Divisions of Family Practice
A GPSC initiative

Fraser Northwest Division

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Our Vision

Vision

Fraser Northwest Division of Family Practice strives to be a leader in supporting a healthy a 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. **Establishing a network for collaboration between Family Physicians and other healthcare partners and community stakeholders.**
5. **Providing a voice for our Family Physicians through grassroots engagement, dialogue, idea gathering, and participation.**
6. **Engagement with our patients to understand their expectations and needs.**

Values

- **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-Chair's Message

Dr. Stephanie Aung
Co-Chair

Dr. Jennifer Yun
Co-Chair

Hello friends,

It has been an incredible 10-year journey for the Fraser Northwest Division of Family Practice.

It is humbling to review all the accomplishments of the Division, driven by amazing family doctors who saw opportunities to improve Family Medicine by being partners in system improvement to support high quality, longitudinal, relationship-based primary care that is the foundation of our Canadian health care system.

The past fiscal year saw us in a perfect situation to support the needs of our members in dealing with the COVID-19 pandemic. We were in a unique position with our Primary Care Network funding to pivot our focus to acute needs. This allowed us to help shift most clinical work to virtual settings, create the Respiratory Assessment Clinic, provide access to PPE, run the first Mass Influenza Vaccination clinic, the New Mom and Well Baby Clinic, the Acute Care Discharge Clinic, and facilitate the opening of the U&PCC. All this and more was accomplished through the hard work of our division staff and by all of you, our members. Our members and specialists have ongoing engagement through many of the Shared Care Initiatives, the Ask the Expert series, and robust Long Term Care Initiative (LTCI) participation.

In looking forward to the next 10 years, despite all the successes and system changes that have occurred in the last 10 years, we still have a lot of work to do.

We need to continue the work of Primary Care Renewal - to create a community that new physicians want to work in and support our members in operating their Patient Medical Homes. We need to ensure the engagement of other focused practice family doctors, like hospitalists, palliative physicians, emergency physicians and many others. We need you to guide us on the Board. Let your voices be heard through the Division to improve your work in caring for your patients with our partners at FHA, GPSC, Doctors of BC, and the Ministry of Health.

Drs. Stephanie Aung & Jennifer Yun

Executive Director's Message

Kristan Ash
Executive Director

As I sit down to write this message, there are so many experiences from our 2020/2021 year that have left me speechless and humbled by our members and your dedication to serve this community and your patients. THANK YOU!

This year did not allow us to publicly celebrate the 10 years of contributions and change that the family doctors in FNW have initiated, supported and engaged in as we had originally hoped. Thanks to the physician leadership legacy in FNW, there is a culture of continuous improvement with dedication to improving the health system for patients … this pandemic has just allowed you all to really show off how important you are!

I look forward to another year serving you and I will take the opportunity to encourage you to please provide us the honour of hearing "what frustrates you in your daily work" so that we can try to make your day just a little better as you do for so many people.

Kristan Ash
Executive Director

Treasurer's Report

Dr. Vincent Wong
Treasurer

Dear Members,

It is with great pleasure that I write to you for the first time as the Board Treasurer after serving on the Board of Directors and Finance & Governance Committee for the past 2 years. This past year, as we all know, has seen many challenges with the COVID-19 pandemic. Our Division continues to focus on continuous improvement and member support, and in the past year we have seen programs and supports extended in response to the pandemic; for example, supporting the COVID-19/Respiratory-Like Illness Assessment Clinic and mass influenza vaccinations. This was made possible through our ongoing fiscal prudence and responsibility, alongside our dedicated and talented colleagues and staff.

This past year we have also seen the addition of several board members into our Finance & Governance Committee, as well as updated several key policies and procedures for the Division. I anticipate that the strength of our Committee and our fiscal prudence will continue to provide a financial foundation that will serve us through challenges that lay ahead.

Dr. Vincent Wong

FRASER NORTHWEST DIVISION

10 YEAR TIMELINE

2010

Fraser Northwest Division of Family Practice was incorporated

2011

- Pathways working group was established and first meeting was held
- First member engagement was held – 90 physicians attended
- First collaborative services committee (CSC) meeting was held
- Second member engagement event was held
- First CME "Dine & Learn was held with Paul Sobey as the speaker
- Shared care project proposal was accepted

2012

- Third meeting engagement event was held
- Kick-off meeting for potential discharge planning project was held
- Member initiated projects program and funding was established
- FNWD first AGM was held
- Shared care projects got underway
- Pathways launched

2013

- A member engagement event was held where attendees had the opportunity to share their views on a number of topics
- EMR survey was conducted to obtain accurate stats on EMR usage across the region
- One of the new RCH break rooms was used for the first time
- Our latest newsletter "Getting the most from pathways" was launched
- Membership reached 185 including the first Division resident
- GP notification system of patient admission to Eagle Ridge Hospital launched
- FNW's 2nd annual general meeting held
- Recruitment exhibit at the BC Family Medicine Conference
- First Trials held for GP notification of admission at RCH
- A GP for Me work gets underway
- Recruitment exhibit at family medicine Forum

2014

- Recruitment and retention committee strategic plan
- GPSC authorizes pathways expansion
- 210 FNW members reached

2015

- The shared care committee ran a successful ACP fair on April 11, 2015. This spurred the City of New West to declare the first ever "Advanced care planning" Day.
- The Tri-cities Rapid access to Psychiatry clinic (RAC) was launched in June to complement the New Westminster (RAC)
- Enhance Recovery after surgery(ERAS)Shared care funding was received to develop protocols and info to help GP'S improve patients preoperative fitness and post-op outcomes for colorectal surgery. Launch planned for fall 2016.
- Pathways -expanded across the province. It is now attracting attention throughout the whole country. GPSC and other divisions are providing dollars for the upkeep of the program which is freeing up FNW division dollars for other projects.

2016

New West Family Practice opened in Royal City Mall, New West B.C. This marked the completion of a two year project titled "Proto-Clinic"

A Identifying a substitute decision maker (SDM) fair was held at RCH attended by 260 physicians and staff. An SDM identification form was then made available in the hospital meditech system for providers to chart with.

2 new residential care facilities were opened and established in medical homes for each, a successful 24 on call schedule was created to allow 2 mrps to be on call after hours for all residential care.

Working together with GPSC, and the Fraser health authority, initiatives will be implemented to improve quality of care and access to appropriate services for the most vulnerable patients in the community.

Nurse Debbie began as an initiative under a GP for me in 2015. Nurse Debbie Shields acted as a physician extender who treated frail patients who need urgent and routine care.

FNW Attachment Hub was created. Fnw Division began operating an attachment hub for high needs patients.

2017

On February 22nd, the use your ER wisely campaign was launched in the Fraser Northwest. Approximately 40 attendees came to the kick-off event.

2018

This year the Division implemented a chronic pain working group to combat chronic pain and opioid misuse.

The division established a mental health working group to repsond to issues around mental health and substance abuse services in the community.

Complex Care planning- Inspired by the success of North Shore Division's approach to EMR optimization and practice efficiency for physicians with complex patients, FNW Division, along with PSP, developed the Complex Care Planning initiative.

In March 2018, a social worker was added to the primary care services team .They were made available to all GPs in the FNW Division.

May 3, 2018 the "First 5 years-Pearls of Wisdom" event was held.

MOA recruitment list launched

In October the FNW PCn Service plan was submitted to the MoH.

In November the First 5 years in practice event was held

In late 2018, the division continued to take steps forward by implementing strategies working alongside community partners to address concerns

2019

- The "Community Showcase" event was held in February that showcased new opportunities in the FNW region.
- Initial funding for the FNW PCN began
- The co-development of the Registered Nurse in Practice program began with consultation between community Physicians and the FHA
- With an Attachment Hub Coordinator, the FNW Attachment Hub saw a 730% increase in attachments compared to the previous year
- IT position identified and hired in summer 2019
- In July 2019, the first PCN funded Nurse Practitioner contract was signed

2020

- The first PCN funded family physician contract was signed
- COVID-19 assessment clinic was launched, there were over 100 physicians and nurse practitioners who responded to the request to be involved in the assessment clinic
- Total of 157 Instagram followers, 145 Twitter followers, 118 Facebook page likes and 48 LinkedIn followers
- PMH Clinic websites launched - by March 2020, 13 websites had been fully launched
- Community Flu vaccination clinics held for the public in New Westminster, Port Moody, Port Coquitlam

Patient and Community-Focused Initiatives

Primary Care Network

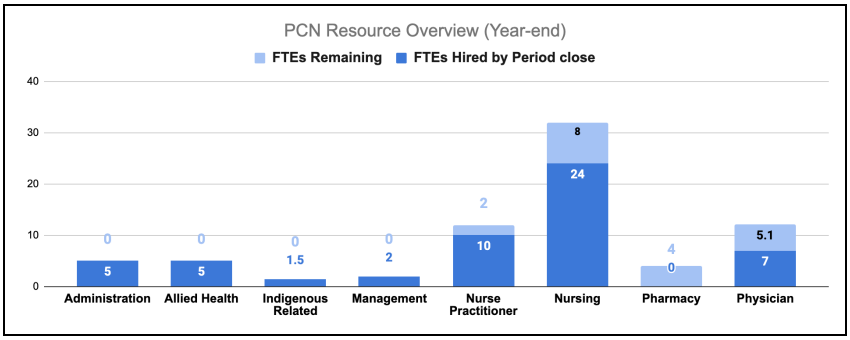
Aim

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 second year of the FNW PCN funding began with immediate redirection of attention towards the community Covid-19 response. That being said, resource utilization over the last year increased significantly with the addition of contracted Family Physicians (FP), Nurse Practitioners (NP), Registered Nurses (RN), and Indigenous Supports. The graph below reflects the successful recruitment of a number of Primary Care Providers (PCPs):



In the first few months of 2021, the FNW community has seen an increase in the number of primary care providers joining the community compared to those leaving (i.e. retiring, moving, changing practice style) which is the first positive offset in 2 years:

	2019	2020	2021
Provider Adds	10	15	6
Provider Losses	15	13	2
Net Loss/Gain	-5	+2	+4

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 the previous year, 14 of the funded 32 RNs were hired into PMHs across the region. Since then, an additional 5 have been hired and placed in PMHs or

supporting relief coverage. Hiring is ongoing for the remaining positions.

Analysis of absentee rates took place in partnership with the Health Authority (HA) and it was identified that RNs in this program on average have an absentee rate of 3.82%, which is below the Fraser Health (FHA) average of 6.34%. This links to anecdotal feedback collected around the value and importance of being a part of a team in a PMH.

Family Physicians have shared experience around having RNs supporting their practice.

IMPACT EXPERIENCE

One Physician indicated that when the RN began doing influenza vaccination clinics in the practice, this reduced pressure and ultimately burnout for Physicians. This Physician shared that they "*didn't realize we were burning out until someone else took the burden off us*."

That being said, the same Physician shared the pressures and fear of having another provider providing these to their patients. This Physician felt that it was their obligation as they were patients' Family Doctor and it is their job to take care of them fully. Ultimately, this Physician identified that they were *"doing more disservice to my patients by spreading myself too thin - when I let this go, I found that I was a better doctor, and could spend more time with patients instead of worrying about the flu shot."*

The biggest aha moment for this Physician when recognizing the contributions of the RN and extension of the Physician's work was when *"I realized that there is someone else that can help me, and report back to me and have that shared care [for my patients]. Seeing happiness from patients afterwards and that they felt they were being well taken care of. Patients [have] said 'I really appreciated the nurse'... I felt like it was an extension of the way we practice and that it was good care - and it didn't have to come from me...I realized that I can release control and there can still be good care for my patients."*

IMPACT EXPERIENCE

Another Family Physician who shared their experience spoke around the impacts of the RN on providing childhood immunizations and - more recently - well-baby checks. Since joining the practice, one of the goals for the RN was to incorporate them into administering the childhood vaccines. "*This role developed from just vaccine administration to a more comprehensive visit: the RN will go in and meet with the family first, answer any questions about nutrition and growth, provide education and reviews all of the developmental milestones. The RN then reviews this with the Physician and the Physician will go in and complete the remainder of the check with the families...This has been a huge value add to the patients as patients feel like they have ample time to ask questions, get education, and the patient leaves feeling more satisfied with their visit."*

IMPACT EXPERIENCE

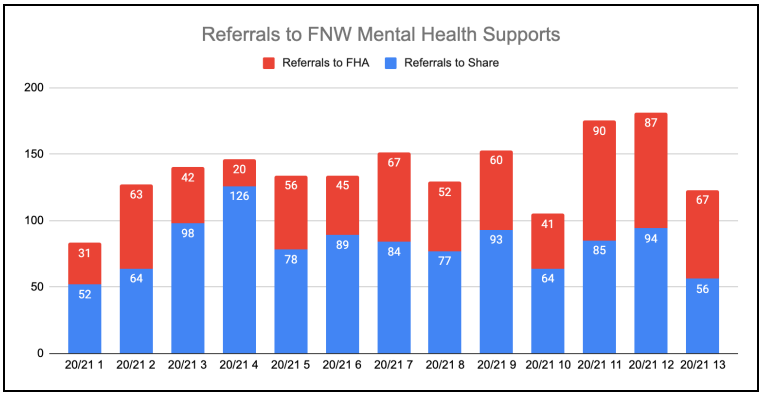
Two other Family Physicians indicated the opportunities for improvement for this program and the importance of identifying an RN who fits with the clinic and who feels the clinic fits with them. Incorporating a probationary period for both parties allows for relationships to build and support efficiency within the PMH so as to allow for increased access for patients and providers. The change of pace in a clinic environment may also be new to RNs and so ensuring they have the time and support to incorporate and adjust to the new environment is key to a successful match.

One Physician indicated that they have had a few experiences with different RNs and reinforced how important 'fit' is to both the FP and the RN within the PMH. Having an RN who is familiar with the system provides an advantage for primary care providers as they may know how to navigate the larger health system to benefit both the primary care providers and their patients.

IMPACT EXPERIENCE

Another Family Physician Lead at a practice shared a note of appreciation around their RN. "*We have a complicated patient who is going for surgery and we were all confused about their meds and what to start/stop, especially being as they have been in and out of hospital a few times recently (which happened after her pre-op optimization consult). With limited time, the RN made a number of calls and connects to ensure that the surgeon and the anesthetist were up to date on the patients new meds, and got them to make a new plan for what to do. This patient has waited 2 years for the surgery and was really scared she would have to postpone or cancel the surgery due to the new meds, and because of the RNs work the surgery is a go!"*

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. With the pandemic, both teams rapidly adjusted to a virtual environment to ensure seamless coverage and access to care for community members in the FNW.



Indigenous Supports: As one of the partner organizations in the FNW PCN, Kwikwetlem First Nation has worked to identify the resources needed in their community. These resources support increased attachment and access to primary care services for the Nation, as well as surrounding urban and away from home Indigenous populations.

The Kwikwetlem Primary Care Clinic opened October 2020 for community members and is staffed by two FNW FPs, an MOA, an NP, an RN, an Elder Home Support Worker and an Aboriginal Wellness Advisor. Members of the nation are able to access primary care services.

Feedback from the community identified "*love[ing] the two new doctors and the elders are incredibly happy with the elder support person. They are seeking an increase in elder support due to increasing needs in the community.*" The doctors and community leaders have identified interest in having the doctors move towards doing outreach in the community.

Urgent & Primary Care Centre

In February 2021, the Tri-Cities Urgent and Primary Care Centre (U&PCC) opened its temporary location at Eagle Ridge Hospital (ERH). The U&PCC is meant to provide primary care access to patients in the community who are unattached or attached and potentially seeking care outside of regular clinic office hours. The U&PCC currently operates from 1pm-8pm, 7 days a week. The U&PCC has capability to support both in-person and virtual appointments and unattached patients can become attached to the clinic itself as opposed to a specific primary care provider.

	February	March
# of in-person visits	25	41
# of virtual visits	24	197
Avg visits/day	3	8.5
% of visits by unattached patients	68%	81.5%
# of new attachments	1	3

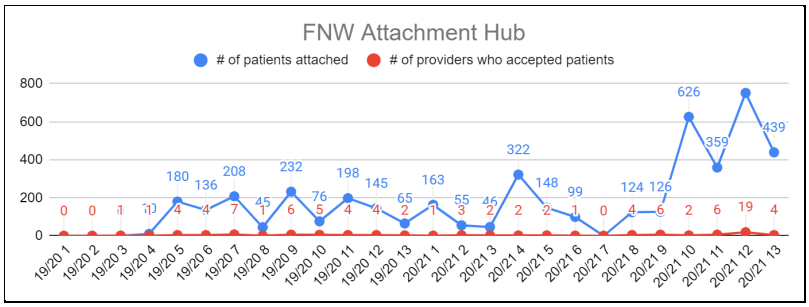
Attachment

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 Coordinator 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 4342 attachments recorded by the end of March 2021.



Active Attachment

In addition to the FNW Attachment Hub, a number of additional mechanisms for access to a primary care provider that wasn't dependent on attachment emerged. In an effort to enable access to primary care despite the effects that the pandemic has had, primary care providers came together to create two supplementary clinics:

1. Acute Care Discharge Clinic: A pathway for those recently discharged from acute care who require follow up by a primary care provider in the community that a) may not currently have access to a primary care provider or b) the provider is unable to follow up with the patient. This clinic emerged through partnerships between community primary care providers and acute care providers.

2. New Mom & Well Baby Clinic: Unattached moms and babies who were seeking prenatal and postnatal care in the FNW communities were directly linked and supported with a local PMH in Port Coquitlam to support them in this process. As the effects of the pandemic forced many PMHs to go virtual, the need and importance for physical assessments of moms and babies were now supported at this local clinic. This short-term service closed at the end of March 2021; however, priority attachment was facilitated for all patients seeking attachment to a primary care provider in the community.

Unattached moms and babies seeking prenatal and postnatal care at the FNW New Mom/Well Baby Clinic (stationed at a local clinic in Port Coquitlam) are now directly linked with the Attachment Hub and upon discharge from this clinic are connected with a Family Physician in the community.

PCN physician lead

Dr. Paras Mehta

U&PCC physician lead

Dr. Nimera Kassam

Long Term Care Initiative

AIM

To improve upon the 5 best practices of care for seniors in long term care (medication reviews, completed documentation, after hours call, care conferences and proactive visits).

The FNW Long Term Care Initiative's (LTCI) last evaluation revealed that the program contributed to having impacts across four areas: improved patient care, improved physician practice environments, improved facility practice environments and healthcare utilization by residents and subsequent decreased health care system costs.

The LCTI's 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.

Year in Review

The FNW LTCI continues to be a stable program for the Division. The fourth evaluation report of this program was completed in the summer of 2020 (reporting April 1, 2019 - March 31, 2020) and ED Visits, admissions and bed days continued to decrease with a slight increase in length of stay over that reporting period.

With the impacts felt by the Covid-19 pandemic, prompt action took place with regards to moving to a virtual environment for LTC practitioners and patients at care homes. Virtual health was made readily available to all sites as tablets were distributed and a website was created to become a long-term care hub. All practitioners were able to obtain virtual health platforms to connect with their medical teams. Practitioners continued to work alongside Medical Care teams, FHA, the Division, and their colleagues to provide access to care for residents.

As this was a high risk population, vaccination efforts were directed to residents immediately upon becoming available for distribution across care homes. By January, most Physicians and office staff had the opportunity to receive the first dose of the Covid-19 vaccine, which indicated on-site visits and assessments started to become more available.

Continuing Medical Education & Events

- April 2020: Covid-19 Overview
- June 2020: BC Coroner Services
- October 6: Traumatic Brain Injury
- January 14: Palliative Approach to Care
- March 18: Roundtable Discussion of Procedures

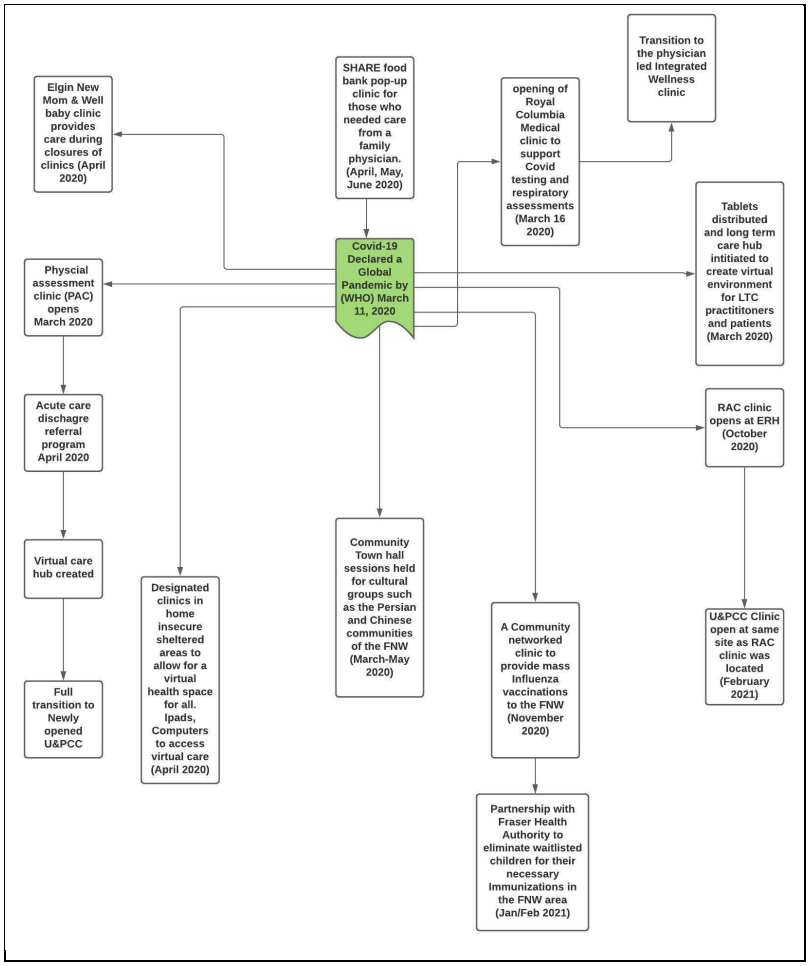
Physician Leads

Dr. Amber Jarvie
New Dr. Lalji Halai, as of September 2020
Dr. Nick Petropolis, ended as of August 2020.
Thank you for your continued support and leadership and we look forward to continuing to work alongside you in your new role.

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. Below is a visual reflection of the FNW communities response to the Covid-19 pandemic.



Patient/Public Partnership

Over the last year, there has been a significant growth in patient and community member engagement in order to ensure continued access to healthcare services throughout the pandemic.

Patient partners have joined the PCN Steering Committee, a number of Shared Care Working groups, and Community Health Focus 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:

- Attachment to a Primary Care Provider
- Maternity and new mom and well baby care
- Covid-19 impacts
- Influenza Vaccination experience
- Childhood Immunizations

Public partnership in service delivery also expanded this last year with a strengthening of relationships with local municipalities, volunteer organizations, and academic institutions. This coordinated effort to provide access reflects the strong focus on healthcare that's apartment across the communities.

Covid-19 Community Response

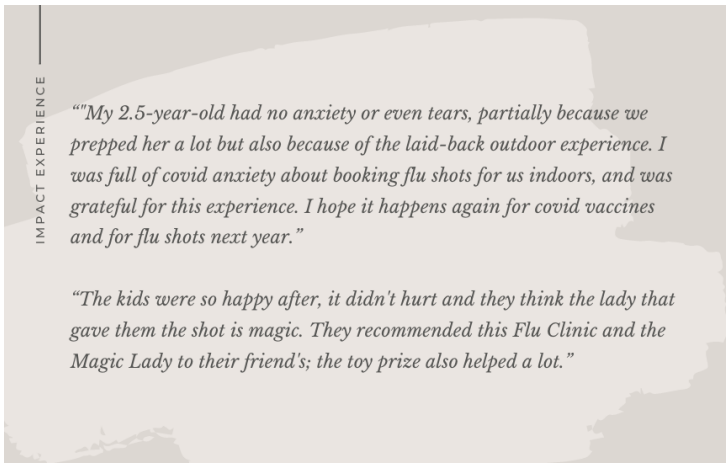
Although the impacts of Covid-19 continue to be felt in many ways, when the pandemic first began there was an instantaneous outpouring of support from community Primary Care Providers, willing to help the communities. Royal Columbia Medical Clinic volunteered their site to support in this community response to support both Covid-19 testing and respiratory assessments to the FNW population. Funding for this clinic concluded in June and subsequently a physician-led clinic opened in the Tri-Cities to continue to support access for people in the community. Physicians supporting this clinic did so in addition to their own practice.

In October 2020, FHA opened a drive through testing site in Coquitlam to support the widespread access to Covid-19 testing. A dedicated Respiratory Assessment Clinic also opened in what is now the U&PCC site at ERH.

Throughout the summer months, there were a number of community outreach townhalls whereby members of the Tri-Cities Chinese Community Society and the Tri-Cities Iranian Cultural Society were invited to learn about the community response as well as have an opportunity to ask questions. These events were supported by interpreters so as to ensure access to the information available. Additional community response was targeted towards the vulnerable and home insecure population in the FNW. A designated clinic area in each of the shelters provided a virtual health space for residents to access a Family Physician virtually. Equipment was donated to assist shelters that needed a computer to ensure residents' access.

Community Clinics

Influenza Vaccination Clinics: FNW members requested that the Division consider a plan for a community networked approach to support mass community influenza vaccinations efforts in Fall 2020 due to the Covid-19 concerns, restrictions and guidelines.
These community clinics ran in November 2020 with strong support and partnership from local Family Physicians, Nurse Practitioners, MOAs, RNs, Pharmacists, HA teams including public health, primary care and home health, municipal governments, local NGOs, volunteer organizations and community members.
These clinics provided immunizations to approximately 6000 residents of the FNW communities ranging in ages from 6 months old to the senior population. Strong community marketing and engagement plans supported distribution of information across communities. Additionally, specific clinics were targeted at vulnerable populations to ensure access to immunizations for those who would like them.
The Division heard from the FNW members that ensuring the availability of influenza vaccines for children was imperative for this community, as the traditional routes of immunization were limited due to resource reallocation to support the COVID-19 community response. Feedback from over 1500 parents, caregivers and family members was positive and highlighted the patient-centred care that was received at these clinics:



Feedback from patients was underwhelming in comparison to what was obtained from the Influenza clinics. Physical handout cards with the survey link were disseminated at these clinics which resulted in a low response rate. A major contributor to the success of survey interactions in the past was access to patient email addresses which supported subsequent electronic survey distribution.

A key theme that brought everyone together was providing accessible, patient-centred care - this is a pivotal foundation to any partnership(s) stepping into this journey of providing community immunization clinics.

Childhood Immunization Clinics: Building off of the success of the Influenza vaccination clinics, an opportunity emerged to partner again with FHA public health teams to provide access for parents and their children to receive necessary immunizations. FHA indicated that there were patients waiting or behind on their childhood immunizations in New Westminster; this number didn't include the patients that were rescheduled for future dated clinics in Tri-Cities or anecdotal feedback from community providers and concerned parents and caregivers. Based on the community partnerships established previously, the City of Port Coquitlam and New Westminster provided spaces and necessary equipment to support these clinics.

Influenza Response physician lead

Dr. Kathleen Ross

Virtual Hub - PAC

The FNW Virtual Care hub was established as an expansion of the Acute Discharge Program which supported an integrated system of care through linkages with Royal Columbian and Eagle Ridge Hospitals, The FNW Attachment Hub and additional PCN services. Access was available to patients with or without a longitudinal provider through self referral or upon discharge from hospital for virtual appointments and follow-up physical assessments. The program's objectives were to

1. Reduce incidence of hospital readmission and ER visits for patients by:
2. To facilitate attachment to continuous primary care for patients without a longitudinal provider
3. To provide access to a virtual care platform for patients seeking after hours care

IMPACT EXPERIENCE

An experience was shared by FHA Community Health Nurses (CHNs) whereby they had been supporting multiple homebound patients whose FP has had to retire on short notice. These patients required timely follow up due to their health status. The CHN was immediately connected with the FNW Virtual Care Hub whereby these patients were able to be seen within the week. The CHN shared this sentiment after connecting with the Virtual Care Hub MOAs to set up appointments "*this was/is very helpful, thank you for getting this information into my hands. I have spoken with [the MOA] this morning at your office and [they were] kind enough to talk over the process for my clients in an effort to make things as easy as possible for them. [They] took all the client information from me on the phone to set up their accounts so that the clients may focus on their scheduling of an appointment and their care moving forward. [The MOA] was fantastic and very helpful! I have now notified both clients that they are to call and book a phone appointment and it is my hope that they will do this as soon as possible as [the MOA] had mentioned that there was some availability this week. Thank you all for your help and guidance here. Hopefully we can make a positive impact on the health of these two clients.*"

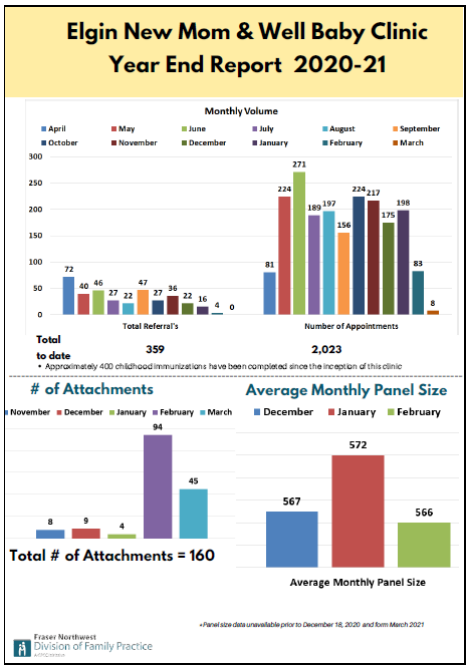
In March 2020, the work of the Virtual Hub transitioned to be under the newly opened U&PCC whereby referrals previously directed to the Virtual Hub are forwarded. Strong collaborative work between the Division, FHA and Physicians at Royal Columbian Hospital (RCH) and Eagle Ridge Hospital (ERH) supported this seamless transition of care for patients recently discharged from the hospital and requiring follow-up.

Elgin New Mom & Well-Baby Clinic

With the impact of the pandemic, access to PMHs, walk-in clinics and other essential primary care services for new moms and babies were significantly reduced for in-person visits. This concern was raised by community physicians identifying a need to support this patient population during the pandemic.

In April 2020, a Newborn and Well-Baby Clinic was set up at Elgin Medical Centre. Physicians working at this clinic were able to provide follow-up care to unattached new moms/babies from discharge to 18 months with the goal of attaching these moms/babies as a priority population with the FNW Attachment Hub. Key partners in the running of this clinic included Elgin Medical Centre Family Physicians, FNW PMHs, FHA Primary Care, FHA Public Health, OBGYNs, local Midwives and the midwifery clinic.

This clinic received over 300 referrals with the first month receiving the highest demand. The clinic closed at the end of March 2020 after facilitating attachment for all new moms and babies to primary care providers across the FNW. Approximately 200 dyads have been attached to primary care providers across the FNW communities.



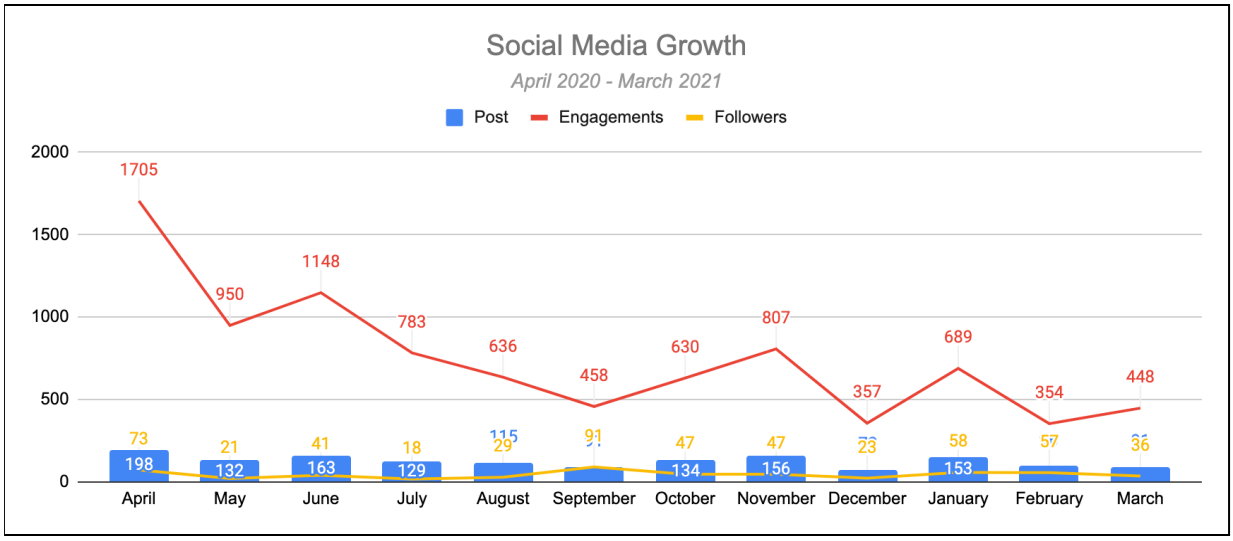
Communications

With the introduction and dedicated focus on more public and community focused communications, the FNW Division saw a significant increase in public engagement. Building on the feedback invited from the public on the FNW Division Landing page, resources were launched through dedicated social media strategies.

Each quarter, a newsletter is distributed to patients in the communities who have signed up to receive newsletters from the Division. When this resource launched in May 2020, there were a total of 170 subscribers, whereas in January the subscribers grew by approximately 1800% to a month end total of 3285 subscribers. This resource continues to connect patients in the community with available health services and supports and recently feedback mechanisms have been incorporated to allow for two-way information sharing between the Division and newsletter subscribers.

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 successfully launched to the public and enables access to resources and supports for the public. The Medical Care Directory was created as 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-Focused Initiatives

PMH Sustainability Program

Overview

Over the last year this program has adapted and shifted to respond to the changing needs of primary care providers working in team-based settings. There continued to be a focus on upskilling of Physicians, Nurse Practitioners, RNs and practice staff working in a PMH setting and in-practice supports for these team members. Navigating how to support PMH's within an expanding virtual care setting was supported by the development and implementation of virtual supports such as creating clinic websites, utilizing existing websites, implementing online booking procedures, and implementing telehealth technologies to facilitate access between patients and providers for ongoing care needs.

In-practice supports

In-practice support pivoted over this last year with the move to a virtual environment and decreased ability to provide in-person supports. Support around practice efficiency, HR and staffing as well as the upskilling of practice staff continued despite having to shift into a virtual format. Medical Practice Efficiency Assessments did take place in the late summer months when access to PPE was more readily available and physician distancing measures were enabled.

Centralized MOA Recruitment Database

The utilization of the community MOA (Medical Office Assistant) recruitment database allows primary care providers to search a list of interviewed and reference checked MOA candidates for hiring into their practice for both temporary and/or permanent positions. This database has continued to be utilized since its inception in 2019 and the list is reviewed and updated on a monthly basis. Wage expectations, EMR (Electronic Medical Record) skills and experience, workplace placement preference and preferred geographic areas are a number of elements that are shared on the centralized recruitment list. This backend process continues to enable the hiring process to be simpler and streamlined for practitioners.

The table below reflects the large number of applicants received compared to the ultimate numbers that are placed on the database. Recognizing the variation in the numbers reflects the diversity of candidate experience and skill and the value of having a centralized team to facilitate and manage this process which ultimately unloads this work from the practitioners themselves.

	FY 19/20	FY 20/21	Change
# of applicants	642	727	↑
Interviews Schedules	85	72	↓
Reference Checks	34	23	↓
Added to	31	22	↓

Database			

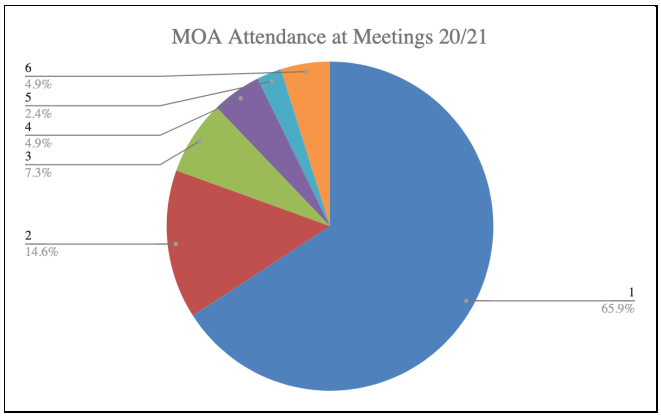
Upskilling Practice Staff

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. EMR User Group sessions were on hold for the first half of this reporting period and collaborative work with the Practice Support Program (PSP) took place to transition the facilitation of these events to PSP.

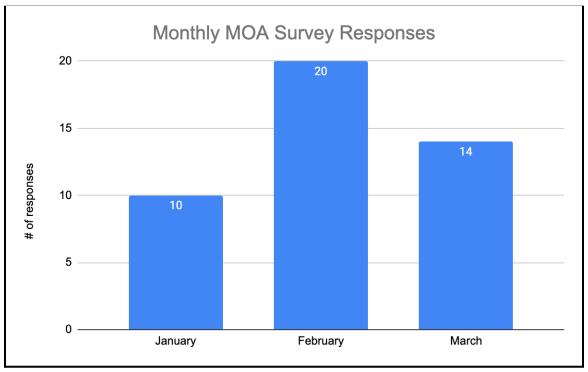
Throughout the pandemic, monthly MOA events and bimonthly Practice Manager events continued to take place with topic areas focusing on:

- April: Scheduling (*MOA*)
- May: Team Dynamics in a Virtual Setting (*MOA*)
- June: Advanced Privacy & Security (*MOA*)
- July: HR & the New Office Environment (*Practice Managers)*
- July: The New Normal and Preparing for Another Wave (*MOA)*
- August: Addictions, Resources and Patient Experience (*MOA*)
- September: Worksafe Occupational Health & Safety (OH&S) in the New Environment (*Practice Managers*)
- September: Concussions, symptoms and telephone protocols (*MOA*)
- October: Elder Abuse (*MOA*)
- November: Medical Practice Manager Meeting (*Practice Managers*)
- November: Practice Efficiencies, sharing tips & tricks (*MOA*)
- December: Referrals & Pathways (*MOA*)

In total, there were 41 MOAs and Practice Managers who attended one or more events in the last year.



In January 2021, engagement of practice staff shifted to introduce feedback mechanisms to ensure real-time feedback and information sharing. Monthly surveys on what is needed in the community to support continued, and increased access to primary care services have been distributed to this network on a monthly basis. More recently, an MOA Advisory Committee has been established to inform and guide present and future engagement work with FNW practice staff.



IT Practice Support

The Division continues to offer in-practice and virtual IT support with the program's key responsibilities to "*assist practices in maximizing use of available information technology resources in order to accomplish improved patient outcomes and increased office efficiency*".

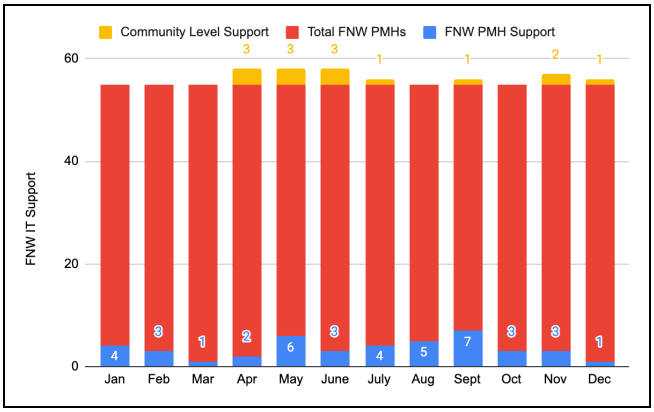
In March/April 2020, with the start of the Covid-19 pandemic, the FNW Division rapidly adapted to support members' pandemic response needs in addition to the ongoing programs and work so this role's portfolio shifted to ensuring support of members in a new virtual environment. Based on the 2020 summary of the work that took place by this program, there was a total of 16 FNW PMH's that were engaged with or were supported with IT related activities ranging from:

- Software and hardware support, consultation, installation;
- Virtual telehealth support for PMHs moving towards virtual care;
- Privacy assessment reviews and implementation of the DTO workbook at each PMH;
- Printer cost assessments and solution recommendations; and
- Phone and internet provider assessment and solution recommendations.

Additional community level support was provided throughout the FNW communities and this included relating to the pandemic response:

- FNW Covid-19 and Influenza Like Illness Assessment Clinic;
- Long Term Care Home Covid-19 virtual telehealth support and devices to support implementation;
- FNW Virtual Hub support for unattached patients and those recently discharged from acute care requiring follow up from Physicians;
- Fall Influenza Community Clinic support; and
- Shelter Housing Covid-19 virtual telehealth support and set up of donated devices to support implementation.

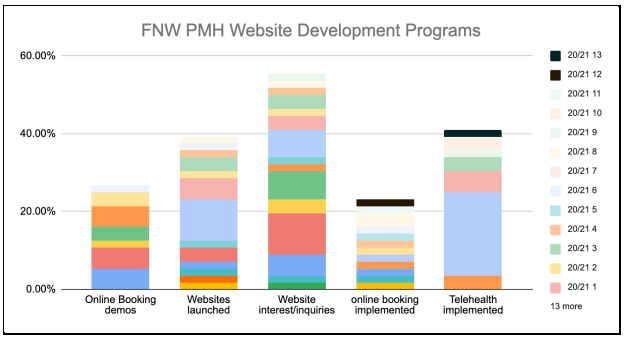
A month over month overview of the number of PMHs supported as well as the number of community level support provided by this role is detailed in the graph below.



FP Virtual Presence

Additional engagement support related to members is the website development supported by the Division. At the end of March 2021, this program has supported almost 40% of FNW PMHs to launch a clinic website. Similarly, almost 40% of PMHs have utilized this service to incorporate telehealth into their practices. The graph below reflects the breakdown of the following services since 2019:

- Online Booking demos completed
- Websites launched
- Website interest
- Online booking implementation
- Telehealth implementation

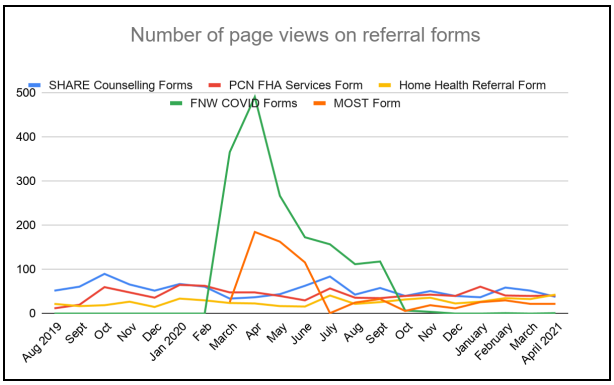


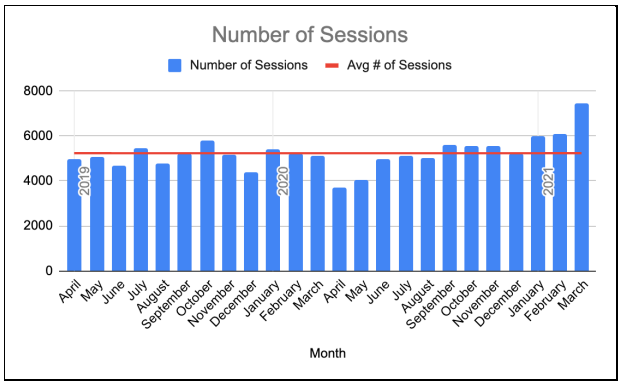
Pathways

Pathways continues to work to produce features within its platform to better support Primary Care Providers in the community. Work continues to be underway to launch the referral tracker in the FNW region. Currently, at the local context, there are:

- 153 FNW Family Physicians with profiles in Pathways
- 140 FNW clinics listed
- 495 Specialists listed
- 1 Urgent & Primary Care Centre
- 2 hospitals

Data pulled from the FNW Pathways site from August 2019 shows the page views of PCN related referral support, as well as details the rapid increase in Covid-19 support since March 2020.





More recently, 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 19% increase in the number of users logging into Pathways over this last year and a 5% increase in the number of sessions.

	Number of Sessions	Average Number of Users Logged in
FY 19/20	61302	179
FY 20/21	64345	214
% Change	**5% ↑**	**19% ↑**

Partnership Supports

Practice Support Program (PSP): PSP continues to support Family Physicians in panel management, EMR support and Small Group Learning Sessions (SGLS). The Division continues to work collaboratively with the region's PSP team to develop and launch further sessions to support FNW PMHs. The Patient Medical Home Activity report for March 2021 is reflected below:

PATIENT MEDICAL HOME ACTIVITY												
PSP SUPPORT			Eligible Panel Incentive**	# PMH	PANEL MANAGEMENT PARTICIPATION							# PET Patient Experience Tool
					% of Eligible		In Progress				Complete	
Community	PSP Team	FTE	# Eligible	# PMH Assess. Comp.	Started Panel	Completed Panel	Started Panel	Working on Phase 1	Working on Phase 2	Working on Phase 3	Workbook Complete	# PET
FRASER NW	Byron, Michelle, Tanmay	3.0	178	116	61%	51%	108	11	2	4	91	1

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 privacy and security guides into PMHs. Over the last year, work was completed related to providing privacy assessment reviews and DTO workbook implementation into PMHs, with support of the FNW IT Coordinator. A fulsome PMH IT Checklist is being developed with input from DTO to support FNW PMHs in understanding IT related needs and assess opportunities for further risk reduction/mitigation within practices. This work will largely take place in the 2021/2021 year.

Physician Leads

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

Shared Care

Aim

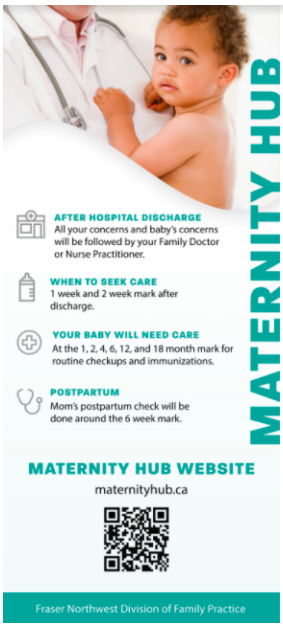
The relationship between family physicians and specialists is fundamental to the delivery of effective health care. Gaps in communication between health care providers can impede the flow of care, resulting in a fragmented experience for patients, caregivers, and families. The overall goal of Shared 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 with a focused practice, and specialist collaboration on quality improvement projects.

Maternity

Project Phase: Proposal Implementation
Description: The purpose of the Maternity Shared Care project is to improve primary maternity care - including prenatal, intrapartum and postpartum care - experiences in the Tri-Cities and New Westminster. Needs assessment activities included patient and provider surveys and focus group sessions that were conducted with eight community organizations in order to hear the voices of underrepresented women. Results revealed that support in the FNW is needed in regard to 1) access to postpartum care (especially breastfeeding support) and 2) access to mental health services. The project group has been developing a virtual maternity hub, with the aim to improve patient access to postpartum support, specifically breastfeeding and mental health support, as well as improve information sharing and collaboration among maternity care providers. To date, there have been 10,000 page views! The team has also been focusing on attachment and information sharing among maternity providers. The project is overseen by a triad leadership model involving Family Practitioners (FPs), Obstetricians (OBs), and Registered Midwife Leads (RMs) and engagement and partnership with other allied health, health authority representatives, and relevant stakeholders.

Check out the news article from the Tri-City News about our Virtual Maternity Hub!



Physician Leads

Dr. Dayna Mudie (Family Physician Lead)
Dr. Aude Beauchamp (Specialist Lead)
Dina Davidson (Registered Midwife Lead)

Older Adult/Medically Complex

Project Phase: Proposal Implementation
Description: Recognizing that older adult patients with multiple comorbidities often require the involvement of multiple specialist physicians and community services, the challenge for providers is to effectively coordinate care for a seamless patient and provider experience. Needs assessment activities for this project included patient and provider surveys and an engagement event where multiple specialties involved in the care of older adults presented their role and challenges they experienced. Based on key learnings from the needs assessment phase, the project will focus on improving care coordination and planning for older adults with complex health concerns by supporting increased family physician and specialist education and understanding of what resources and services are available to them and their patients. The committee has developed a Geriatric Rounds series aiming to foster a virtual learning community consisting of geriatric specialists and family physicians that use case based learning to gain improved competence in providing care for older adult and medically complex patients.

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)

Mental Health and Substance Use

Project Phase: Proposal Implementation
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. Key activities include implementing a series of psychiatry and sub-specialist events and sessions aimed to increase family physician capacity, education, and relationships with specialists.

Physician Leads

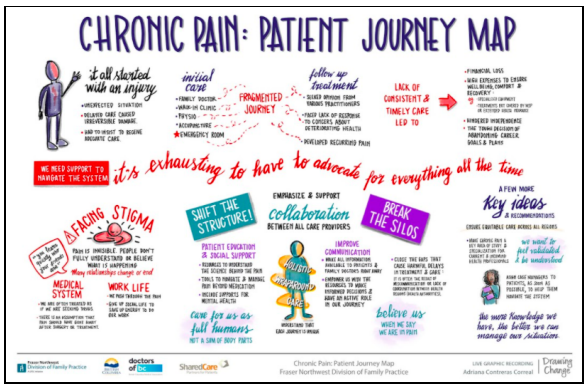
Dr. Carllin Man (Family Physician Lead)
Dr. Stephanie Aung (Family Physician Lead)
Dr. Stephan Ogunremi (Specialist Lead)

Chronic Pain

Project Phase: Proposal Implementation
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. Needs assessment activities for this project included patient and provider surveys. Key themes from the surveys include patient difficulty in accessing services, cost of service to patient, experiencing stigma, care coordination among multiple providers, provider education, lack of referral pathways, and lack of resources.

The Chronic Pain Shared Care committee had a session led by Dr. Stephen Barron to visually demonstrate the system gaps and frustrations of patients navigating chronic pain.



PHYSICIAN LEADS

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

PALLIATIVE

Project Phase: Proposal Implementation
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. At the Expression of Interest stage, the project evaluated the current state of palliative care in the community and identified gaps in service. Through needs assessment activities, the following challenges have been identified: opioid/pain management prescribing and symptom management, family physician access to rapid palliative consult, clarification of the referral process, transition in care and care coordination process, and family physician education. The team worked to develop a four-part learning series for family physicians which focuses on fostering relationships and education using case based examples. Topics include pain management, opioid and symptom management, advance care planning, serious illness conversation guide, and panel style discussions with community services and practitioners. The palliative shared care committee has also been focusing on attachment concerns and referral processes to the palliative teams. As well, the Fraser Northwest Palliative Shared Care committee has created a Palliative Resource Sheet consisting of services in the region that are of particular relevance to Family Physicians. Please click here to download this resource sheet.

Please visit the FNW member website to access the learning series recordings!

PHYSICIAN LEADS

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

Dr. Joan Eddy (Palliative Physician Lead)

GERIATRIC PSYCHIATRY

Project Phase: Proposal Development
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 will focus 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.

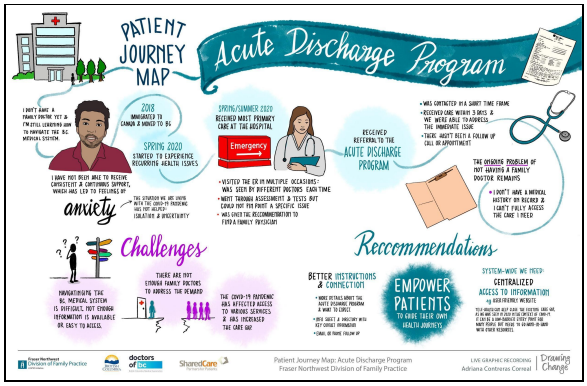
PHYSICIAN LEADS

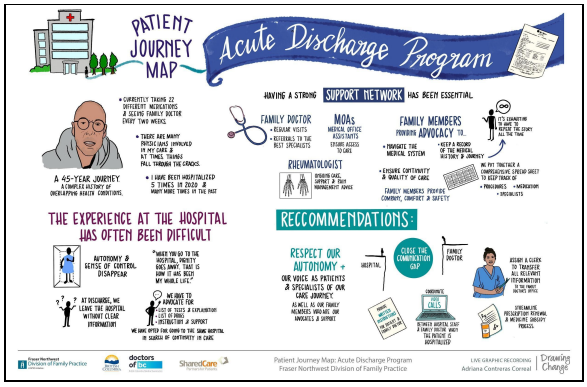
Dr. Carllin Man (Family Physician Lead)
Dr. Simon Woo (Specialist Lead)

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. Acute care providers and hospitalists may refer both attached and unattached patients to the Acute Discharge Program to ensure follow-up by a FNW Virtual Care Hub physician. Referrals may also be made for the purpose of attachment to a primary care provider. The Acute Discharge Program has now transitioned to the new U&PCC and the committee continues to advocate for timely follow up in the community and smooth transition in care processes.

In order to understand the patient's experience navigating multiple touchpoints and care coordination throughout different systems from acute to primary care and back again, the following patient journey map sessions were conducted by Dr. Jennifer Yun.





PHYSICIAN LEADS

Dr. Jennifer Yun (Family Physician Lead), Dr. Ali Okhowat (Family Physician Lead), Dr. Joseph Ip (Specialist Lead)

Women's Health

Project Phase: Expression of Interest
Description: The goal of the Women's Health Shared Care Project is to reduce wait times for prolapse and incontinence patients through implementation of a patient care pathway in primary care settings and a successful urogynecology clinic model.

Physician Leads

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

Breast Health

Project Phase: Proposal Implementation
Description: The focus of the Cancer Care (Breast Health) Shared Care project is to ensure residents in the Fraser Northwest region receive high quality cancer prevention, preventative screening, and diagnostic services. The needs assessment phase of the project included: activities to understand the patient experience navigating the breast health system and exploring how the Breast Health Clinic will impact patients; activities to understand the unattached patient experience; and engagement with local family physicians to define the referral criteria, target population, and to obtain feedback. Key activities will include strategies to enhance the prevention of cancer, access to early screening, and streamlining the clinical pathway from screening to diagnosis by implementing a local Breast Health Clinic.

Physician Leads

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

Respiratory/Pulmonary Function

Project Phase: Expression of Interest
Description: The aim of this project is to refresh family physician knowledge regarding diagnostic testing for Respirology, in particular, choosing the right test for the patient and guidance on how to make that decision, as well as, community management of Chronic Obstructive Pulmonary Disease (COPD) and COVID-19 impact.

Physician Lead

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

Member Engagement

Recruitment/Membership

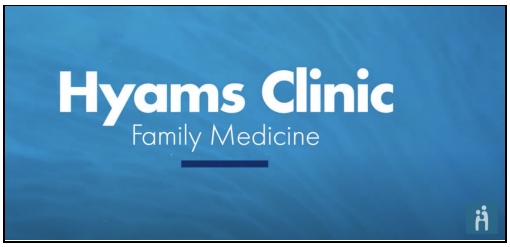
Overview

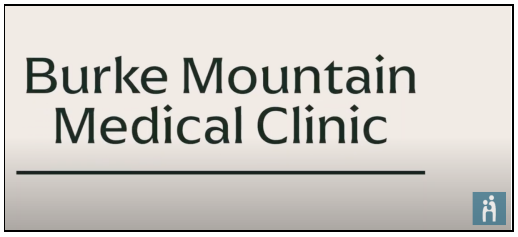
The Fraser Northwest Region has 475 members ending this year. This is a 30% increase from the previous year, which is likely due to the establishment of distinct strategies to support new member engagement, recruitment and the availability and growth of distinct practice styles. Further details on this 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 significantly contributed to the increase in Physicians joining the community. Partnerships with the Practice Ready Assessment (PRA) program, UBC International Medical Graduates (IMGs), PCN funded contracts, 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.

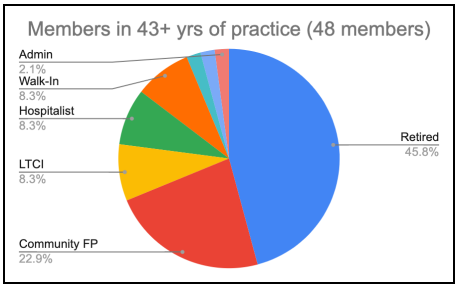
Clinic specific recruitment videos were also developed by 3 local PMHs; further work to support recruitment for FNW PMHs is underway.

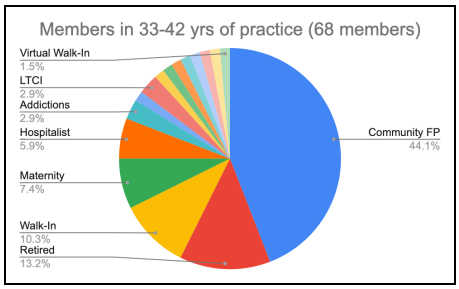


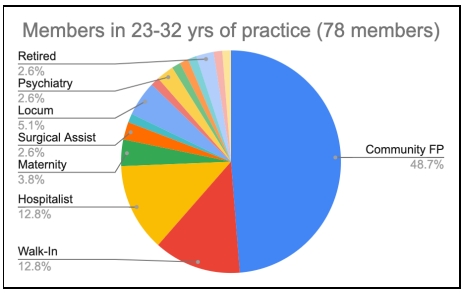


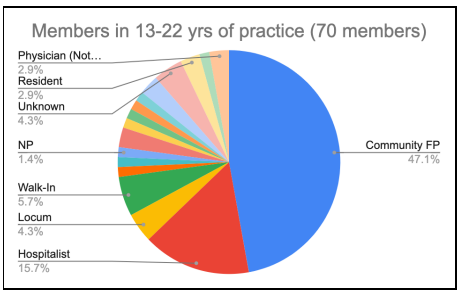
Composition

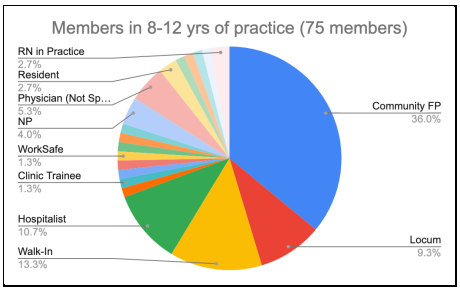
FNW membership continues to be largely comprised of Family Physicians. Locums, Walk-In Physicians and Hospitalists, when combined, make up a similar portion of membership. Nurse Practitioners, Residents, Registered Nurses and Medical Students also comprise a growing associate membership base. A detailed breakdown of the membership composition by provider type and years in practice is shared below:

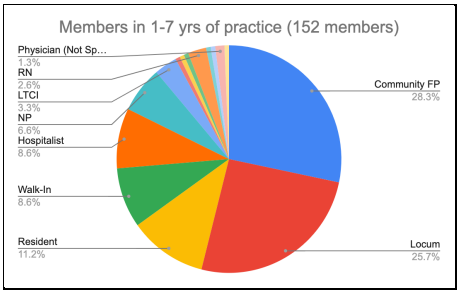




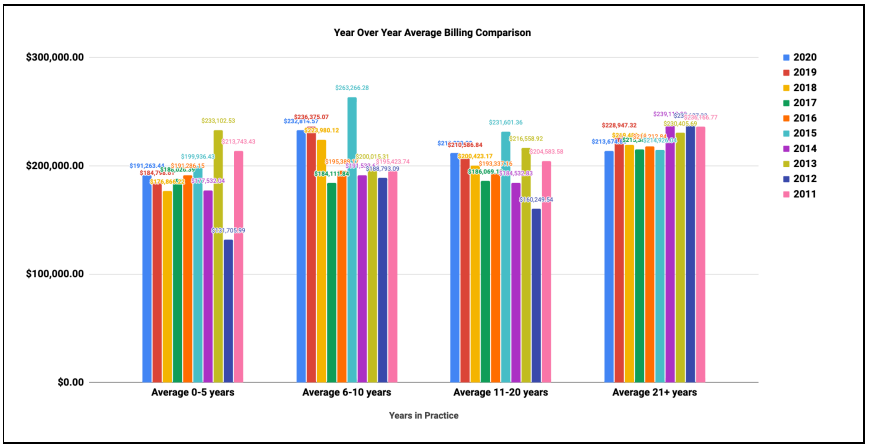






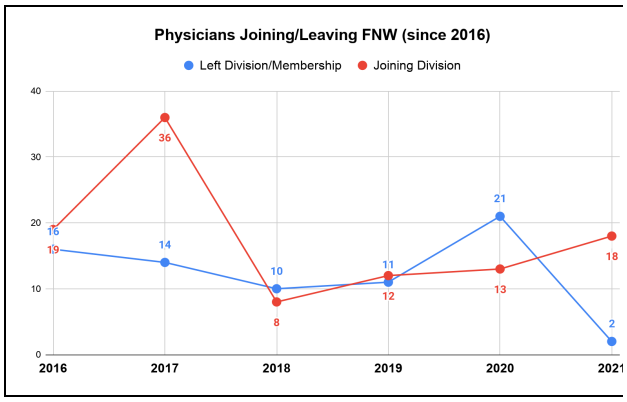


This last year has seen a growth in distinct membership types with new members joining who have practiced in the community for years. Anecdotal feedback recognizes that the Division has become an information hub and access to this information has been paramount over the changing landscape of this past year. The Division works to ensure that the primary care system is sustainable for 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:



Projected Retirements

The number of physicians retiring and/or leaving the community continues to grow, with those leaving citing high costs that the Fee for Service compensation model currently can't meet with how some family physicians practice. Since 2016, there have been approximately 77 physicians leaving the community, with 11 physicians leaving in 2019 and an additional 21 leaving in 2020 already. The graph below shows the distribution of membership changes since 2016.



Projected retirements in the next year are set at 7 with a five year forecast of 25 family physicians retiring out of the FNW communities. 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.

Physician Leads

Dr. Gary Hayes

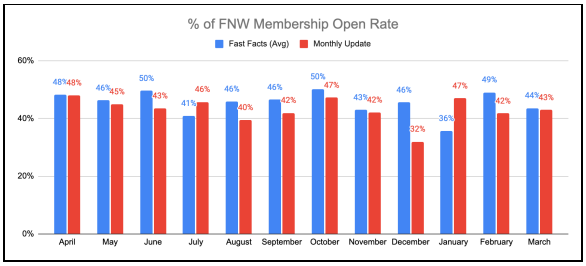
Engagement

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. Online newsletters including biweekly Fast Facts and a Monthly Newsletter continue to share relevant practice specific resources and information, upcoming events, changes to community resources/services and opportunities for feedback sharing and engagement. 25 Fast Facts and 12 Monthly Updates were distributed to members in the last year with, on average, 206 members opening these communications. This roughly equates to 44% of members engaged in these communications; a detailed breakdown of the month over month distribution can be found below:

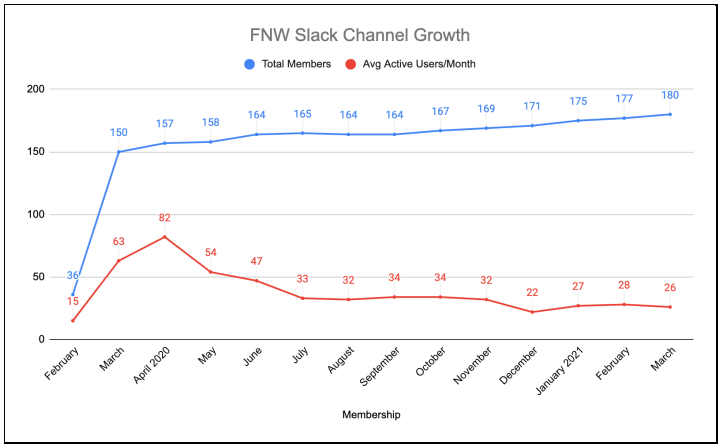


Additional formal communication mechanisms were established through focus groups between Family Physicians, Nurse Practitioners and allied health services to support the continuous improvement of access throughout the changing landscape of this past year. Topics included:

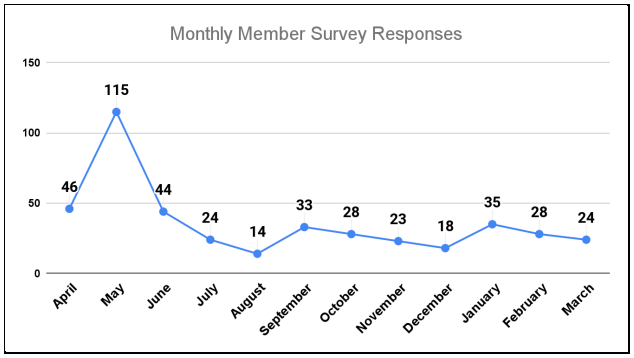
- Recruitment
- Clinic Consolidation
- Home Health
- Mental Health
- Community Health Services
- Geriatric Psychiatry
- After Hours Care

Informal means of communication have also increased over this last year - largely due to the ability to share information, resources, and updates in real-time. Slack was

introduced as a platform where FNW members could connect, access community level data/reports, share Division updates based on member feedback and facilitate informal conversations and wayfinding between peers. The graph below reflects the significant impact that this platform has had based on the distinct increase in users that aligns with when the pandemic started:



Monthly Member surveys were implemented in April - initially as a biweekly survey - to reach out and engage members to gather feedback on the changing landscape given the pandemic. Since April, 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.



Examples below reflect the feedback gathered and the response from the Division:

What We Heard: *barriers or obstacles in referring to specific programs*

Community Response #1: *Active reach outs to each PMH to ensure knowledge of who the FHA Community Health Nurse (CHN – aka 'Nurse Debbie) is and how to contact that nurse.*

Community Response #2: *Development of monthly focus groups with FHA Home Health and FHA MHSU programs*

What We Heard: *Members provided feedback on need for social prescribing for patients*

Community Response: *CAREs program launched at Share Family & Community Services. Co-developed referral pathways for this program and RNs in Practice have been provided specific training on referring patients to this service.*

The Division will continue to reach out, listen and respond to the needs of the primary care providers in the FNW communities to enhance access to health services for providers and their patients.

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.

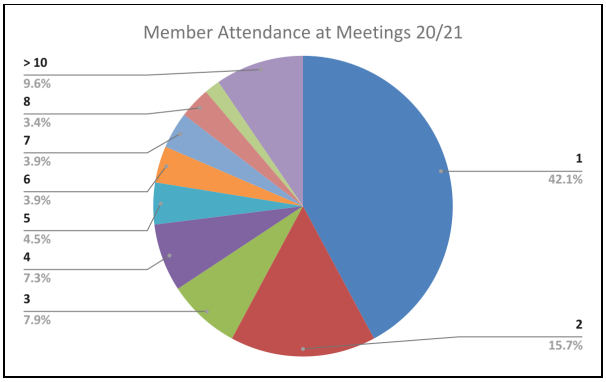
The mentorship program continues to be a resource available to members practicing in the FNW. Categories of mentorship include: EMR support, running/building a practice, navigating community resources, and specialized focus areas to name a few. This program connects those seeking mentorship with pre-identified mentors willing to support in the identified topic areas.

Covid-19 Weekly Updates

The mode at which Covid-19 updates and communication have been delivered throughout the community has been a journey on its own over the past year. What started with local Physician leadership advocating for access to testing and assessment for community members transformed into the regional approach utilized by the HA. Constant communication between FNW Primary Care Providers, Division staff, HA staff, the MoH, DoBC and additional community members has continued over this last year. Since transitioning from providing weekly clinic updates, the Division continues to listen to the needs of the members, as well as the community as a whole. The Division's social media is used as an information pathway which continues to share weekly updates on resources and community specific exposures.

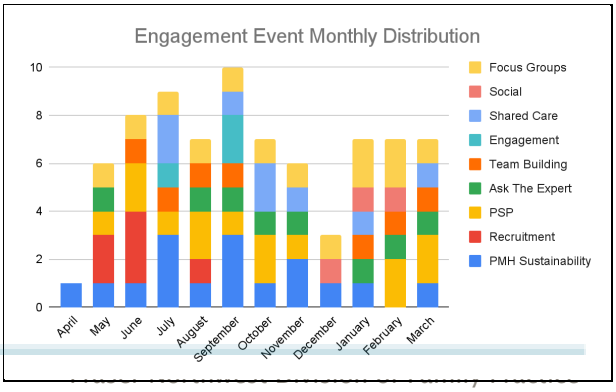
Events

Despite the move to virtual means, FNW members continued to engage by participating in events, workshops and education opportunities with their peers and colleagues. 38% of Division members attended one or more events over this last year with almost 60% of those members attending 2 or more events.



ACCOMPLISHMENTS

The Division hosted approximately 80 events in the last year - a 36% increase compared to the previous year.



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Dr. Wai Phan, Palliative Physician Lead

Dr. Fify Soeyonggo, Palliative Physician Lead
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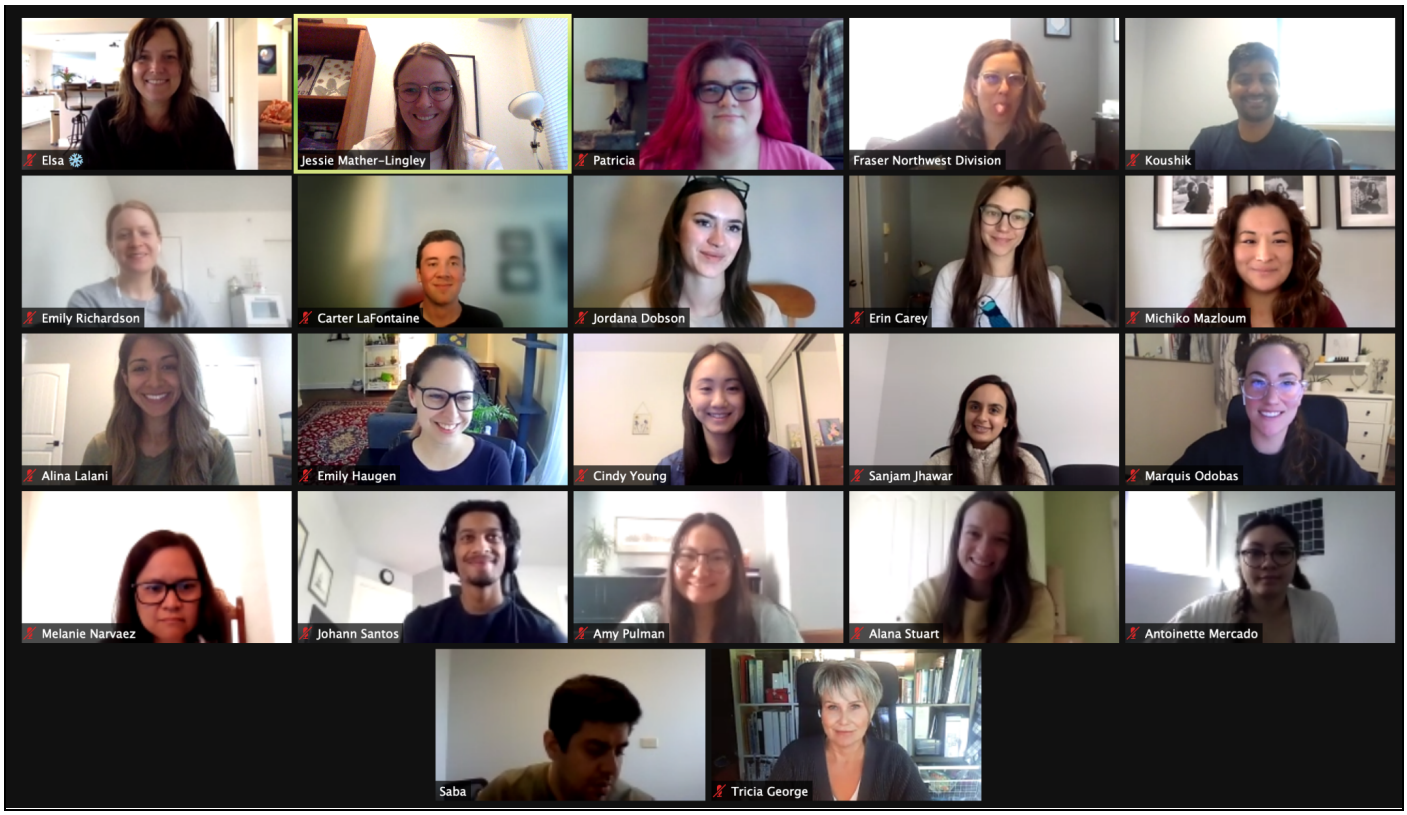

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Divisions of Family Practice
A GPSC initiative

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