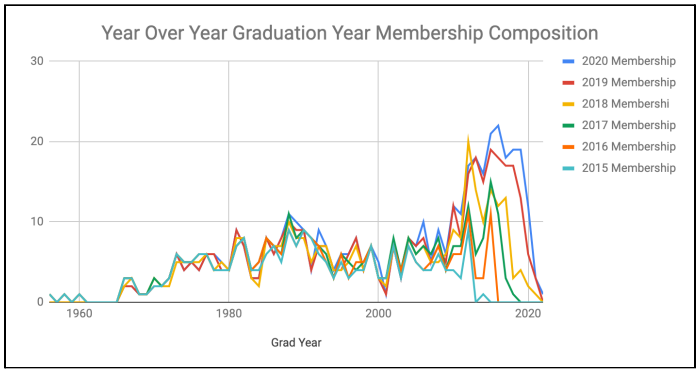
FNW Primary Care Network Progress Towards Outcomes Report

Community Overview

Since funding started in April 2019, the Primary Care Network (PCN) is a network of local primary care service providers working together to provide primary care services that a population requires. 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-centered, 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

FNW Division membership comprises approximately 500 physician and provider members. Although this number is large, almost 40% of FNW members have been in practice for 20+ years, making up a significant portion of the membership of FNW. Membership is, not surprisingly, largely made up of community Family Physicians with a similar number of locums and hospitalists comprising the bulk of the members. Year over year membership composition continues to show strong numbers for Physicians in their first 10 years of practice, the graph here represents the year over year membership composition based on members' graduation year.



In the summer of 2021, 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 will redirect to a short video of the board members sharing their experiences.

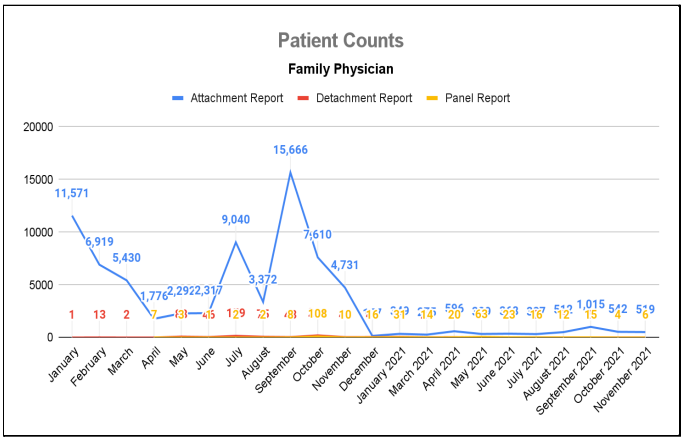
The following sections of this report detail the implementation of the work, the successes, challenges and remaining opportunities as they relate to the PCN Core Attributes

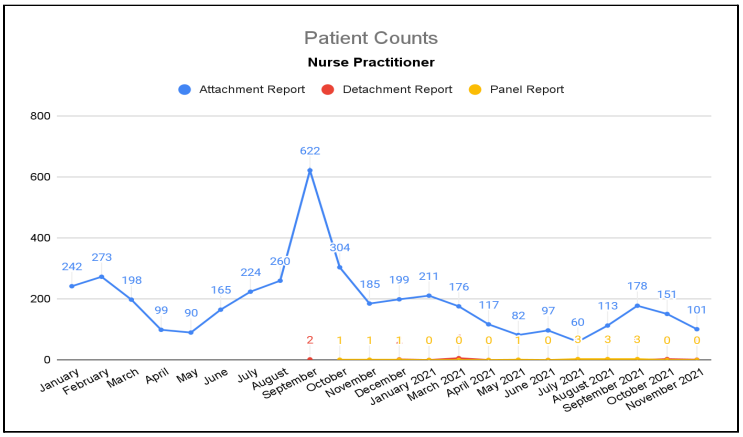
1. Process for ensuring all people in a community have access to quality primary care, and are attached within a PCN

Measuring true attachment and access is highly dependent on who and how it is defined. Attachment from the perspective of patients, providers, healthcare administration, Health Authority, Municipal leaders, Ministry of Health, Ministry of Finance and the provincial government may all slightly differ. Needless to say that varieties in definitions exist, at the core it is about the patient and provider relationship. Mechanisms for measurement such as the 0$ fee code to report out attachment level data provides a distinction between types of providers and patient counts. A challenge with implementing for all PMHs to incorporate the use of these codes has been the consistency in education across a variety of PMHs who utilize differing EMRs. This data is shared by the MoH out to FNW PCN partner organizations.

In tandem with the 0$ fee code, the FNW Division has an internal Attachment Hub mechanism which supports patients in the FNW seeking a primary care provider to be attached to primary care providers accepting new patients in the FNW communities.

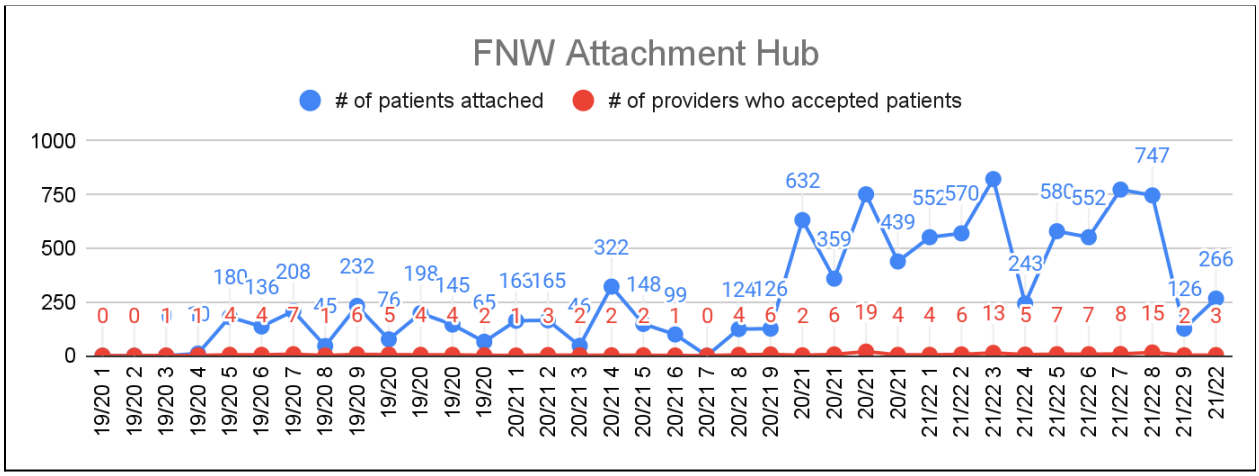
Attachment data from the MoH is available and provides an analysis of the breakdown of attachments and detachments based on provider type and the associated patient counts. Data was shared starting from January 2020 reflecting the trends of provider counts and patient counts - broken down by type of provider type and patient counts. An overestimation of attachment in the FNW is reflected in the data from 2020 whereas the 2021 data may reflect a more accurate representation of attachment in the community. The visuals below reflect the month over month trends for distinct patients (that are attached/unattached to a Family Physician or a Nurse Practitioner):





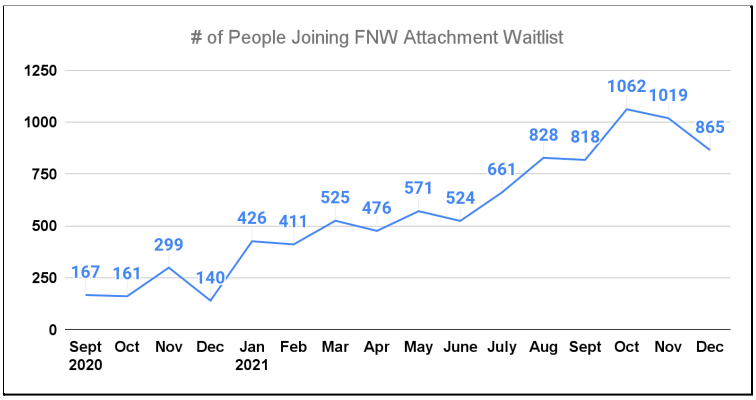
Alongside the 0$ Fee code, the FNW Division Attachment Hub continues to support the attachment between the public seeking primary care providers accepting new patients. Data

for this attachment mechanism is reported in periods as opposed to months so as to align with the MoH reporting periods:



An important piece of this work is recognizing the sheer volume of people waiting to be attached as well as the average wait time of those who have been attached:

Community	**Average Wait Time *(days)***
New Westminster	191
Port Moody	243
Coquitlam	170
Port Coquitlam	108



Recruitment

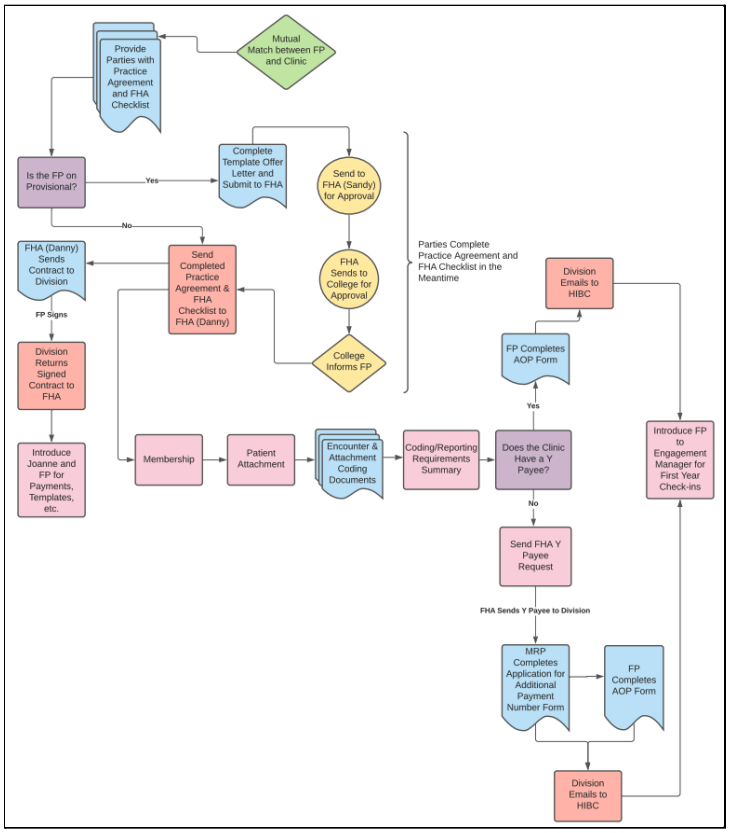
The work of the Primary Care Network is to support a decrease in the unattachment gap in local communities by facilitating and supporting resources that aim at creating capacity for new providers and existing providers to take on patients seeking attachment. In theory, the clearest mechanism in supporting increased attachment is the additional support of new providers joining the community. The FNW PCN received funding for 12 Family Physician contracts and 12 Nurse Practitioner contracts. Although these contracts significantly help and entice providers to join the community, it is also incredibly important to recognize the number of existing providers retiring, moving out of the community or leaving longitudinal family practice. The table below details the provider adds and losses since 2019:

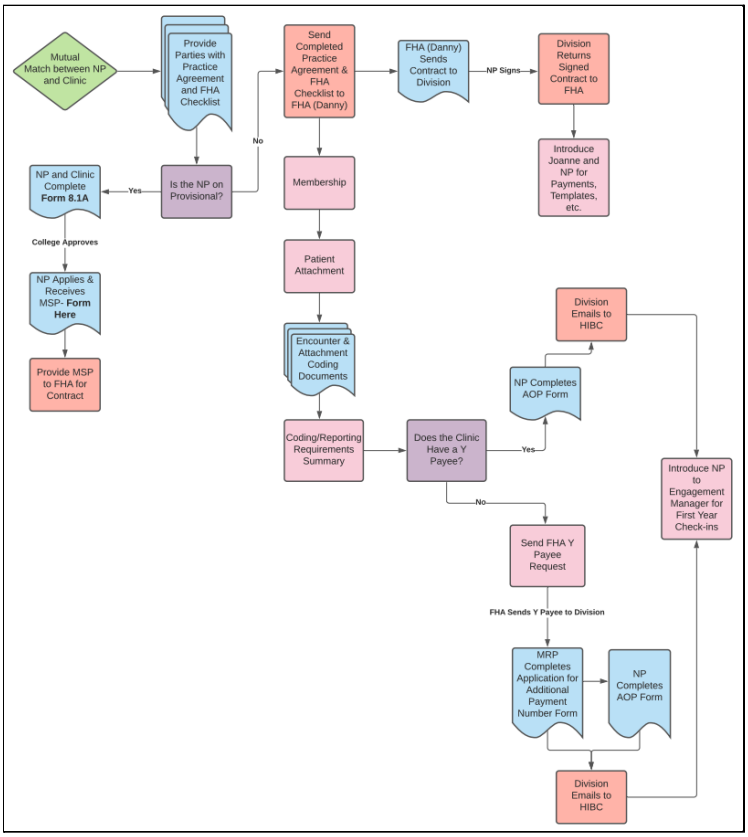
	2019	2020	2021	Total Add/Loss
Provider Adds	12	18	18	**-7**
Provider Losses	27	13	15	
Net Loss/Gain	-15	+5	+3	

Successfully, all 24 contracts had been filled in October 2021; however, since then 3 Family Physicians on contracts have decided to withdraw, with 1 leaving the community all together and the other transitioning into FFS. Work is underway to fill the vacant contracts and all contracts should be filled by the end of FY 21/22.

Family Physicians in the area recognize the impact of retaining and recruiting primary care providers to the FNW communities. Recently, one FP 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):





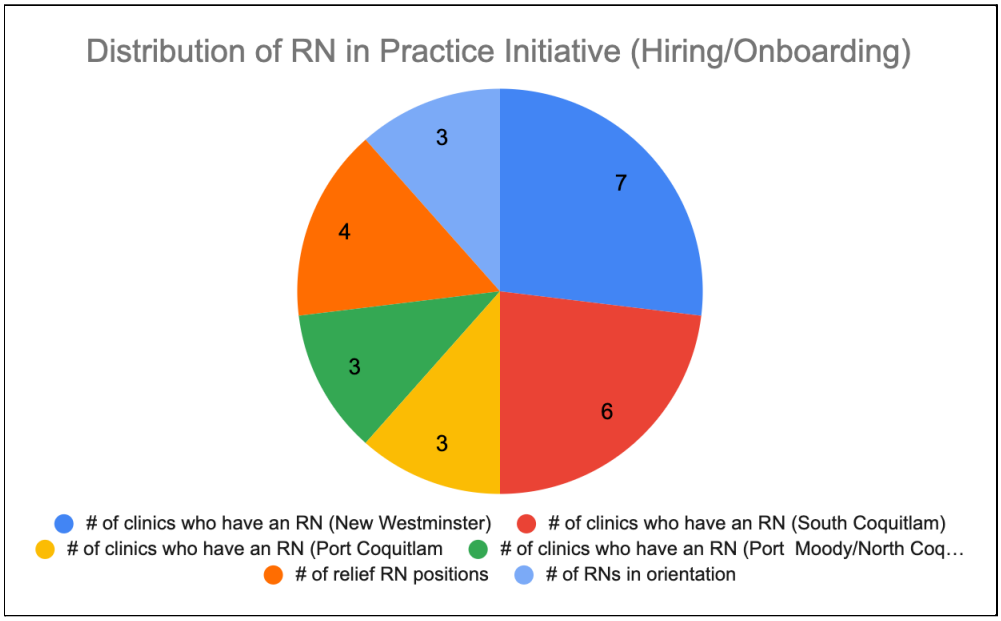
For FFS providers joining the community, a wrap-around approach is provided in order to seamlessly integrate these providers into the clinic as well as the community. Each new provider, regardless of their payment model, is provided the following supports:

- 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.

Creating Capacity

Creating capacity for existing providers to attach new patients is a strategy that's essential to recruiting new and retaining existing providers in the communities. Resources such as Rapid-Access Mental Health clinical counsellors and the placement of Registered Nurses in Practices are two PCN funded mechanisms that work to support the extension of team-based care within and outside of the PMH. In terms of attachment, it was originally anticipated by the MoH that by incorporating a RN into a practice, that would create capacity for the practice to attach an estimated 500 new patients. In Spring 2021, reach outs between Division staff and PMH practice staff (where RNs were placed) took place to identify net new attachments since PCN inception. It was identified that from 13 clinics who were able to participate, the average community level attachment/PMH is well above 500 net new attachments - in reality, there was an average of 900+ new attachments with the lowest being 24 and the highest being 2400. 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. Recruitment and



implementation of these RNs continues to be tracked, and at the end of November 2021, 43% of FNW PMHs has a permanent or temporarily placed RN in the practice. 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 of having an RN working in clinics as an extension of primary care.

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. 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	↓

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.

Remaining Gaps

Work continues to be underway to support people in the FNW communities to have access to regular and ongoing primary care services by a primary care provider. By the end of December 2021, there are over 6300 people waiting to be attached through the FNW Attachment Hub with an anticipated higher number in the community who have not registered on the FNW Attachment Hub.

	New Westminster	**South Coquitlam**	**Port Coquitlam**	**Port Moody, Anmore, Belcarra, North Coquitlam**	**Total**
# of patients waiting to be attached *(on FNW Attachment Hub)*	2009	2445	116	1760	6330

Understanding the impacts of this for those people and their families truly reflect the importance and huge need of attachment and access to a primary care provider. Through mechanisms such as the Division's Attachment Hub, stories are shared from community members reflecting the impacts of not having access to a longitudinal primary care provider. Wait time data such as the table shared in an earlier section reflect the length of time - on average - it takes for attachment to occur after signing up for the waitlist. One recent story shared reflected the severity of a patient's need in finding a provider to support longitudinal care - and the implications of not finding one

> *"I do not think this doctor is a match for me, or anyone suffering from chronic pain. It seems that most GPs do not have tolerance for someone who has trouble navigating the medical system. I do not have the ability to take care of myself anymore, and [the Dr.] seems to be frustrated. I think I am done seeking help-I have tried numerous times in my years of suffering, and will seek medically assisted suicide from now on. Thanks for your help"*

Another patient shared the necessity of having a longitudinal primary care provider, especially when in later stages of life. Patients face challenges in understanding the scope of the healthcare system and how complex and interwoven the systems and services have become, thus making it difficult to navigate.

> *"I have never been a burden on the BC healthcare system, I have worked hard all my life, never collected welfare or EI and this is what we get. I am getting older and I am just looking for a family doctor and after several months of waiting (that's understandable) I was kicked to the curb on Friday afternoon. Now I have to start all over."*

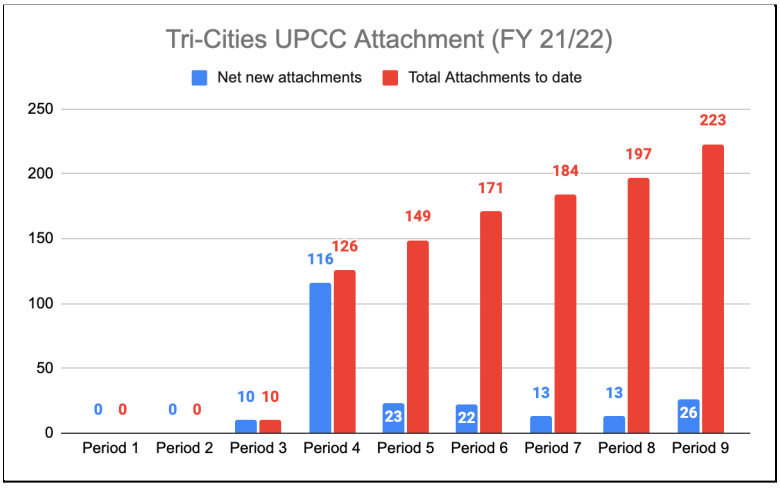
Patients also have identified the importance of having access to preferred providers. One patient has waited on the waitlist for approximately 9 months and upon finding a provider able to take this patient on, they identified that their comfort level would be to have a preferred gender provider and so were willing to wait until one became available.

Another patient and their family identified the importance of finding the right 'fit' with their longitudinal primary care provider as well as the importance of having a positive interaction from the initial phone call with clinic staff. This illustrates the complexity of finding and building a relationship with a longitudinal primary care provider.

Patients who previously had a primary care provider and are now unattached also may have ongoing health concerns and needs which may be complex to support through alternative means of access such as walk-in clinics, the U&PCC and telehealth. Examples of these include patients who have chronic pain needs where medication for these needs is not easily available through these alternative primary care services.

2. Provision of extended hours of care including early mornings, evenings and weekends

Enabling access for patients in the community through extended hours of care is essential for meeting community primary care needs. As reported in the FNW PCN quarterly reports, 46% of FNW PMHs (including maternity clinics and the Tri-Cities UPCC) provide some degree of extended hours of services. In addition to the extended hours of care, 38% also have a known after-hours call system or process in place. Additionally, 45% of PMHs have not yet shared their after-hours call system with the FNW Division. In February 2021, the Tri-Cities Urgent & Primary Care Centre opened in a temporary space to



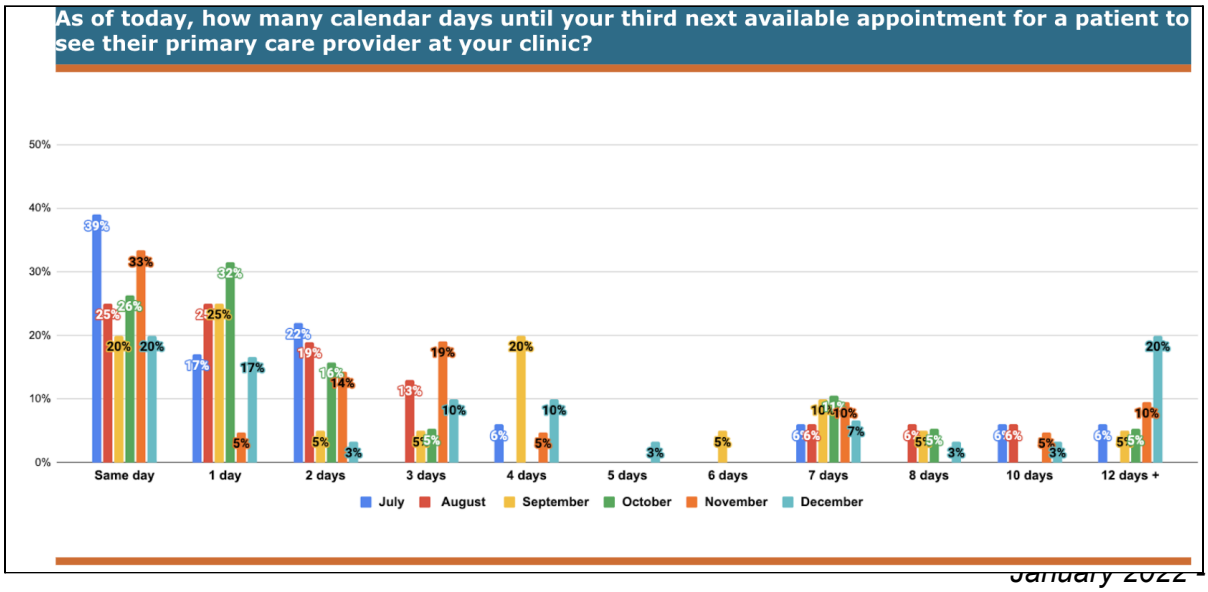
enable enhanced access for patients in the community seeking urgent and primary care needs. Since opening, the U&PCC has attached 223 patients. The clinic is open 7 days/week from 1pm - 8pm and in its current - and temporary - location is co-located at Eagle Ridge Hospital.

Remaining Gaps

Access to extended hours of care relies heavily on availability of resources and primary care providers to provide this care. Creating capacity in existing providers as well as establishing a desirable environment for physicians to be recruited into is essential in order to allow for extension of access to longitudinal primary care. Alleviating experiences of burnout in existing providers through incorporating mechanisms that support the sustainability of these existing providers as well as creating capacity to continue to provide access to primary care outside of traditional hours are essential areas of support. These areas require immediate attention and focus in order for extended hours to be sustainable to people in the FNW communities.

3. Provision of same day access for urgently needed care through the PCN or an Urgent Primary Care Centre

Same day urgent access for patients is available through both a number of longitudinal primary care clinics, walk-in clinics and the UPCC. "The 'third next available appointment' is a metric used by the PCN to measure access to care. However, when PMHs were asked about this in relation to their own clinical availability, their understanding was related to same day access for patients." This is an example of what was detailed in the earlier section regarding the recognition of the importance of interpretation depending on the perspective and role. The visual below is a reflection of this interpretation and feedback was collected from Primary Care Providers over the span of 6 months:



As noted in this, the vast majority of appointments are available on the same day, and what clearly articulates the interpretation of third next available = same day is the subsequent qualitative feedback provided:

- *I always keep same-day access spots available and even if I am fully booked I will always make sure to fit in patients who can't wait days until an appointment*
- *I have at least two same-day urgent access appointments every day and will always make time for extra patients if they truly have an urgent issue that cannot wait until the next day.*
- *Depends on the urgency of the appointment. Will try my best to fit them in the same day for urgent issues or refer to urgent care if I really cannot see them the same day.*
- *I always see urgent pt the same day*
- *I have the same day appointments available. Unfortunately we are short staff and some patients have to wait 30 +min on hold which they found frustrating.*
- *Same day accommodation for urgent fit ins. Also will fit in earlier if needed based on triaging. Finally, have locums covering after hours and weekends in case of more urgent needs.*
- *Urgent care is always seen on the same day*

For clinics where same day access may not be available, or space is limited, the Tri-Cities UPCC is an available option. The UPCC is open 7 days/week from 1pm - 8pm and has an MOA, RN, and a Physician on site at all times. Since opening in February, the UPCC has seen a total of 4963 visits by the end of FY 21/22 Period 9.

An impact assessment was done between FHA and the Division to identify the ED visit and readmission rates of those patients seen at the UPCC between February 22, 2021 (UPCC opening date) and March 31, 2021.

As noted in the data inclusion notes, patients who were included in this were those that had had a previous ED visit or admission. Of the patients that had previous ED visits, 61.4% of them had a subsequent visit to the ED 1 month post UPCC referral. 12.4% of patients who had a

What do the return to ED, hospital readmissions and mortalities look like for UPCC patients?

Data Inclusions:

- Patients who had a referral to Tri-Cities UPCC (may or may not be accepted)

☐ Readmission could have occurred prior to being seen at Tri-Cities UPCC- read this as an indicator of UPCC patient complexity vs. effectiveness of UPCC diversion from ED

- Patient had an ED visit or inpatient hospital admission in the past
- Patient returned to ED or hospital within time frame (7,14,21,30 days)

	Total (n=363 patients)	# of Patients	% of Patients
ED Return	7 days	160	44.1%
	14 days	191	52.6%
	21 days	212	58.4%
	30 days	223	61.4%
Mortality	0		

	Total (n=225 patients)	# of Patients	% of Patients
Hospital Readmission	7 days	11	4.9%
	14 days	25	11.1%
	21 days	27	12%
	30 days	28	12.4%
Mortality	0		

previous hospital admission returned for an admission 1 month post UPCC referral.
Prior to the opening of the UPCC, the FNW Division ran a Virtual Care Hub in response to high demand for accessing primary care services brought on by the Covid-19 pandemic. In March 2020, a local PMH volunteered their site to support a community response to support both Covid-19 testing and respiratory assessments to the FNW population. In October of that same year, this access shifted to a FHA led drive through testing site in Coquitlam. Subsequently, the FNW Virtual Care hub was established 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. Further details on the Virtual Care Hub will be discussed in the next section on this report.

Remaining Gaps

Collaborative work between FNW PMHs and the Tri-Cities UPCC continues in order to create pathways for seamless and consistent access for both attached and unattached people in the community to seek care for health related concerns. As the UPCC is awaiting its permanent site, the clinic is not yet working to its full scope of care. Ongoing work between primary care providers in the community, those working in the UPCC, FHA administration and leadership, as well as Division leadership continue to identify opportunities for how this site can meet the needs of the population in the FNW communities based on demographic and population based data and feedback from providers, patients, government and community stakeholders

4.Access to advice and information virtually (e.g. online, text, email) and face to face

Virtual Care Hub
As mentioned in the previous section, the FNW Virtual Care Hub was established to support an integrated system of care between PCN services, local hospitals and the FNW Attachment Hub. This hub was available to both attached and unattached patients in the FNW communities and the program's objectives were to:

1. Reduce incidence of hospital readmission and ER visits for patients by:

IMPACT EXPERIENCE

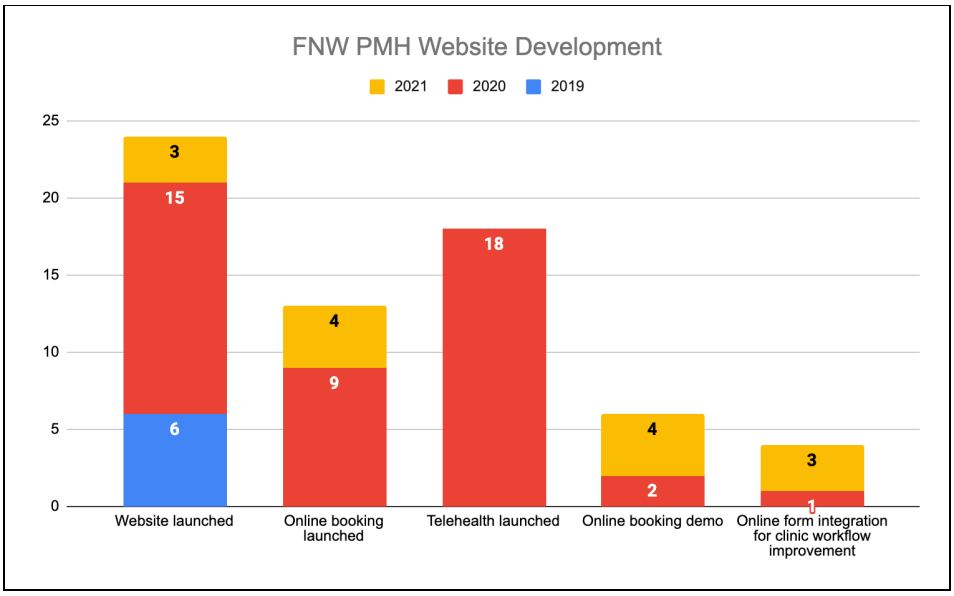
An experience was shared by FHA Community Health Nurses (CHNs) whereby they had been supporting multiple homebound patients whose FP has had to retire on short notice. These patients required timely follow up due to their health status. The CHN was immediately connected with the FNW Virtual Care Hub 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.*"

2. Facilitating attachment to continuous primary care for patients without a longitudinal provider
3. Providing access to a virtual care platform for patients seeking after hours care

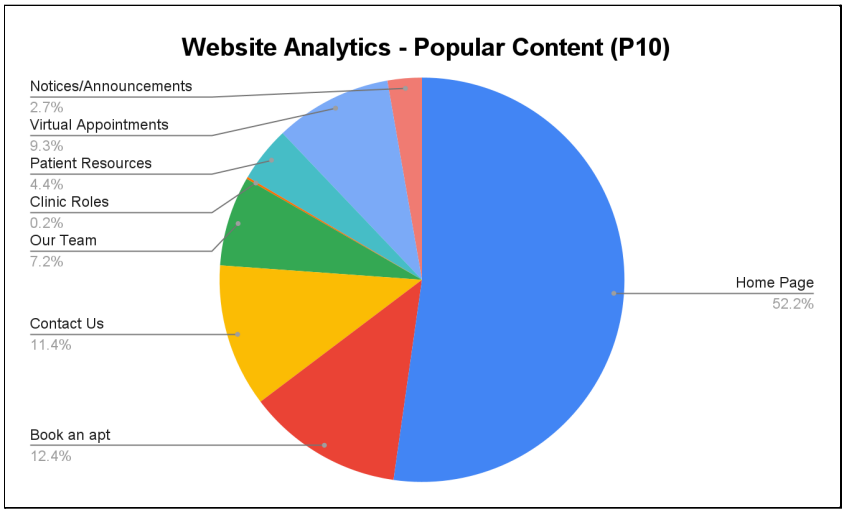
In March 2021, the work of the Virtual Hub transitioned to be under the newly opened UPCC whereby referrals previously directed to the Virtual Hub are forwarded. Strong collaborative work between the Division, FHA and Physicians at Royal Columbian Hospital (RCH) and Eagle Ridge Hospital (ERH) supported this seamless transition of care for patients recently discharged from the hospital and requiring follow-up. The UPCC continues to provide access to both in-person and virtual care for patients seeking urgent and//or primary care needs. Access to virtual care is paramount given the current uncertainty that the pandemic has brought on. Recently, physicians on the FNW Board sat down and shared their reflections on the impacts and benefits of virtual care in a short video (*click the picture below*).

PMH Virtual Presence

Navigating how to support PMH's within an expanding virtual care setting continues to be supported by the development and implementation of virtual supports such as creating clinic websites, utilizing existing websites, implementing online booking procedures, and implementing telehealth technologies to facilitate access between patients and providers for ongoing care needs. At the end of 2021, 41% of PMHs in the FNW have launched a website through the FNW Website Development Support Coordinator. A detailed breakdown of the year over year growth is shared below:



A full list of the clinics in the FNW and their associated websites can be found by clicking here. Analytic data provided below from websites provides an overview of patient navigation based on popular content and searches for all clinic websites for FY 21/22 Period 10.



At the time of writing this report, 58% of FNW PMHs have implemented online booking into their websites with additional clinics exploring the process with the FNW Website Development Coordinator. PMHs who currently have online booking have provided feedback around how the FNW Division can continue to support the clinic with online booking:

- *Automatic email notifications for patients who book certain procedures that take longer appointment times*
- *Technical support*
- *Training, financial and technical support*
- *Wayfinding solutions for same day bookings and in-person bookings*

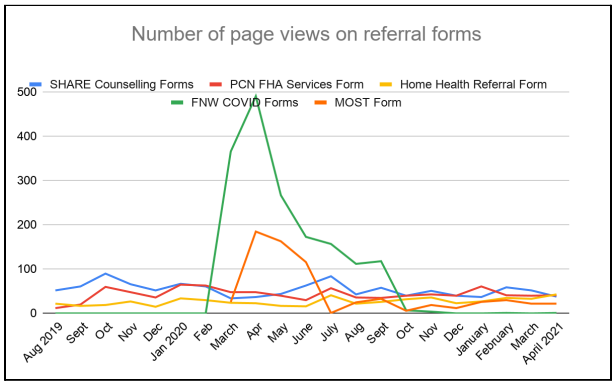
This iterative type of feedback is immediately incorporated into the existing processes and support structures put into place by the Division and provides strategies for supporting future clinics.

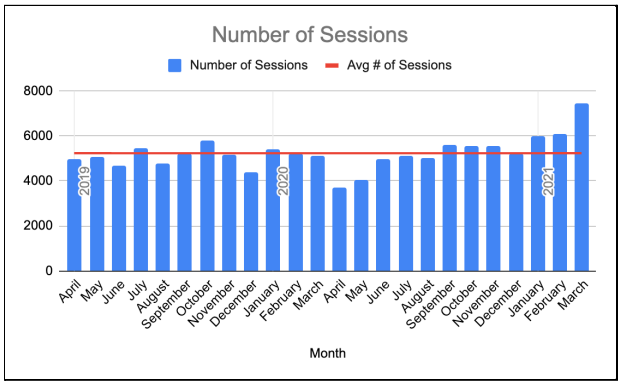
Pathways

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

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

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





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

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

In 2021, Pathways expanded its platform to support patients and community members to access healthcare supports, services and resources within their communities. The Community Service Directory and the Medical Care Directory both successfully launched to the public and enabled access to resources and supports for the public. The Medical Care Directory was

created as a 'one-stop' online directory for the public to find clinic and booking information for their own primary care provider or to identify primary care providers accepting new patients.

Patient Engagement

Since PCN inception, there has been a significant growth in patient and community member engagement in order to ensure continued access to healthcare services throughout the pandemic. Patient partners have joined the PCN Steering Committee, a number of Shared Care Working groups, and Community Health Focus Groups. In addition to this leadership, understanding how patients navigate the healthcare system is inherent to ensuring the Community Primary Care Providers and partners work to ensure continued coordination and quality of care. Patient Journey Maps have provided snapshots of the impacts on how the system sets patients up to effectively - and ineffectively - navigate for their healthcare needs. Patient experience surveys continue to provide input around program, project and service delivery. Patients have shared their experience with regards to:

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

Public partnership in service delivery also expanded this last year with a strengthening of relationships with local municipalities, volunteer organizations, and academic institutions. This coordinated effort to provide access reflects the strong focus on healthcare that's apparent across the communities. With the introduction and dedicated focus on more public and community focused communications, the FNW Division saw a significant increase in public engagement. Each quarter, a newsletter is distributed to patients in the communities who have signed up to receive newsletters from the Division. When this resource launched in May 2020, there were a total of 170 subscribers, whereas in May 2021 the overall year end growth was 2103%. A breakdown of the # of subscribers, opens and % of opens is below:

	# Subscribers	# Opens	% Opened
May 2020	170	63	38.20%
August 2020	573	279	49.60%
November 2020	1982	1447	73.60%
February 2021	3288	1364	41.70%
May 2021	3745	2203	59.10%

August 2021	3830	1012	28.3%
November 2021	3459	1474	42.6%

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. Through the distribution of the patient newsletter, people were asked to share their perspectives and experiences related to virtual care. Responses highlighted the diversity of access to the health system when asked the following questions:

- We want to know: what are your thoughts on this form of doctor's appointments?
    - What kind of visits do you think should be done virtually?
    - What kind of visits do you think should be done in-person?
    - What other thoughts/opinions do you have on this topic?

One experience highlighted the opportunities for improvement around the healthcare system as well as themed phrases from all responses are shared in the word bubble:

*"We've been in the lower mainland for three years, we'd be happy to *get* a family doctor, virtual or otherwise. Myself and two daughters use walk-in clinics because we have not found a physician accepting patients. It has materially affected how we seek out and receive care. Fortunately, we are moving out of province soon, to a location in the Prairies that, as a side benefit, actually has physicians!* ***Access to a waiting list is not access to care****. This system is badly broken. Please pass this comment on and never let it go. No amount of cheerful emails or apps or press releases compensates. Access to a waiting list is not access to care. I have lived in Finland and in the United States. *Both* systems are better."*

Remaining Gaps

Since PCN inception, there have been different models of care trialed within the FNW communities, with some yielding more success than others; however with the ongoing pandemic, sustainable solutions are required to support primary care access for patients and providers. In order to identify models of sustainment, ongoing support is necessary locally, regionally and provincially. Recognizing that implementing sustainable models cannot be

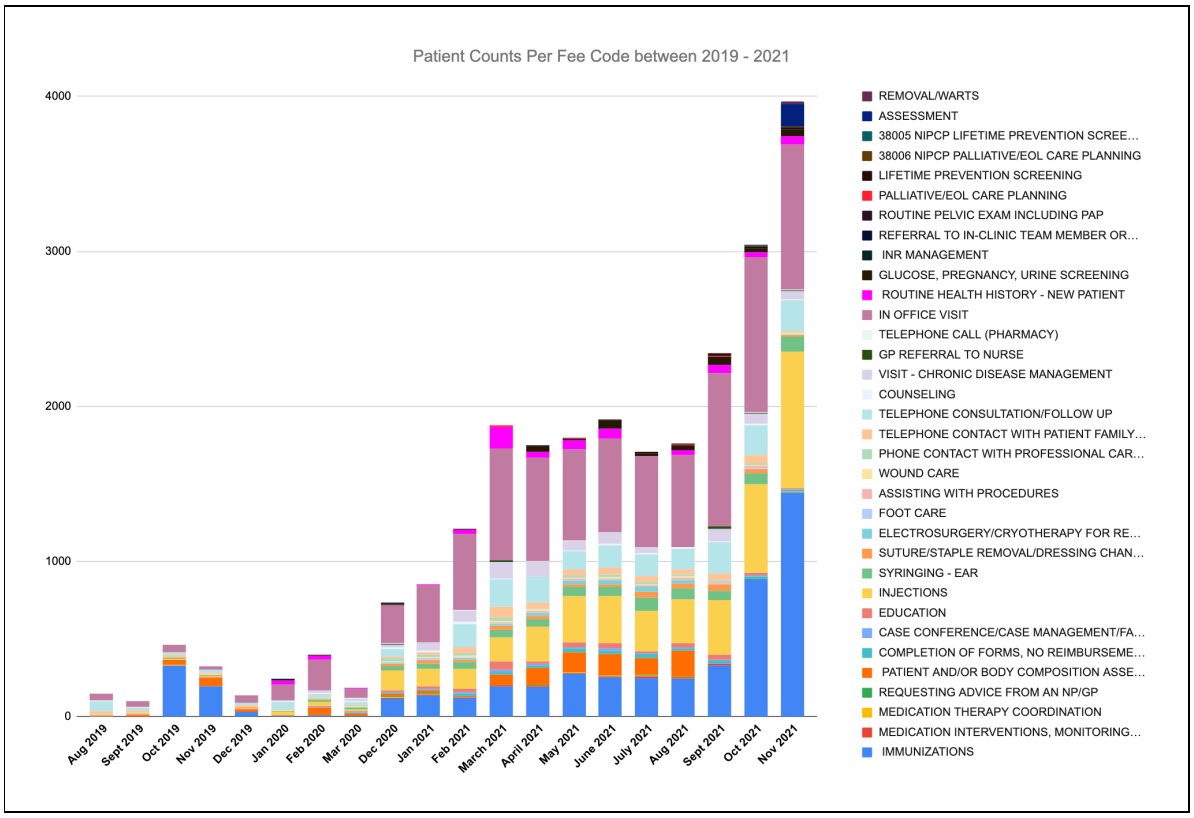
interpreted as a 'one size fits all' approach, but rather must continue to allow for tailored support to the local communities - and PMH - context.
Understanding the impacts and importance of community engagement in supporting not only access, but a broadening understanding of the scope of primary care services is one facet of education that the Division continues to explore through locally developed campaigns and outreach engagement.

5. Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care

The extension of the PMH team continues to occur within the clinic, with the introduction of RNs in Practice, New Family Physicians, Nurse Practitioners and Practice staff support; but also extends outwards to the community with the introduction of rapid access mental health clinical counsellors, Primary Care Clinical Pharmacist and the continued enhancement of existing services such as Community Health Nurses (CHNs), FHA Clinical Counsellors, FHA Pharmacist, and social workers. These services integrated within and outside the clinic continue to establish and strengthen a network of comprehensive primary care services for both providers, their patients and the community.

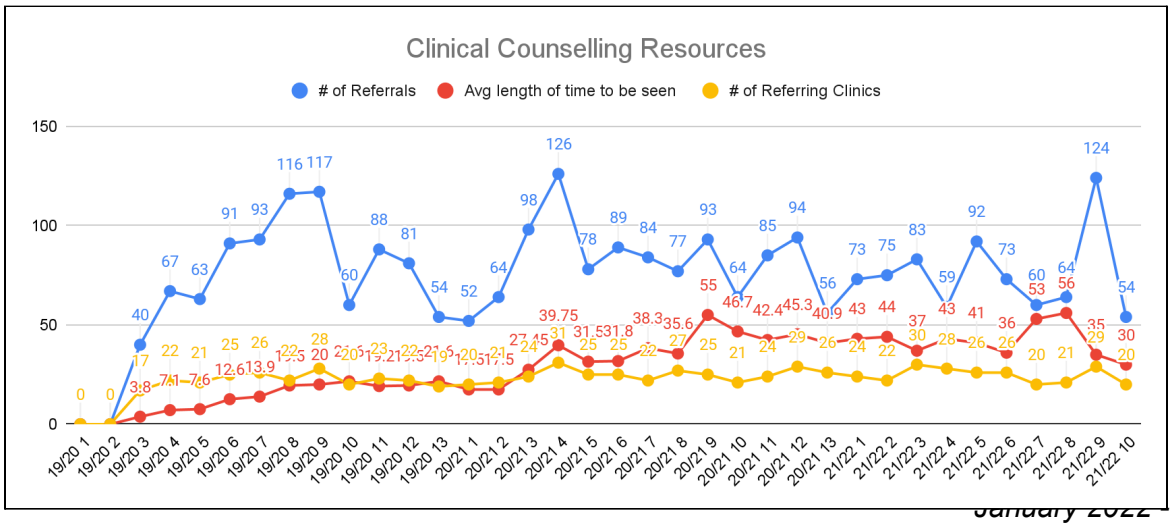
Registered Nurse in Practice

With the introduction of the RN in Practice initiative, these RNs have not only continued to support the PMH team and their patients as noted by the visuals below that document the use of the RN encounter codes, but these providers also support and extend the networking with community primary care services.



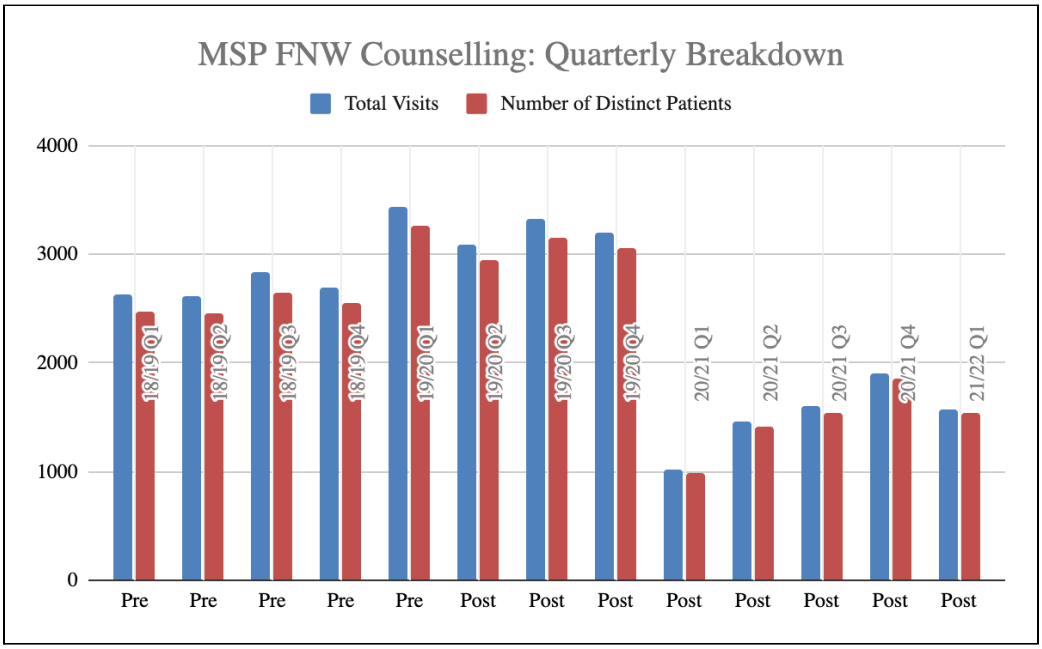
Mild/Moderate Mental Health Support

As part of the FNW PCN, funding for 5 Clinical Counsellors was provided to a local non-profit agency in the FNW communities. These resources were established to provide rapid access for patients in the community with mild-moderate mental health concerns. Providers in the community are able to connect with these clinical counsellors who then provide short-term support as well as navigation to alternative community resources for patients. The visual below shows the growth of this program since PCN inception.



On average, each period, there are approximately 160 patients seen and over 270 appointments scheduled - this shows the significant need. In parallel to this service, FHA established a team of clinical counsellors to also support mild-moderate mental health services in providing short-term clinical counselling and system navigation.

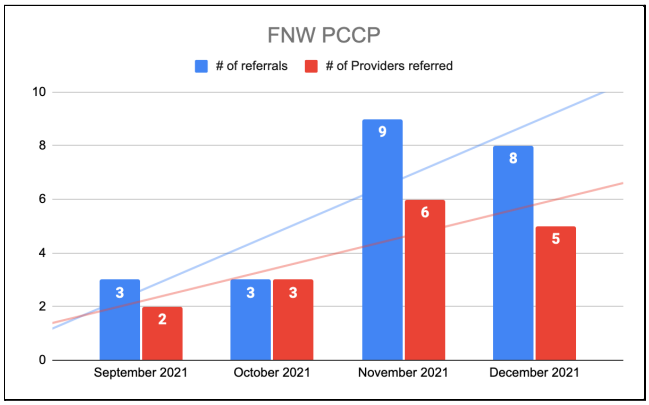
Through the co-development of these programs, the intention was to increase patient and physician access to rapid counselling supports given the high waitlist for existing community supports. This intent in turn decreases the burden in caring for these patients that is placed on family physicians which then could create increased capacity. Year over year comparative data provided from the Ministry of Health which looked at the MSP billings for those physicians in the FNW who have referred to this program details that although there has been an increase in the number of physicians billing, the counselling fees, distinct patients and average counselling visits/provider have all decreased. This table looks at the data that was submitted pre PCN program (July 2019 and earlier) implementation and post-PCN program (august 2019 and later) implementation as well as the change in trends over time. The significant drop in March and April 2020 is likely due to the initial impacts that the Covid-19 pandemic had on access to primary care. The table below shows the year over year comparison broken down by FY quarter for total visits and number of distinct patients:



Primary Care Clinical Pharmacist

As part of the funding for the FNW PCN, the New Westminster and Tri-Cities communities were allocated resources for 4 Clinical Pharmacists across the FNW communities. Work has been

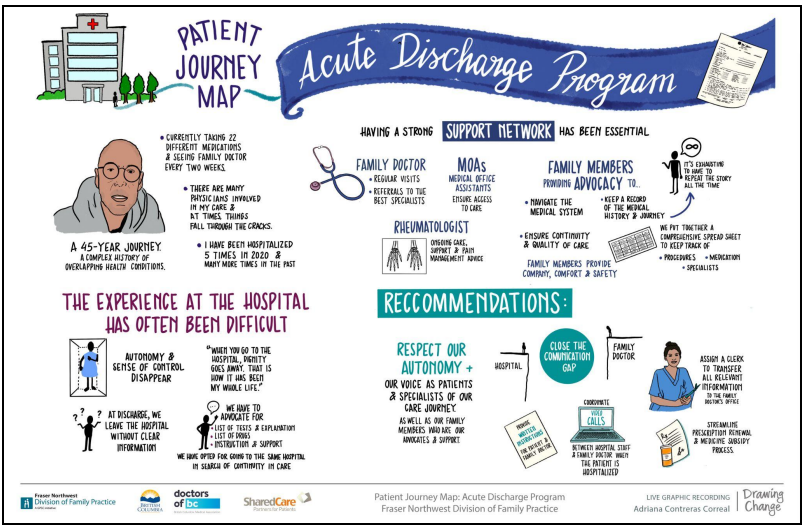
underway since the PCN inception around identifying strategies for incorporating these positions to support longitudinal primary care services. The first Pharmacist was hired in August 2021 and has been meeting with FNW clinics to set up clinic meet and greets and introductions to identify how best to support providers and their patients needs. Work is currently underway to establish ongoing discussions between UBC, FHA, FNW Primary Care Providers and Division staff to better understand the implementation plan of these resources as well as navigate and establish a collaborative and equitable reporting structure to share out the successes, challenges and lessons learned from this program. As noted by the graph, the number of referrals and referring providers are trending upwards likely due to the community PMH engagement work that the Pharmacist, and program administrators are performing.

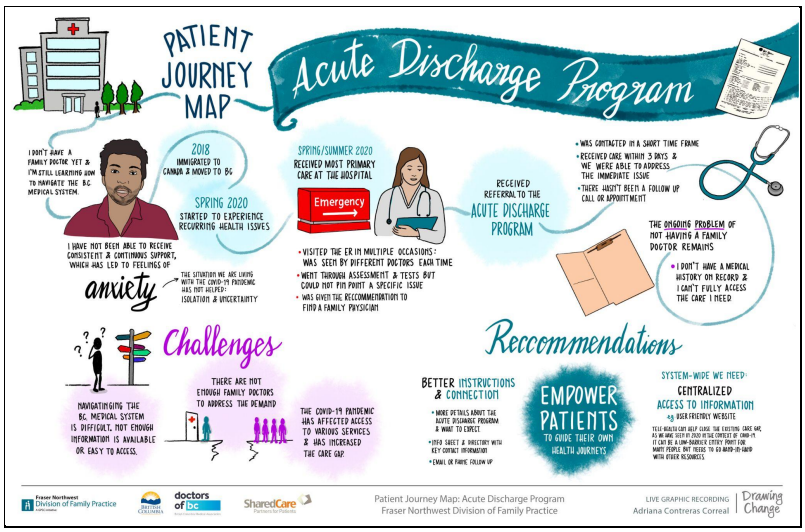


Pilot Virtual Care Hub: Acute Discharge

As mentioned in the previous section, the availability of the Virtual Care Hub (now transitioned into the UPCC) allows for extended access to primary care services for members of the community. The creation of the Virtual Care Hub emerged out of a Shared Care project focusing on recent discharges from acute care to ensure patients being discharged from Eagle Ridge Hospital and Royal Columbian Hospital were 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 referred both attached and unattached patients to the Acute Discharge Program to ensure follow-up by a FNW Virtual Care Hub physician. Referrals also could 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 a local Family Physician:





A Physician recently 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.

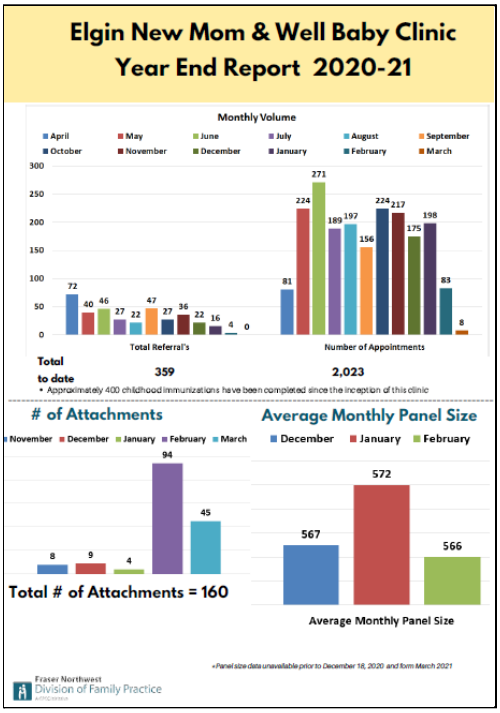
Pilot New Mom & Well Baby Clinic

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

In April 2020, a Newborn and Well-Baby Clinic was set up at a local PMH. Physicians working at this clinic were able to provide follow-up care to unattached new moms/babies from discharge to 18 months with the goal of attaching these moms/babies as a priority population with the FNW Attachment Hub.

This clinic received over 300 referrals with the first month receiving the highest demand.

The clinic closed at the end of March 2020 after facilitating attachment for all new moms and babies to primary care providers across the FNW. Approximately 200 dyads have been attached to primary care providers across the FNW communities.



Remaining Gaps

Since PCN inception, there have been different models of care trialed within the FNW communities, with some yielding more success than others; however with the ongoing pandemic, sustainable solutions are required to support primary care access for patients and providers. In order to identify models of sustainment, ongoing support is necessary locally, regionally and provincially. Recognizing that implementing sustainable models cannot be interpreted as a 'one size fits all' approach, but rather must continue to allow for tailored support to the local communities - and PMH - context. For vulnerable populations, this commitment to timely and accessible health care is even more important. Sustainable community solutions that ensure people with mild/moderate mental health concerns have access to the support when they need it ultimately reduces pressures on the acute system, with the aim of meeting needs at the early onset of concern as opposed to the moderate/severe end of the spectrum. Access to longitudinal primary care for new moms and babies continues to decrease in the community based on available resources, incentives to provide maternity care, retirements and leaves of existing providers and the overall disproportionate amount of providers leaving the community compared to those entering the community.
Maternity care in the community is a significant concern in terms of sustainability as many of the providers currently providing this care are later in their careers and the desire for new providers to begin practicing this type of care is limited. Members provided feedback on the following barriers to providing maternity care:

What prevents Family Doctors in our community from doing maternity care? What are the barriers?
• Being on call, I gave up maternity because it was draining on me and my family to be called out to the hospital all the time. • Also when I last did maternity there was underlying tension with nurses and family physicians, and between the family practice groups like they were competing for money. • For me, it's a lack of comfort with the field. I did not have a good experience in residency. • I personally have a lack of interest in this area of medicine, and don't keep up with the guidelines so it becomes harder and harder to practice it. • I provide maternity care up until 20 something weeks. I don't do deliveries. Do you mean barriers to providing e.g. any care vs. care up to 10 weeks vs. deliveries • Lack of confidence, training, and interest. • Accessibility to timely support if things get complicated or urgent care required • On-call and hours. Training and loss of experience from not practicing it. • Time limitations. Usually it takes longer to care for them and answer all their questions, which is often not well compensated. Some doctors continue to do early prenatal visits due to their interest, but are aware that they are compensated less compared to other visits that don't take as long. • Everything feels very rushed when we want to do a good job. It does make some people want to seek midwife care because they feel there is more time. • Feeling overworked already. Unable to take on more night and evening shifts due to being on the brink of burnout, already burned out, or recovering from burnout.

Recently, a Nurse Practitioner attended a prenatal member education event which prompted the provider to engage with the Division team to share that they were accepting new babies and moms as patients and provided details on how to reach out. This example is a reflection of the importance of including Nurse Practitioners in member focused events as they also are able to attach patients to their panel.

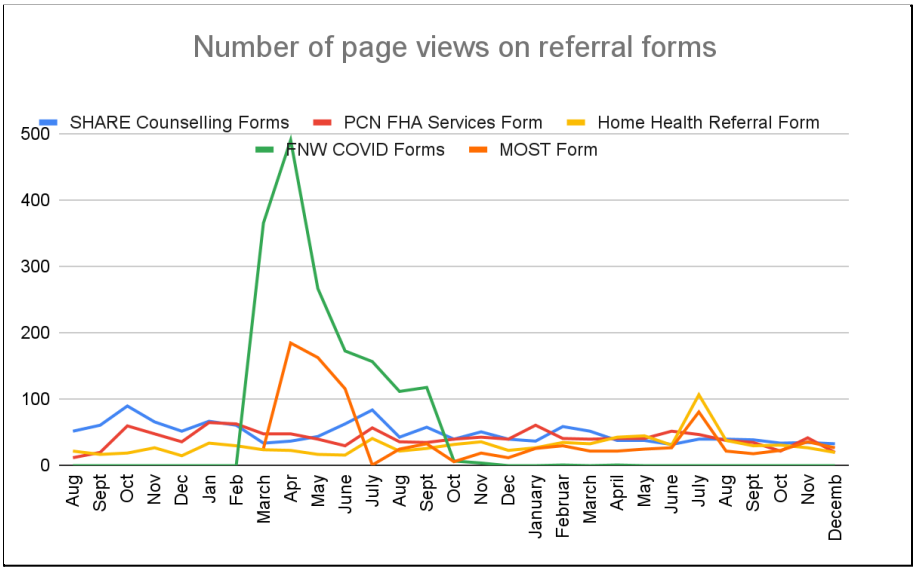
6. Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community

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. Funding from Shared Care supports family physicians with a focused practice, and specialist collaboration on quality improvement projects. Shared Care is one of four Joint Collaborative Committees (JCCs) representing a partnership between the government of BC and Doctors of BC. Although not under the funding umbrella of the Primary Care Network, Shared Care facilitates and strengthens the network through the provision of established projects focusing on:

- Maternity
- Older Adult/Medically Complex
- Mental Health & Substance Use
- Chronic Pain
- Breast Health
- Palliative
- Geriatric Psychiatry
- Acute Discharge
- Women's Health
- Respiratory/Pulmonary Function

Pathways is a virtual directory that allows local Family Physicians and providers to identify and access resources, supports and services for their patients on a variety of healthcare related concerns. It is a tool used by Physicians and Specialists for referral resources, wait times, and has been proven to play an important role in the coordination of care between providers. Data

pulled from the FNW Pathways site from August 2019 shows the page views of PCN related referral supports as well as details the rapid increase in Covid-19 supports since March 2020. This chart below specifically details the number of popular page views as detailed by referral forms.



Primary Care Provider engagement and collaborative leadership with specialists, health authority administration and community service providers is integral to the successful development and delivery of services and resources. This engagement is reflected through a number of provider working groups and advisory committees which include:

- PCN Steering Committee
    - *The purpose of the FNW PCN Steering Committee is to provide governance and leadership to the activities, working groups and strategic planning for the FNW PCNs*.
    - *Membership is comprised of PCN partner organizations, community family physicians, hospitalists, administrative program staff and non-profit and stakeholder groups*
- PCN/PMH Provider Advisory Committee
    - *The purpose of this committee is to advise the Division and FHA Leadership regarding the direction of the primary care improvement work underway in the FNW communities*
    - *Membership is comprised of FNW Family Physicians, Hospitalists, Nurse Practitioners, Maternity providers and Division program staff*
- RN in Practice Physician Leads group

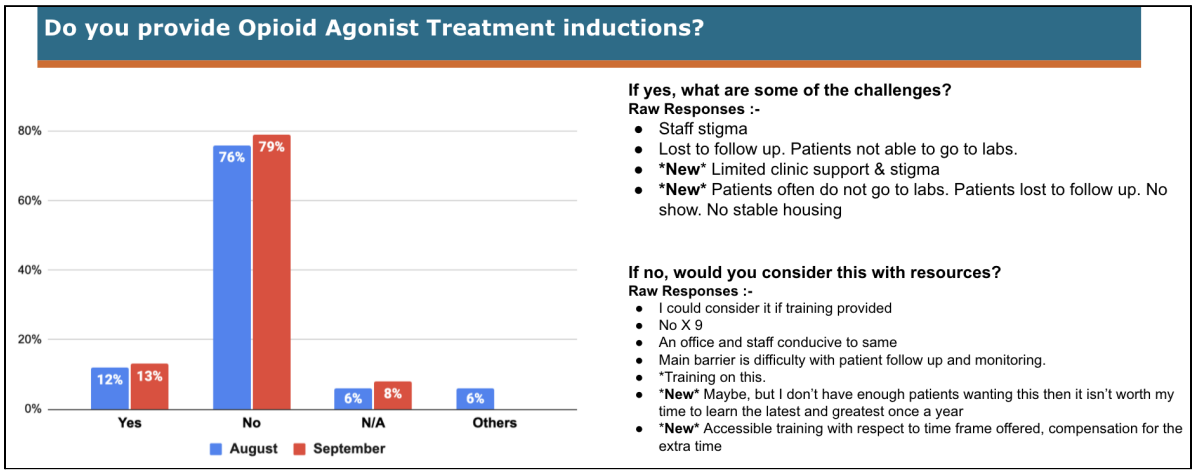
- *The purpose of this group is to provide a space for Physician leads at clinics where RNs are placed to come together, share learning, ask questions and support the ongoing development of the initiative within PMHs and the FNW PCN.*
- *Membership consists of Physician Leads for clinics who have RNs in practice and Division program staff.*

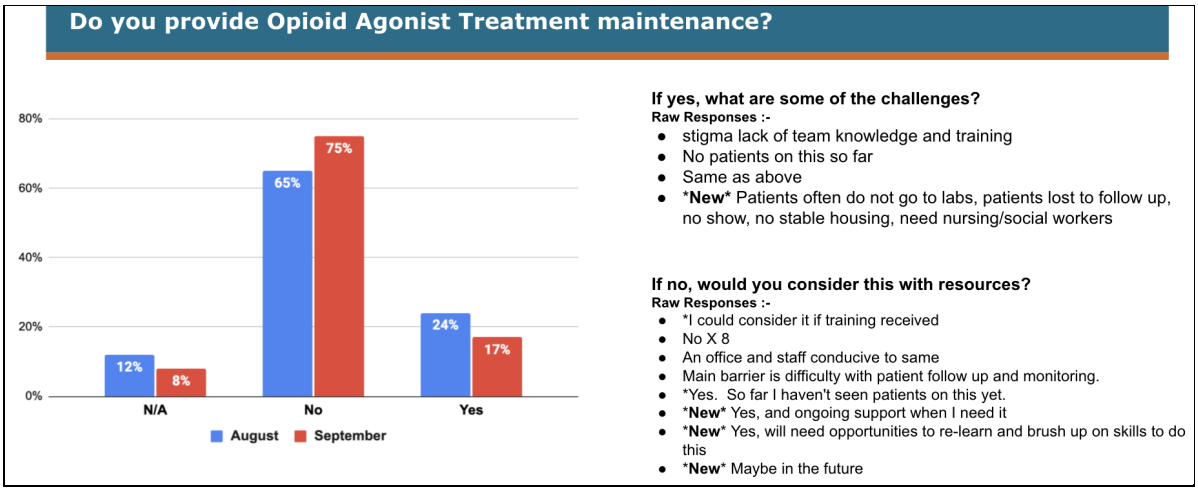
- Community Health Focus Groups
  - *Initially launched to support discussion and conversation between FHA Home Health and Family Physicians, these recurring monthly focus groups have evolved to encompass additional aspects of community care including medication management, and mental health supports.*

Remaining Gaps

Opportunity for further work to support the attainment of this attribute in the FNW communities, as noted by concerns and feedback around access to Opioid Agonist Treatment, mental health supports such as the implementation of Car 67, accessible and sustainable maternity care and women's health needs.

Opioid Agonist Treatment: Coordination and access to services for vulnerable and high-risk populations is a priority for the FNW, and as such, recognizing the current state and gaps in access to care has been identified by community physicians through feedback collected from surveys as well as interviews. Physicians have identified barriers to providing Opioid Agonist Treatment inductions and maintenance:





Car 67: Additionally, community resources such as a Car 67 has been identified as a need in the community from FNW community physicians through recent interviews. The benefits and impacts of a resource like this is shared in a short video (*click the picture below*).

Aggregate data shared from the RCMP Mental Health Unit identified that officer's average time on scene in a mental health related call was 189 minutes in the case of an apprehension and 74 minutes without apprehension. The average time that officers wait with patients upon arriving at the hospital is approximately 100 minutes. The mental health and substance use calls for Coquitlam and Port Coquitlam note the year over year changes below:

Coquitlam - Mental Health Statistics						
	2016	2017	2018	2019	2020	2021 (Jan 1 - Sep 30)
Mental Health Related Files	1289	1267	1187	1156	1288	960
Population Estimate	146019	148055	149309	150636	152800	154207
Mental Health Files per 1,000 residents	9	9	8	8	8	6

Port Coquitlam - Mental Health Statistics						
	2016	2017	2018	2019	2020	2021 (Jan 1 - Sep 30)
Mental Health Related Files	590	584	606	574	611	545
Population Estimate	61441	61943	62932	63654	63503	64445
Mental Health Files per 1,000 residents	10	9	10	9	10	8

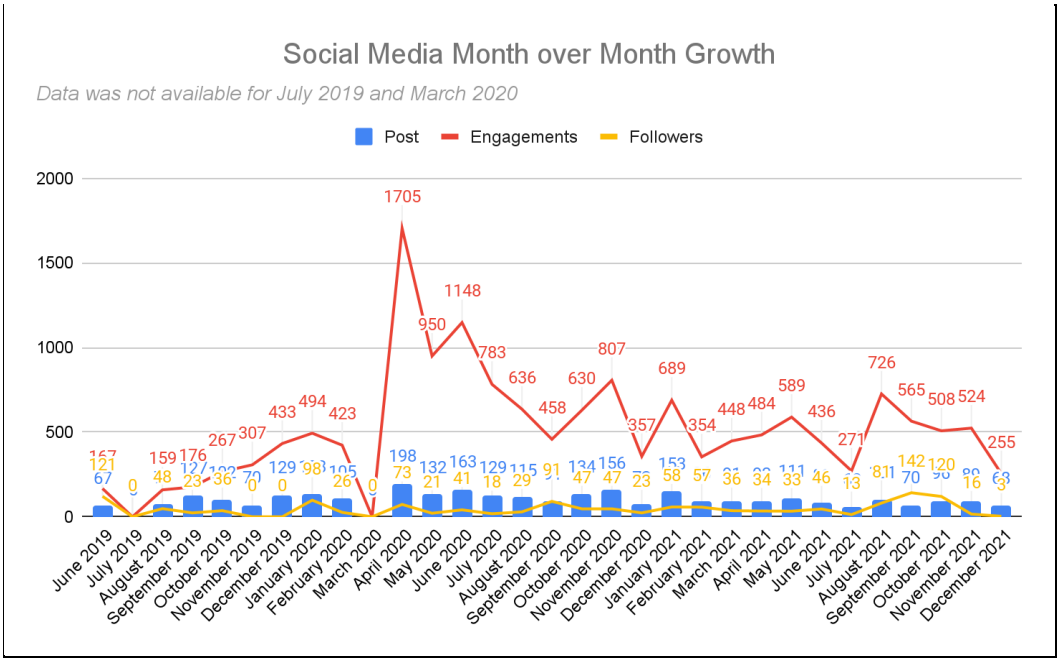
Women's Health: Access to paps is an important preventative health measure for many women. FNW Primary Care Providers require access to reliable resources and testing supports in order to enable and offer this service to their patients. In 4 months (June - September), the number of FNW PMHs offering this screening on the BC Cancer website has decreased significantly by -200%. There are 3 other health centres providing this screening; however, these are not PMHs. This raises a concern around timely access for women seeking this screening and is an example of not only the challenge, but also provides an opportunity for discussion around alternative resources that may be able to provide this service such as the U&PCC, a women's network, or skill-based education for interested practitioners.

7. Clear communication within the network of providers and to the public to create awareness about and appropriate use of services

With the introduction and dedicated focus on more public and community focused communications, the FNW Division saw a significant increase in public engagement. The goal of the FNW communications program is to provide internal and external stakeholders, members and the general public with access to Division communications and events. The program's goals are to:

1. Create and maintain an effective communications plan including developing and implementing internal and external communications strategies;
2. Create and implement a web content strategy that supports our Patient Medical Homes and Primary Care Networks, Patient Attachment, and Member Recruitment.

Since PCN inception, dedicated communications staff have tailored social media platforms to engage and enhance communication to and from the general public. Engagement, posts and followers continue to grow on all platforms. As noted by the high spike in engagement below, this is due to the transition to provide information and resources at the beginning of the pandemic.



In June 2021, FNW Division launched "*What's Up Doc?*", a community engagement series aimed at providing a space for dialogue and conversation between community members and Primary Care practitioners and experts to support a growth in public education and capacity building for creating a common understanding of health related needs in an accessible format. Topics have focused on infant development, general care, palliative and long term care.

With the rollout of covid-19 vaccines across the province, the FNW Division created a campaign targeted towards Vaccine Hesitancy within a number of priority populations. This campaign aimed to amplify the voices of family doctors as trusted community members in addressing public concern over the Covid-19 vaccines, and encourage vaccine uptake. The Division did this through a video series that leveraged social media advertising to reach target populations, which included minority groups, pregnant patients, young people, and the general public within the Greater Vancouver areas of BC. Videos were created in English, Arabic, Farsi, Cantonese and Korean. A total of 10 videos were created, all with subtitles, addressing different areas of concern surrounding the Covid-19 vaccines. Four key topics covered including the vaccines in maternity & pregnancy, the importance of the second dose, seeking reliable information about the vaccines and using stories and personal experiences from the physicians point of view. The primary goal was link clicks to the Government of BC's Get Vaccinated webpage and the campaign received a total of **27,868 link clicks** from social media ads. The secondary goal was impressions which received **over 1.3 million (1,345,095) impressions.**

Community network engagement that facilitates cross-organizational communication continues to be supported by FNW Division staff within a number of community networks. Participating in

networks supporting at-risk and vulnerable populations, Overdose Community Action Teams, Seniors networks and local immigration networks facilitate the extension of resource sharing amongst 64 community and local government organizations. This spread reflects the opportunity for involvement and engagement facilitated by the Division to promote and incorporate longitudinal primary care provider feedback into these discussions. The intent of these local networks include, but are not limited to:

- *Supporting at-risk and vulnerable populations include but are not limited to families, individuals, and households. The working group comprises government, faith, and non-profit representatives who put their minds, resources and prior experience together to establish a plan of action to tackle issues.* (At Risk and Vulnerable Populations Task Force & Seniors and Persons with Disabilities Task Force)
- *Community organizations meet to collaborate, share, and raise awareness on overdose prevention resources and projects in the Tri-Cities region. (Tri-Cities Overdose Community Action Team (TCCAT))*
- *A space for organizations to share information and events, provide program updates and learn about ways to best support seniors in the community (Senior's Inter-Agency Network)*
- *Bringing community leaders and organizations together to set priorities and coordinate services for immigrants and refugees, and to create a community where everyone can be welcomed and belong. (The Tri-Cities Local Immigration Partnership)*

Remaining Gaps

Identifying strategies for public engagement and strengthening community awareness require a targeted approach that relies on utlizing and networking with the public itself. Establishing strategic communications that necessitate buy-in from the public are being developed through a coordinated approach between the community family physicians, FNW Division, FHA, local representatives, municipalities and patient representatives.

A lesson learned that occured recently, was around establishing a clear intent when communicating with the public. The FNW Division developed a press release detailing the shortage of primary care physicians in the New Westminster and Tri-Cities communities accompanied by the growing population size resulting in an imbalance between the number of patients requiring a primary care provider and the number of available doctors. Although this messaging is important to the sustainability of primary care in the FNW communities, identifying a clear intent and 'buy-in' for the public was a perspective that was not clearly articulated, as per feedback from local communication bodies.

Further opportunities are evident when it comes to establishing clear and sustainable communication pathways between providers and the public and the PCN partner organizations continue to work alongside these groups to ensure the creation of targeted strategies for

awareness and use of existing primary care services.

8. Care is culturally safe and appropriate

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 Kwikwetlem Primary Care clinic opened mid-October 2020 for community members. The clinic is staffed with two doctors (52 FP Sessional), an MOA, a Nurse Practitioner, a Registered Nurse, elder home support worker (0.5 FTE) and an Aboriginal wellness advisor (1.0 FTE). The members of the Kwikwetlem First Nation are accessing the services from the clinic. The Physicians are in on one day/week.

The elder home support worker started with serving three elders and had two elders waiting to be seen. Now, they are in 3 days/week and help the elders with meals, housework, shopping, medical appointment transport for specialist appointments, referral for specialists, and when it can be done safely planning activities for the elders in the community hall.

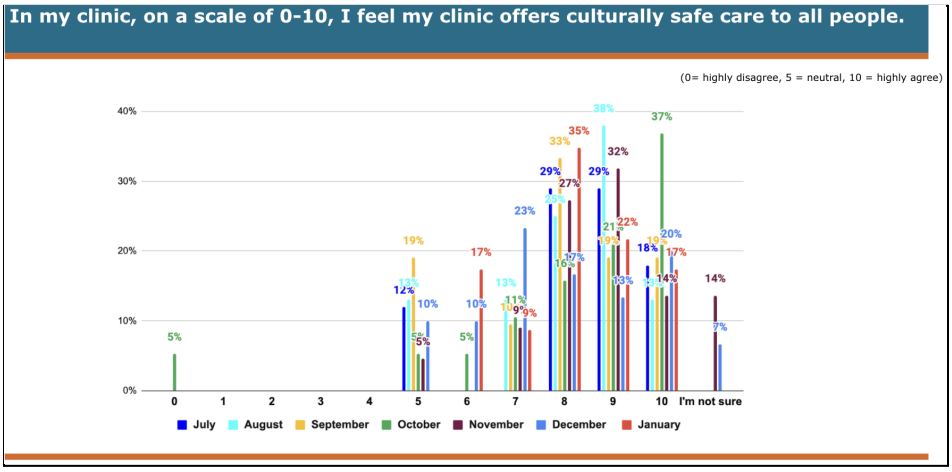
The Aboriginal wellness advisor assists the Director of health to assess the wellness needs of the community. They are currently working on meeting the needs of the community by seeking community partnerships with local organizations. Lastly, the Aboriginal wellness advisor worked with the Nurse to hand out food to the community members and provide lunch for the children, youth, and elders.

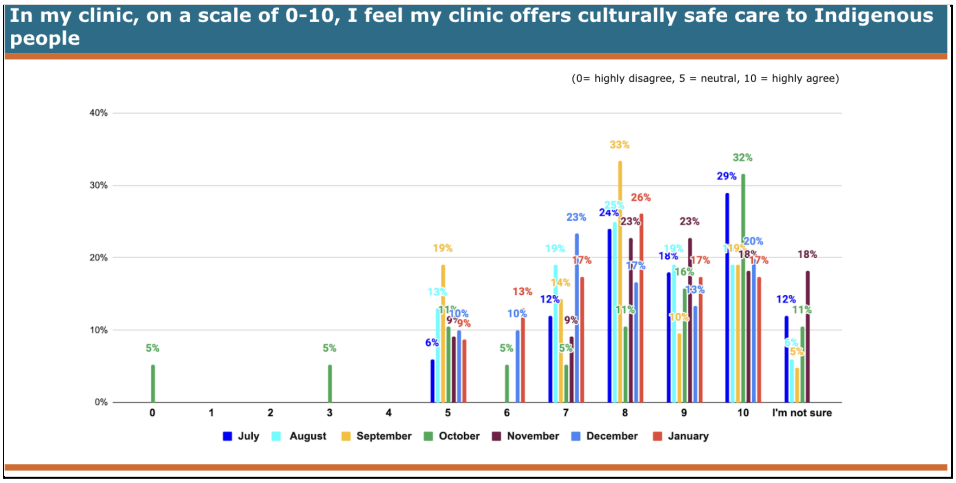
Feedback from the community identified “love[ing] the two new doctors and the elders are incredibly happy with the elder support person. They are seeking an increase in elder support due to increasing needs in the community.” The doctors and community leaders have identified interest in having the doctors move towards doing outreach in the community. The health clinic continues to work on relationships with other partners in the Tri-Cities communities.

In the FNW communities, cultural safety training and awareness has taken place with the intended audience to be FNW members and practice staff. At the time of writing this report, there have been events focusing on Truth and Reconciliation, Cultural Humility and Safety, a number of Intercultural Communication Mindset series cohorts (with additional cohorts planned in Spring 2022) and more recently, PMH tailored lunch sessions with a representative from a local community non-profit.

Remaining Gaps

Establishing a primary healthcare system that is culturally safe and appropriate for Indigenous, Metis, and minority populations is an ongoing process requiring commitment to understanding discrepancies in accessible care based on systemic discrimination and priveldge. Ongoing healthcare access and support for the Kwikwetlem First Nations community must continue as these resources have been successfully integrated into the community through PCN. Work in the community to establish cultural safety within PMHs is inherent to creating an accessible and safe environment. Ongoing Representations from Indigenous leaders, patient leaders and minority populations at the leadership tables is a step in the right direction in order to better understand what is needed at the local level. Over a 6-7 month period, FNW providers were asked whether they feel their clinic is culturally safe to Indigenous people, the groups responded in varying ways over this time period reflecting the diversity in recognition of cultural safety as well as the opportunity for further improvements. The same members were asked to rate their clinic in offering culturally safe care to Indigenous people and similar to above, the responses varied. Anecdotal feedback focused on themes of the importance of ensuring the patients experience is heard in accessing care, being mindful of experiences and differences and self-reflection in understanding the impact that health system providers and supports may have on people.





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.