Patient Medical Home
Sustainability & Support Model Report

Fraser Northwest Division of Family Practice

December 2021

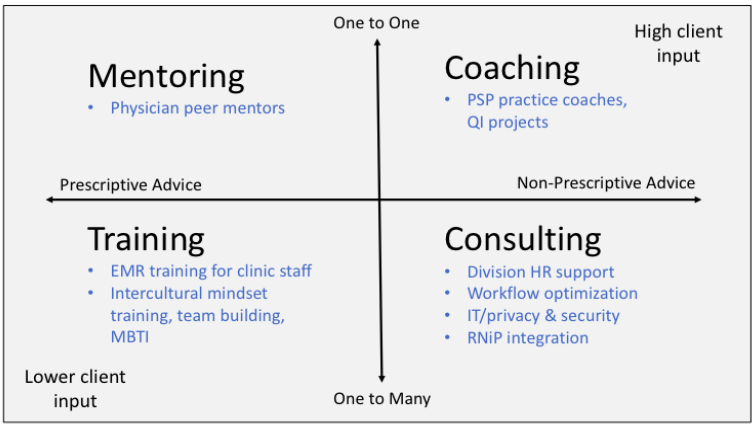
Program Overview

The Fraser Northwest Division of Family Practice (FNW DoFP) encompasses Family Physicians in New Westminster, Coquitlam, Port Coquitlam, and Port Moody, representing the traditional catchment area of the Royal Columbian and Eagle Ridge Hospitals. Together, members and division staff work to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians. Our Division is comprised of 51 primary care clinics and 415 Physician and Nurse Practitioner members.

The vision for primary care within the FNW Division, and provincially, is to enable access to quality primary health care that effectively meets the needs of patients and populations in the province, using the Patient Medical Home (PMH) to form the foundation for care delivery within a broader, integrated system of primary and community care. PMHs are the evidence-based practice model for delivering key service attributes associated with full-service primary care and offered by family physicians and nurse practitioners working to their full scope and complimented by a team of nurses and other health care professionals.

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.

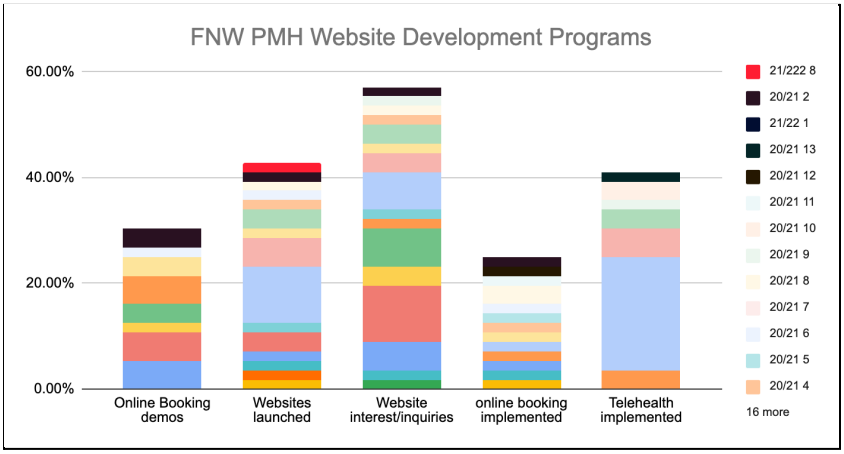


With increased challenges to primary care seen over the past two years, including continued uncertainty around the COVID-19 pandemic, higher rates of patient unattachment, provider burnout, and medical office staff shortages, FNW Division has remained committed to supporting the sustainability of the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

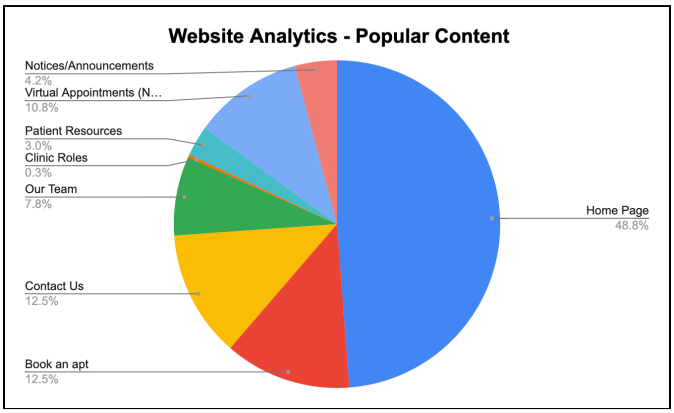
In-Practice Support

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



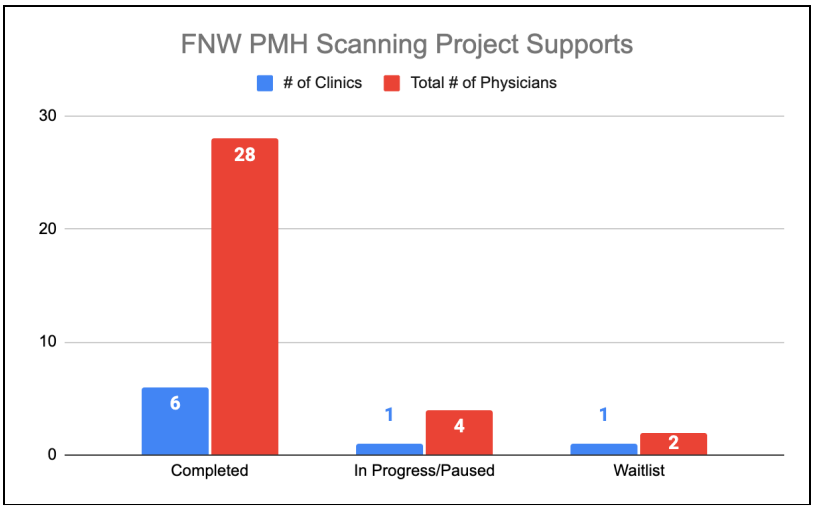
Data Analytics pulled from each clinic website details the high number of users and where the traffic is typically going when clicking on the clinic website. With online booking optimized through clinic websites, this is the second highest means for entry into the clinic websites by patients as shown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



Based on feedback shared from a June 2021 Ask The Expert event on Transcare, **inclusive space materials** were created and distributed to clinics across the FNW seeking to ensure visible safe spaces for trans and gender diverse people. When asked *"Considering the transgender patient population, what would you identify as a need in your clinic environment with regards to areas of education you and your team may benefit from?"* clinics identified themes around:

- Cultural safety training and education for all clinic staff - specifically around pronouns and gender diversity
- Communication - how to ensure all patients feel safe in the clinic environment
- Mental health resources and supports
- Ensuring forms are reflective of gender beyond the traditional scope

Division staff are working alongside subject matter experts and those with lived experience to ensure that clinics have access to resources and support in order to make a safe space for all. A clinic catalog has been developed and provides stickers, flags, and posters that clinics can order that demonstrate a safe and inclusive space for minorities, members of the LGBTQIA+ community and other marginalized groups.

Information Technology

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

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

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

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

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

Lesson Learned: During this time, FNW Division also began supporting the shift to virtual care through reimbursement of the costs for Zoom licenses. However, through member feedback it was discovered that the free version of this software was sufficient to meet the needs of most physicians.

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.

Team Member Enhancement

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

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

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

Lesson Learned: 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.

Lesson Learned: Many innovative ideas and solutions have come forward from Division members, one of which was a regional clinic manager, who would provide administrative and HR support to all FNW PMHs. However, once planning for this resource commenced, the Division found that providers were not eager to adopt it and use it within their practice. This reflects one of the ongoing challenges inherent in serving the needs of a large member organization - when support is available, they may not use it.

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.

This manual also covers the process for onboarding and orienting new allied health providers into the clinic. As part of the FNW Primary Care Network, the **RN in Practice initiative** places RNs into FNW PMHs. These providers work to extend the capacity and accessibility of primary care between patients and their primary care providers. Division staff work alongside the Fraser Health Authority (FHA) to support the onboarding of these positions into FNW clinics. Since the initiative's inception in 2019, 27 RNs have been hired and placed into clinics across the FNW. Onboarding and orientation for RNs are a combined effort of partner organizations to ensure proper knowledge and tools are shared to support seamless transition into PMHs. Currently, EMR training for RNs is being supported by the FNW Division; however, the hope is that the Practice Support Program may be able to extend its ability to support EMR specific training for the RNs in this initiative.

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 below shares these firsthand experiences and benefits of having an RN working in clinics as an extension of primary care.

As part of the measurement of the success of the Primary Care Network, **0$ fee attachment codes** have been created and Division staff have facilitated and provided training on how to incorporate these codes into the workflow of onboarding newly attached patients to primary care providers. This training is ongoing as new primary care providers, RNs and practice staff join clinics so as to ensure accurate and ongoing reporting.

Network & Community Supports

MOA Network

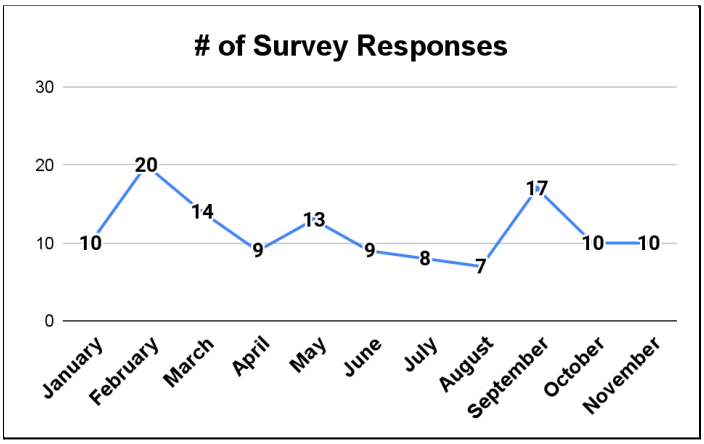
Strengthening team-based care is a priority for the FNW Division and it's recognized that ensuring practice staff are provided opportunities to engage, learn, and share experiences is a key measure of success in a PMH. By having Division program staff reach out and engage with PMHs and practice staff, learning opportunities emerge that were brought back to community engagement events. EMR User Group sessions were on hold for the first half of this reporting period and collaborative work with the Practice Support Program (PSP) took place to transition the facilitation of these events to PSP.

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

- April 2020: Scheduling (*MOA*)
- May 2020: Team Dynamics in a Virtual Setting (*MOA*)
- June 2020: Advanced Privacy & Security (*MOA*)
- July 2020: HR & the New Office Environment (*Practice Managers)*
- July 2020: The New Normal and Preparing for Another Wave (*MOA)*
- August 2020: Addictions, Resources and Patient Experience (*MOA*)
- September 2020: Worksafe Occupational Health & Safety (OH&S) in the New Environment (*Practice Managers*)
- September 2020: Concussions, symptoms and telephone protocols (*MOA*)
- October 2020: Elder Abuse (*MOA*)
- November 2020: Medical Practice Manager Meeting (*Practice Managers*)
- November 2020: Practice Efficiencies, sharing tips & tricks (*MOA*)
- December 2020: Referrals & Pathways (*MOA*)
- April 2021: MOA Focus Groups
- September/October/November: MOAs Communication with Marla & Lesley Cohort (3 sessions)
- December 2021: MOA Advisory Committee Meeting
- January 2022: Workflow Workshop: Demystifying the Specialist Referral Process
- February/March/April 2022: Intercultural Mindset with Marla & Lesley (3 sessions)

In January 2021, engagement of practice staff shifted to introduce feedback mechanisms to ensure real-time feedback and information sharing. Monthly surveys on what is needed in the community to support continued, and increased

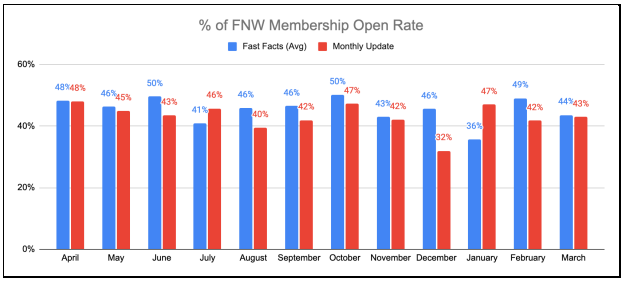
access to primary care services have been distributed to this network on a monthly basis. More recently, an MOA Advisory Committee has been established to inform and guide present and future engagement work with FNW practice staff.



FNW MOAs have been invited to connect and share learnings, resources, successes and challenges together on a **Facebook page** designed for the MOAs and practice managers currently working in the FNW communities.

Member Engagement

The FNW Division continues to reach out to members through both formal and informal means of communication. Online newsletters including biweekly **Fast Facts** and a **Monthly Newsletter** continue to share relevant practice specific resources and information, upcoming events, changes to community resources/services and opportunities for feedback sharing and engagement. 25 Fast Facts and 12 Monthly Updates were distributed to members in the last year with, on average, 206 members opening these communications. This roughly equates to 44% of members engaged in these communications; a detailed breakdown of the month over month distribution for FY 20/21 can be found here.



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

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

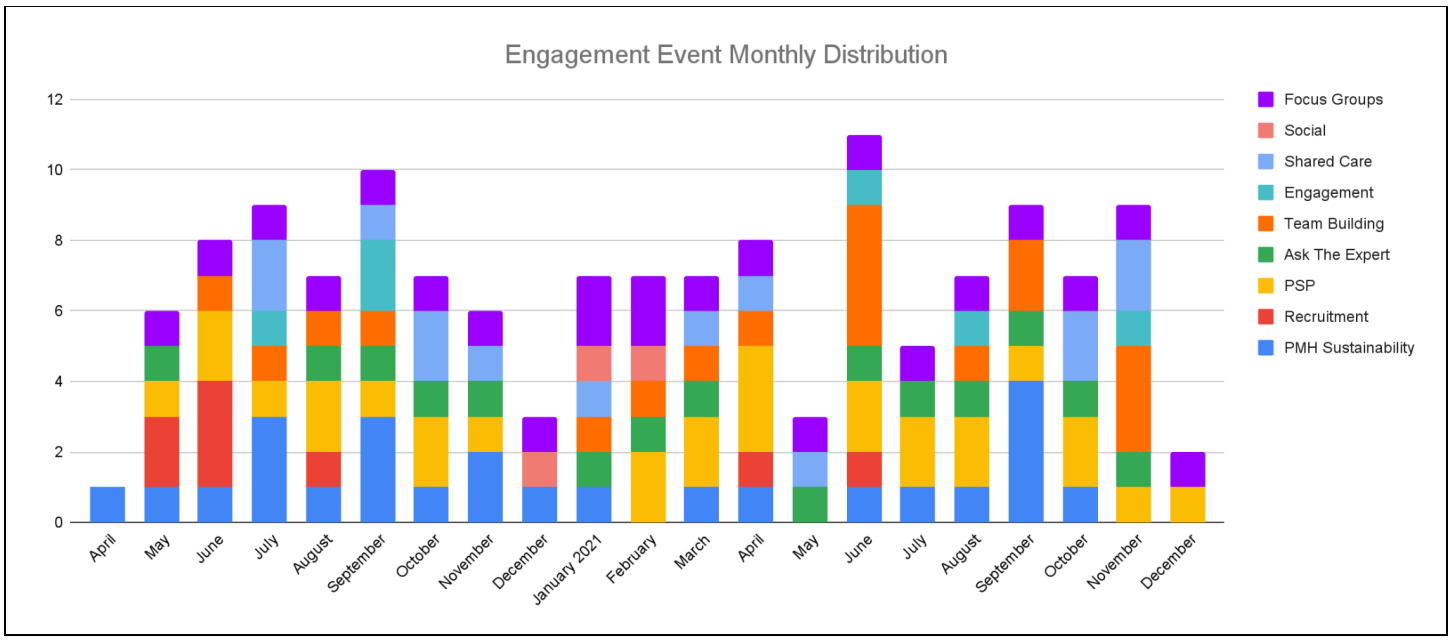
Smaller, targeted sessions such as clinic team member development have been instrumental in facilitating and engaging physicians and PMH teams in identifying their leadership style, strengthening intercultural communication, cultural safety and communication training. Since January 2021, there have been:

- 3 X 5 session cohorts of Physician Leadership training
- 2 X 2 session cohorts of Intercultural Mindset training
- 1 Physician Wellness training
- 1 X 3 session cohort for MOAs and practice staff on effective communication
- 8 MBTI assessments are scheduled to be completed with clinics/physicians by March 2022

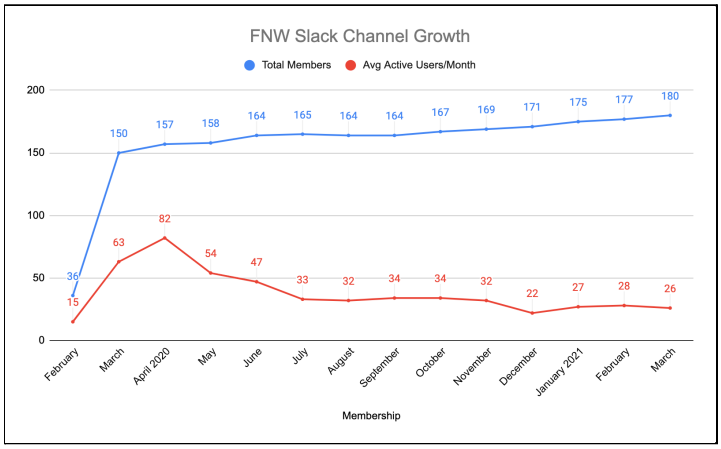
Member engagement through **events** and **educational sessions** and networking gatherings have been an ongoing staple for support and engagement with the FNW members since the Division's inception. In April 2020, despite the move to virtual means, FNW members continued to engage by participating in events, workshops and education opportunities with their peers and colleagues. 38% of Division members attended one or more events over this last year with almost

60% of those members attending 2 or more events. The division hosted approximately 80 events in that FY - a 36% increase compared to the previous year.

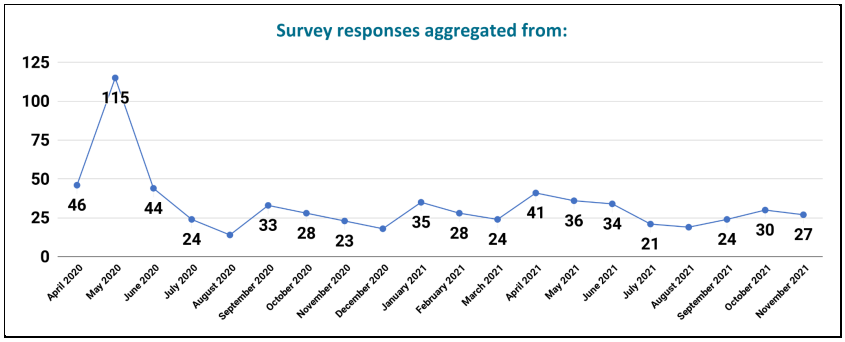
Since April 2021, the Division has continued to host monthly engagement events based off of current feedback and interest from FNW members and has successfully delivered over 60 events by December 2021.



Informal means of communication have also increased over this last year - largely due to the ability to share information, resources, and updates in real-time. Slack was introduced as a platform where FNW members could connect, access community level data/reports, share Division updates based on member feedback and facilitate informal conversations and wayfinding between peers. The graph below reflects the significant impact that this platform has had based on the distinct increase in users that aligns with when the pandemic started.



Monthly Member surveys were implemented in April - initially as a biweekly survey - to reach out and engage members to gather feedback on the changing landscape given the pandemic. Since April, these surveys have been distributed to members where feedback is collected, collated and shared with the FNW Board. These surveys have significantly impacted the work that the Division does as hearing directly from primary care providers in real-time supports continued improvement.



Lesson Learned: In Spring 2021 **Public Education** was identified by members as an opportunity to engage with patients at a community level to share information and resources that physicians want them to know. FNW Division launched the 'What's Up Doc?' series, whereby physicians provided virtual presentations on topics including:

- Baby's First Year
- General Town Hall
- Palliative Care
- Long Term Care

Unfortunately, due to the virtual platform or disinterest among the public, uptake by community members was lower than expected, which prompted the cancellation of the series.

The FNW Division works closely alongside the **Practice Support Program (PSP)** to collaborate and share out engagement opportunities and facilitate connections between PSP and FNW PMHs. PSP hosts monthly EMR sessions, Small Group Learning Sessions and Team-Based Care events. PSP provides family physicians the opportunity to *"practice more efficiently, focus on providing proactive care, and work towards adopting attributes of the Patient Medical Home."* As reported by PSP, most of the PMH/PCN work that is taking place relates to:

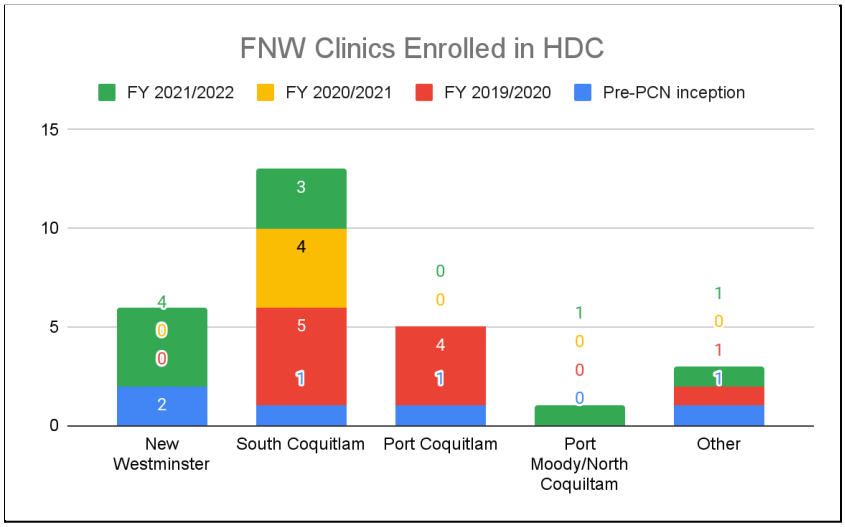
- Panel Management
- Panel Maintenance
- Patient Experience Tools
- EMR Skills Assessments

Below is the month over month comparison from the previous report shared:

	# of MSOC Physician	**# of PMH Assessments completed**	**% started Panel (MSOC)**	**% Completed Panel (MSOC)**	**Started Panel**	**Working on Phase 1**	**Working on Phase 2**	**Working on Phase 3**	**Workbook Complete**
Previous month (September 2021)	179	116	63%	53%	112	12	1	5	94
Current month (October 2021)	180	117	64%	53%	116	14	2	4	96
Change	↑	↑	↑	=	↑	↑	↑	↓	↑

The **Health Data Coalition** is a non-profit organization funded by GPSC that *"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*

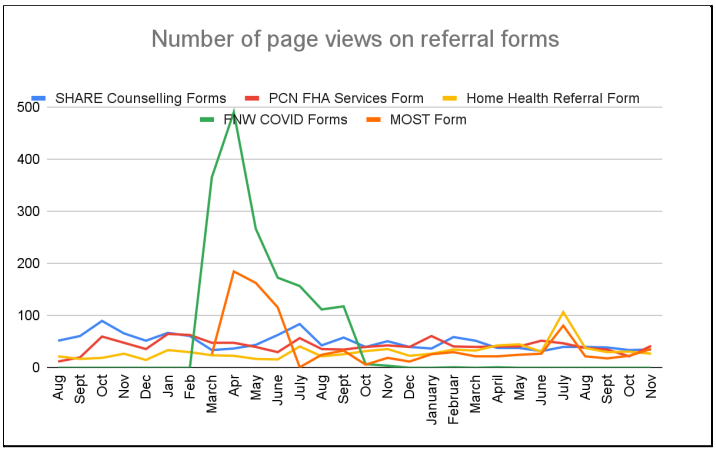
anonymized aggregate data" for physicians and practices. HDC representatives are working alongside FNW Division staff and Physician leadership to identify opportunities for integration into FNW led engagement events for members. This tool will provide practical and tangible solutions to specific topic areas that events are centered around.

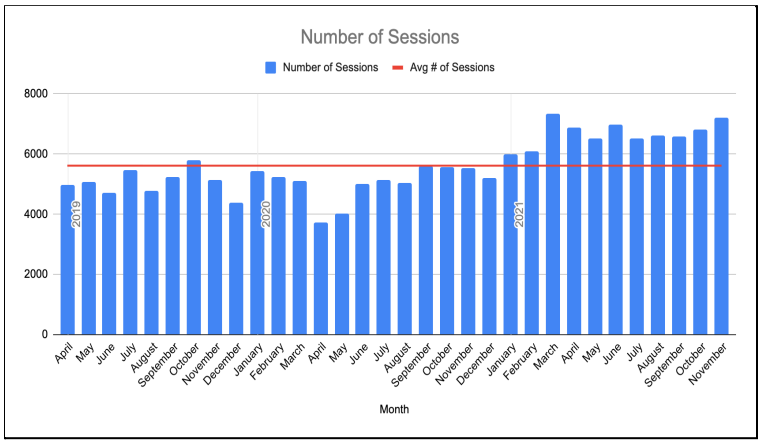


Pathways continues to work to produce features within its platform to better support Primary Care Providers in the community. Work continues to be underway to launch the referral tracker in the FNW region. Currently, at the local context, there are:

- 181 FNW Family Physicians with profiles in Pathways
- 332 Specialists listed
- 1 Urgent & Primary Care Center
- 2 hospitals

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





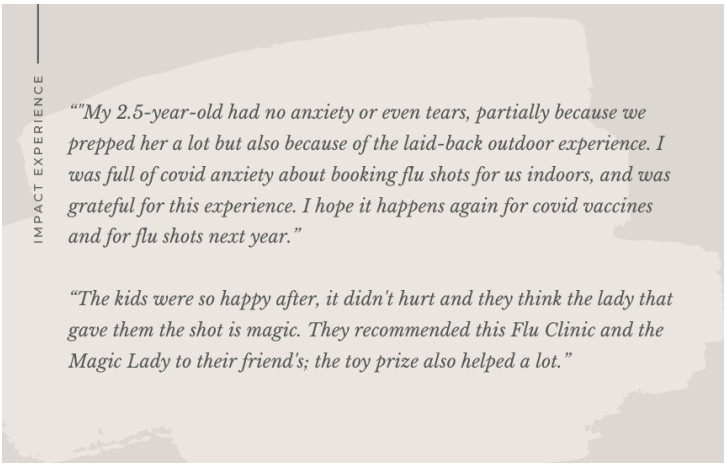
More recently, there has been alignment with FNW engagement events by incorporating how Pathways can support integration of subject matter covered at these events into daily practice. There has been a 19% increase in the number of users logging into Pathways over this last year and a 5% increase in the number of sessions.

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

Community Network Program Engagement

Although the impacts of Covid-19 continue to be felt in many ways, when the pandemic first began there was an instantaneous outpouring of support from community Primary Care Providers willing to help the communities. Royal Columbia Medical Clinic volunteered their site to support in this community response to support both **Covid-19 testing** and **respiratory assessments** to the FNW population. Funding for this clinic concluded in June and subsequently a physician-led clinic opened in the Tri-Cities to continue to support access for people in the community. Physicians supporting this clinic did so in addition to their own practice.
In October 2020, FHA opened a drive through testing site in Coquitlam to support the widespread access to Covid-19 testing. A dedicated Respiratory Assessment Clinic also opened in what is now the U&PCC site at ERH.
Throughout the summer months, there were a number of community outreach townhalls whereby members of the Tri-Cities Chinese Community Society and the Tri-Cities Iranian Cultural Society were invited to learn about the community response as well as have an opportunity to ask questions. These events were supported by interpreters so as to ensure access to the information available.
Additional community response was targeted towards the vulnerable and home insecure population in the FNW. A designated clinic area in each of the shelters provided a virtual health space for residents to access a Family Physician virtually. Equipment was donated to assist shelters that needed a computer to ensure residents' access.

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



In Fall 2021, although the same resources were not available to support a community clinic approach, delivery was provided to PMHs providing in-practice influenza immunizations to ensure ease of access to the supplies needed to support their patients.

Childhood Immunization Clinics: In Winter 2020, building off of the success of the Influenza vaccination clinics, an opportunity emerged to partner again with FHA public health teams to provide access for parents and their children to receive necessary immunizations. FHA indicated that there were patients waiting or behind on their childhood immunizations in New Westminster; this number didn't include the patients that were rescheduled for future dated clinics in Tri-Cities or anecdotal feedback from community providers and concerned parents and caregivers. Based on the community partnerships established previously, the City of Port Coquitlam and New Westminster provided spaces and necessary equipment to support these clinics.

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

IMPACT EXPERIENCE

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

In Summer 2020, **The FNW Virtual Care hub** was established as an expansion of the Acute Discharge Program which supported an integrated system of care through linkages with Royal Columbian and Eagle Ridge Hospitals, The FNW Attachment Hub and additional PCN services. Access was available to patients with or without a longitudinal provider through self referral or upon discharge from hospital for virtual appointments and follow-up physical assessments. The program's objectives were to

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

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

Shared Care

Shared Care is one of four Joint Collaborative Committees (JCCs) representing a partnership between the government of BC and Doctors of BC. Funding from Shared Care supports family physicians with a focused practice, and specialist collaboration on quality improvement projects. 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. At the time of writing this report in December 2021, the FNW Division is currently supporting the following projects in specific stages:

Expression of Interest Development	Proposal Development	Proposal Implementation	Sustain & Spread
Respiratory/Pulmonary Function: 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. **Addictions:** This project aims to focus on the challenges and solutions in providing care for patients with a primary diagnosis of Alcohol Use Disorder (AUD) who may be at risk of using other substances. Building upon the trusted patient-primary care provider relationship, the goal is to strengthen providers' confidence in knowing how to effectively screen patients and equip them with the necessary tools to manage patients with AUD.	**Geriatric Psychiatry**: 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 **Women's Health:** Patients are currently waiting up to 1.5-2 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 (HRQOL) questionnaire. Hip and knee replacements are currently only 98 days from referral to surgery. Prolapse patients suffer an equally poor quality of life for an additional 436 days. This project aims to reduce the wait list by	**Maternity**: 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. The project group has been developing a virtual maternity hub, with the aim to improve patient access to postpartum support, specifically breastfeeding and mental health support, as well as improve information sharing and collaboration among maternity care providers. **Older Adult/Medically Complex**: 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. 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. **Mental Health & Substance Use:** 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,	**Acute Discharge:** 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.

	50% and wait time by 6 months for prolapse and incontinence patients by implementing a detailed patient care pathway in primary care settings and a successful urogynecology clinic model.	psychiatrists, and mental health teams across the FNW region. **Chronic Pain**: 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. **Palliative**: 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. **Breast Health:** 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	

Attachment

The FNW Division Attachment Coordinator continues to support the attachment between the public seeking primary care providers accepting new patients. It is important to note that these numbers do not capture the full scope of the community attachment taking place as there are primary care providers attaching patients without connecting with the FNW Attachment Hub. Since the inception of this dedicated resource to the community in Summer 2019, the waitlist for patients continues to grow and recent data provides an indication of the average wait time of those who have been attached broken down by community:

Community	**Average Wait Time (*days)***
New Westminster	190
Port Moody	243
Coquitlam	168
Port Coquitlam	109

The number of people being connected to a primary care provider in the FNW continues to grow, alongside the number of people seeking attachment:

	Total # of people attached since April 1, 2019	Current # of people waiting to be attached
New Westminster & Tri-Cities	**9500+**	**5900+**

Lesson Learned: One of the main challenges clinics have faced with attachment is ensuring timely and accurate transmission of patient information to the clinic. Patients would often call the clinic they were accepted to book an appointment, only to find that the MOA on the receiving end having no knowledge of this. To streamline the process and reduce the burden and stress on both the patient and clinic staff, FNW implemented a novel technology solution whereby the patient enters their information on a secure form through the clinic's website on a private password protected page. When the provider is able to accept new patients, the Attachment Coordinator sends the patients on the attachment list the private page URL and password, where they then complete the application.

Recruitment, Retention & Engagement

The number of primary care providers (including both Family Physicians and Nurse Practitioners) providing longitudinal primary care in the New Westminster and Tri-Cities communities comprises approximately 33.4% of the total FNW membership. Recently, 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.

Since April 2019, there continue to be primary care providers joining and leaving the community. The table below denotes the addition of primary care providers (including both Family Physicians and Nurse Practitioners) to the FNW communities; the leaves of primary care providers (including retirements and other leaves); and the correlating attachment based on data collected from the FNW Attachment Hub.

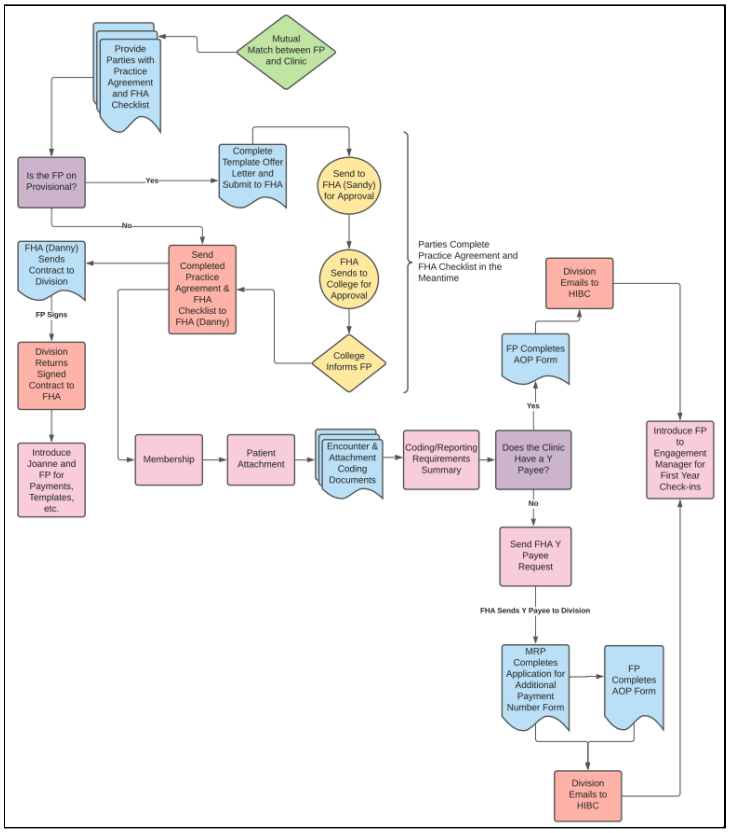
	2019	2020	2021

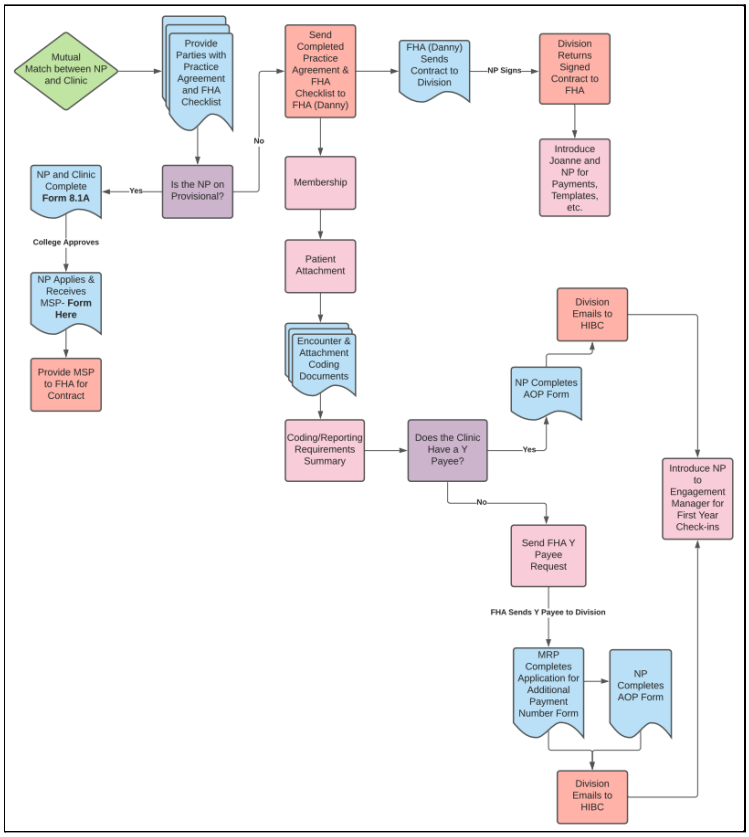
Provider Adds	12	18	15
Provider Losses	27	13	13
Net Loss/Gain	-15	+5	+2

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 counseling resources and practice improvement support are paramount to retaining the current physicians in the FNW, and recruiting future physicians to practice in these communities.

Family Physicians in the area recognize the impact of retaining and recruiting primary care providers to the FNW communities. Recently, 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."*

When new providers join the community, the FNW Division has developed structured orientation and onboarding processes depending on the type of provider, below are two examples of the onboarding process for FPs (image on the left) and NPs (image on the right) joining a contract (funded through the FNW PCN):





For FFS providers joining the community, a wrap-around approach is provided in order to seamlessly integrate these providers into the clinic as well as the community. Each new provider, regardless of their payment model, is provided the following supports:

- FNW Attachment Hub connection
- Membership option with the FNW Division
- Engagement check-ins at designated intervals
- Overview of Division Member Supports and program list

Each provider may require something slightly different and so having Division support staff to navigate and structure a successful onboarding experience is integral to not only the recruitment process, but also retention.

Sustainability

Patient Medical Home sustainment is complex and interconnected. Each moving piece of the support that the FNW PMH program provides supports primary care providers to continue practicing and supporting longitudinal primary care services. Recognizing that providing support such as websites, online booking, IT support, practice staff support and community/network investments, alleviates additional pressures from primary care providers in order for them to see patients and create meaningful and long-lasting patient/provider relationships.

In order to fully recognize the impact of initiatives such as the FNW PMH program, it's important to reflect on how the primary care landscape in New Westminster and the Tri-Cities may function if these supports were not available. The responsibility in identifying the need, establishing a solution, implementing the solution, and monitoring and sustainment, would all fall directly onto the primary care provider or would have a direct financial impact on these providers should they individually reach out for support elsewhere. The supports and resources that are currently available, as well as any future initiatives, are critical for fostering the growth and sustainment of relationship-based longitudinal primary care in our community. Ensuring that this foundational piece of the healthcare puzzle remains strong ultimately supports care provision in other healthcare settings from acute care to community services. The importance of these interdependencies highlights the value of prioritizing sustainability of the Patient Medical Home, and ultimately, timely, appropriate, and equitable access for patients.