Fraser Northwest Division

Annual Report

2021-22

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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**

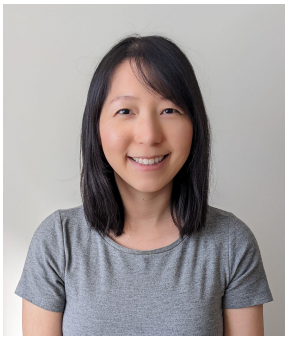
Mission

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. **Providing a voice for our Family Physicians through grassroots engagement, dialogue, idea gathering, and participation**
5. **Engagement with our patients to understand their expectations and needs**

Values

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

Co-Chairs' Message



Dr. Gina Zheng
Co-Chair

Dr. Jennifer Yun
Co-Chair

Dear friends and colleagues,

This past year we saw the increasing burden you all shouldered as we navigate the second year of the Covid-19 pandemic in a health care system with limited resources. We saw many of you face the challenge of continuing to provide longitudinal care when the demands on you seem to be ever increasing. We saw many of you strive to fulfill your roles as acute care and obstetrical care providers when the infrastructure seems to be crumbling, with limited nursing and clerical support. We see your struggles, but we also see your resilience and your compassion as health care providers.

FNW division staff have been keeping close contact with many of you and continue to work hard to support the day to day operations of running your practice during the pandemic, helping with Clinic website creation, online booking support and ensuring you have access to UCI or CareConnect. The Division has worked hard to create the team around you: RN in Practice, MOA supports, Clinical Pharmacist, SHARE counselors, and Nurse Practitioners as primary care partners in your practices. Many division members have been busy making a difference on how we manage patients with breast disease, chronic pain, and more with Shared Care projects with our consultant colleagues. Please read the annual report on what you and your division have been doing in the past year.

As board members, we represent you to the bigger health care system. We collaborate with the Fraser Health Authority to ensure our care of patients are unhindered. We participate with other divisions in FHA to promote the primary care lens to the health authority. We bring up the struggles we hear from you to our partners in FHA, Doctors of BC, GPSC and the Ministry of Health, so that your voices are heard. Please continue to inform us of your struggles and challenges, as we are here to help, so you can focus on what you do best–looking after your patients–and find the joy in what you do again.

Drs. Jennifer Yun & Gina Zheng

Executive Director's Message

Kristan Ash
Executive Director

Dear Members,

As I reflect on the past year, I want to recognize the continuation of stressors and burdens that have impacted you, your families, your patients, your staff and your colleagues. You have weathered through the continuation of the pandemic, vaccines and vaccine hesitancy, overdose crisis, floods, heat domes and, of course, the newly identified primary care crisis. Yet you are all still here in our community providing patient care, and I continue to be amazed by the resourcefulness, resilience and stamina I see in the Family Doctors in Fraser Northwest.

Despite the challenges, we have seen many positive outcomes that we would be remiss not to celebrate. We have honed our skills and developed flexible mindsets regarding how we support our members and how you all keep treating your patients through a blended or hybrid virtual and in-person.

This year we celebrate several retirements of long practicing members who had extended their practice through the pandemic and have now determined that it is time to enjoy a new chapter of life. We have welcomed new Family Doctors to the community and continue to work toward making Fraser Northwest the best place to practice in the province. We will continue to support you in your practice, and I welcome an invitation to meet over Zoom or a coffee in person to hear how the Division can help your innovative ideas on how to increase physician capacity while decreasing the physician burden.

I hope you take the time to read the annual report and reflect on the many events and activities that have occurred in the past year. It has been my pleasure to serve you all, and I look forward to serving you this next year.

All my gratitude,
Kristan Ash
Executive Director

Treasurer's Report

Dr. Vincent Wong
Treasurer

Dear Members,

I am honoured to be writing to you as the Board Treasurer and Chair of the Finance and Governance Committee.

The 2021/22 fiscal year was fraught with multiple challenges, including the vast number of unknowns to funding faced with our vendors, and the PMA which is currently in negotiations.

Thankfully through the efforts of our Executive Director, Controller, and the Finance & Governance Committee, we arrived at a budget that supports the Division's operations in the upcoming year.

We continue to review the Division's policies on a regular basis to ensure that they are kept up-to-date and support best governance practices.

As we look towards the new year, with multiple advocacy voices regarding the primary care crisis, I hope that we will arrive at a financial landscape that not only supports our Division but family practice as a whole.

Dr. Vincent Wong

Patient and Community-Focused Initiatives

Primary Care Network

Aim

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

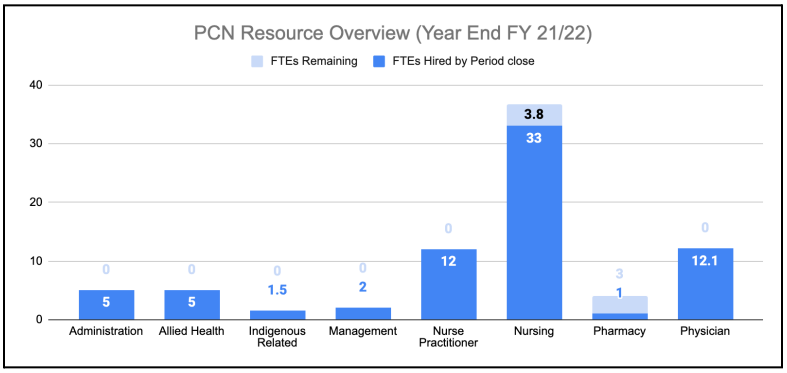
- To create a quality, integrated and coordinated delivery system for primary care that is patient-centred, effective in meeting population and patient needs and delivers a quality service experience for patients
- To create the structures necessary to enable all members of the community to receive the 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 third year of the FNW PCN funding continued with increased resource utilization with the addition of contracted Family Physicians (FP), Nurse Practitioners (NP), Registered Nurses (RN),Indigenous Supports and the first Primary Care Clinical Pharmacist (PCCP). The graph reflects the successful recruitment of a number of Primary Care Providers (PCPs).

The PCN Steering Committee co-created a shared Coordination of Care Principles which included:

1. Patient Centered Care
2. Easily Accessible
3. Team-Based Care
4. Relationships
5. Safe Care



Although there werenet gains in the previous years, the third year saw a significant net loss in the number of PCPs leaving the community. Providers leaving the community noted the increasing costs of overhead, ongoing burnout and overall health system structural supports as being contributors to moving away, retiring early, or moving into a different type of practice away from longitudinal primary care.

	2019	2020	2021	2022	Total
Provider Adds	12	18	18	3	**-12 providers since PCN inception**
Provider Losses	27	13	15	8	
Net Loss/Gain	-15	+5	+3	-5	

One FP reached out and expressed concern and interest in getting involved in recruiting potential providers to the area. This provider identified the impacts of losing these providers and that *"it's beginning to feel a bit hopeless being a youngish doc in this area and seeing/hearing all the docs retiring or planning to soon. It's causing me some panic too about the state of things moving forward. Although I already feel overwhelmed and overworked,* ***I feel like I need to find a way to be part of the solution to this.*** *If you could let me know who I could speak with about finding a way to be involved, I'd appreciate it."*

In early 2022, an overview report of the FNW PCN progress towards outcomes report was created and looks at the network's progress towards 8 PCN Core Attributes. This report can be found on the FNW Division website or by clicking here.

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

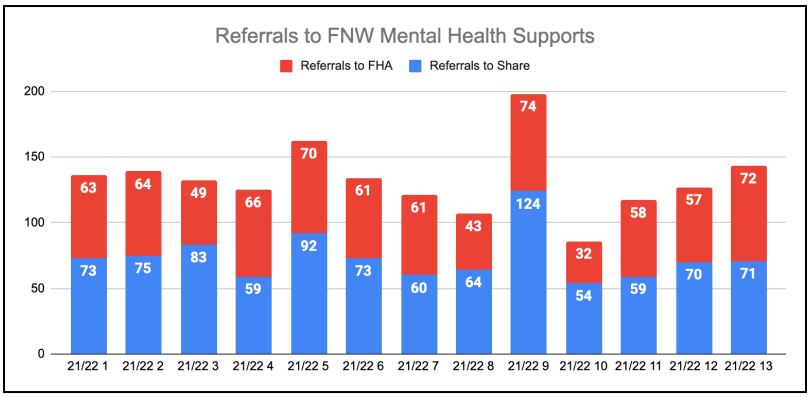
Registered Nurse in Practice Initiative: At the end of this year, 24 PMHs have RNs in practice (20 with permanent coverage and 4 with temporary coverage). Clinics continue to actively recruit alongside program administrators to fill the remaining positions. Relief coverage shifted in the last year to have one relief RN cover a selection of Patient Medical Homes (PMHs) to ensure familiarity and consistency when permanent RNs are away. Out of the 9 relief positions, all are active with 2 new positions identified to support the initiative - a CRN and a Clinical Resource RN.
A number of providers shared their experiences of having a RN in practice as an extension of team based care within the PMH. **The short video (click on the image below)** shares these firsthand experiences and benefits of having an RN working in clinics as an extension of primary care.

Recently, *it was shared that a new Family Physician has started to practice at one of the FNW community maternity clinics. In citing reasons why they began to practice in maternity care - which traditionally in this community has seen challenges in recruitment and retention- they cited the capacity created by the RN in practice working at this clinic. The extension of the team allows for an increased coordinated approach in providing care to patients.*

As part of the FNW PCN Service Agreement, attachment targets per provider were shared in association with PCN funded provider resources. For RNs, it was identified that the addition of this provider could support up to 500 new attachments in PMHs. In Summer 2021, reach outs between Division staff, and PMH practice

staff took place to identify net new attachments since PCN inception. Of the 13 clinics that reported back with their attachment numbers, the average community level attachment/PMH is well above 800 net new attachments. Incorporating an RN into a practice not only enables attachment, but increased coordination, communication and quality of care between providers, patients, and health care services.

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



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

The members of the Kwikwetlem First Nation are accessing the services from the clinic. The Physicians are in on Wednesdays. There is also a Nurse Practitioner in the clinic on alternate Fridays. The Community Health Nurse is in 2 days/week to do drop-in for Kwikwetlem First Nation's members for injections, medical assessments, referrals, wellness checks, blood pressure, blood glucose checks, wound care and assisting with the Physician of the day's phone calls. The Aboriginal wellness advisor has assisted the Director of Health to assess the wellness needs of the community. They are currently working on meeting the needs of the community by seeking community partnerships with local organizations. In addition, the wellness team is actively seeking grants for wellness programs. Lastly, the Aboriginal wellness advisor worked with the Nurse to hand out food to the community members and provide lunch for the children, youth, and elders.

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

Attachment

Aim

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

Attachment Hub

This year, the FNW Division Attachment 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 over 10,000 attachments recorded by the end of March 2022.

	FY 19/20	FY 20/21	FY 21/22	Total Attachment
New West	1295	826	2559	3385
South Coquitlam		1376	2117	3493
Port Coquitlam		947	1194	2141
Port Moody, Belcarra, Anmore & North Coquitlam		116	384	500
Total		**3265**	**6254**	**10814**

PCN Future Sustainment

The sustainability of the PCN model in the FNW communities requires ongoing commitment to implementing Quality Improvement initiatives, seeking feedback from partners, and ensuring a coordinated and supportive effort is demonstrated by leadership organizations. In the FNW community, recognizing the demographic distribution of the existing primary care providers, and their projected retirements, coupled with the larger than average panel size, complexity of patients, and high overhead, are factors that require attention in order to recruit new providers and retain existing providers. In order to meet the FNW PCN goals and outcomes, continued partnership between health authorities, physicians, nurse practitioners, nurses, allied health and other community providers is necessary in order to attain a patient-centred quality, integrated and coordinated delivery system for primary care.

PCN physician lead

Dr. Paras Mehta

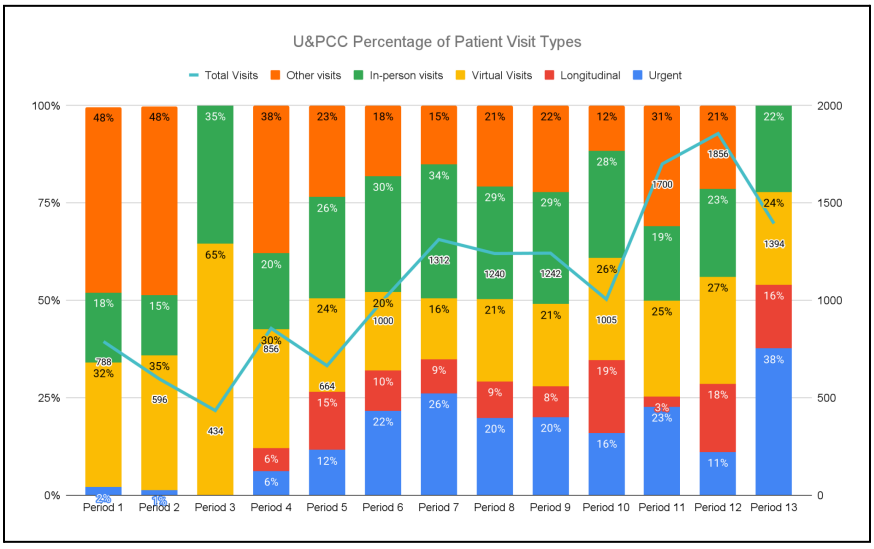
Urgent & Primary Care Centre (UPCC)

October 2019, the Ministry of Health (MoH) released an updated policy paper for the UPCC. The Division Board reviewed the updated policy and identified Port Moody as a community in need, with the population growth and cost of office space preventing a sustainable solution for Family Medicine.

From Spring 2020 until late Summer of 2021, the Division engaged with Fraser Health (FH) and the MoH to open a UPCC in Port Moody.

In February 2021, the Tri-Cities UPCC opened its temporary location at Eagle Ridge Hospital (ERH). The UPCC 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 UPCC currently operates from 9am-8pm, 7 days a week. The UPCC 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.

A permanent location for the UPCC was identified by FH and the lease signed in July 2021. In late August after reviewing some of the language within the lease agreement, the Division Board Directors had to make a difficult decision regarding the continuation of the engagement in the operational design and formally withdrew the Division's support of the lease at the permanent location. For more information please contact FNW Executive Director Kristan Ash.



The Division continues to work to find ways of attaching patients to longitudinal providers within FNW and recognize the importance and need for affordable clinical space.

A Physician shared an experience whereby having access to the Tri-Cities UPCC enabled follow-up for a patient who was considered high risk and had received routine testing in the ER; however, was not attached to a primary care provider in the community. The UPCC was able to contact this patient for ongoing treatment regarding the test results and ensure follow-up is supported at this site.

U&PCC Physician Lead

Dr. Nimeera 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. A *Year in Review* report was completed in the summer of 2021 (reporting April 1, 2020 - March 31, 2021) and ED Visits, admissions, bed days, and length of stay continued to decrease. Over the last year, much of the focus of the initiative focused on strengthening the recruitment and orientation process for LTC Physicians and staff. Improved processes to track candidates and available placements through identified workflows for Division administrators to provide proactive support throughout recruitment stages has resulted in enhanced networks of support for the community care homes. Onsite orientation support with facility medical directors, Division administrators and the introduction of information checklists for facilities to support the orientation process have been established in this last year. Once the orientation process is complete, ongoing support for newly recruited providers includes strengthened collaboration to improve the mentorship program and an annual meeting hosted by the lead physicians for providers new to working in LTC.

Community engagement work that occurred over the last year included:

- LTCI Lead Physicians presented a webinar for the community on what to expect when moving into long-term care ("Whats Up Doc")
- Updating the Fraser Northwest LTC Hub website to become a resource for the facilities
- Coordinated access for physicians who are on-call to view and chart on other facility's EMR

Continuing Medical Education & Events

- May 2021: Anxiety and Depression in Dementia Patients
- June 2021: Covid-19 Recovery and Physician Burnout
- September 2021: Competency Assessments
- November 2021: Suturing Skills
- January 2022: Canadian Medical Protective Association
- March 2022: Wound Care Basics

Physician Leads

Dr. Amber Jarvie
Dr. Lalji Halai

Community Centred Engagement & Communications

AIM

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

Patient/Public Partnership

Patient partners joined the PCN Steering Committee, a number of Shared Care Working groups, and Community Health Focus Groups over the last year. 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:

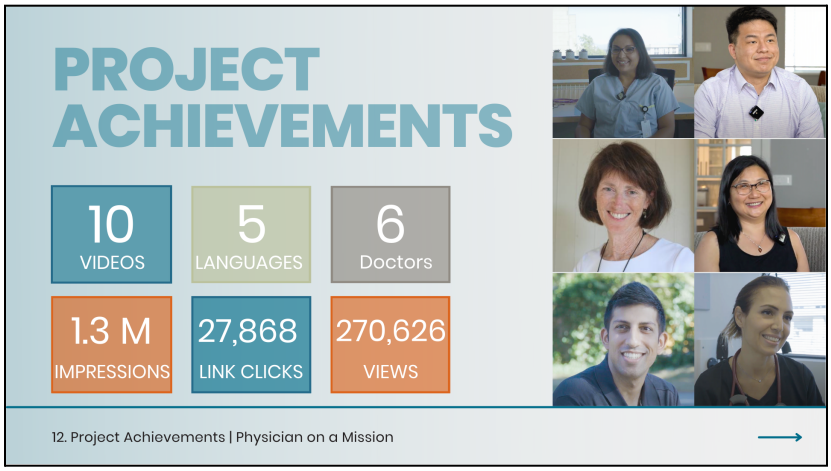
- Attachment to a Primary Care Provider
- Vaccine Hesitancy/Uptake
- Access to Virtual Health
- Importance of access and impacts of lack of access to primary care in their community

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 important across the communities. Patients articulated their journeys in accessing different types of care - namely the shift to virtual care over the last 2 years. **Clicking on the visual below will redirect to a short video** from FNW community members.

Covid-19 Video Vaccine Campaign

Physicians on a Mission was a Health Canada grant campaign in which the goal was to amplify the voices of local family physicians in the hopes of increasing vaccine confidence in the FNW communities in Summer 2021. Six Family Doctors participated in videos which were distributed through social media platforms and community network partners. Final project reports were submitted to a national committee in September 2021 and through the powerful messages from

members, the community engagement and impact, the FNW Division was selected as the grand prize winner of the Vaccine Community Innovation Challenge!



Communications

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

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

The team launched resources related to public engagement through various FNW Division social media strategies where the division's communication team is utilizing multiple social media platforms. Over the last year, ongoing changes in public engagement through social media platforms such as Facebook, Twitter, Instagram and Youtube have contributed to increased utilization.

Pathways

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

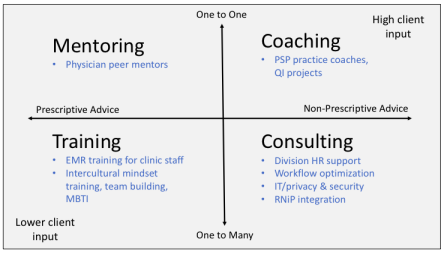
Physician-Focused Initiatives

Patient Medical Home (PMH) Sustainability Program

Overview

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

Recognizing that each provider and practice setting is unique, and that engagement requires a dynamic and nuanced approach, FNW Division has adopted a service model that is highly individualized and adaptive. Taking on the roles of coach, consultant, mentor, and trainer in different capacities enables the Division to provide meaningful support that is responsive to the needs of its members.



With increased challenges to primary care seen over the past two years, including continued uncertainty around the COVID-19 pandemic, higher rates of patient unattachment, provider burnout, and medical office staff shortages, FNW Division has remained committed to supporting the sustainability of the patient medical home through increased efforts to enable physicians and their teams to provide timely, accessible, and equitable care for patients in the community.

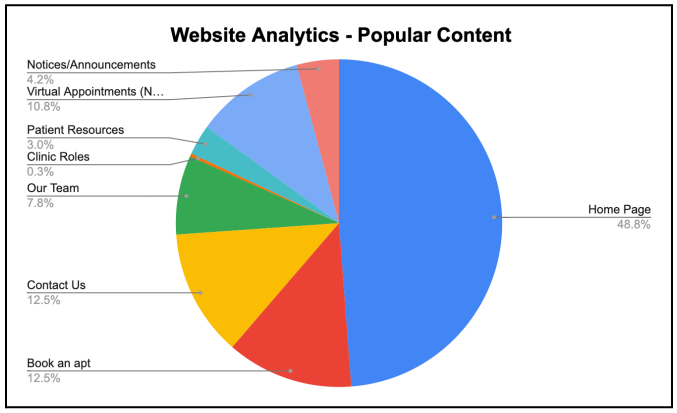
Workflow Optimization

Member specific workflow innovation reimbursements and support are ongoing through the FNW Division. **Clinic website** and online booking development and implementation have supported almost 50% of FMW PMHs to launch a clinic website. Similarly, almost all of these have utilized this service to incorporate telehealth into their practices. The graph

here reflects the breakdown of the following services since 2019:

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

Data Analytics pulled from each clinic website details the high number of users and where the traffic is typically going when clicking on the clinic website. With online booking optimized through clinic websites, this is the second highest means for entry into the clinic websites by patients as shown in the graph here.



For clinics where **online booking** has been implemented, feedback collected from these clinics has identified that the implementation process went "*quite smoothly*"; however, clinics are mindful that training and support for non-tech savvy staff members is important to facilitate so as to ensure seamless integration into the workflow. Clinics identified opportunities for future support to other interested clinics that focus on:

- Peer engagement and support - connecting interested clinics with clinics already using the online booking support
- Financial support and continued maintenance of clinic websites
- Training staff and providing education sessions
- Patient education

GPSC incentives such as the Minor Tenant Improvement (MTI) funds and the Team-Based Care Grant have been promoted and supported in FNW clinics. Since 2019, 9 FNW PMHs have applied for the MTI funds and 8 of these have been approved. Division staff support clinics through making recommendations on what spatial supports could increase efficiency and clinic provider capacity.

A recent example has presented as an opportunity for a QI project, which has been supported by both the Division and PSP. Recognizing the impact that clinic organization and space utilization has on efficiency of work, this clinic has been making substantial changes to inventory management, exam room layout, and spacial reconfigurations. This has been beneficial to all team members, and in particular streamlining the onboarding process and ongoing satisfaction of the RNs in practice, without adding additional burden to the family doctors at the clinic.

Recently, Division staff have provided support in freeing up clinic space by transferring paper medical records to the clinic's current EMR. This work supports clinics and clinic staff in utilizing space that was storage for medical records resulting in

the availability of additional clinical space. This project was originally piloted in 2019, before the pandemic, and has since restarted to support interested clinics in Winter 2021.

Team Member Enhancement

In Fall 2021, a number of FNW PMHs sent out urgent communications related to current practice staff leaves without notice. These leaves have significant effects on clinic workflow as well as increase the rate of burnout for the remaining clinic staff. In responding to these requests, the Division team has pivoted this model to reflect the immediate need in the community by reconfiguring this database to be a short-term MOA Locum pool while simultaneously providing more one to one clinic support to better meet their individualized HR needs. Additionally, division staff have created a short-term role to support and alleviate some of the pressures that unplanned notice can have on clinics by creating a '**floating' MOA support** position whereby this person can provide short-term coverage for clinics when needed.

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

MOA Network

Strengthening team-based care is a priority for the FNW Division and it's recognized that ensuring practice staff are provided opportunities to engage, learn, and share experiences is a key measure of success in a PMH. By having Division program staff reach out and engage with PMHs and practice staff, learning opportunities emerge that were brought back to community engagement events. Engagement mechanisms shifted over the last year to ensure events are tailored to the immediate and shifting needs of practice staff. Over this last year, event engagement has focused on:

- April 2021: MOA Focus Groups
- September/October/November: MOAs Communication with Marla & Lesley Cohort (3 sessions)
- December 2021: MOA Advisory Committee Meeting
- March 2022: MOA Virtual Town Hall
- February/March/April 2022: Intercultural Mindset with Marla & Lesley (3 sessions)

Continuing since January 2021, feedback mechanisms were introduced 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

In Spring 2021, the IT program pivoted to increased proactive support and clinic engagement to ensure clinics are up to date on their privacy and security needs. An IT Inventory Checklist was created based on privacy and security recommendations made through Doctors of BC (DoBC), Doctors Technology Office (DTO) and the Canadian Medical Protective Association (CMPA). Since launching in May 2021, approximately 42% of FNW PMHs have completed this inventory with the remaining PMHs currently engaged in completing this process. This inventory provides a thorough review of the recommended privacy/security requirements and allows for the Division staff to support in ongoing implementation and maintenance of requirements based on the individual clinic's needs and priorities.

In Winter 2022, The Division launched a pilot program supporting local PMHs to apply for funding to support improved clinic workflow and efficiency. Applications were accepted for clinic technology trials, to be funded until the end of FY 21/22. The Division staff was able to provide project management, implementation, and vendor liaison support as needed.

Emergency Preparedness

In Summer and Fall 2021, the province faced a number of emergency weather conditions including intense heat, flooding and wildfires. Although not all extreme weather directly impacted the FNW communities, the extreme heat had a significant impact on the FNW communities as many buildings are older builds and therefore have limited access to air conditioning and effective air circulation. Members identified concern and raised questions around preparedness moving into Summer 2022 for both their patients and their clinics.

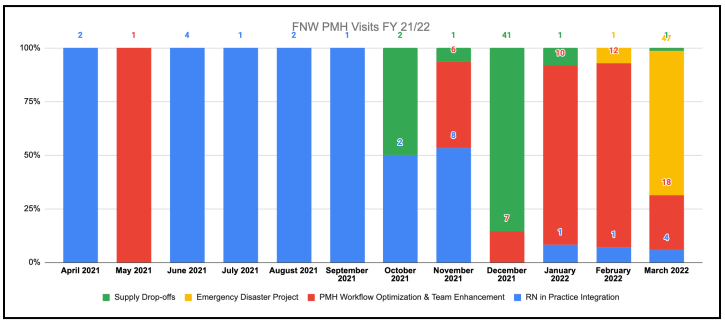
The Division took on the responsibility of supporting the FNW PMHs to be prepared as a clinic group in the event of a major disaster. By putting together disaster relief plans and kits, the hope was that this would reduce workload on physicians and MOAs and bring a sense of relief when this is completed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

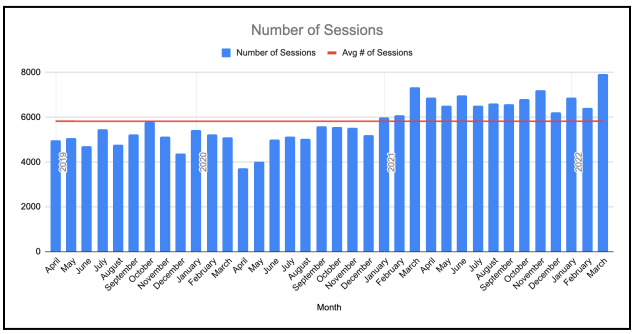
FNW PMH Visits

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

- Supply Drop-Offs
- Emergency Preparedness
- Workflow Optimization & Team Member Enhancement

- *and* RN in Practice Integration





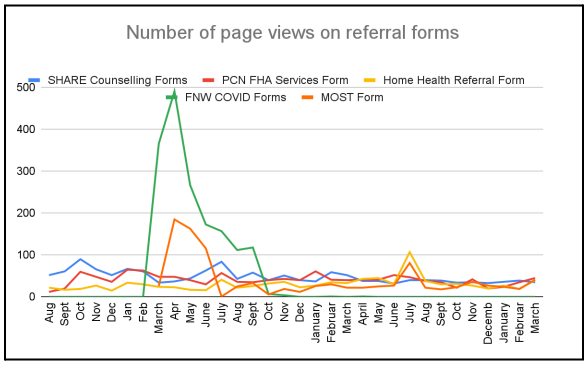
There has been alignment with FNW engagement events by incorporating how Pathways can support integration of subject matter covered at these events into daily practice. There has been a 24% increase in the number of users logging into Pathways over this last year and a 27% increase in the number of sessions.

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:

- 180 FNW Family Physicians with profiles in Pathways
- 93 FNW clinics listed
- 291 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.



	Number of Sessions	Average Number of Users Logged in
FY 20/21	64345	214
FY 21/22	81533	266
% Change	**27% ↑**	**24% ↑**

Pathways Integration at Ask The Expert (ATE) Events

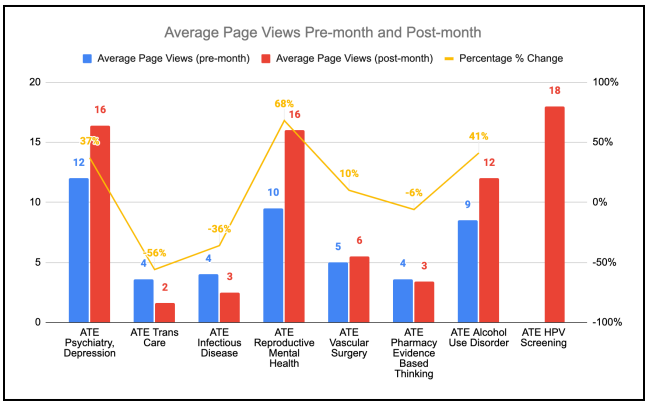
In FY 21/22, the FNW conducted Pathways resource demonstrations for a total of 8 ATE events. During these Pathways demonstrations, Primary Care Providers were exposed to resources aimed at educating themselves, in addition to providing support to their patients across various health-related topics and speciality areas.

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

- Physician Resources

- Patient Information
- Community & HA Services
- Forms

To showcase the impact of these demonstrations, data were pulled from the Pathways website. Specifically, the average number of page views one month prior to the event, and the page views one month following the event were used. As a result, there was an 8% average increase in the number of page views across the highlighted resources for each event.



Partnership Supports

Practice Support Program (PSP): PSP continues to support Family Physicians in panel management, 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.

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

Doctors Technology Office (DTO): DTO continues to offer toolkits for support in implementing IT and privacy and security guides into PMHs. Over the last year, work was completed related to developing a privacy and security manual for PMHs, with input and feedback from DTO and direct implementation support from the FNW IT Coordinator. A fulsome PMH IT Checklist has been developed in partnership with DTO to support FNW PMHs in understanding IT related needs and assess opportunities for further risk reduction/mitigation within practices. This work will continue to take place in the 2021/2022 year. Building a stronger partnership with DTO over the past year has also led to more opportunities for information sharing based on member feedback related to IT and privacy & security concerns and frustrations, as well as identification of education opportunities, which are currently being planned.

Health Data Coalition (HDC): The Health Data Coalition *"is a physician-led data sharing network that encourages self-reflect and practice improvement in patient care. HDC provides access to a secure, core set of anonymized aggregate data"* for physicians and practices. HDC representatives have worked alongside FNW Division staff and Physician leadership to identify opportunities for integration into FNW led engagement events for members. At the end of FY 21/22 there are 29 FNW PMHs enrolled with HDC.

Physician Leads

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

Shared Care

Aim

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

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

A Shared Care Steering Committee was formed in November 2021 to oversee all FNW Shared Care projects and to provide advice and input to the development, progression and alignment of Shared Care projects to address the community gaps in care.

Maternity

Project Phase: Sustain and Spread
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 developed the 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 address communication concerns and information sharing, the committee implemented a newborn discharge summary that can be given to patients at discharge to take to their primary care provider. The team has also been focusing on facilitating an earlier attachment process with the patient during the pregnancy period in order to avoid mom/baby being discharged from the hospital with no plan for family physician follow ups. 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.

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

Physician Leads

Dr. Dayna Mudie (Family Physician Lead)
Dr. Natasha Simula, as of October 2021 (Specialist Lead)
Dina Davidson (Registered Midwife Lead)
Dr. Aude Beauchamp, ended as of October 2021 (Specialist Lead)
Thank you for your support and leadership.

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

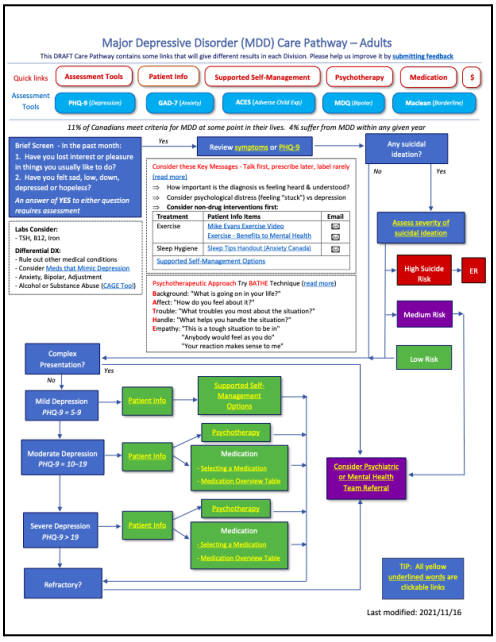
Dr. Kathy Kiani (Family Physician Lead)
Dr. Simon Woo (Specialist Lead)

Mental Health and Substance Use

Project Phase: Sustain and Spread
Description: Patient and provider surveys revealed that challenges exist with referrals, resources available, specialist wait-times, and family physician time required to diagnose and treat patients. The goal of the Adult Mental Health and Substance Use Shared Care project is to foster relationship-building, learning, communication, and capacity for

communication between family physicians, nurse practitioners, psychiatrists, and mental health teams across the FNW region. A key activity implemented was a series of psychiatry and sub-specialist events and sessions aimed to increase family physician capacity, education, and relationships with specialists. A depression care pathway was also developed in collaboration with Pathways for primary care providers to be able to quickly access information in one spot. The care pathway includes a clinical flow chart with links to frequently needed assessment tools, emailable patient resources, services, medication and billing tips.

The depression care pathway resource is available provincially to primary care providers on Pathways. As well, please visit the FNW member website to access the event recordings.



Physician Leads

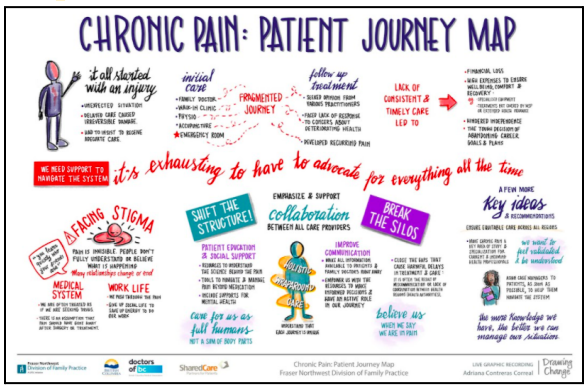
Dr. Carllin Man (Family Physician Lead)
Dr. Stephanie Aung (Family Physician Lead)
Dr. Stephan Ogunremi (Specialist Lead)
Dr. Angelo Wijeyesinghe (Specialist Lead)

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, feedback, and journey mapping. Key themes from the surveys include patient difficulty in accessing services, experiencing stigma, unattachment, provider challenges with opioid prescribing, care coordination among multiple providers, provider education, lack of referral pathways, and lack of resources. In response to the challenges, the team is currently working on increasing awareness of services available to support patients, developing a care pathway for chronic pain, developing a pilot model to opioid prescribing to help patients on high doses connect to a family physician, and provider, RN in practice, and MOA education. 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. So far, the following learning sessions have been completed: pain management, opioid and symptom management and Advance Care Planning. In preparation for the advance care planning session, an easy to use resource to help clinicians with the Advance Care Planning process was developed with Fraser Health. This resource includes interactive quick links to relevant forms, physician resources and emailable patient information. The final panel style engagement session with Palliative community services and practitioners will wrap up the series. 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.

The Palliative Resource Sheet and the Advance Care Planning resource is available to primary care providers on Pathways. Visit the FNW member website to access the learning series recordings!

Physician Leads

Dr. Ali Sanei-Moghaddam (Family Physician Lead)
Dr. Wai Phan (Palliative Physician Lead)
Dr. Fify Soeyonggo (Palliative Physician Lead)
Dr. Elizabeth Wu, as of March 2022 (Palliative Physician Lead)
Dr. Joan Eddy, ended as of October 2021 (Palliative Physician Lead)

Dr. Cindy (Lou) Roper, ended as of March 2022 (Palliative Physician Lead)
Thank you for your support and leadership.

Geriatric Psychiatry

Project Phase: Proposal Implementation
Description: Mental health needs of older adult patients who are 65+ differ from those of younger patients, and thus services specific to this population are available. However, this is not reflected in the current referral process, which triages adults and older adults through the same pathways, resulting in delays and excessive times spent on waitlists. The geriatric psychiatry shared care initiative 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. The following referral algorithm was developed so primary care providers can better understand how to navigate the geriatric MHSU services. As well, a dementia care pathway was developed to provide suggestions on workflow when diagnosing a patient with dementia. Other key project activities include processes for primary care providers to access a quick phone consult from a local Geriatric Psychiatrist, development of a referral acknowledgement letter, differentiating the criteria between geriatric medicine and geriatric psychiatry, and member engagement events focusing on dementia.

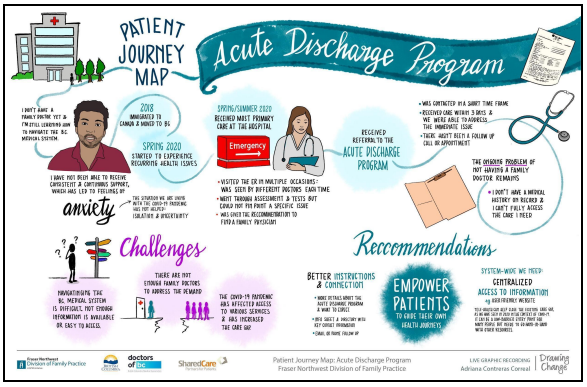
Physician Leads

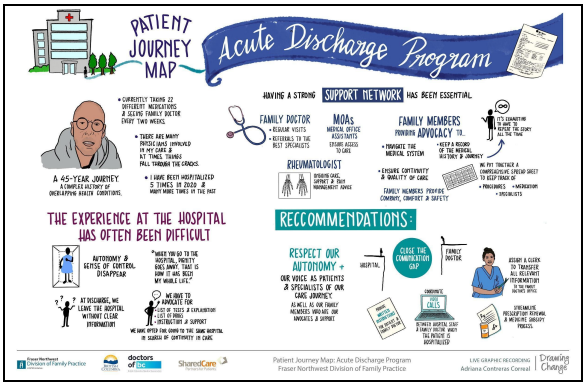
Dr. Carllin Man (Family Physician Lead)
Dr. Simon Woo (Specialist Lead)

Acute Discharge

Project Phase: Proposal Implementation
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 UPCC 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.





Moving forward, the committee will focus on improving and streamlining the communication between acute providers and primary care providers in the patient's discharge plan.

Physician Leads

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

Women's Health

Project Phase: Proposal Implementation
Description: Patients are currently waiting up to 1.5 years from FP referral to surgical procedure. During this time, their quality of life suffers greatly. Urogynecology patients awaiting surgery for pelvic organ prolapse showed similar emotional distress and disability compared with orthopedic patients awaiting hip or knee replacement based on a validated Health Related Quality of Life questionnaire. 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. The project team is currently piloting the new clinic model by fast tracking patients to a specially trained family physician.

Physician Leads

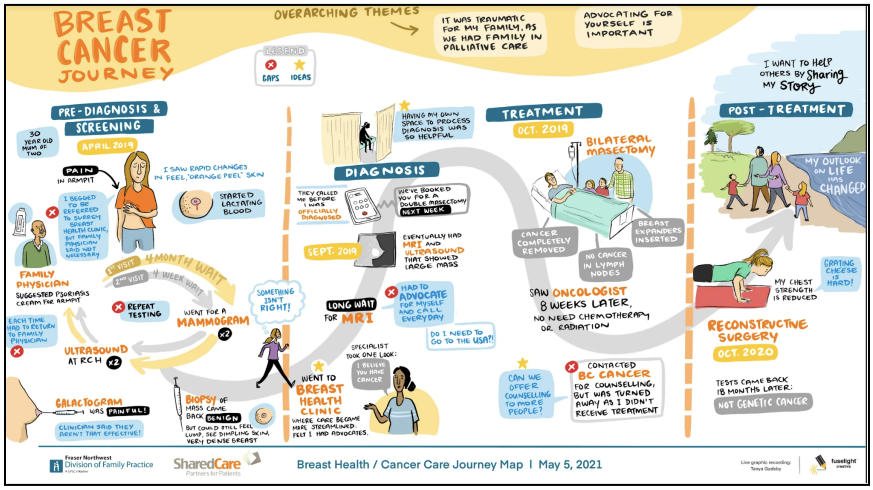
Dr. Sanja Matic (Family Physician Lead)
Dr. Sara Houlihan (Specialist Lead)

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 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.

Led by Dr. Jennifer Yun, the patient journey map helped to inform the development of the Breast Health Shared Care project. We asked a local patient partner to walk us through their cancer care journey from: screening & pre-diagnosis, abnormal test result to breast cancer diagnosis and treatment, and post-treatment.



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 Leads

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

Alcohol Use Disorder

Project Phase: Expression of Interest
Description: This project aims to focus on the challenges and solutions in providing care for patients with a primary diagnosis of Alcohol Use Disorder. Recognizing the prevalence of substance use disorders and the number of patients who may go undetected by the health care system due to various reasons, it is important to build on the trusted patient-primary care provider relationship and strengthen primary care providers' confidence in how to effectively screen patients and equip them with the necessary tools needed to manage patients with AUD. The group recently had its first focus group to conduct the initial needs assessment.

Physician Leads

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

Member Engagement

Recruitment/Membership

Overview

At the end of this year, the Fraser Northwest Region had 434 members. This is a 9% decrease from the previous year, which is likely due to anticipated retirements, leaves, moves out of the community and moves out of longitudinal primary care. Further details on this can be found in the next section as well as the Engagement section of this report.

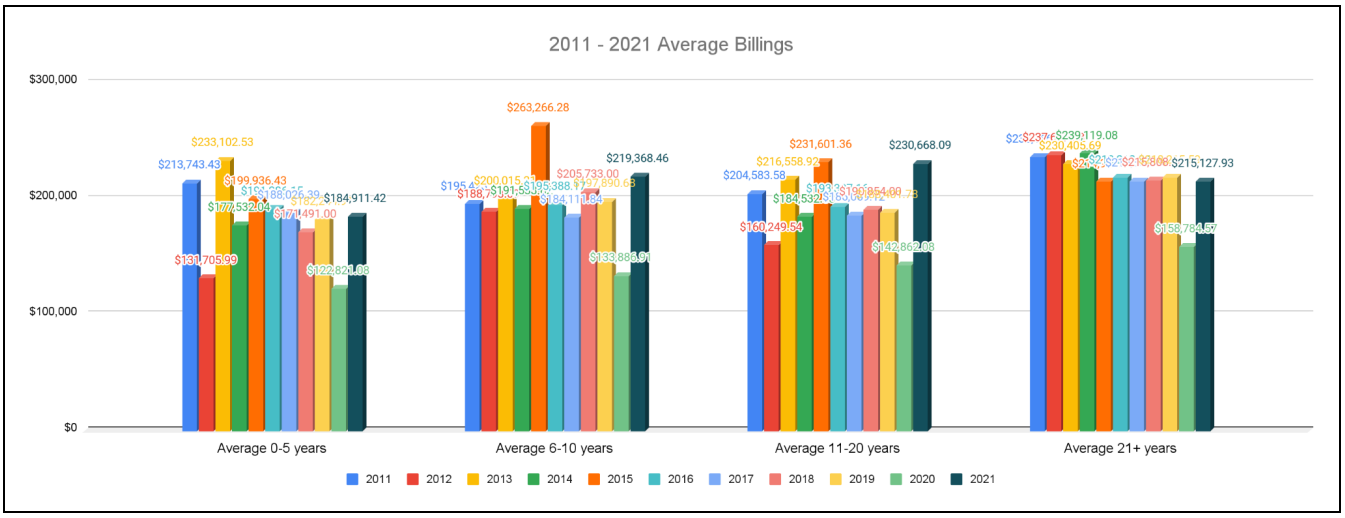
Incentive to Practice in FNW

Over the last year, recruitment and retention practice incentives have contributed to the recruitment of Physicians joining the community. Partnerships with the Practice Ready Assessment (PRA) program, UBC International Medical Graduates (IMGs), PCN funded contracts, 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.

Members of the FNW Board reflected on how much primary care has shifted and evolved over the past 5 years and how the support of the Divisions continue to enable a strengthened system of primary care. **Clicking on the visual below will redirect to a short video** of the board members sharing their experiences.

Composition

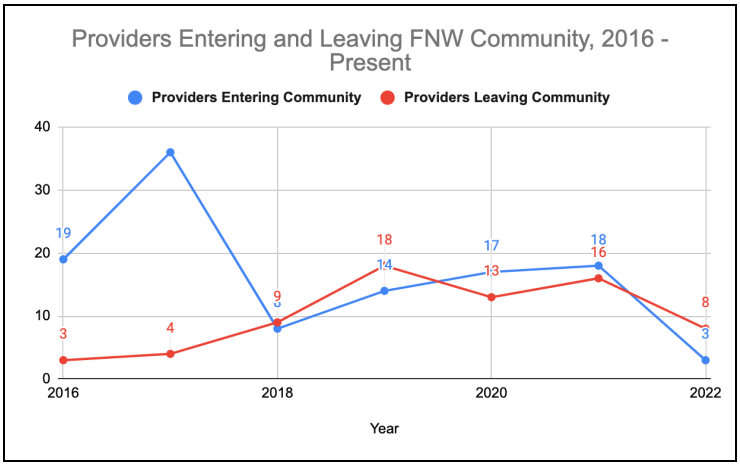
FNW membership continues to be largely comprised of Family Physicians. Locums, Walk-In Physicians and Hospitalists, when combined, make up a similar portion of membership. Nurse Practitioners, Residents, Registered Nurses and Medical Students also comprise a growing associate membership base.



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

Projected Retirements

The number of physicians retiring and/or leaving the community continues to grow, with those leaving citing high costs that the Fee for Service compensation model currently can't meet with how some family physicians practice. Since 2016, there have been approximately 71 physicians leaving the community, with 16 physicians leaving in 2021 and an additional 8 leaving in 2022 already. The graph below shows the distribution of membership changes since 2016.



Projected leaves in the next year are set at 19 due to anticipated retirements, moves/relocation, short term leaves, releasing panel and leaving family practice. Projected retirements in the next year make up 7 of the total 19 leaves 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.

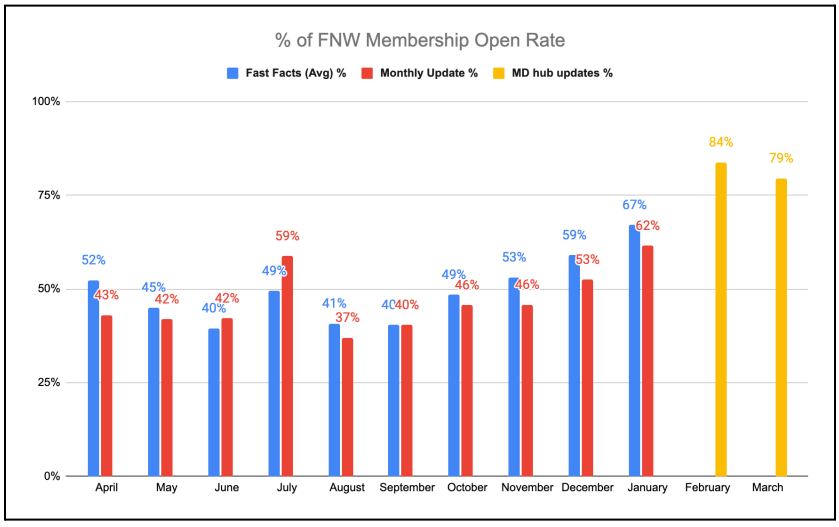
Engagement

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 pivoted to an online forum called the MD Update. NineMD Hub Updates, 20 Fast Facts and 10 Monthly Updates were distributed to members in the last year with, on average, 244 members opening these communications. This roughly equates to 51% of members engaged in these communications; a detailed breakdown of the month over month distribution can be found in the graph below.



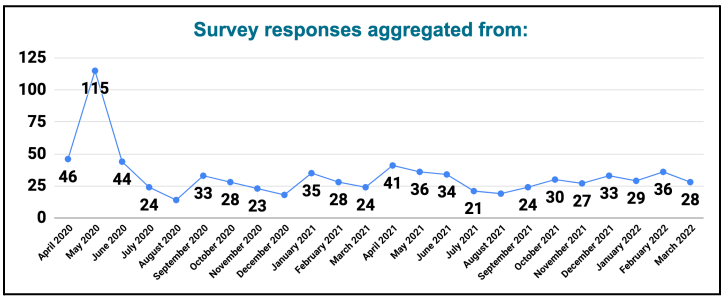
Additional formal communication mechanisms were established through focus groups between Family Physicians, Nurse Practitioners and allied health services to support the continuous improvement of access throughout the changing landscape of this past year. Topics included:

- Recruitment
- Clinic Consolidation
- Home Health
- Mental Health
- Community Health Services (including Home Health, Home Support and Community Outpatient Services)
- Geriatric Psychiatry
- After Hours Care

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

Reach outs for this next year will pivot from a monthly to a bimonthly basis. 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.



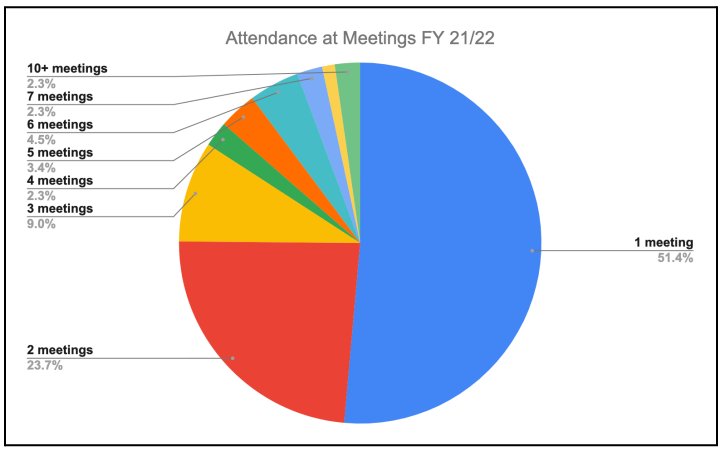
New Member Engagement

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.

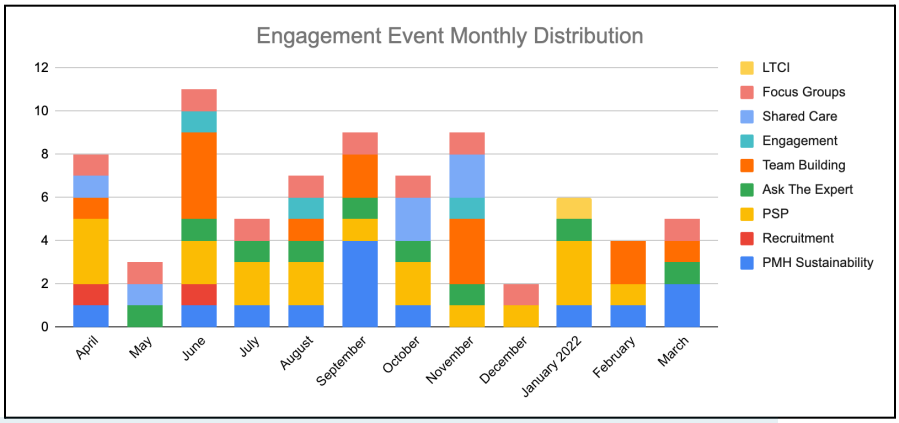
Events

FNW members continued to engage by participating in events, workshops and education opportunities with their peers and colleagues. 51% of Division members attended one or more events over this last year with almost 45% of those members attending 2 or more events.



Accomplishments

The Division hosted approximately 75 events in the last year with the most events occurring in June 2021. The Ask The Expert events continue to be highly successful and well attended. Additionally, in the last year, PMH team development Lunch and Learns have been introduced to strengthen PMH teams. Smaller, targeted, clinic team member development have been instrumental in facilitating and engaging teams in identifying their leadership style, strengthening intercultural communication, cultural safety and communication training.



Board of Directors and Staff 2020

Board members

Dr. Cathy Clelland, Secretary
Dr. Kathy Jones, Knowledge Keeper
Dr. Nimeera Kassam
Dr. Johnny Lee
Dr. William Mak
Dr. Amelia Nuhn
Dr. Ravi Parhar, Resident Advisor
Dr. Christine Sorial
Dr. Vincent Wong, Treasurer
Dr. Jennifer Yun, Co-Chair
Dr. Gina Zheng, Co-Chair

Finance and governance committee

Dr. Johnny Lee
Dr. William Mak
Dr. Ravi Parhar
Dr. Vincent Wong (Treasurer)
Dr. Jennifer Yun
Dr. Gina Zheng

Staff

Kristan Ash, Executive Director
Erin Carey, Program Director
Tricia George, Patient Medical Home Sustainability Support Manager
Emily Haugen, Program Coordinator
Patricia Hockhousen, IT Coordinator
Allison James, Administrative Coordinator
Saron Kassay, Evaluation Program Coordinator
Carter LaFontaine, Project Coordinator
Sanjam Laura, Project Manager
Tricia Lewin, Pathways Administrator
Jessie Mather-Lingley, Program Director
Michiko Mazloum, Program Director
Antoinette Mercado, Accounting Assistant
Jordana Moxin, Attachment Hub Coordinator
Melanie Narvaez, Operations Manager & Controller
Marquis Odobas, Communications Coordinator
Emily Richardson, Program Coordinator
Johann Santos, Videographer
Alana Stuart, Program Manager
Alina Spring, Project Manager
Cindy Young, Project Manager

Committees and Working Groups

Collaborative Services Committee

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

Long-term care initiative Medical Advisory committee

Dr. Amber Jarvie - Physician Lead
Dr. Lalji Halai - Physician Lead
Dr. Kathy Kiani
Dr. Mahsa Mackie
Dr. Sanaz Gharedaghi
Dr. Abhineet Garg
Dr. Ali Sanei-Moghaddam
Dr. Andrew Cheong
Dr. Anthony Tran
Dr. Ashvin Punnyamurthi
Dr. Hortensia Shortt
Dr. Majid Jafari
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Dr. Azim Ladhani
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Dr. Ramesh Avinashi
Dr. Teresa Tan
Dr. Doug Moseley
Dr. Eileen Fan
Dr. Gangadevi Lokuwattage
Dr. Gene d'Archangelo
Dr. Graham Burns
Dr. Gregory McAnulty
Dr. Kasia Baker
Dr. Katie Gates Manhas
Dr. Mina Elmasry
Dr. Pamil Malhi
Dr. Shelia Mogga
Dr. TJ Dhesi

PCN Steering Committee

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

PCN/PMH Advisory Committee

Dr. Paras Mehta, Physician Lead
Dr. Jennifer Yun
Dr. Nimeera Kassam
Dr. Cathy Clelland
Dr. Gina Zheng
Dr. Christine Sorial
Dr. Vincent Wong
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Dr. Carllin Man
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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.