is an 8% increase from the previous year, which is likely due to additional providers joining the communities. Further details on this can be found in the next section as well as the Engagement section of this report.

Incentive to Practice in FNW

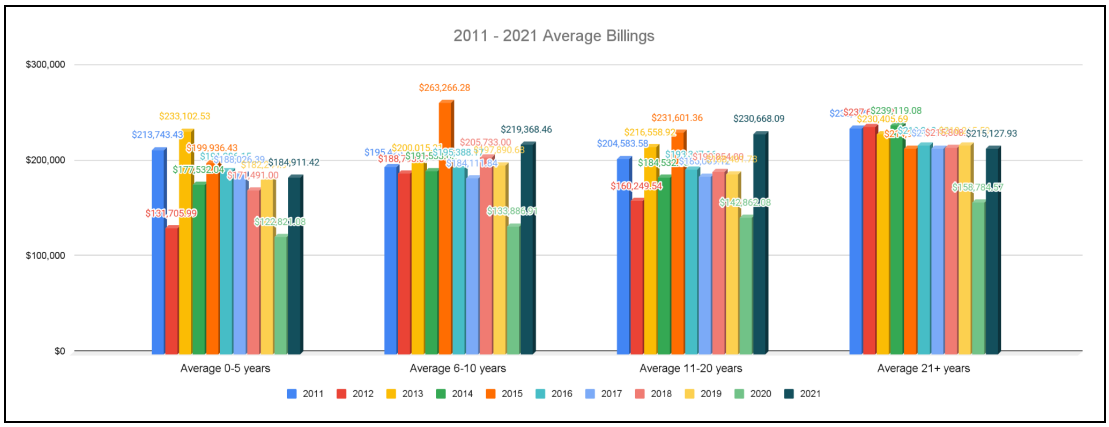
Over the last year, recruitment and retention practice incentives have contributed to the recruitment of Physicians joining the community. Partnerships with the Practice Ready Assessment (PRA) program, UBC International Medical Graduates (IMGs), PCN funded contracts, newly introduced payment models, PMHs able to support education for residents, medical students and the growth of the mentorship program all contributed to a growth in recruitment and retention of primary care providers. A snapshot of the retention of IMG Return of Service (ROS) Providers was conducted and an average of 79% of providers from the last 5 years continue to practice in the FNW communities.



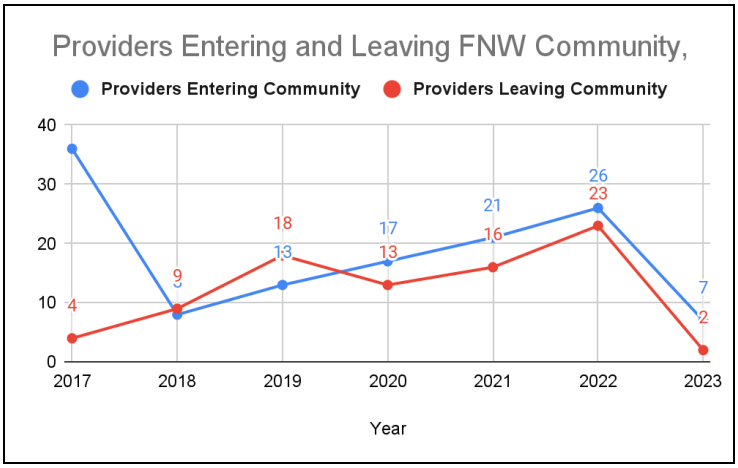


Composition

FNW membership continues to be largely comprised of Family Physicians. Locums, Walk-In Physicians and Hospitalists, when combined, make up a similar portion of membership. Nurse Practitioners, Residents, Registered Nurses and Medical Students also comprise a growing associate membership base.



The Division continues to advocate for a sustainable primary care system for recruiting and retaining Family Physicians. Given this, we continue to look at the remuneration of our members; the following is a 10 year review of our memberships MSP billing data by years of practice (*graph above).*



Projected Retirements

The number of physicians retiring and/or leaving the community continues to grow, with those leaving citing high costs of operating a practice that the Fee for Service compensation model currently can't meet. Since 2016, there have been approximately 87 physicians leaving the community, with 24 physicians leaving in 2022, and an additional 2 leaving in 2023 already. The graph below shows the distribution of membership changes since 2016.

Projected leaves in the next year are set at 11 due to anticipated retirements, moves/relocation, short term leaves, releasing panel and leaving family practice. Supportive resources such as RNs in Practice, access to rapid clinical counselling resources and practice improvement support are paramount to retaining the current physicians in the FNW, and recruiting future physicians to practice in these communities.

Engagement

Aim

Engagement is the extent to which FNW members, stakeholders and community feel passionate about primary care in our communities, are committed to the value of comprehensive primary care, and put discretionary effort into this collective work as a primary care network. Engagement goes beyond activities, games, and events; it drives the sustainability of our local primary care system.

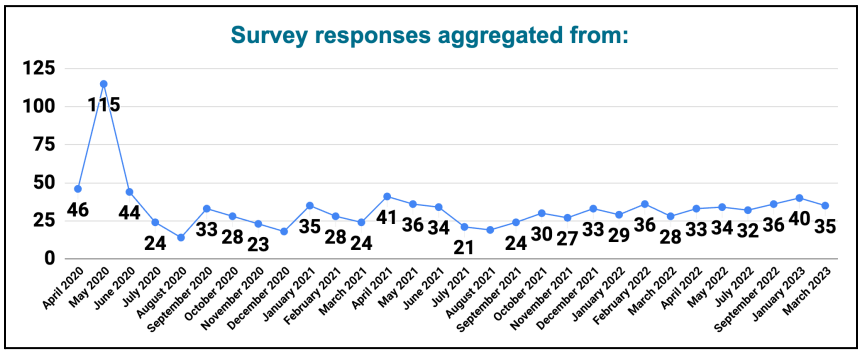
Formal and Informal Communication

The FNW Division continues to reach out to members through both formal and information means of communication. The MD Hub Update is in its second year of circulation.

Additional mechanisms were established through focus groups between Family Physicians, Nurse Practitioners, FHA leadership and allied health services to support the continuous improvement of access throughout the changing landscape of this past year. Topics included:

- Physician Owned Business Operator Groups
- Recruitment
- Clinic Consolidation
- Mental Health
- Community Health Services (including Home Health, Home Support and Community Outpatient Services)
- After Hours Care

Informal means of communication continued to foster feedback mechanisms between members. Monthly member surveys continued to provide a mechanism to reach out and engage members to gather feedback on the changing landscape given the pandemic. These surveys have been distributed to members where feedback is collected, collated and shared with the FNW Board. These surveys have significantly impacted the work that the Division does as hearing directly from primary care providers in real-time supports continued improvement. Below is a month over month distribution of the number of responses received.

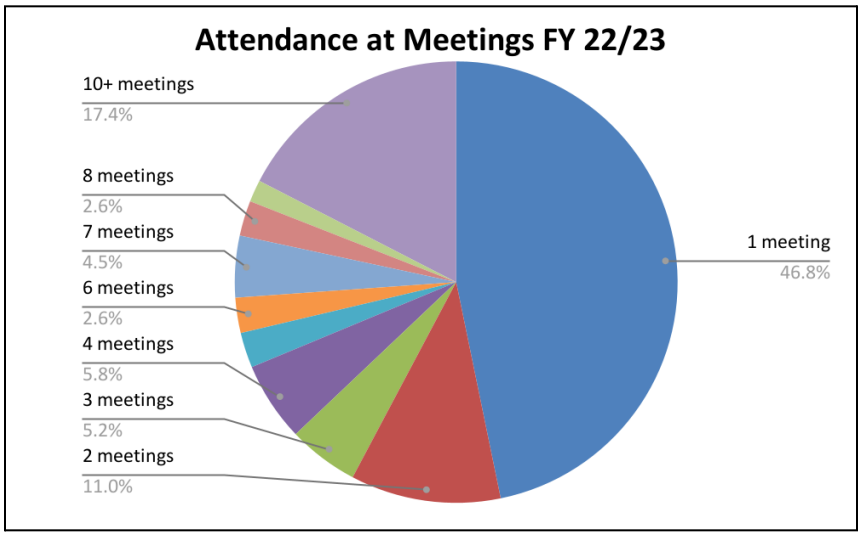


New Member Engagement

Proactive engagement strategies have been developed and implemented to support new members' awareness, involvement and overall engagement in the Division. Although these strategies had to transition and adapt in a virtual environment, this last year saw an increase in member involvement from providers who have practiced in the communities for years as well as an increase in new members taking on leadership roles.

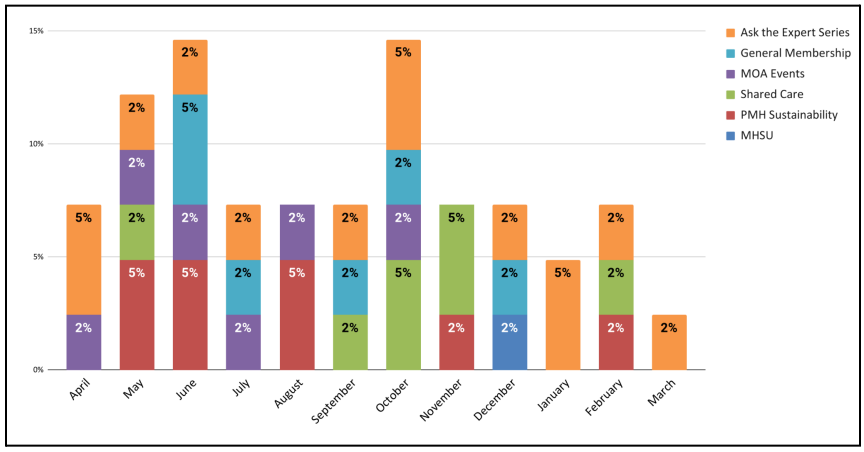
The mentorship program continues to be a resource available to members practicing in the FNW. Categories of mentorship include: EMR support, running/building a practice,

navigating community resources, and specialized focus areas to name a few. This program connects those seeking mentorship with pre-identified mentors willing to support in the identified topic areas.



Events

FNW members continued to engage by participating in events, workshops and education opportunities with their peers and colleagues. 65% of Division members attended one or more events over this last year with 35% of those members attending 2 or more events.



Accomplishments

The Division hosted approximately 41 events in the last year with the most events occurring in June and October 2022. The Ask The Expert events continue to be highly successful and well attended. Additionally, in the last year, PMH team development Lunch and Learns have been introduced to strengthen PMH teams.

Board of Directors and Staff 2022/23

Board members

Dr. Cathy Clelland, Secretary
Dr. John Yap, Knowledge Keeper
Dr. Nimeera Kassam
Dr. Amber Jarvie
Dr. William Mak
Dr. Amelia Nuhn
Dr. Ravi Parhar, Treasurer
Dr. Christine Sorial
Dr. Perveen Gill, Resident Advisor
Dr. Jennifer Yun, Co-Chair
Dr. Gina Zheng, Co-Chair

Finance and governance committee

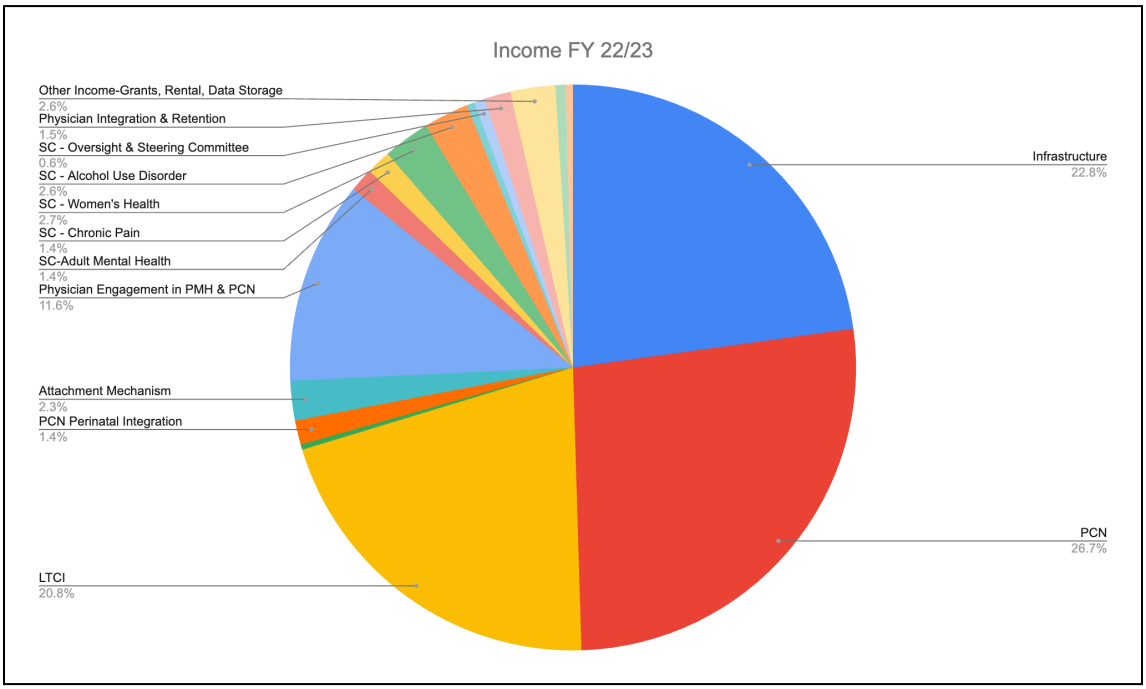
Dr. William Mak
Dr. Ravi Parhar (Treasurer)
Dr. Perveen Gill
Dr. Jennifer Yun
Dr. Gina Zheng
Dr. Cathy Clelland

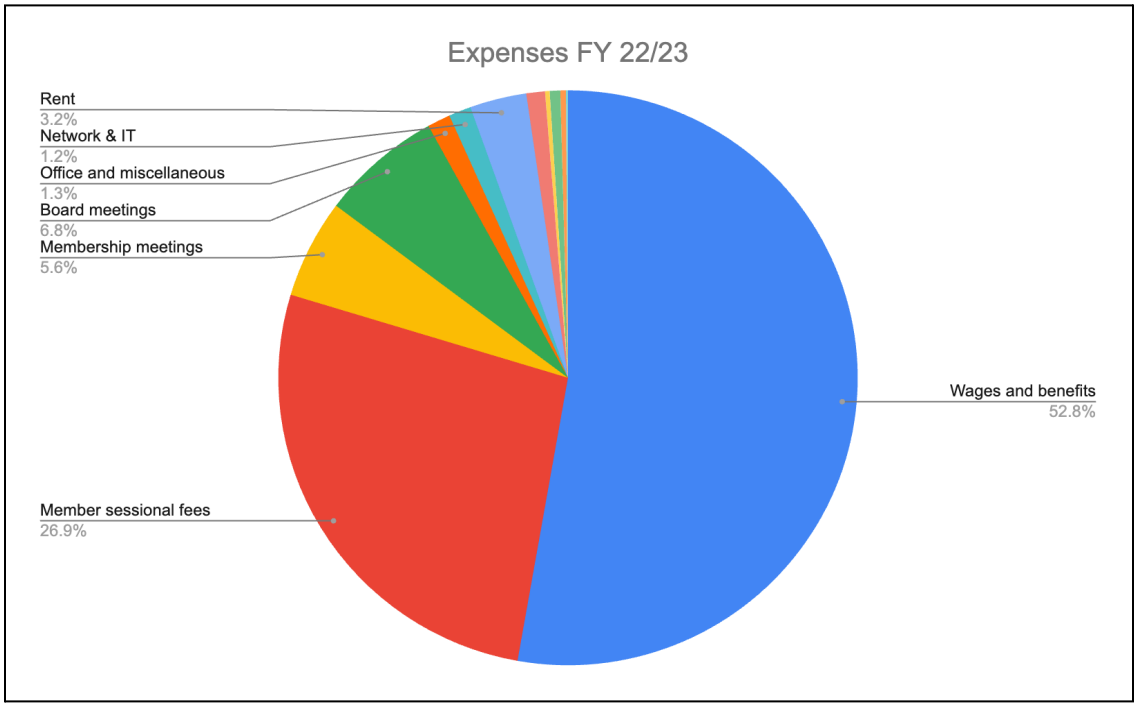
Staff

Kristan Ash, Executive Director
Erin Carey, Program Director
Trin Gonzalez Castillo, HR Program Assistant
Allison James, Administrative Coordinator
Saron Kassay, Evaluation Program Coordinator
Carter LaFontaine, Project Coordinator
Sanjam Laura, Project Manager
Jessie Mather-Lingley, Program Director
Osob Mahdi, Project Coordinator
Michiko Mazloum, Program Director
Antoinette Mercado, Accounting Assistant
Melanie Narvaez, Operations Director & Controller
Marquis Odobas, Communications Coordinator
Mayowa Oduwole, Project Coordinator
Emily Richardson, Program Manager
Alana Stuart, Program Manager
Cindy Young, Project Manager

Statement of Financial position

The 2022/2023 income was $3,314,758 from 17 program contracts with a total expense of $3,458,380. The breakdown of income and expenses are provided below.





The Division work is a product of physician leadership time. Under the BC Society Act and as a measure of true transparency, we present the following information of physician sessional payments greater than $20,000 and staff remuneration greater than $75,000 made by the Division during 2022/2023 Fiscal year.

Kristan Ash	Executive Director	$161,671.43
Lesley Michiko Mazloum	Program Director	$114,757.20
Melanie Narvaez	Controller	$114,751.59
Jessie Mather-Lingley	Program Director	$103,276.48
Sanjam Laura	Project Manager	$90,627.87
Cindy Young	Project Manager	$90,052.56
Emily Richardson	Program Manager	$86,690.63
Allison Tanaka	Administrative Coordinator	$77,836.65
Patricia Hockhousen	IT Coordinator	$75,525.91
Dr. Katayoon Kiani-Goodarzi	Long Term Care Initiative, Shared Care Physician Lead	$42,931.91
Dr. Catherine Clelland - Board	Board Member, Shared Care Physician Lead	$33,796.72
Dr. Mahsa Mackie Inc.	Long Term Care Initiative	$32,808.30
Dr. Majid Jafari Inc.	Long Term Care Initiative	$32,476.31
Dr. Gina Qin Zheng - Board	Board Co-Chair	$32,011.00
Dr. Amber Jarvie Inc.	Board Member, Long Term Care Initiative Physician Lead	$31,375.23
Dr. Sanaz Gharedaghi Ltd.	Long Term Care Initiative	$29,968.38
Dr. Jennifer Yun - Board	Board Co-Chair, Shared Care Physician Lead	$29,554.63
Dr. Lalji Halai Inc.	Long Term Care Physician Lead	$29,286.89
Dr. Ali Sanei-Moghaddam Inc.	Long Term Care Initiative	$28,315.63
Dr. N. Petropolis Inc.	Long Term Care Initiative	$28,091.10

Dr. Paras B. Mehta Inc.	PCN Physician Lead	$26,592.69
Anthony Tran Medical Corporation	Long Term Care Initiative	$25,029.35
Dr. William Mak - Board	Board Member, Shared Care Physician Lead	$26,479.95
Dr. Nahla Fahmy Inc.	Long Term Care Initiative	$25,681.56
Dr. Ravi Parhar - Board	Board Member	$25,163.60
Dr. Giap Swee Teresa Tan Inc.	Long Term Care Initiative	$24,896.31
A.K. Punnyamurthi, MD Inc.	Long Term Care Initiative	$24,631.76
Dr. Ramesh Avinashi MPC	Long Term Care Initiative	$24,576.91
Dr Kaveesh Dissanayake Inc	Long Term Care Initiative	$21,842.22
Dr. K.M. Andrew Cheong Inc.	Long Term Care Initiative	$21,815.31
Dr. Laura Ziefflie Inc.	Long Term Care Initiative	$21,809.28
Dr. Sara Houlihan Inc.	Shared Care Physician Lead	$21,201.61

Committees and Working Groups

Collaborative Services Committee

Dr. Gina Zheng
Dr. Jennifer Yun
Dr. Paras Mehta
Dr. Kathy Jones
Dr. William Mak
Dr. Cathy Clelland
Dr. Ravi Parhar
Dr. Vincent Wong
Erika Scholten, KFN
Scott Brolin, FHA
Sandy Drieschner, FHA
Walid Chahine, FHA
Sheila Finamore, FHA
Dr. Ingrid Tyler, FHA
Dr. Aamir Bharmal, FHA
Cindy Convey, FHA
Dr. Steve Reynolds, FHA
Dr Mitchell Fagan, GPSC
Cindy Convey, FHA
Dr. Aly Somani, FHAi
Zamina Lalji, FNHA

Long-term care initiative Medical Advisory committee

Dr. Amber Jarvie - Dr. Dayna Mudie, Physician Lead

Physician Lead
Dr. Lalji Halai - Physician Lead
Dr. Ramesh Avinashi
Dr. John Azer
Dr. Kasia Baker
Dr. Graham Burns
Dr. Andrew Cheong
Dr. Amir Danishwar
Dr. Kaveesh Dissanayake
Dr. Mina Elmasry
Dr. Rosemary Ezimora
Dr. Nahla Fahmy
Dr. Abhineet Garg
Dr. Premveer Gill
Dr. Sanaz Gharedaghi
Dr. Chiho Hatakeyama
Dr. Majid Jafari
Dr. Nimeera Kassam
Dr. Kathy Kiani
Dr. Hana Kolac
Dr. Azim Ladhani
Dr. Gangadevi Lokuwattage
Dr. Mahsa Mackie
Dr. Carllin Man
Dr. Gregory McAnulty
Dr. Daniel Metzak
Dr. Sheila Mogga
Dr. Doug Moseley
Dr. Ravi Parhar
Dr. Mina Perez Flores
Dr. Nick Petropolis
Dr. Ashvin Punnyamurthi
Dr. Paul Ricci
Dr. Ali Sanei-Moghaddam
Dr. Teresa Tan
Dr. Anthony Tran
Dr. Peter Wang
Dr. John Yap
Dr. Laura Ziefflie
Dr. Hortensia Shortt
Dr. Gene d'Archangelo
Dr. Katie Gates Manhas
Dr. Peter Le Voi
Dr. Pamil Malhi
Dr. Eileen Fan
Dr. TJ Dhesi

PCN Steering Committee

Voting Members:
Dr. Paras Mehta, Physician Lead
Deborah Martelluzzi, KFN
Non-Voting Members:
Dr. Gina Zheng
Dr. Jennifer Yun
Dr. Nimeera Kassam
Dr. Mitch Fagan, GPSC
Ernie Cardinal, SOTC
Claire Maclean, Share
Sandy Drieschner, FHA
James Musgrave, Share
Kristine Byer, FHA
Mangat Vohra
Ross Howell, FHA
Scott Brolin, FHA
Sheila Finamore, FHA

PCN/PMH Advisory Committee

Dr. Paras Mehta, Physician Lead
Dr. Jennifer Yun
Dr. Nimeera Kassam
Dr. Cathy Clelland
Dr. Gina Zheng
Dr. Christine Sorial
Dr. Vincent Wong
Dr. William Mak
Dr. Carllin Man
Dr. Herb Chang
Dr. Tarek Khalil
Chelsea Bruce

MHSU PCN Working Group

Dr. Carllin Man, Physician Lead
Dr. Tracy Monk
Dr. Ashvin Punnyamurthi
Dr. Hortensia Shortt
Chelsea Bruce
Jean Marc Lemarche, FHA
James Musgrave, Share
Bridgette Ebing, Share

Community Health Services Focus Group

Dr. Tracy Monk
Dr. Fahreen Dossa
Dr. Ashvin Punnyamurthi
Dr. Ida Gallo
Dr. Abhineet Garg
Dr. Kiet Do
Dr. Leanna Chen
Dr. Hoda Rezaei
Dr. Amir Danishwar
Nick Fitterer, NP
Jacqueline Lemiuex, NP
Scott Brolin, FHA
Wendy, Magnusson, FHA
Helen Chow, FHA
Maria Colocado, FHA
Tracey Demibras, FHA
Michelle Salazar, FHA
Shannon Ogilvie, FHA

Mental Health Focus Group

Dr. William Mak
Dr. Tracy Monk
Dr. Hoda Rezaei
Dr. Ashvin Punnyamurthi
Dr. Fahreen Dossa
Dr. Paula Flynn
Loredana Donciag, RN
Walid Chahine, FHA
Jeffrey Nikkel, FHA
Allison Luke, FHA
Sharon Sing, FHA

Shared Care Steering Committee

Dr. Jennifer Yun, Family Physician Lead
Dr. Miroslav Stavel, Specialist Lead
Dr. Ali Sanei-Moghaddam
Dr. Alyssa Hodgson
Dr. Angelo Wijeyesinghe
Dr. Aude Beauchamp
Dr. Carllin Man
Dr. Cathy Clelland
Dr. Dayna Mudie
Dr. Fify Soeyonggo
Dr. Huy Nguyen
Dr. John Yap
Dr. Joseph Ip
Dr. Kathy Kiani
Dr. Karen Shklanka
Dr. Michelle Goecke

Dr. Natasha Simula
Dr. Sanja Matic
Dr. Sara Houlihan
Dr. Samir Malhotra
Dr. Simon Woo
Dr. Stephanie Aung
Dr. Stephen Barron
Dr. Stephen Ogunremi
Dr. Wai Phan
Dr. William Mak
Dina Davidson, RMW
Jamie Carballo, DoBC

Maternity Shared Care

Dr. Dayna Mudie, Physician Lead
Dr. Natasha Simula, Specialist Lead
Dr. Aude Beauchamp, Specialist Lead
Dina Davidson, Registered Midwife Lead
Dr. Cathy Clelland
Dr. Grover Wong
Dr. Kathy Jones
Dr. Miroslav Stavel
Abby Mikkelson, RMW
Cheryl Britton, RN
Jessica Marcelino, RN in Practice
Lisa Valladares, MOA
Susan Foster, MCFD
Suzanne Wilson, MOA

Older Adult/Medically Complex Shared Care

Dr. Kathy Kiani, Physician Lead
Dr. Simon Woo, Specialist Lead
Dr. Belinda Rodis
Dr. Hem Phaterpekar
Dr. Liliana Cioata
Dr. Nishi Varshney
Dr. Peter O'Connor
Dr. Tracy Monk
Dr. Wendy Lin
Debbie Halyk
Susan Prosser
Helen Chow

Adult mental health and substance use Shared Care

Dr. Carllin Man, Physician Lead
Dr. Stephanie Aung, Physician Lead
Dr. Stephen Ogunremi, Specialist Lead
Dr. Angelo Wijeyesinghe, Specialist Lead
Dr. Asmaa Abdalla
Dr. Gina Zheng
Dr. Gunpreet Singh
Dr. Janel Casey
Dr. Nahla Fahmy
Dr. Steven Barron
Dr. Tracy Monk
Annie Liao
Chelsea Bruce
Debbie Halyk
Ruphina Muir
Veronica Freeman

chronic pain Shared Care

Dr. Huy Nguyen, Physician Lead
Dr. Alyssa Hodgson, Specialist Lead
Dr. Janel Casey
Dr John Koehn
Dr. Lalji Halai
Dr. Martha Koehn
Dr. Ramak Shadmani
Dr. Stephen Barron
Dr. Tracy Monk
Brenda Poulton, NP
Wendy Magnusson, FHA
Debbie Halyk, Patient Partner

acute discharge Shared Care

Dr. Jennifer Yun, Physician Lead
Dr. Joseph Ip, Specialist Lead
Dr. Jerusha Millar, Specialist Lead
Dr. Ali Abdalvand
Dr. Ameila Nuhn
Dr. Carllin Man
Dr. Cori Gabana
Dr. Jon Braunstein
Dr. Meghan Ho
Dr. Nimeera Kassam
Dr. Leanna Chen
Vesna Ivkov

Palliative shared care

Dr. Ali Sanei-Moghaddam, Physician Lead
Dr. Wai Phan, Palliative Physician Lead
Dr. Fify Soeyonggo, Palliative Physician Lead
Dr. Joan Eddy, Palliative Physician Lead
Dr. Elizabeth Wu, Palliative Physician Lead
Dr. Cindy Roper
Dr. Mina Perez Flores
Dr. Tracy Monk
Bella Wang
Joanne Hum
Shelley Briggs

geriatric psychiatry shared care

Dr. Carllin Man, Physician Lead
Dr. Simon Woo, Specialist Lead
Dr. Ashvin Punnyamurthi
Dr. Fahreen Dossa
Dr. Hortensia Shortt
Dr. Ian Woods
Dr. Kathy Kiani
Dr. Mahsa Mackie
Dr. Ramak Shadmani
Dr. Sue Rajabali
Dr. Tracy Monk
Annie Liao
Debbie Halyk

women's health shared care

Dr. Sanja Matic, Physician Lead
Dr. Sara Houlihan, Specialist Lead
Dr. Doug Waterman
Dr. Kathy Jones
Dr. Stephanie Aung
Dr. Leanna Chen
Dr. Hortensia Shortt
Dr. Nimeera Kassam
Dr. Shilpa Dabholkar
Dr. Namrata Jhamb
Dr. Cathy Clelland
Dr. Tracy Monk
Dr. Dorrit Klarke
Dr. Teresa Tan
Annie Liao, NP
Ruphina Muir, NP
Chelsea Bruce, NP
Fiona Chu, RN in Practice

Cancer Care

Dr. Cathy Clelland, Physician Lead
Dr. Michelle Goecke, Specialist Lead
Dr. Fahreen Dossa
Dr. Jennifer Dolden
Dr. Jennifer Yun
Dr. Stephanie Aung
Dr. Reza Algehnbanan
Johnnie Kuo, Patient Partner
Laurier Nobert, FHA
Lucy Shorthouse. FHA
Scott Brolin, FHA
Wendy Magnusson, FHA
Alanna Haberstock, FHA
Helen Chow, FHA

Pulmonary Rehab

Dr. John Yap, Physician Lead
Dr. Randy Chung, Specialist Lead
Dr. Samir Malhotra

Alcohol Use Disorder

Dr. William Mak, Family Physician and Addiction Medicine Lead
Dr. Karen Shklanka, Addiction Medicine Lead
Dr. Ameila Nuhn
Dr. Fahreen Dossa
Dr. Gregory Cohen
Dr. Hoda Rezaei
Dr. Leanna Chen
Dr. Nancy Liu
Dr. Nimeera Kassam
Dr. Tracy Monk
Sukhwant Jassar

Communications committee

Dr. Herb Chang
Dr. John De Couto
Dr. Kathy Jones
Dr. William Mak
Dr. Paras Mehta

Recruitment, retention and retirement committee

Dr. Gary Hayes, Physician Lead
Dr. Cindy Ding
Dr. Perveen Gill
Dr. Amir Danishwar

Dr. Ashvin Punnyamurthi
Dr. Ravi Parhar
Dr. Kendra Strong
Dr. Vincent Wong
Dr. William Mak

Deep Vein Thrombosis Shared Care

Dr. Jennifer Yun, Physician Lead
Dr. Jon Braunstein, Specialist Lead
Dr. Kenneth Wong

Dermatology Shared Care

Dr. Ali Sanei-Moghaddam
Dr. Masha Mackie, Physician Lead
Dr. Leanna Chen
Dr. Aaron Wong, Specialist Lead
Dr. Derek To
Dr. Sabrina Nurmohamed
Dr. Simon Wong
Dr. Gordon Jung
Dr. Ali Abdalvand

Attention-Deficit/Hyperactivity Disorder Shared Care

Dr. Amber Jarvie, Family Physician Lead
Dr. Varinder Parmar, Specialist Lead
Dr. Kathy Kiani
Dr. Janel Casey
Walid Chahine, FHA

Dizzy/vertigo ENT

Dr. Ravi Parhar, Physician Lead
Dr. Margaret Aron, Specialist Lead

Opioid Prescribing

Dr. Stephan Barron, Physician Lead
Dr. Alyssa Hodgson, Specialist Lead
Dr. John Koehn
Dr. Janel Casey
Brenda Poulton, NP
James Musgrave, SHARE
Matt Smith, FHA

Contact Us

CONTACT INFORMATION

Fraser Northwest Division of Family Practice
407-625 Fifth Avenue
New Westminster, BC
Website: https://www.divisionsbc.ca/fraser-northwest

Divisions of Family Practice
An FPSC initiative

The Divisions of Family Practice Initiative is sponsored by the FamilyPractice Services Committee, a joint committee of the BC Ministry of Health and Doctors of BC.