Divisions of Family Practice

A GPSC initiative

Fraser Northwest Division Annual Report 2019–20

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Our Vision

VISION

Fraser Northwest Division of Family Practice strives to be a leader in supporting a healthy a sustainable commnunity 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. **Building capacity in our physician community**
3. **Establishing a network of collaboration between Family Physicians and other health care partners and community stakeholders**
4. **Encouraging grassroots physician engagement, dialogue, and contribution by providing a voice for Family Physicians and their experience**

VALUES

- **We prioritize key projects in accordance with our vision and mission and only after consultation with our members**
- **We appreciate 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 are fiscally prudent**

Co-Chair's Message

Dr. Stephanie Aung
Co-Chair

Dr. Jennifer Yun
Co-Chair

Dear Friends,

Another amazing year has passed. We can't adequately express in words the incredible work within the division thanks to our members and division staff. Time and time again, our division as a whole has overcome obstacles and worked together, triumphing in improving care for our patients and community. All I can say is bravo, and a quote from a member that our division "is one of the best divisions that they have ever had a pleasure to work in." We want to thank you, members, for your involvement, your passion and your hard work.

Here are some themes that we have witnessed as co-chairs that bring us such great pride to share:

Emphasizing primary care as a basis of good overall patient care:

With the incredible work of our division staff, physician leads and our members in the community, we were able to make tremendous progress with the Patient Medical Home and Primary Care Networks in pursuit of our goal to provide good longitudinal care for patients in the community. We did so through initiatives such as the Registered Nurse in Practice program, by continuing our work with physician-lead projects in areas such as mental health and chronic pain, and by supporting practices and practice efficiencies. In turn, we hope these efforts helped you to establish better long term relationships, build trust and find ways to overcome barriers in health care.

Responding to crisis and emergency to protect our community

When the WHO, on March 12, 2020, declared a pandemic due to COVID-19, our community was in short supply of personal protective equipment (PPE), and many practices had to shut down or risk the consequences of COVID-19 exposure for both patients and providers. Our division and members responded along with the help and partnership of the health authority and consolidated our supplies. An incredible amount of hard work resulted in creative initiatives such as the COVID-19 and Influenza-like illness assessment clinic and the Non-COVID Physical Assessment clinic. These initiatives helped to protect both physicians and patients by providing adequate protection when in-person assessments were needed. Thank you, members, for always being ready to step up to help each other in the community to protect your colleagues and your patients.

Our fingers on the pulse - responding to when change is needed

The COVID-19 pandemic and the effects of social distancing and self-isolation in the community caused limitations in our practices. Our community needed a way to shift from mostly in-

person encounters to virtual encounters. Within weeks, with the division's help, almost all of the physicians in our community were able to offer virtual options to see patients. Though it was a significant change in practice, many of our physicians showed the importance of being nimble with our practices and being open to different ways of communicating with our patients. Thank you, members, for your quick response and your dedication to patient care.

Looking Ahead

Through the toughest of times and through the best of times, we just wanted to let you know that our members have been a beacon of strength and commitment. Our hope as a division is to facilitate your ability to deliver care, improve access for your patients and improve our community's health. Please always remember that being a family physician is priceless, and your voice is what keeps this work going for the better of our community and patients. Please send us your feedback, engage in our working groups and take part in our initiatives. Keep being the leaders that you are. We cherish your strong voice. What you do now will affect you and future generations of family physicians to come in making this community a better place.

Drs. Stephanie Aung & Jennifer Yun

Executive Director's Message

Kristan Ash
Executive Director

It is hard to believe that we started our fiscal year with the implementation of the FNW Primary Care Network and ended with Covid-19 response supported by this primary care network. To be honest, the community and our work has transformed over this year unlike anyone could have predicted.

I am proud of the work of our members and Division staff (we also doubled in size this year) to address the opportunities of creating a practice community of practice continuously improving to address the gaps of members of the community with limited or no access to primary care.

As we move into the monumental 10th year of the FNW Division existence, it will be an exciting time with all the changes that have occurred and all those yet to come as we settle into a "new normal" post Covid.

Thank you once again to our fearless Division Physician Leaders who provide direction and to the dedicated staff team who work to ensure Fraser Northwest is the best community to practice family medicine in the province of BC.

Kristan Ash
Executive Director

Treasurer's Report

Dr. Huy Nguyen
Treasurer

Having served on the Board for the past 5 years and as the Treasurer for the Division for the past 2 years, I feel fortunate to have had the opportunity to work alongside so many dedicated and talented colleagues and division staff. Our Division has always focused on continuous improvement in delivering programs with high return values for our membership while being fiscally responsible and judicious about our spending. As the Division's scope and funding has increased substantially, the Finance and Governance Committee was created 3 years ago, the role of which is to review our financial status and policies in support of these aims. In addition, the Division has benefited tremendously from having hired a CPA-qualified Operations Manager. As such, towards the end of this fiscal year, as the COVID-19 pandemic arose, we were able to rapidly respond to our member's needs. As we move together into an uncertain future, we believe we have set up a financial foundation that will serve us through the challenges that lie ahead.

Dr. Huy Nguyen

The Year in Review

2019 - 2020

CREATING MEMORIES

TIMELINE OF EVENTS

APRIL

MOA MONTHLY
HR WEBINAR

JUNE

MBTI & INTERPERSONAL EFFECTIVENESS WORKSHOP
UBC SCHOLARS DINNER
PRACTICE MANAGERS MEETING
MOA MONTHLY
HR WEBINAR

AUGUST

PRACTICE MANAGERS MEETING
MOA MONTHLY
IMG ROS WELCOME DINNER
PLAYLAND
HR WEBINAR

OCTOBER

PRACTICE MANAGERS MEETING

MAY

OSCAR EMR USERGROUP
MOA MONTHLY
PCN LAUNCH
MATERNITY CARE WORKSHOP
COMMUNITY PARTNERSHIP ALCOHOL USE DIALOGUE

JULY

PSP CCPM
PADDLEWHEELER
EMPLOYEE MANAGEMENT & COMPENSATION WORKSHOP
MOA MONTHLY
HR WEBINAR

SEPTEMBER

ALCOHOL USER DISORDER - CME
MOA MONTHLY
AGM
HR WEBINAR

NOVEMBER

CULTURAL HUMILITY AND SAFETY

OSCAR EMR USER GROUP

PSP CCPM

HR WEBINAR

MOA MONTHLY

OLDER ADULT & MEDICALLY COMPLEX RESOURCE LAUNCH

DECEMBER

HOLIDAY DINNER AND DANCE

BRUNCH WITH SANTA

MOA MONTHLY

JANUARY

PRACTICE MANAGERS MEETING

ASK THE EXOERT: MHSU OPEN HOUSE

OSCAR EMR USER GROUP

TELEHEALTH SOLUTIONS

PSP CCPM

FEBRUARY

4 DS - DISCOER

MOA MONTHLY

ASK THE EXPERT: PELVIC FLOOR

ASK THE EXPERT: CHRONIC PAIN

MARCH

LTCI YEAR IN REVIEW

ASK THE EXPERT: PEDIATRICS (VIRTUAL)

PRACTICE MANAGERS MEETING

MOA MONTHLY

BEST PRACTICES COVID

STI UPDATE & INITIATING PRE-EXPOSURE PROPHYLAXIS FOR HIV

MOA MONTHLY

MED ACCESS USER GROUP

HR WEBINAR

PCN IMPLEMENTATION UPDATE

LTCI

PSP

SHARED CARE

SOCIAL

PMH

PCN

PI

RECRUITMENT

Patient and Community-Focused Initiatives

PATIENT MEDICAL HOME SUSTAINABILITY PROGRAM

OVERVIEW

Over the last year, the Patient Medical Home Sustainability Program developed and grew in a number of ways. There were several key areas that focused on supporting the Patient Medical Homes. Focusing on upskilling of practice staff including MOAs, Practice Managers, Registered Nurses, Nurse Practitioners and Physicians to facilitate a strengthened team-based model of care within each distinct PMH. In-practice support such as physical space utilization projects, practice assessments, privacy and security audits, general IT support and PCN attachment coding support were all key aspects of this program. Additional work was provided to Family Practices in the ever-changing digital world to create clinic websites, utilize existing websites, facilitate the launch of online booking, and more recently - with the growing need for access in a physically distanced environment – virtual telehealth supports.

CENTRALIZED MOA RECRUITMENT DATABASE

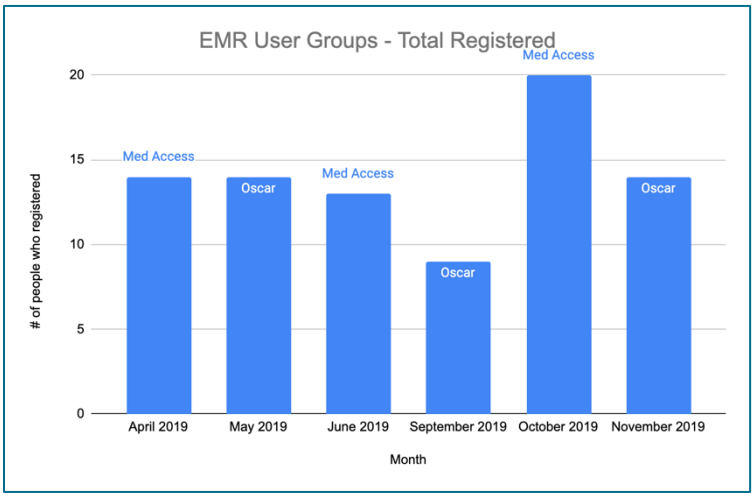
The continued development and utilization of a community MOA recruitment database has allowed physicians to search a list of interviewed and reference checked MOA candidates for hiring in their practice for both temporary or full-time positions. This program keeps the list up to date on a monthly basis and interviews and screening is work is done throughout the month. Wage expectations, EMR skills and experience, temporary or permanent workplace placement preference, and preferred geographic area are a few elements of what is shared on the centralized recruitment list. This backend process enables the hiring process to be simpler and streamlined for the physicians. Physicians can get a new MOA into the clinic for training before their current MOA leaves. The table below reflects the large number of applicants that the program received and comparing that number to the ultimate number of applicants that were added to the list reflects the diversity in candidate experience and skill. Having a centralized team to facilitate the manage this work can take this workload off of Physicians.

FY 19/20	
Number of Applicants	642
Interviews Scheduled	85
References Checked	34
Added to Database	31

UPSKILLING PRACTICE STAFF

Over the last year, this program continued to provide educational and upskilling opportunities to PMHs to support and strengthened team-based care across the FNW. By having program staff go into practices to

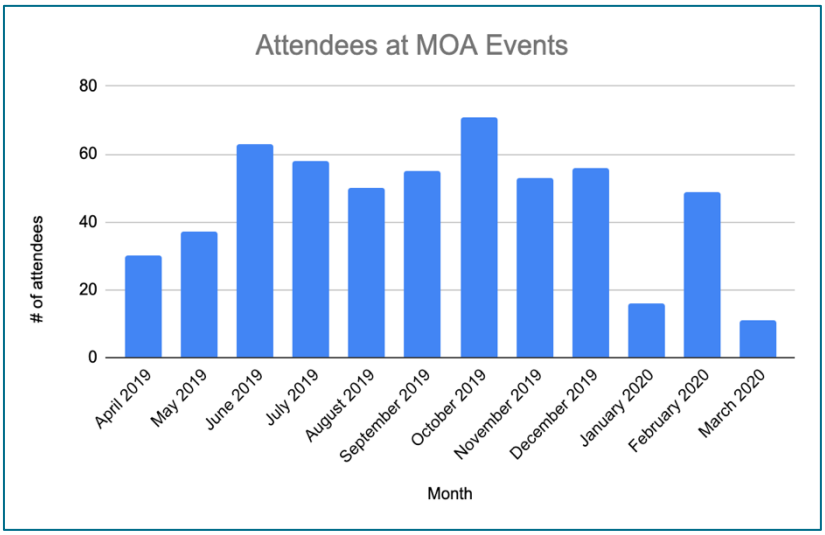
shadow practice staff, assess workflow, assess physical layout utilization opportunities and offer practice assessments to clinics, a number of key learning opportunities emerged that were brought to the larger regional practice staff engagement events. Much like last year, 6 EMR User Groups were held between April 2019 and March



2020, 3 of which were for Med Access and the other 3 for OSCAR.
These groups are intended as learning opportunities for improved practice EMR use and efficiency for Physicians. These events saw a total of 84 registrants with the October 2019 Med Access User Group receiving the highest number of attendees.
Reoccurring monthly MOA events allowed for continued upskilling of MOAs and practice staff and – in some cases – were done in tandem or conjunction with engagement events for Physicians. Over the last year, each MOA event focused on a distinct topic area where subject matter experts were brought in to facilitate the session. Topics presented over the last year include:

- April 2019: Technology Beyond your EMR
- May 2019: Cold Chain Management and Panel Management
- June 2019: Accounts Receivable
- July 2019: Conflict in the Office
- August 2019: Reignite Your Passion
- September 2019: Improve your Telephone Skills
- October 2019: Medical Legal Issues
- November 2019: Primary Care Networks Update
- December 2019: Pathways
- January 2020: Telehealth Solutions
- February 2020: Privacy & Security
- March 2020: Communicating with our Allied Health Care Team

In total there were 170 MOAs and 48 Practice Managers who attended one or more MOA Event in the last year. Approximately 52% of MOAs and 40% of Practice Managers attended more than one event. Of those that registered, on average, 72% of people attended the actual event. The most attended event for



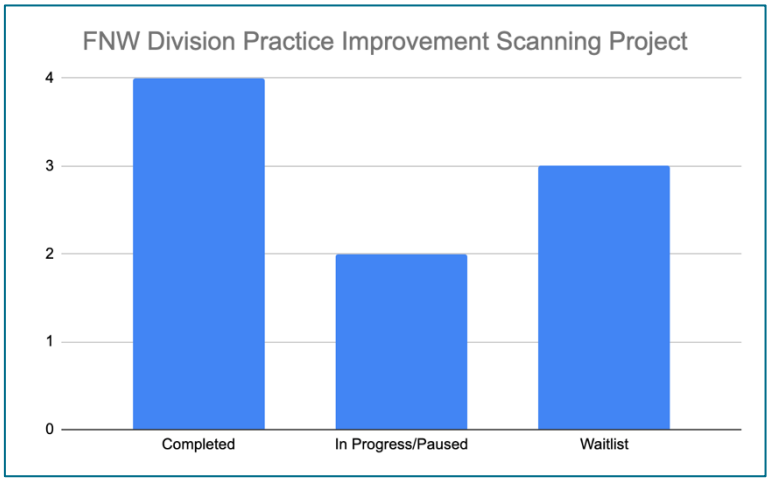
MOAs last FY was the October, Medical Legal Issues, event.

Upskilling Registered Nurses as part of the RN in Practice PCN Initiative grew into a significant aspect for this program. Upskilling and supporting RNs who may have limited experience working in primary care settings became imperative as part of seamlessly integrating a new team member into existing practices. Providing support for not only the RNs, but also the practice staff and Family Physicians became a foundational aspect for the successful integration of RNs into clinics. The PMH Sustainability Program Manager provided one to one training for all onboarded RNs, and Physicians and their clinic staff on an as needed basis throughout the development and launch of the initiative.

INFORMATION TECHNOLOGY PRACTICE SUPPORT

A dedicated IT Coordinator joined the Program team in Summer 2019. This position was developed as part of the identified need for ongoing IT support – specifically around supporting privacy and security within family practices - in early 2019. Within the first few months of this program being filled, 18 different clinics had IT practice visits where the IT Coordinator supported, identified and incorporated various IT related practice efficiency supports.

In addition to this IT support, the program launched a short-term pilot project to support clinics to optimize the physical space they have available by converting existing paper charts to the clinic's EMR. This work was done after hours by a team so as not to disrupt the clinic flow. This project began in May 2019 and continued throughout the year until the onslaught of Covid-19. At year end, the project has successfully supported 4 clinics to optimize additional physical space that was previously used as paper-chart storage.

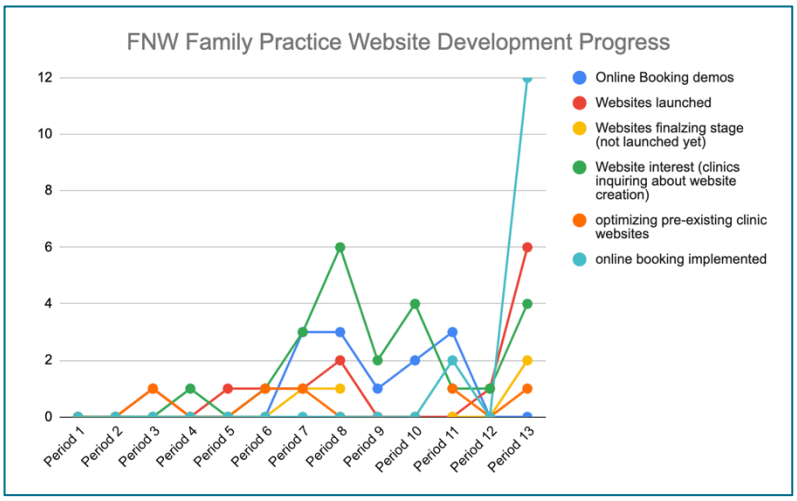


In January and February 2020, two events held for Physicians and MOAs drastically increased the IT Coordinators engagement with family practices around strengthening privacy and security measures. After the February 2020 MOA event, approximately 20 Privacy & Security Binders were distributed to Family Practices. With this work, additional engagement emerged between January and March where the IT Coordinator engaged with over 35 clinics to support on practice efficiency work spanning from privacy & security, in-practice optimization, and telehealth optimization.

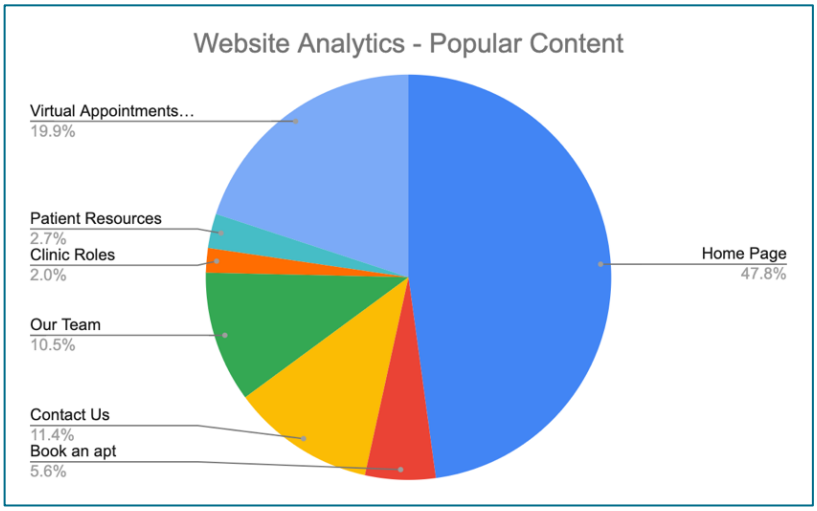
FAMILY PRACTICE VIRTUAL PRESENCE

Additional engagement support provided to FNW physicians is the website development as supported by a Digital Content Coordinator. At the end of March 2020, there have been 13 clinic specific websites launched. More

recently, there has been a significant surge in incorporating telehealth into family practices due to the impacts that Covid-19 has had on family physicians in March 2020. The move to providing primary care services in a virtual setting continues to grow and expand. A full list of the clinics in the FNW and their associated websites can be found by clicking here. The chart below details the main steps in clinic website developments period by period. Website analytics that looks at the total page views and visits from the public on popular links from each clinic website and approximately 20% of the total 'clicks' were on accessing a Virtual Appointment with a Family Physician.



Since the onset of Covid-19, Family Physicians have had to look into alternative modes of providing primary care services through utilizing technology. Virtual telehealth has seen a fast expansion and adoption across family practices. In late March the Division facilitated a callout to Practice Managers across the FNW and the response was impressive. Within a few days, almost 20 clinics responded and indicated their interest in setting this up.



PHYSICIAN LEAD

Dr. Ian Woods

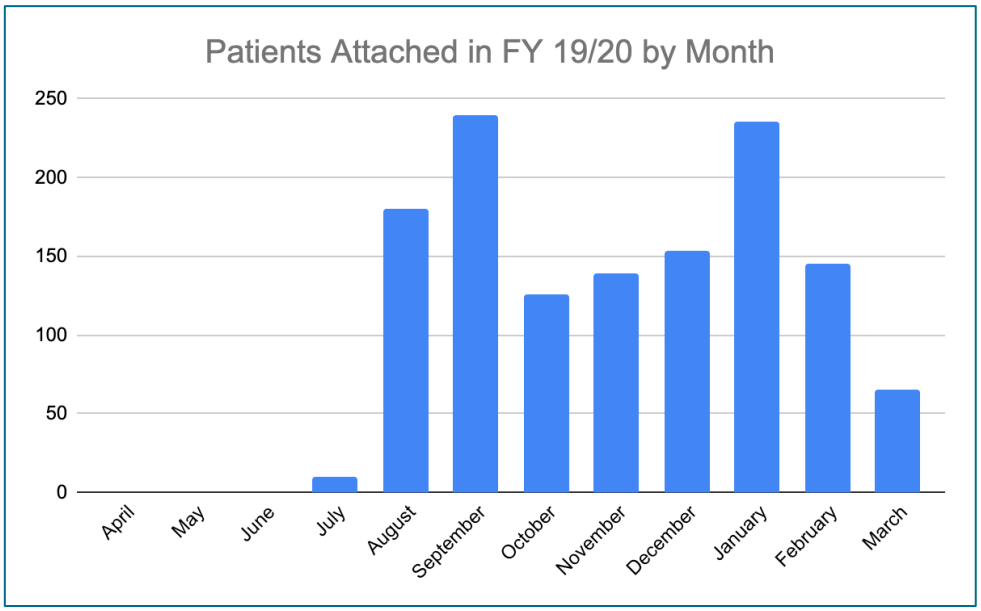
ATTACHMENT HUB

AIM

To provide meaningful attachment between people living in the New Westminster and Tri-Cities regions with longitudinal primary health care provider.

ACCOMPLISHMENTS

In the last year, a dedicated Attachment Hub Coordinator position was posted and filled as part of resources allocated through the FNW Primary Care Network. This role was designed to work in conjunction with the Ministry of Health's "Health Connect Provincial Registry" which has not yet launched - originally the launch date was set for early July 2019. Attachment work has been well underway despite this push back in the portal's launch and compared to the total number of attachments in 2018/2019 there has been a 730% increase in total attachments for this last year. The graph below illustrates the attachment trends over time since the Attachment Hub Coordinator joined the FNW Division in late summer 2019.



PATIENT MEDICAL HOME/ PRIMARY CARE NETWORK

The Patient Medical Home (PMH) is a family practice supported to operate at its full potential. The core of the model is longitudinal care, with the patient and their family practice at the centre of primary care. The PMH contains key attributes of what an ideal practice can deliver and how it can best be supported, including team-based care.

The Primary Care Network (PCN) is a network of local primary care service providers (a partnership between health authorities, physicians, and other community providers) working together to provide all the primary care services a population requires. The patient medical home (PMH) is a family practice supported to operate at its full potential. The core of the model is longitudinal care, with the patient and their family practice at the centre of primary care. The PMH contains key attributes of what an ideal practice can deliver and how it can best be supported, including team-based care.

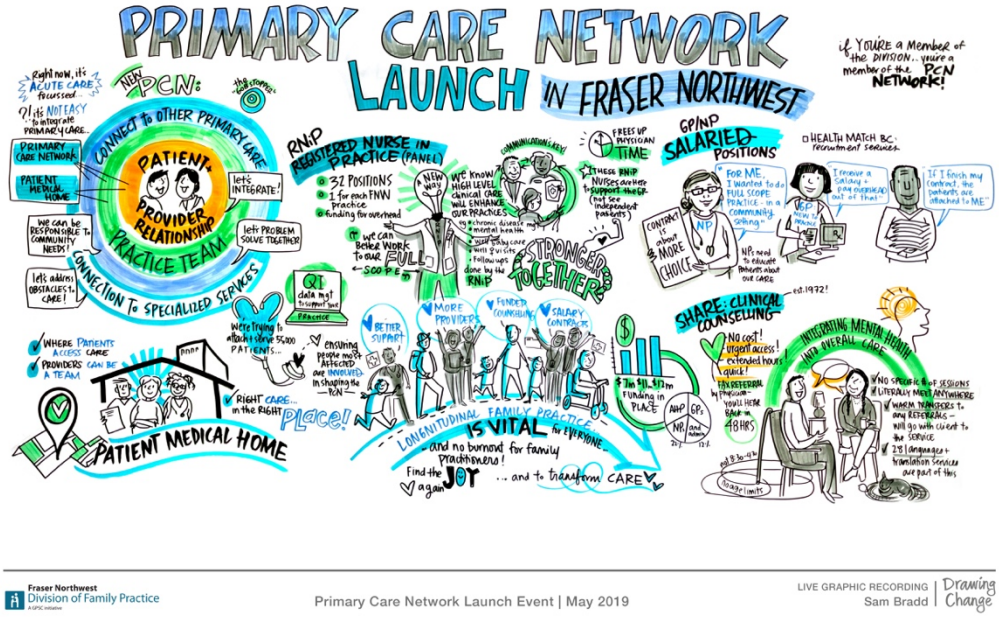
AIM

The Fraser Northwest PMH/PCN program goals and outcomes:

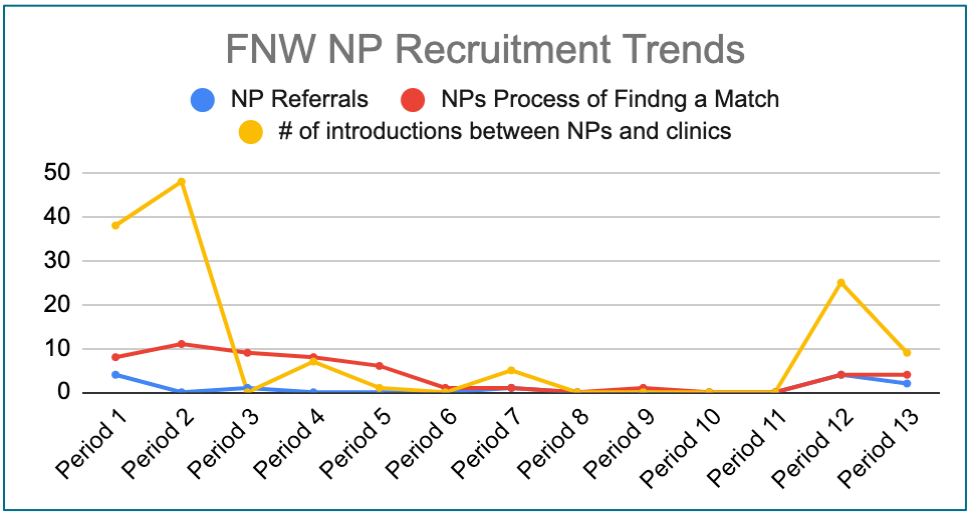
- To create a quality, integrated and coordinated delivery system for primary care that is patient-centred, effective in meeting population and patient needs and delivers a quality service experience for patients
- To create the structures necessary to enable all members of the community to receive the 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 provide longitudinal care through the support of teams, allied health care providers, and easily-accessed health authority services

PCN: YEAR IN REVIEW

Initial funding for the FNW PCN began April 1st, 2019. In the FNW region, the current attachment gap is at approximately 14% of the population. This, coupled with growing panel sizes and projected retirements represent how foundational PCNs and PMHs are central to creating an integrated system of care.



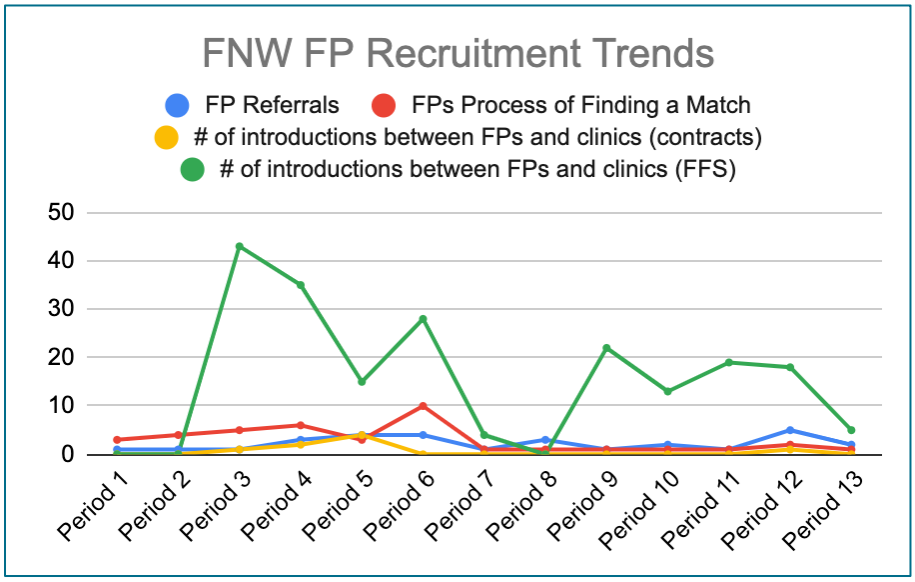
In April 2019, the co-development of the Registered Nurse in Practice program began with consultation between community Physicians and the FHA.



Between April and June, a RN in Practice Manager was hired as well as the first 3 RNs. In May 2019, there was an FNW PCN Launch event where Family Physicians were invited to interact and learn about what supports were available as part of the FNW PCN. The Share Clinical Counselling Program was launched in June 2019. This program was designed to provide rapid access support to FNW Physicians and their patients with mild-moderate mental health concerns. Within the first month of launch, the program received almost 100 referrals.

In July 2019, the first PCN funded Nurse Practitioner contract was signed. In September, 3 more were signed with an additional contract being signed in October, bringing the toal NP contracts that were signed in FY 19/20 to 5.

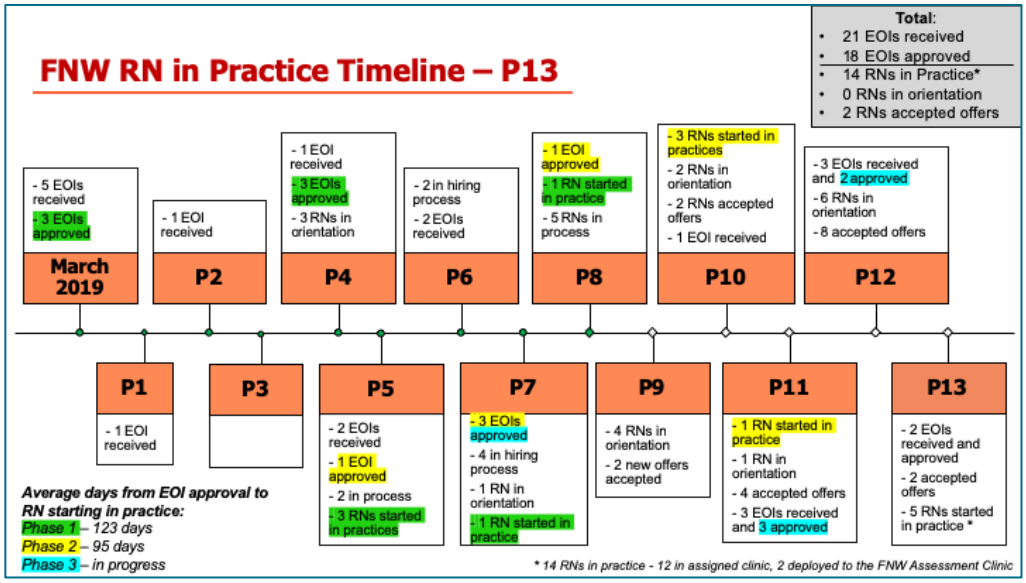
In October 2019, a PCN Update event was held and themed "Meet Your Team" and the overall event was Well received by members and further education was provided to members in regard to the people on their PCN team. Before this event took place, physicians across the community were engaged with and asked a similar question, what does a Primary Care Network mean to you? Physicians were also asked how primary care services have evolved in the FNW. At the event, attending members (including both physicians and NPs) shared what allied healthcare provider they'd like to work with.



In January 2020, the first PCN funded Family Physician contract was signed. This was the only Physician contract signed in the reporting year.

Additional engagement events were held in January where Physicians were invited

to attend a Mental Health and Substance Use Services Open House. This event was supported by the Division and led by FHA and invited community Family Physicians to come to an Open House event which had various community MHSU services, supports and resources available. In addition, representatives from each of these programs were present to answer questions, share in dialogue and build relationships with Physicians.



By the end of March 2020, there have been 14 RNs hired (out of the total PCN funding for 32 RNs) and placed in Family Practices across the FNW. There have been 18 Expression of Interests from Family Practices that have been approved and work has been underway to onboard additional RNs to continue to meet the needs of Family Physicians providing team-based care across the FNW.

PMH: INTEGRATOR

The Integrator project was a joint project between the Fraser Northwest Division of Family Practice and the Fraser Health Authority. This 1-year pilot project was designed to integrate and implement a sharing tool that supports real-time communication between different EMRs, providing family physicians and PCCRNs access to shared data. Since implementation, the integrator servers have been used to store and share appropriate clinical information across practices. The project's overall goal was to support innovation, promote provider working relationships and obtain Oscar Integrator pilot expansion learnings to be applied to a long term solution for all EMR to EMR operability.

The program's main deliverable objectives were centred around:
1. Improving information exchange and coordination of care between FNW primary care providers
2. Collect ongoing learning around the pilot expansion project

The figure below demonstrates the information sharing between a provider and Primary Community Care RN (PCCRN) using the Integrator to support frail home-bound patients versus information sharing between a provider and an allied health provider (not limited to a nurse).

Based on feedback from community physicians utilizing the Integrator to support their frail homebound patients, the objectives behind the technology proved both useful and successful for supporting this specialized patient population.

Ongoing learnings from this pilot project suggested that data sharing and co-charting between EMRs and providers improves patient care through access to primary care providers when needed.

This project has supported and invested resources in attaining the following Patient Medical Home (PMH) service attributes:

- Commitment
- Contact (timely access)
- Continuity of Care
- Coordination of Care

In addition to meeting the PMHs service attributes, this project supports the overall goal of the PMH which is providing patient-centred, whole persons care.

PMH: PATHWAYS

Pathways continues to work to produce features within its platform to better support Family Physicians 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 on Pathways
- 120 FNW clinics listed
- 489 specialists listed
- 2 hospitals

PMH: COMMUNITY HEALTH NURSES (CHN'S)

Over the last year, the Community Health Nurses (CHN's), also known from the successful "Nurse Debbie" concept, have continued to expand across the FNW and the program is fully implemented and operational with the FHA New West and Tri-Cities Home Health restructuring complete. To date, the team has expanded to include 30 primary care nurses, 2 social workers and 1 clinical pharmacist to support community GPs with help for their complex patients. These primary care nurses perform a variety of functions, from wound care to chronic disease management and serve as a point of contact between the GP and the patient. In September 2019, an article published in the BC Medical Journal provides a snapshot of the impacts that this program has had on the FNW communities. At the time of writing this report, the CHNs are supporting a total of 167 Family Physicians in the FNW and 1225 of their patients.

PMH: PRACTICE SUPPORT PROGRAM

The Practice Support Program continued to support Family Physicians in Panel Management, offer Small Group Learning Sessions (SGLS) and in the past year work began to launch the Patient Experience Tool in FNW Family Practices. In January 2020, upon high demand, a SGLS on Dementia was offered to FNW Physicians. This session filled up within a day and reflects the appetite for further sessions like this within the community. The FNW Division is working collaboratively with the region's PSP team to continue to develop and launch further sessions as well as continue to support Family Physicians in their practices. The Patient Medical Home Activity report for March 2020 is reflected below on this page.

PATIENT MEDICAL HOME ACTIVITY

PSP SUPPORT			MSOC	# PMH	PANEL MANAGEMENT PARTICIPATION						# PET
					% of MSOC		In Progress			Complete	
Community	PSP Team	FTE	# MSOC Physicians	# PMH Assess. Comp.	Started Panel	Completed Panel	Started Panel	Working on Phase 1	Working on Phase 2	Working on Phase 3	Workbook Complete	# Patient Experience Tool
FRASER NW	Byron, Michelle, Tanmay	3.0	171	112	61%	47%	105	11	6	8	80	2

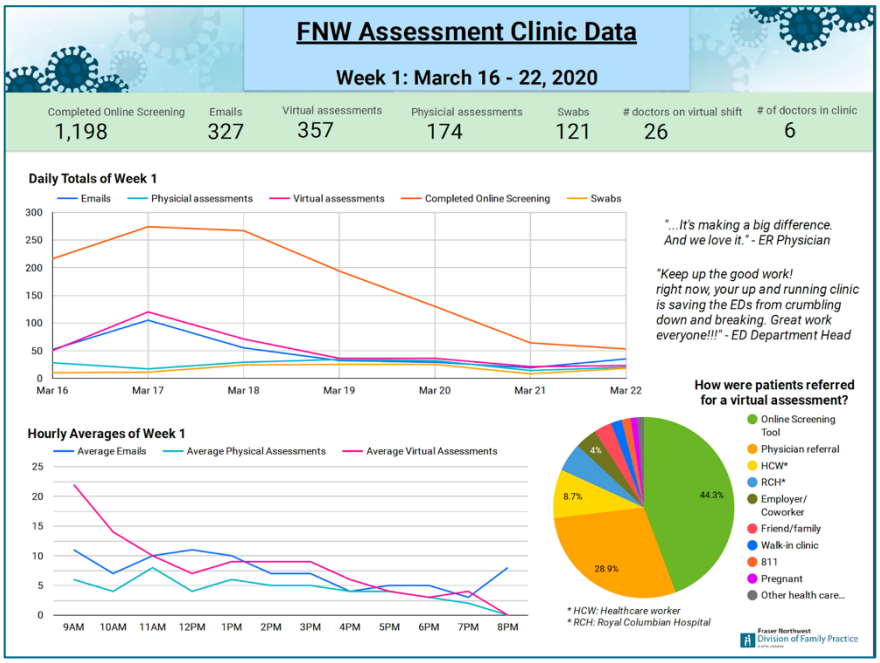
PCN PHYSICIAN LEAD

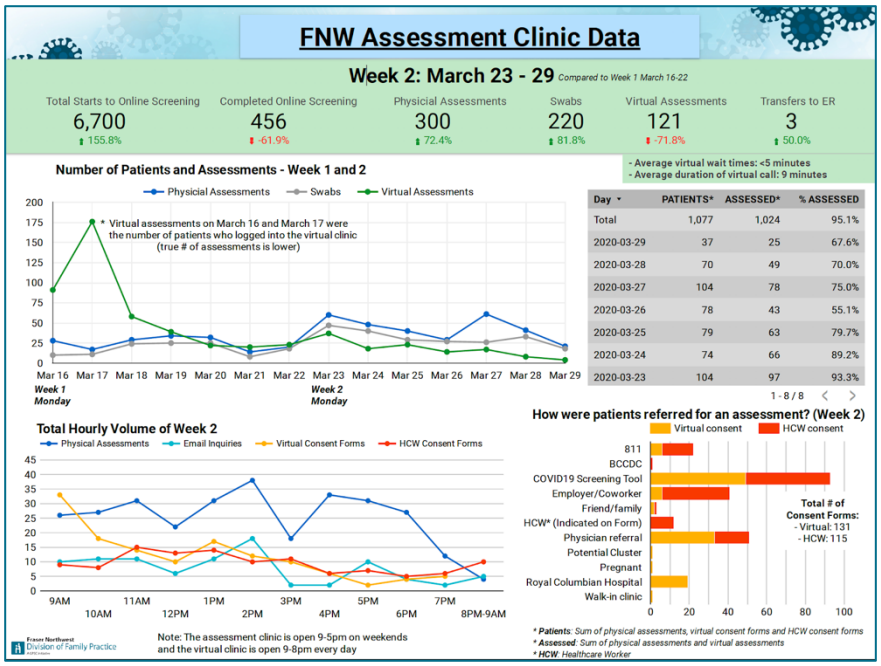
Dr. Paras Mehta

COVID-19 COMMUNITY RESPONSE

With the declaration of Covid-19 as a pandemic by the WHO on March 12, combined with the growing concern in the FNW around safety, accessible Personal Protective Equipment (PPE), closures, and impacts to community Family Physicians, the Division partnered with FHA to launch both a physical and a virtual assessment clinic hosted at a local family practice in New Westminster on March 16. This multi-phased approach included the development of a community based online screening tool (http://covid19tool.com/), the setup of a virtual telehealth clinic and the setup of a physical assessment clinic in close proximity to Royal Columbian Hospital in New Westminster.

There was an outpouring of a response from community physicians who were willing to support these clinics by taking on shift work as well as a reshuffling of resources by the HA to adequately equip the clinic team with the necessary equipment, supplies and human resources to support this community outreach work. Within the first week of the callout to members to support these clinics, there were over 100 Physicians and Nurse Practitioners who responded to the request. The visuals shared show the data collected and shared in the first two weeks of the program's launch.





PHYSICIAN LEAD

Dr. Ali Okhowat

LONG-TERM CARE INITIATIVE

During this past year, the name of this program changed. The Residential Care Initiative was renamed to Long-term Care Initiative (LTCI) effective November 2019. This was in recognition of the Truth and Reconciliation process in Canada and with BC's Indigenous peoples and the importance of supporting the provision of patient-centred culturally safe care.

The FNW LTCI has continued to be a stable program in the Division. Improving upon the 5 best practices of care for seniors in long term care (medication reviews, completed documentation, after hours call network, care conferences and proactive visits) continue to be the program goals . The third evaluation report for this program was completed in the summer of 2019 (reporting April 1, 2018- March 31, 2019) ED visits, admissions, length of stay and average number of bed days have all continued to decrease over that reporting period. Major themes surrounding the lessons learned revolved around the importance of physician and stakeholder engagement and communication. Highlighted is the event held on March 4th between the LTC & Acute Care Practitioners. This event focused on the handover between the LTC MRPs and ER Physicians and Hospitalists. Fulsome discussions have inspired the teams to work together to improve the communication systems between these groups.

With the onslaught of Covid-19, prompt action with regards to electronic communication between Care Homes and practitioners occurred in the FNW due to the relationships and network of the FNW LTCI. Virtual health was made readily available to all sites as iPads were distributed and a website was created to become a long-term care hub. All practitioners were able to obtain virtual health platforms and could connect with their medical teams, as the health authority's recommendation was to limit their onsite visits.

The coordination of practitioner scheduling and shift rostering for the COVID-19 clinics, both virtual and onsite, was easily set up due to the pre-existing scheduler that was used for our LTC on-call network. Having this easily accessible sign up method ready, those members who wished to support the COVID-19 clinic did so quickly.

CONTINUING MEDICAL EDUCATION & EVENTS

- April 2019: Pneumonia
- June 2019: Urinary Tract Infections
- September 2019: Difficult Conversations with Families
- October 2019: Dogwood Pavilion LTC informational video screen
- November 2019: Century House LTC informational video screen
- January 2020: MOST education and review
- March 2020: LTC & Acute Care Practitioner Engagement
- March 2020: Emergency MAC COVD19 response meeting

PHYSICIAN LEADS

Dr. Amber Jarvie

Dr. Nick Petropolis

Physician-Focused Initiatives

SHARED CARE

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, to improve information sharing and collaboration among maternity care 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.

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. A pilot endeavour, which will launch in July 2020, has been developed. The aim is 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. As well, wallet sized resource cards for seniors will be distributed to FNW clinics.

PHYSICIAN LEADS

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

MENTAL HEALTH AND SUBSTANCE USE

Project Phase: Proposal Development
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 Adult Mental Health and Substance Use Shared Care project is to increase collaboration and communication between GPs and Psychiatrists, reduce mental health service wait times, and improve patient care.

PHYSICIAN LEADS

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

CHRONIC PAIN

Project Phase: Proposal Development
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 and 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.

PHYSICIAN LEADS

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

PALLIATIVE

Project Phase: Expression of Interest
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 EOI development stage, the project will continue evaluate the current state of palliative care in the community and identify gaps in service. So far, 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.

PHYSICIAN LEADS

Dr. Ali Sanei-Moghaddam (Family Physician Lead)
Dr. Cindy Lou (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: Expression of Interest
Description: The intent of this Shared Care project is to focus on changes to the referral process for Geriatric Psychiatry services, in order to expedite patient access to specialist care and to improve communication channels between GPs and Psychiatrists to enable better coordination of care

PHYSICIAN LEADS

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

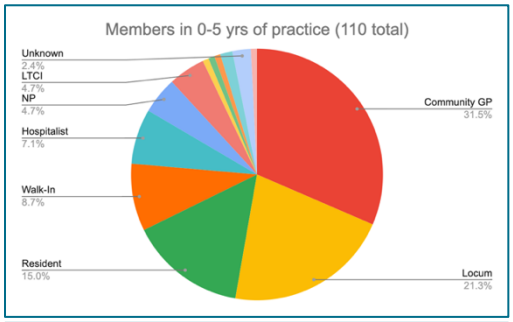
PHYSICIAN LEADS

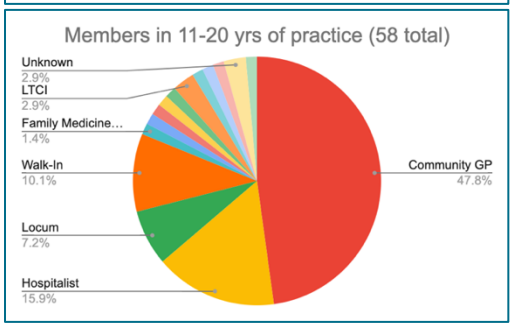
TBD (Family Physician Lead)
Dr. Sara Houlihan (Specialist Lead)

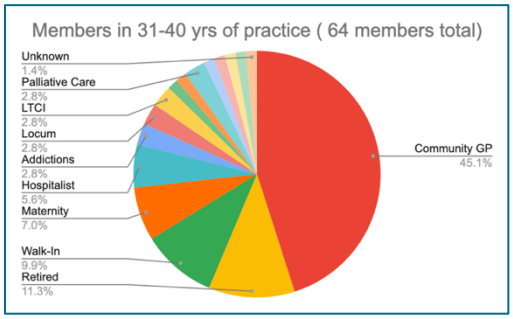
RECRUITMENT/MEMBERSHIP

OVERVIEW

Fraser Northwest has 365 members ending this year. Our membership represents Family Physicians that have recognized themselves and completed membership application. Our membership continues to grow each year. When looking at the breakdown of the membership into Years in Practice, approximately 40% of FNW members have been in practice for 20+ years. In the last year, there have been an additional 3 Fee for Service Family Physicians who joined the FNW community and an additional 1 Family Physician who signed a PCN funded contract position to provide longitudinal care within the FNW.



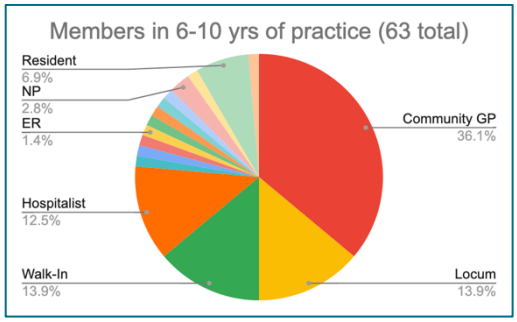


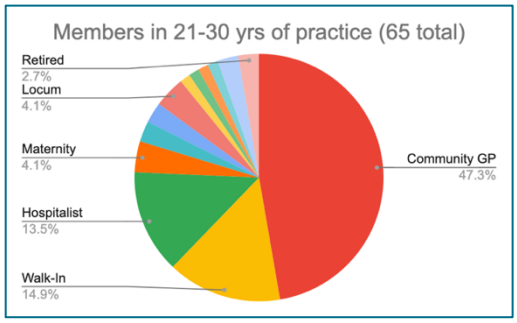


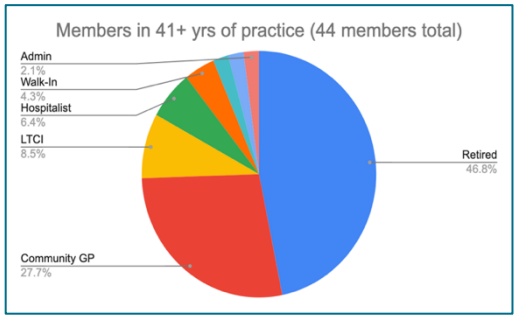
COMPOSITION

FNW membership is, not surprisingly, largely made up of community Family Physicians with a similar number of locums and hospitalists comprising the bulk of the members. Residents make up a large subset of the membership and there is a range of approximately 23 other positions including Nurse Practitioners, specialized physicians, retired physicians and medical students - some members may also have multiple roles. A detailed breakdown of the membership composition is shown here.

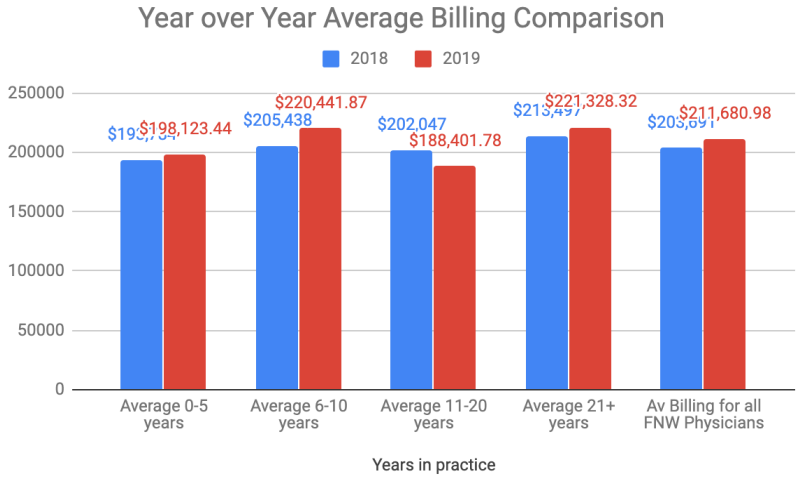
The purpose of the work in the Division is to ensure that the primary care system is sustainable for Family Physicians. Given this, we continue to look at the remuneration of our







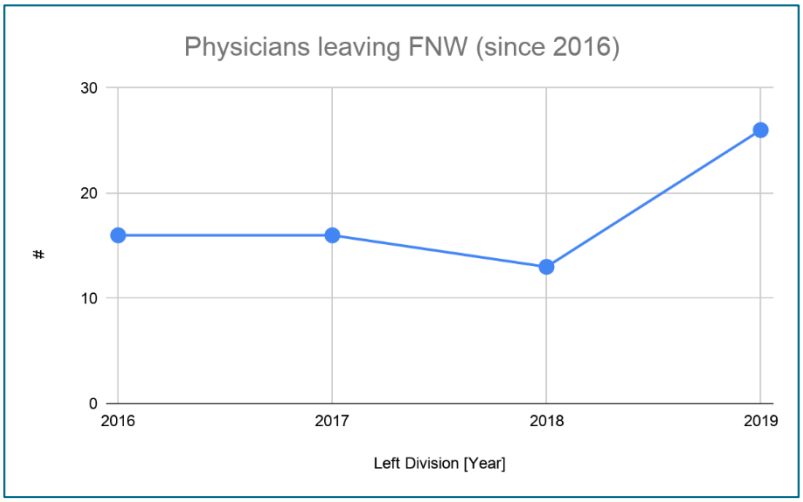
members, the following is a review of our membership MSP Billing Data by years in practice.



PROJECTED RETIREMENTS

The number of physicians retiring and/or leaving the community continues to grow with those leaving citing high costs that the FFS compensation model currently can't meet with how some family physicians practice. Since 2016, there have been approximately 47 physicians leave the community with 11 physicians leaving in 2019 alone. Since the launch of the PCN, there have been 2 family physicians who have retired, 6 who have left the community and a practice of approximately 15 Family Physicians recently moved to a neighbouring community.

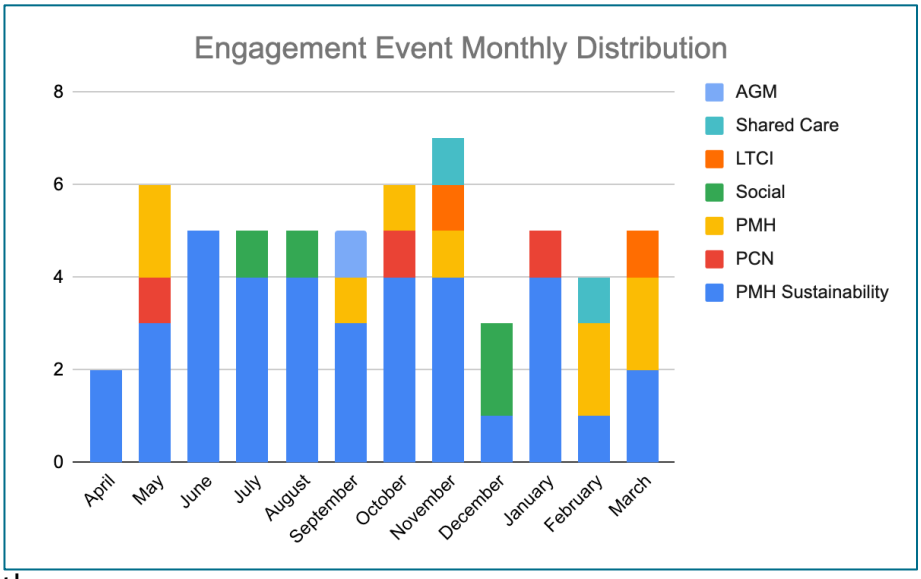
Projected retirements in the next year are set at 7 with a five year forecast of 25 family physicians retiring out of the FNW communities. This projection is an estimate and is based on an estimate that approximately 10% of our members that are 21+ years in practice will retire between 2020-2024 as we have 173 members that are 21+ yrs. 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.



Communications and Engagement

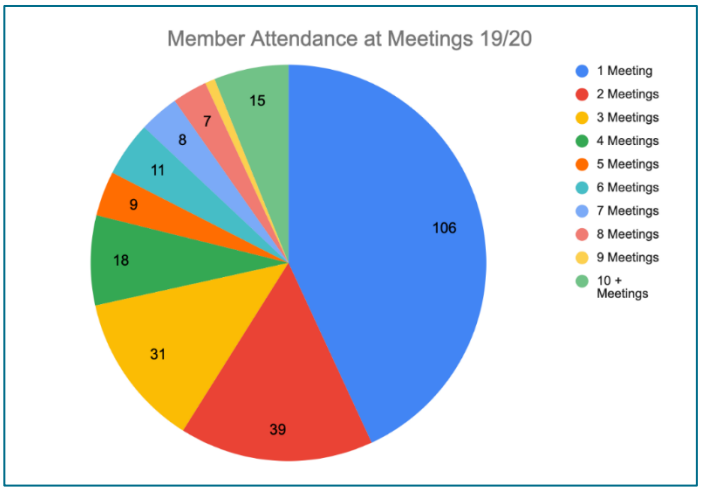
ENGAGEMENT EVENTS

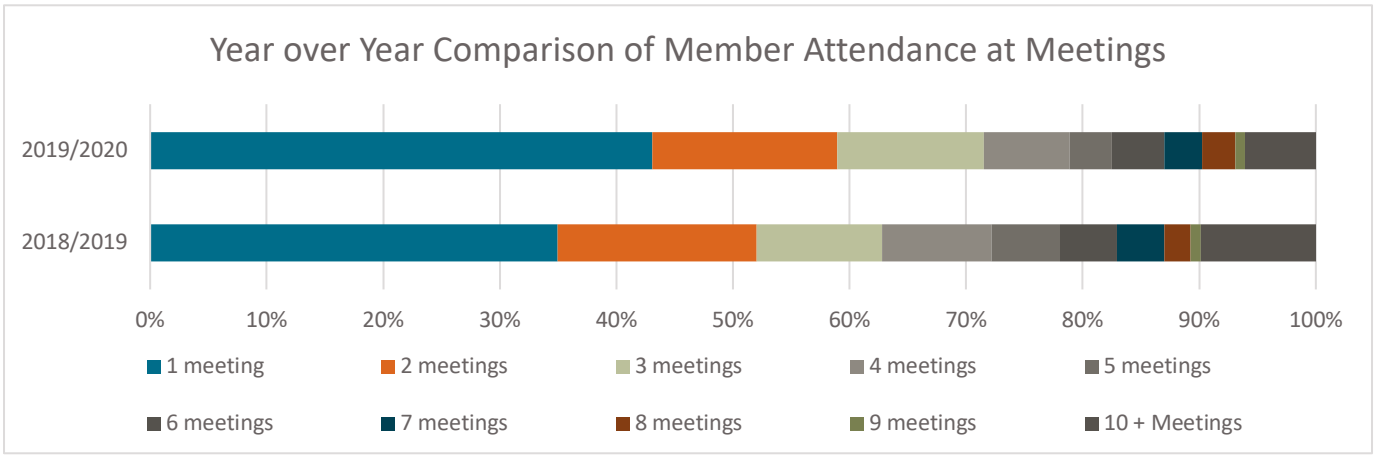
Over the last year, the Division hosted or partnered in hosting 59 events. Approximately 60% of all events were hosted as part of a specific program area and are noted in the designated program area. To the right of this shows a recap of the number of events and their categorized program area by month. A video was put together to showcase a few shining moments from last years events, click here to access the video.



ACCOMPLISHMENTS

244 Division Members attended events in the past year with 57% of them attending 2 or more events.



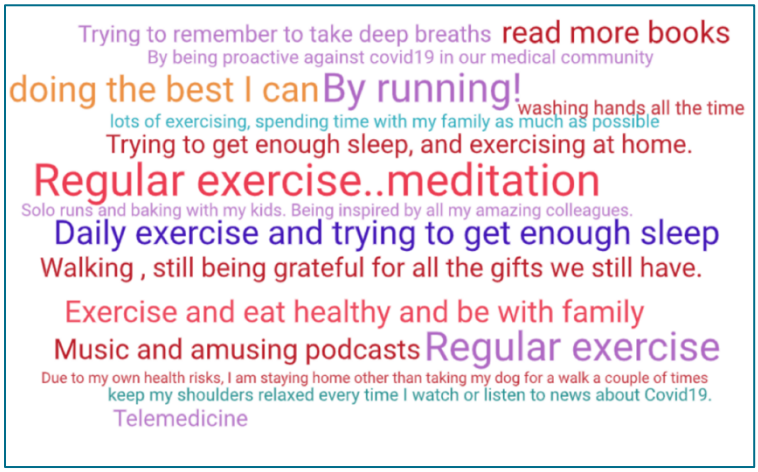


MEMBER COMMUNICATIONS

YEAR IN REVIEW

Over the last year, the FNW Division continues to reach out to members through online newsletters including biweekly Fast Facts and a Monthly Newsletter. These communications share relevant practice specific resources and information, upcoming events, changes to community resources/services, and opportunities for feedback sharing and engagement. 29 Fast Facts communications were distributed over the last year with an average if 44% of those who received the communication, opening it. Of the links provided in these communications, 7% of those who opened these communications clicked on relevant links. In each Fast Facts, a survey question is incorporated to invite members to share their feedback.

The below word bubble reflects feedback from Physicians on what they do for personal self-care.



PUBLIC COMMUNICATIONS

YEAR IN REVIEW

The FNW Division previously introduced an opportunity for the public to share feedback through the public facing division website. Themes from this data collection largely focused on the need for attachment to FPs in the community with additional feedback inquiring about finding either a FP or an NP in the community. Responses and feedback compiled from April 2019-March 2020 show the most common words used by visitors, as shown by this word cloud.

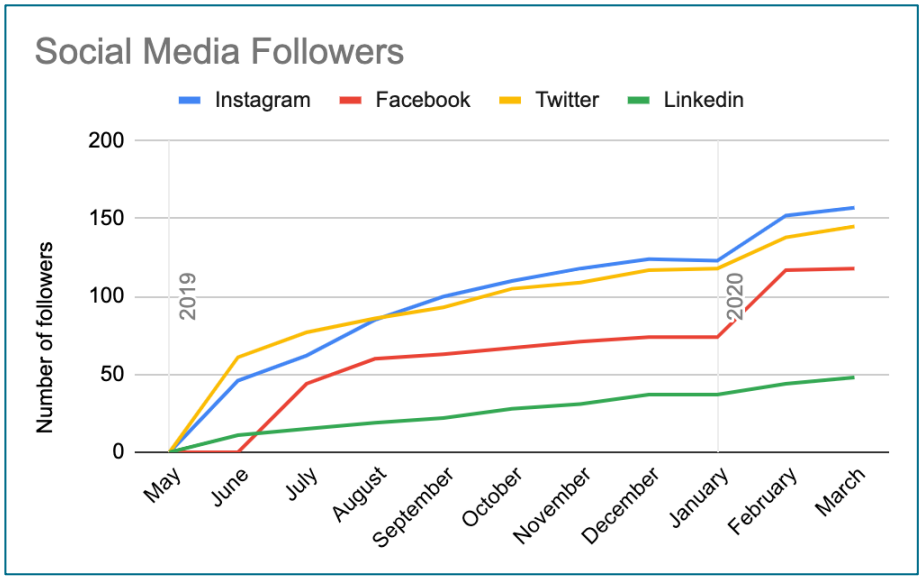
Additional resources were launched related to public engagement through various FNW Division social media strategies where the division's communication team is utilizing multiple social media platforms to:

- Increase public perception, understanding and satisfaction of what primary care services are available in the FNW
- Increase the promotion of division specific activities and programs to members through ongoing maintenance of division resources on the public facing website

- Increasing attachment and access to primary care services in the community through increased public education and understanding of what's available, but also how to properly utilize the primary care services within their communities.

GROWTH

Public Engagement saw a rapid growth by utilizing social media platforms such as Facebook, Instagram, Twitter and LinkedIn for the FNW Division starting June 2019. As of March 2020, there are a total of 157 Instagram followers, 145 Twitter followers, 118 Facebook page likes and 48 LinkedIn followers.



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Dina Davidson, Registered Midwife Lead
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Dr. Gina Zheng
Chelsea Bruce
Annie Liao
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Dr. Mahsa Mackie
Dr. Carlin Man
Dr. Josee Poulin

Dr. Vincent Wong
Dr. Jennifer Yun

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Dr. Cindy Lou, Palliative Physician Lead
Dr. Wai Phan, Palliative Physician Lead
Dr. Fify Soeyonggo, Palliative Physician Lead
Dr. Joan Eddy, Palliative Physician Lead
Dr. Doris Barwich
Dr. Cristina Liciu
Dr. Mina Perez Flores
Bella Wang

Joanne Hum
Shelley Briggs
Kathleen Yue

GERIATRIC PSYCHIATRY SHARED CARE

Dr. Carlin Man, Physician Lead
Dr. Simon Woo, Specialist Lead)
Dr. Hem Phaterpekar

WOMEN'S HEALTH SHARED CARE

TBD, Physician Lead
Dr. Sara Houlihan, Specialist Lead
Project Group TBD

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Dr. Vincent Wong
Dr. Jenni

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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.