Fraser Northwest Primary Care Network

Period 10 Addendum Report

All data collected and shared between partner organizations (Fraser Health Authority, Kwikwetlem First Nations and Fraser Northwest Division of Family Practice)

Version - January 21, 2020

Overview of FNW Program Strategies

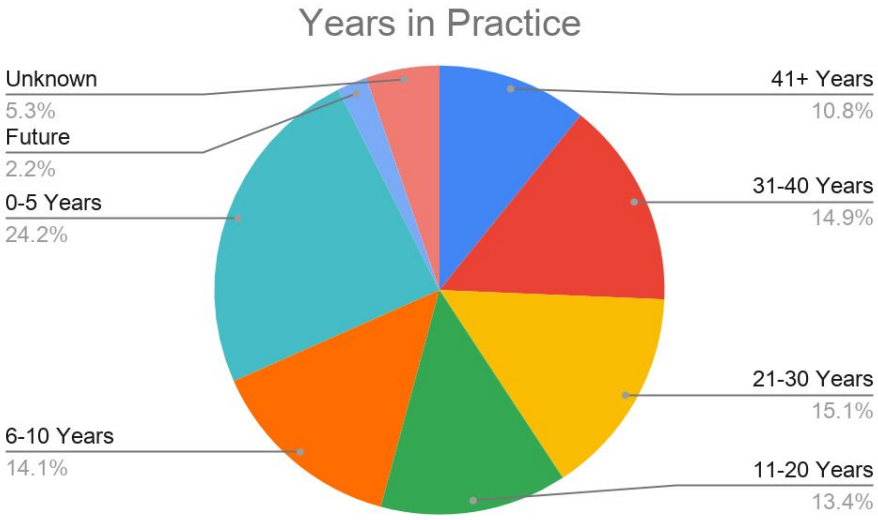
With a total population of 315,000 in the Fraser Northwest (FNW) and an attachment gap of 43,210 (Source: 2016/17 MoH Community Matrix data), an introduction of the PCN supports and services would significantly reduce this gap for members of the community seeking a family physician. On average, FNW physicians see approximately 21 patients/day which is significantly lower than that of other communities in the province and this may be largely due to the growing complexity of the patient population paired with a growing mental health population. Through the development process, 4 distinct PCN's have been identified by the Ministry of Health (MoH) within the FNW:

1. *New Westminster*
2. *Port Coquitlam*
3. *South Coquitlam*
4. *Port Moody/Anmore/Belcarra/North Coquitlam*

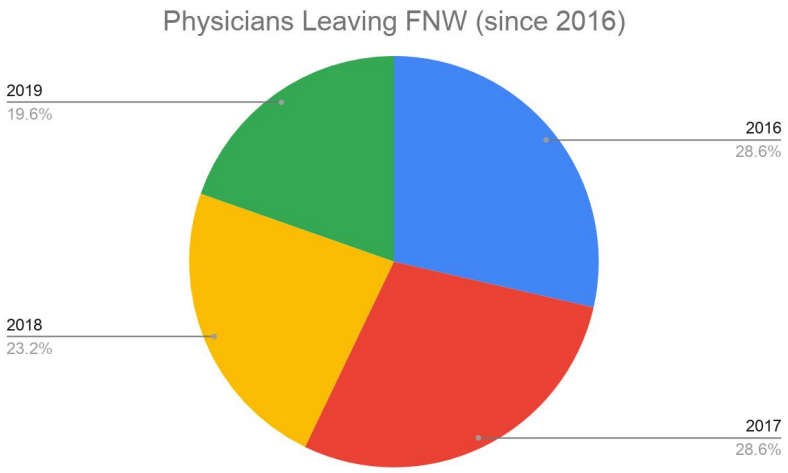
Further details on the distribution of PCN resources and the community demographics can be found at the end of this report.

FNW Community Overview

FNW Division membership is comprised of approximately 419 physician and provider members. Although this number is large, 41% of FNW members have been in practice for 20+ years. This is a significant portion of the membership of FNW. A detailed breakdown can be seen in the chart below:

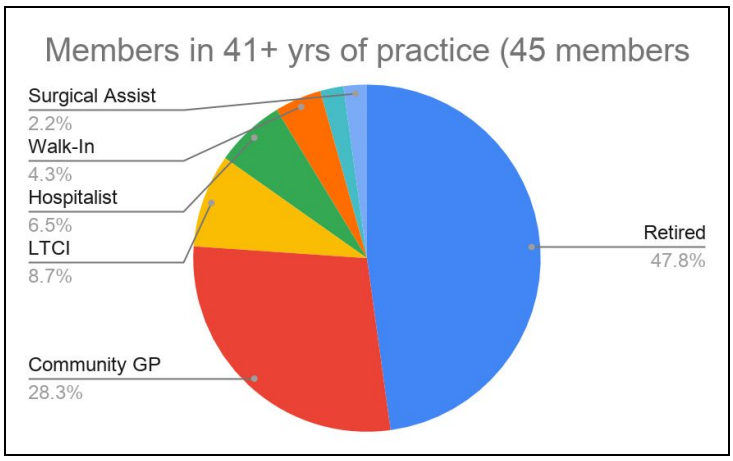


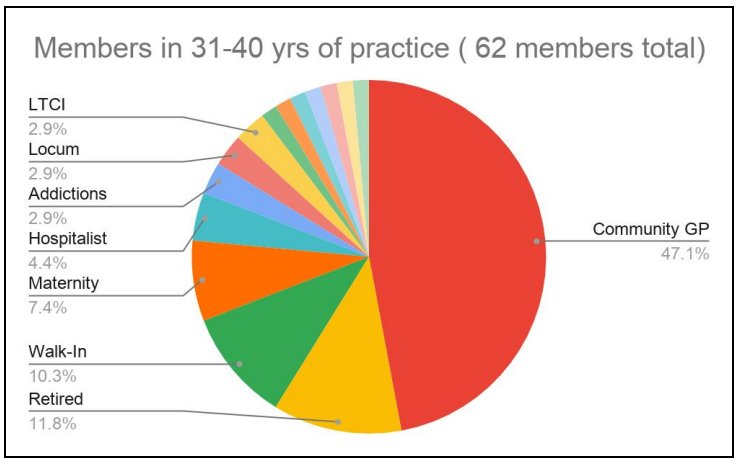
The number of physicians retiring and/or leaving the community continues to grow with those leaving citing high costs that the FFS compensation model currently can't meet with how some family physicians practice. Since 2016, there have been approximately 47 physicians leave the community with 11 physicians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



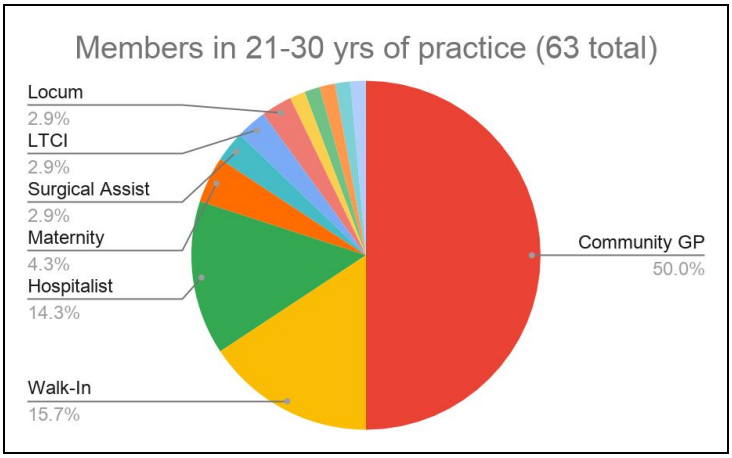
Projected retirements in the next year are set at 7 with a five year forecast of 25 family physicians retiring out of the FNW communities. This projection is an estimate and is based on an estimate that approx 10% of our members that are 21+ years in practice will retire between 2020-2024 as we have 173 members that are 21+ yrs. Supportive resources such as RNs in Practice, access to rapid clinical counselling resources and practice improvement support are paramount to retaining the current physicians in the FNW, and recruiting future physicians to practice in these communities.

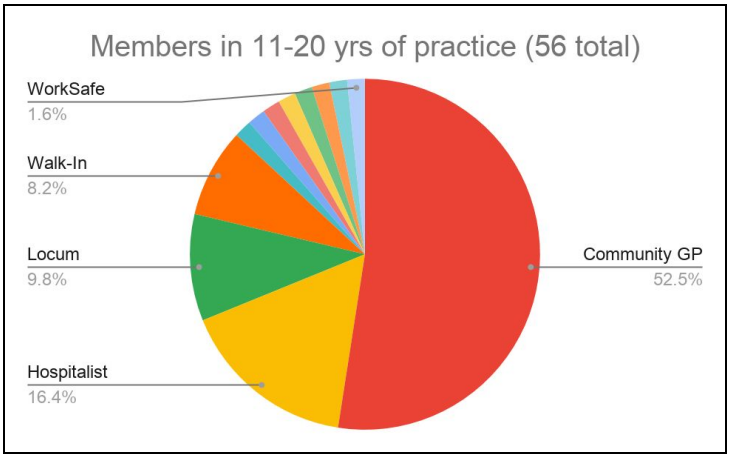
FNW membership is, not surprisingly, largely made up of community Family Physicians with a similar number of locums and hospitalists comprising the bulk of the members. Residents are also popular members and there is a range of approximately 23 other positions including Nurse Practitioners, specialized physicians, retired physicians and medical students - some members may also have multiple roles. A detailed breakdown of the membership composition and years in practice is noted below:

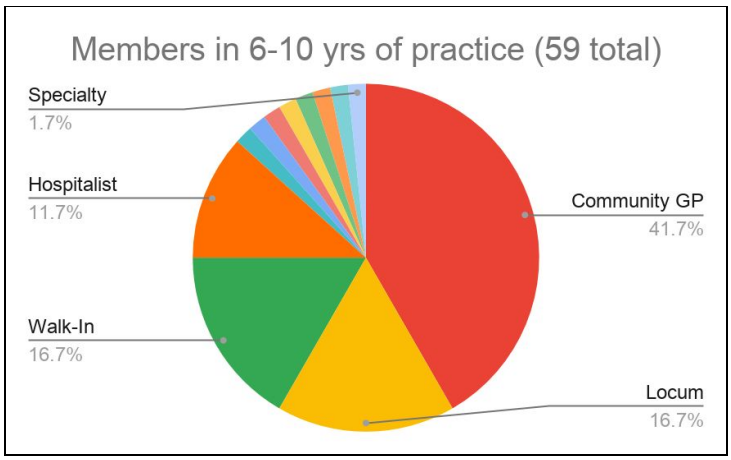


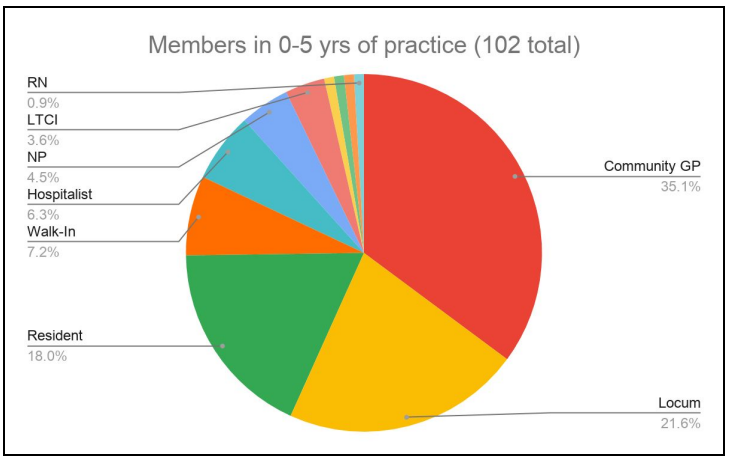


All data collected and shared between partner organizations (Fraser Health Authority, Kwikwetlem First Nations and Fraser Northwest Division of Family Practice)









This period overlapped with the holiday season and it's important to note that for FFS physician and clinics, closing over the holiday season can be difficult as patients still require their healthcare needs to be supported. There were at least 13 family practices confirmed that were open on Christmas Eve in 2019. Typically, the only additional closures that family practices take are the statutory holidays; whereas other professions may take the traditional 2 weeks.

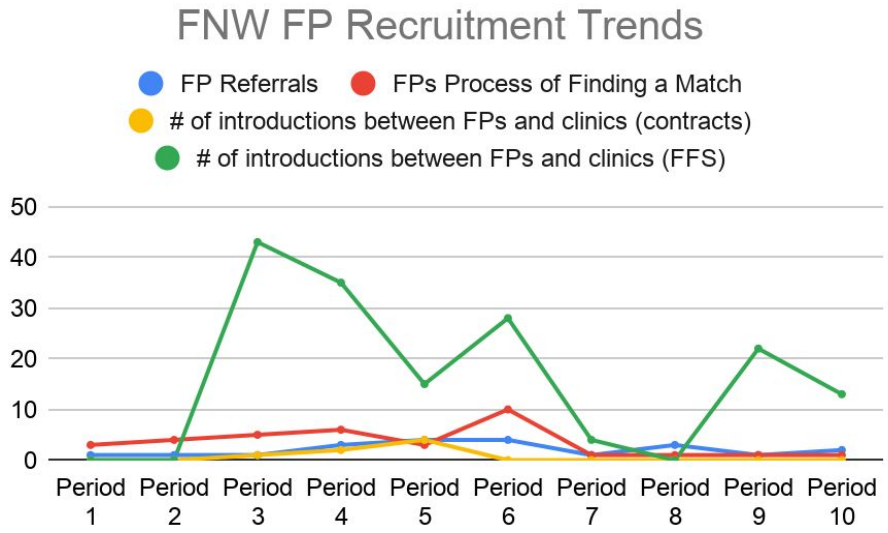
Family Physician and Nurse Practitioner Contracts

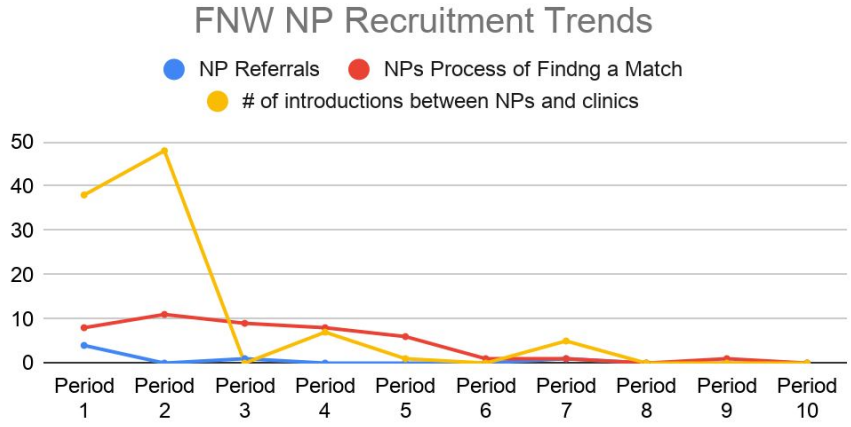
Collaborative work between the FNW, Fraser Health (FHA), HealthMatch and the Ministry of Health is vital in order to support increased FP and NP resources in the FNW communities. In Period (December 13 - January 9), clinic openings grew from 17.6 FTE to 19.6 FTE due to 2 FPs leaving the area. Table 1 below provides a status overview and update on the breakdown of the NP and FP contracts by PCN within the FNW:

	Referrals		# in the process of finding a match	# of introductions between provider and clinics	# of contracts signed
	# of New Referrals	Running Total of Referrals			
Family Physician	2	28	1	0	1

All data collected and shared between partner organizations (Fraser Health Authority, Kwikwetlem First Nations and Fraser Northwest Division of Family Practice)

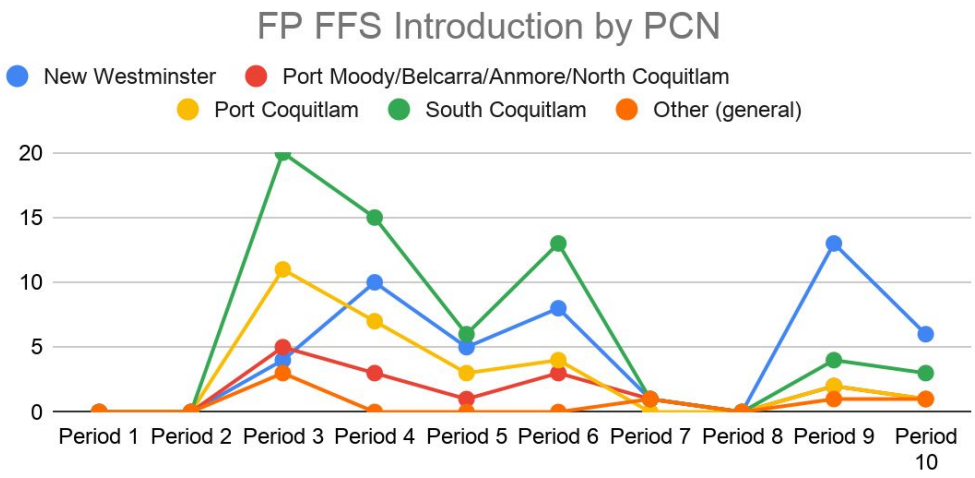
					YTD = 1
Nurse Practitioners	0	16	0	0	0 YTD = 5





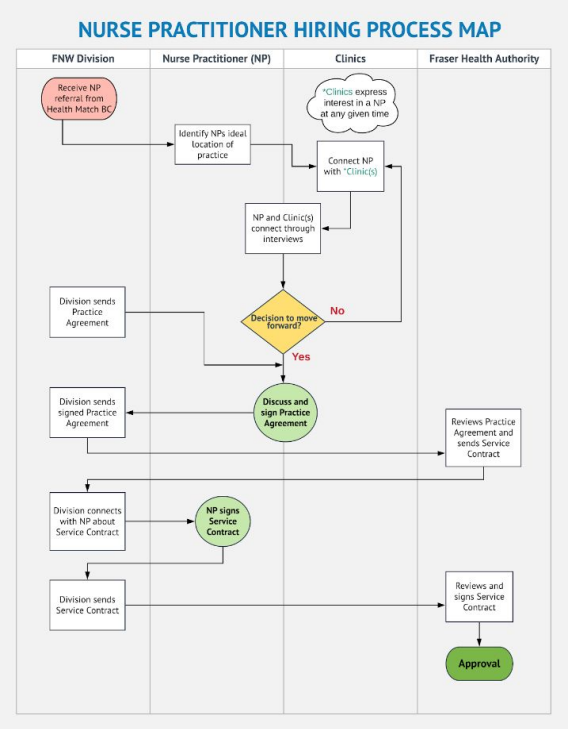
The number of FPs in the process of finding a match changed during the period, but by period close it remained at 1. This change was due to 1 FP signing a contract mid-way through period 10. The number of NPs in the same process changed from 1 to 0 by period close as the NP opted to go with a position in a different community after a drafted practice agreement and verbal commitment were provided to an FNW clinic. Unfortunately, this has been the second time this clinic has experienced a last minute shift in provider recruitment. The number of active postings on HealthMatch BC for FPs for both FFS or contract positions grew in this period to 40 active postings. Opportunities for these postings include: locum and permanent part-time and permanent full-time in the FNW.

Fee For Service opportunities and engagement efforts are underway on an ongoing basis and in this period, there were 12 new introductions between FPs and practices for FFS opportunities such as locum, permanent part-time and permanent full-time.

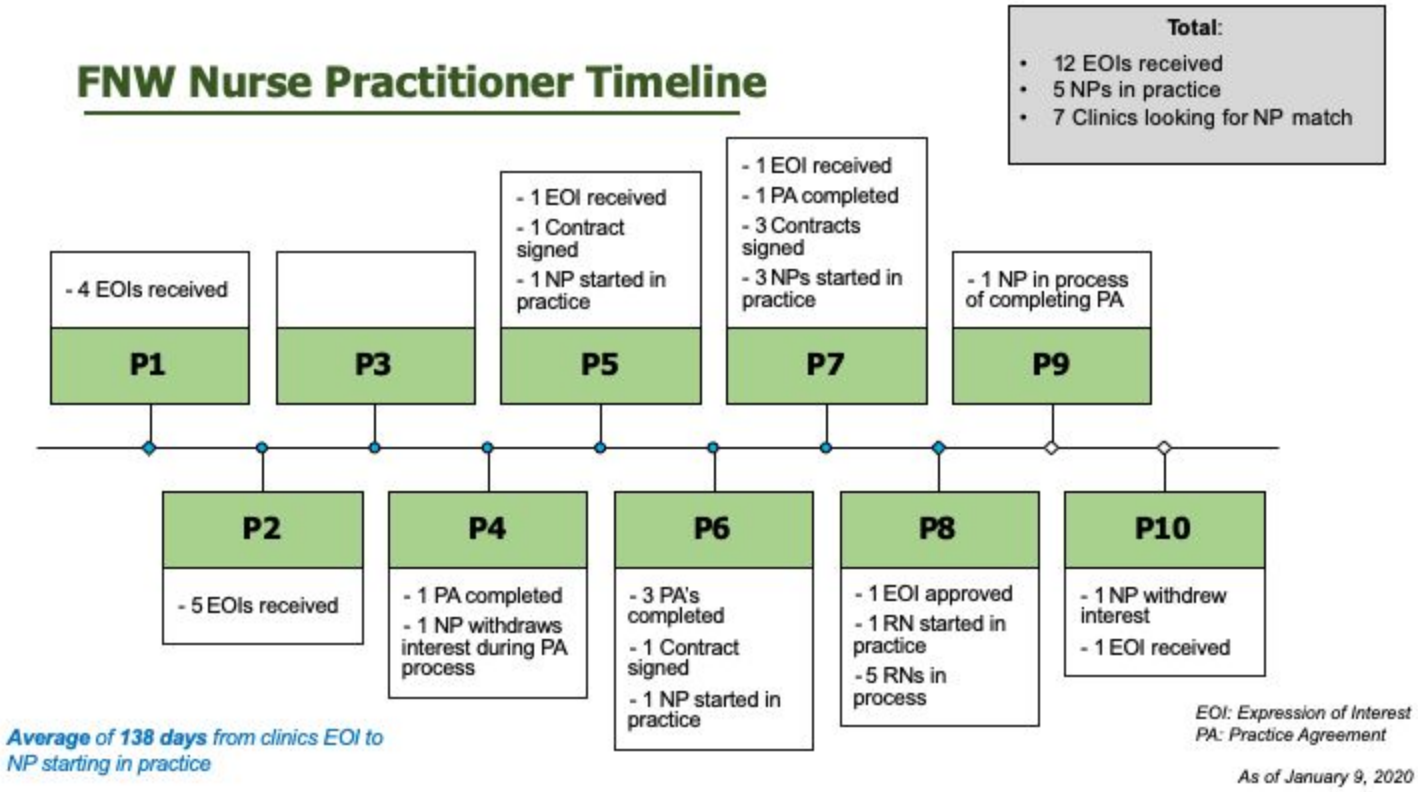


It's been identified that the onboarding of Nurse Practitioners to the FNW communities is a complex process. A hiring process map has been created to provide a visual description of the many steps in this process (Figure 1).

The timeline below (Figure 2) details the process so far for onboarding NPs into the FNW communities. The Expression of Interest (EOI) denotes those clinics that have reached out and expressed interest in onboarding an NP into the clinic. Once a match has been identified, the NP and clinic sign a Practice Agreement (PA). After this is signed off, FHA drafts a formal contract for the NP to sign. To date, the average length of time for this onboarding process is 138 days.



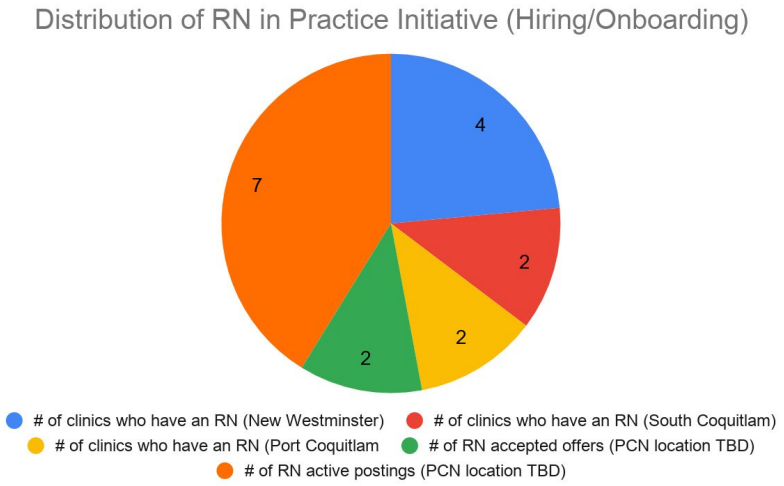
All data collected and shared between partner organizations (Fraser Health Authority, Kwikwetlem First Nations and Fraser Northwest Division of Family Practice)



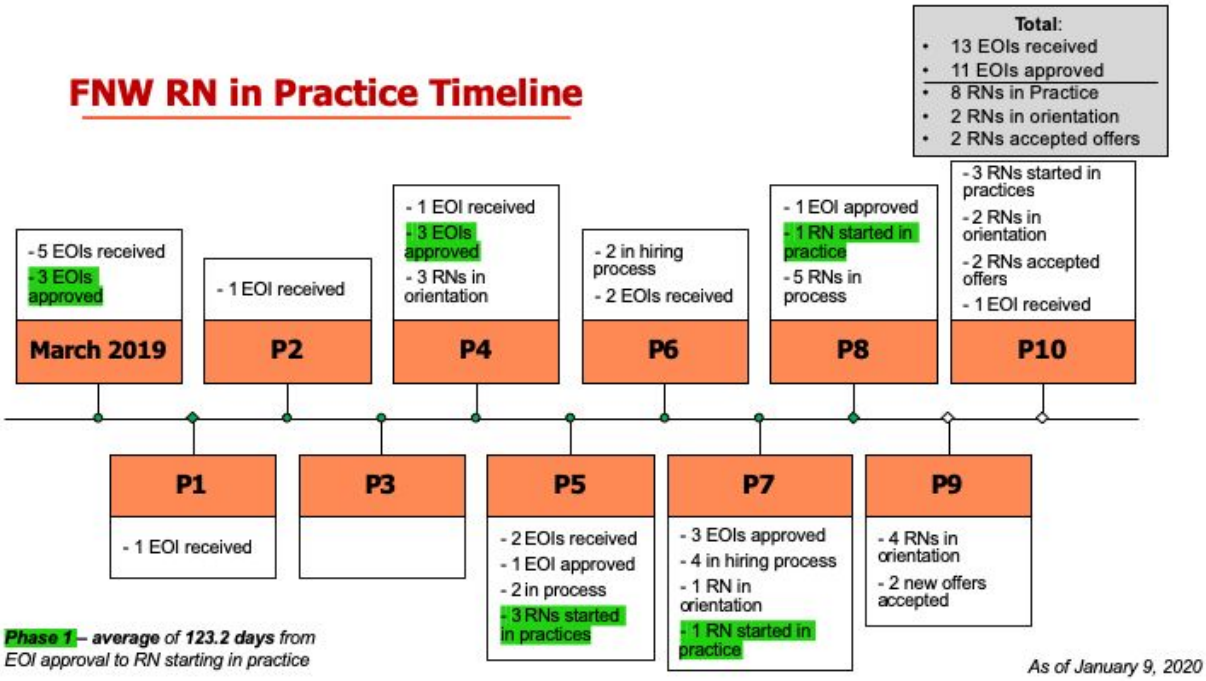
Identifying reasonable timelines for contract payments is necessary for all providers. This period, the first Physician contract was signed by a physician who is new to Canada and is the sole provider for their family. Salary payments are scheduled to be paid out every 2 weeks; however, there was a 1 month delay between the contract being signed and the first payment that the Physician received. A factor in this physician signing a contract was the certainty of a steady income and payments to support their family as working in the FFS model didn't allow for this. Feedback from providers and clinics note this continued theme on delayed payments by the Health Authority and it's important to highlight that these providers have families and delays in receiving payment disrupt not only clinic flow, but have a larger impact on physicians and their families lives. Collaborative work needs to occur in order to identify a less disruptive process.

Registered Nurse in Family Practices

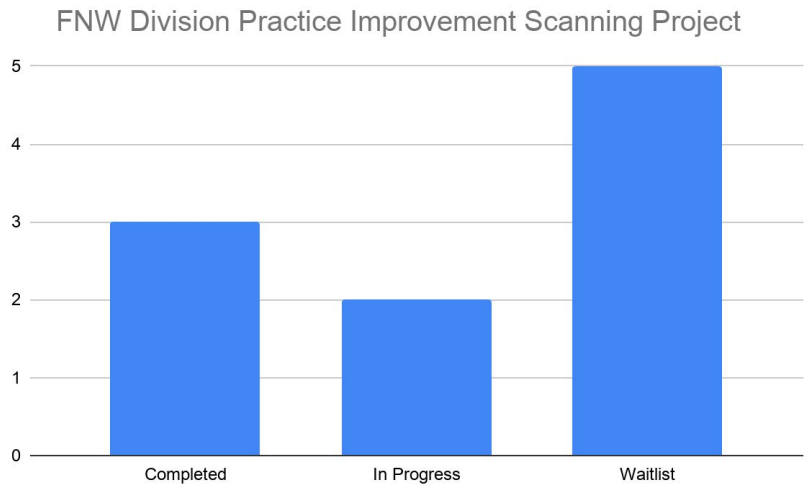
Work between the FNW Division, family practices and the FHA is well underway to deploy these resources into the community practices in a phased approach. This phased approach provides an opportunity to learn from what works and what opportunities are available for the next phases of this initiative's implementation. 6 family practices now have a nurse with 2 additional clinics having nurses in the orientation process. There have been 2 additional RNs who have accepted offers, and 7 positions currently posted. The YTD distribution across the PCN's are:



A timeline of the initiative's overall process can be found in Figure 3 below.



As part or supporting the clinic optimization and preparation before the onboarding of a Registered Nurse in Practice, the FNW Division's Practice Improvement team supports clinics to optimize the physical space they have available by converting existing paper charts to the clinic's existing EMR. This work is done after hours by a team so as not to disrupt the clinic flow. The YTD clinics that have taken part in this project or are waiting to take part is represented below:



An unanticipated consequence of working within multiple organizational structures and systems has been the overall timeline for payment to FNW family practices who have an RN in the clinic. These clinics are private businesses and as with any new initiative, these unanticipated factors such as delays in overhead compensation for these clinics by the Health Authority may have consequences on the family practice. Tracking of these unintentional consequences will continue throughout the next reporting periods. Figure 4 below details the RN overhead invoice tracking from the start of placing the RNs into clinics until the end of Period 10.

FNW RN Invoice Payment Tracking

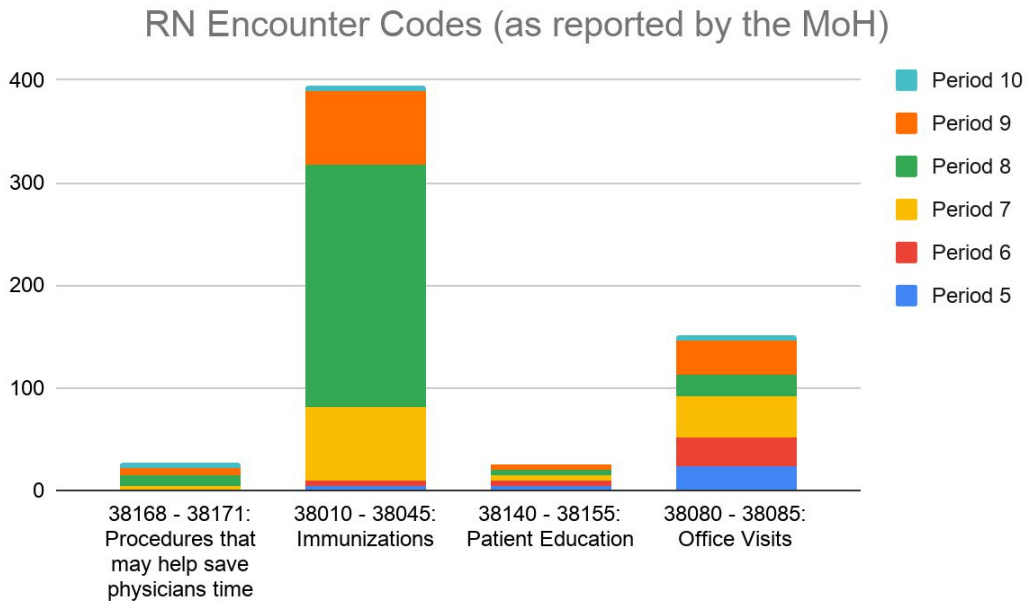
	Clinic Invoice Months							
	7 July	8 Aug	9 Sept	10 Oct	11 Nov	12 Dec	1 Jan	2 Feb
# of Submissions	3	3	3	5	7	9	9	8
# Pending	0	0	0	1*	2*	4*	5**	4**
# Received	3	3	3	4	5	5	4	4
Average # of Days to Receive Payment	67	67	66	38	~45	N/A	N/A	N/A

**Waiting for clinic response on payment status*
***Waiting for clinic response or have not received payment yet*

As of January 28, 2020

Work has been underway this period to track and monitor the role and scope of these RNs and how they are working to support physicians, clinics, and patients accessing primary care services in the FNW. Encounter code reports were previously generated by manually pulling this information from clinic EMR data; however, as of period 9, the Ministry of Health has provided an aggregate report that provides an overview of RN encounter

codes. This report does not currently provide the same level of detail as previous reports as it is an aggregated report; however, work is underway to identify strategies in providing as much detail as possible moving forward. The table below provides an overview of the encounter code data provided by the Ministry:



MSP data has a 90 day lag time before it becomes accurate in the system and so current and accurate period data is difficult to share. It's important to note that this data does not match what has been previously reported through the available clinic EMR data (collected and reported up until Period 8) and anecdotal feedback from clinics have noted that there have been a number of encounter code billing rejections therefore leading to a snapshot of the encounter code data. Work is underway with the MoH to correct these reporting issues, this is an important ongoing learning opportunity between all PCN partners, funders and stakeholders. Accurate encounter code data is vital to the ongoing implementation of RNs in practices and it's important that PCN funded resources do not add to the workload, but reduce it. Clinics that receive billing rejections have noted that correcting these are increasing the overall workload as opposed to reducing it.

Unanticipated costs related to supplies for the RNs in family practices are documented here as these costs were not specifically funded by the MoH for the FNW PCN. As reported in the previous period, the YTD costs for supplies across the FNW is $5754.00.

RN In Practice Case Stories

These stories explore the initial impacts of the Registered Nurse in Practice Program from the perspective of physicians and members of the clinic's care team. The stories describe where the program is working well, and how it has influenced multiple outcomes including access to care, access to advice and chronic disease care, reduced clinic waits, increased patient attachment, and improved patient and clinician satisfaction. Learn more in these stories of clinical impact below.

Anthony's story: How the RN in Practice "Saved the day"

Anthony[±] is a family physician practicing in the Fraser Northwest Division of Family Practice. He typically sees around thirty-five patients a day in his clinic. Right before the holidays, he found himself with a doubled workload while covering his colleague's patients as well. Anthony was feeling pretty stressed.

On one of the days where he was feeling stretched thin, one of his colleague's patients came in about a recent car accident. Those visits are complex, and generally involve a lot of detailed paperwork. He asked his coworkers if anyone else had the capacity to see the patient. Their Medical Office Assistant (MOA) realized that the Registered Nurse (RN) was available, and the RN jumped into action to assist.

In Anthony's words, "the RN turned my thirty-minute car accident visit into a five-minute visit." The RN performed a detailed, twenty-minute history, and filled out the majority of paperwork required. The RN then briefed Anthony on the nature of the patient's condition, and highlighted which parts of the paperwork required his input.

Anthony went in and confirmed what the nurse had discussed with the patient. He then performed a physical exam to rule out any red flags. His finished the paperwork and provided a prescription of physiotherapy, occupational therapy, and massage. Anthony was elated: "the nurse saved the day for me. Imagine a whole waiting room of patients in need, and spending another thirty minutes on that one visit. I was at a breaking point. I couldn't do it. To me, that's the where the RN in practice made a huge difference…as an extra helper in the clinic."

Improvements to Access and Attachment

This kind of support the RN offers also helps speed up access to care for patients. Normally, Anthony would have to fit in such a long and complex appointment at the end of his day, which on that day would have meant over a two hour wait for the patient. Instead, the RN was able to see the patient within ten minutes, and Anthony was able to quickly fit in the patient between his other appointments. This meant a smoother and more productive day for Anthony, where he could see more patients and work to the top of his scope. It also meant improved waits and access to care for the clinic's patients.

The time savings from the nurse have also translated to an initial increase in new patient attachments among Anthony's team. The nurse helped free up additional capacity for many common concerns. Before, their clinic would normally allocate twenty or thirty minutes for chronic disease visits. Now, these take only ten minutes of the FP's time. He says, "we all found that we had a little more time, so we took on some more patients to our panel. We felt less swamped." This change also translates to better patient access to care via co-location.

As an added bonus, having an RN in the clinic reduces scheduling and transportation challenges for patients. In the past, follow-ups for diabetes care often took place in a separate diabetes clinic. Now, Anthony says, "the nurse can see them in the same clinic, during the same visit…it's easier for the patient."

Overall, Anthony is pleased with how the RN in Practice is working in his clinic. In his words, "the initiative has taught me that cooperation can make my work much easier."

[±] Some names and identifying details have been changed to protect the privacy of individuals.

Linda's Story: How the RN in Practice improved Communication, Preventive Care, and Helped Triaging for more Appropriate Care

Linda is the office manager at a clinic in the Fraser Northwest Division of Family Practice. When Linda heard about the Registered Nurse (RN) joining their clinic, she was uncertain about what this change would mean to her daily procedures. After working with the RN, Linda says that "it's been a huge plus. Working with her and seeing what she does, hearing her with the patients, seeing the positivity from the doctors, has been amazing."

Adjusting to the new flow of work with the nurse took some changes. Linda had to work with the family physicians in the clinic to sort out logistics around scheduling and space. "We had to figure out how much time she needed per patient, and which days there would be adequate space. If there's only one room available, and the nurse is in there, the doctor won't be able to see patients. So we revamped our room system, and assigned rooms to different doctors. The structure is predictable, helpful, and works well."

Improved Patient Communication

The nurse has been instrumental helping communicate with patients about their results, or upcoming visits. As Linda describes, "the RN helps with recalls, like calling patients for Pap tests and explaining their results. She helps MOAs understand the patient's needs, and when is most appropriate for them to come back – whether in three months, six months, whatever the case may be. She does a lot of these calls, which helps free up me to do my job more efficiently." This helps the medical office assistants (MOA) deal with more urgent administrative and patient concerns.

Improved Access to Chronic and Preventive Care

The nurse has also helped improve patient access to chronic disease and preventive care. She conducted flu clinics before the office opened as well as after hours, which helped navigate space and scheduling constraints. The RN also performs all the infant immunizations, which used to occupy the doctor's time. Linda also has noticed that patients appreciate all the additional time the nurse is able to take to help them with lifestyle and dietary advice. She says, "the nurse sits with patients and gives them relatable, actionable advice on their nutrition. She'll ask what they ate that day, and then relate it back to their blood sugar results, and provide them with pamphlets and advice on how to substitute foods to manage their blood sugar better."

Triaging for Appropriate Care

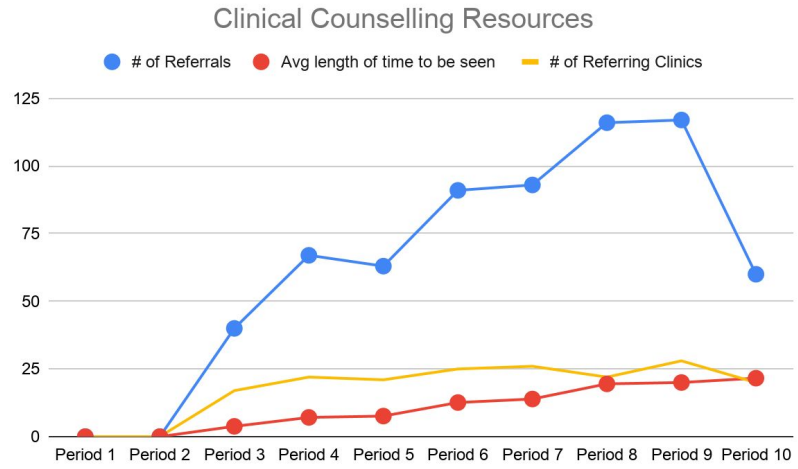
The RN has also helped triage visits so patients get appropriate care. Linda recalled an example where a patient was concerned about whether their child was in need of emergency care. The child was still having headaches seven days after sustaining a concussion, and the patient was considering going to the emergency room. Linda enlisted the RN's help, who looked up the patient's history and triaged the case. The RN called the patient to confirm that everything was progressing normally, and talked them through the course of treatment. As Linda relates, "this was the best case scenario. Their regular doctor wasn't scheduled for that day, and the on-call doctor was fully booked. The patient got the advice they needed right away, and we avoided an unnecessary visit when we were at capacity."

Allied Health (Clinical Counsellors) Supports - *Contracted Agency*

The number of referrals and referring clinics during this reporting period decreased. Table 2 below details the change over the last period to the current period:

	Previous Period (P9)	Current Period (P10)	Difference
# of Referrals	117	60	↓
# of Referring Clinics	28	20	↓
Average length of time for patients to be seen (*days)*	20.0	21.9	↑

The chart below details the period over period trends for the # of referrals, # of referring clinics and the average length of time for patients to be seen after first contact.



Feedback from patients includes:

> ***"Client felt empowered to come forward to police and report potential sexual abuse done to her son that may have been done by their old neighbour, after coming to counselling. As counselling ended, client reported feeling a weight off her chest and would like to come back to the program in the future if needed as she reported having a wonderful experience and feeling accepted."***
>
> ***"A counsellor reported that when a client shares that he/she is ready to move on as a result of coping tools provided in sessions it proves very impactful."***

Although the PCN funded supports for this program are for 5 FTE clinical counsellors, there are additional resources and FTE involved in ensuring this initiative is providing care to the patients of FNW physicians. Program administration reported this breakdown for FTE involved in Period 9:

- 4.6 FTE Clinical Counselling Resources (**Funded by FNW PCN**)
- 1 FTE Intake Support Worker

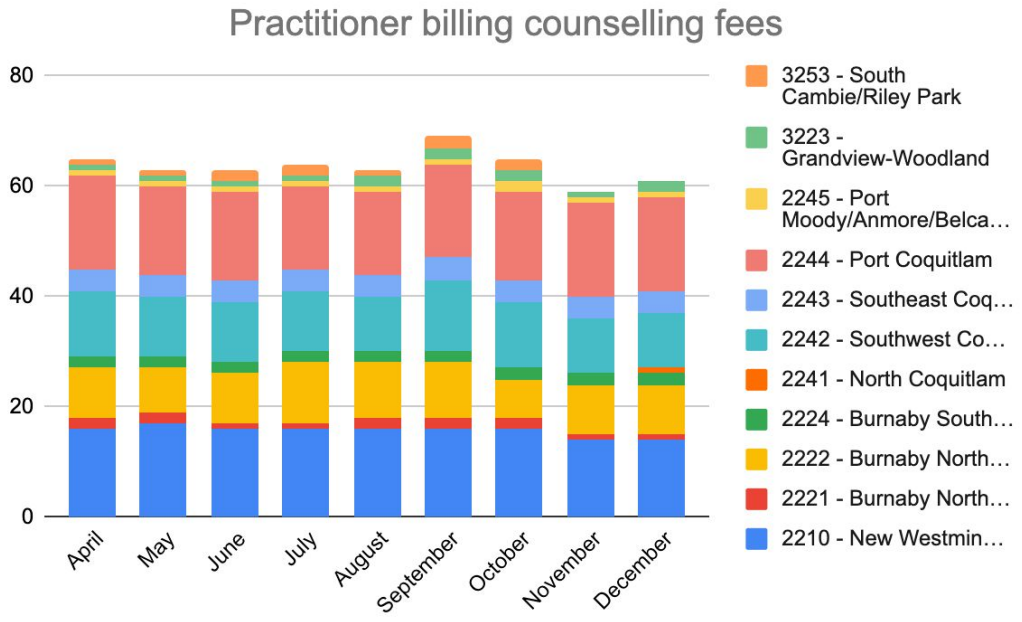
All data collected and shared between partner organizations (Fraser Health Authority, Kwikwetlem First Nations and Fraser Northwest Division of Family Practice)

- .38 FTE Supervision

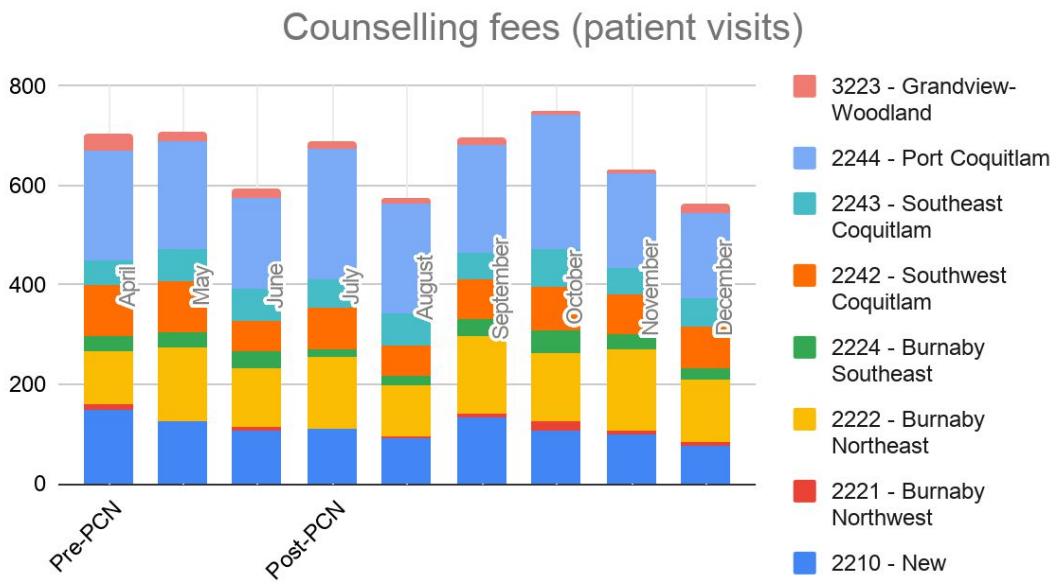
Program Impact

Through the co-development of this program, 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.

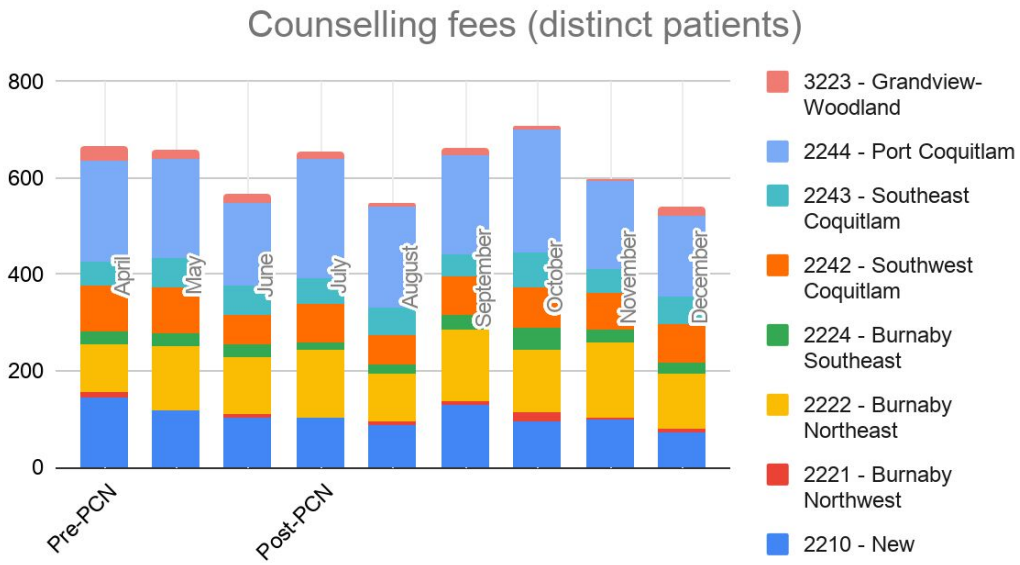
Data provided from the Ministry of Health which looked at the MSP billings for those physicians in the FNW who have referred to this program details that, on average, there has been a decrease in FP counselling billings when looking at the number of billings pre-launch of this program (April 2019 - June 2019) and comparing that to the post-launch (July 2019 - December 2019) billing details. This data is based on the FPs billing address and so some locations may fall outside of the FNW PCN as these could reflect the physician mailing address (i.e. home office). As a note, MSP data is not fully complete until as it requires a 90 day billing window. The table below shows a significant drop in the number of physicians billing counselling fees when looking at April 2019 to December 2019.



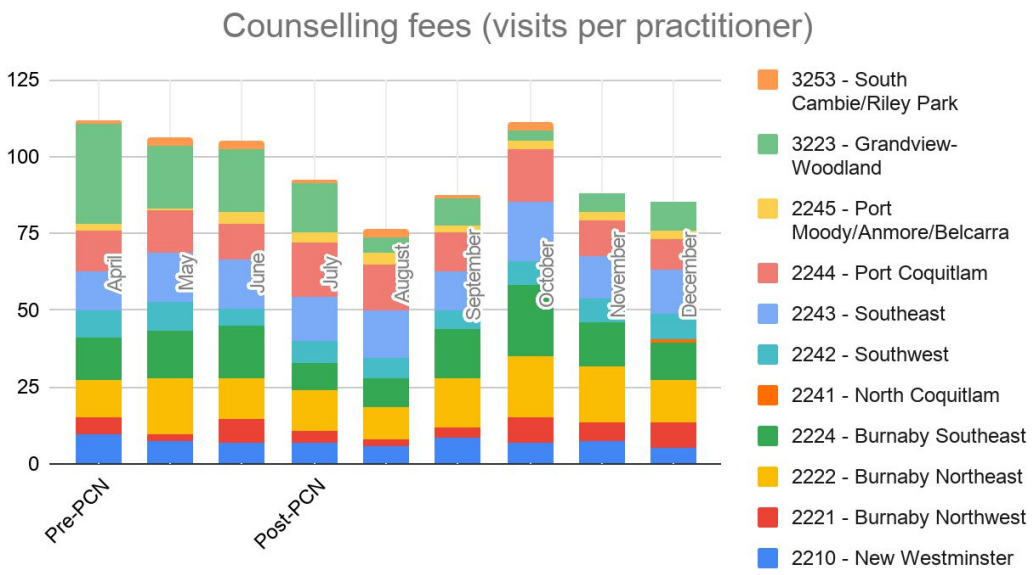
The overall total of counselling visits also shows a decrease in billings. Looking at the month by month breakdown, in April there were a total of 708 counselling visits provided, whereas in December there were 566. The table below compares the pre-launch (Apr - June) and post-launch (July - Dec) of this program:



When looking at the total average pre-launch compared to post-launch there is also a decrease in the total average. The table below shows the overall total of counselling fees for distinct patients and a decrease is also represented:

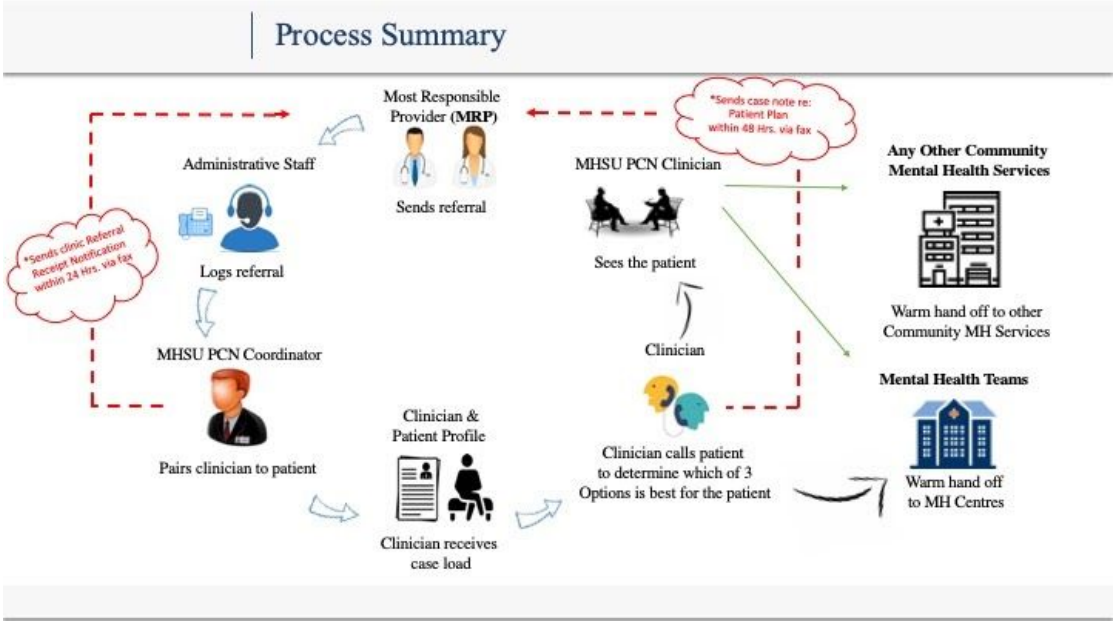


The total average visits per practitioner by counselling fees for the pre-launch was approximately 10.4 visits per practitioner whereas the average visits per practitioner decreased to 9.1 since the launch of this program. The table below breaks down the counselling fees by visits per practitioner month-by month and a notable decrease can be seen when looking at the pre-launch months compared to the post-launch months.



Allied Health (Clinical Counsellors) Supports - *FHA MHSU*

A recently launched resource within the FHA to support access to mental health and substance use supports for FNW community physicians recently launched where 4 FTE Mental Health Clinical Counsellors are available to FNW physicians to support providers and patients as part of the Primary Community Care team. Below is the process summary for this service:



The FHA MHSU clinical counsellors have reached out to clinics in the FNW to set up 'meet and greets' where physicians and practice staff can learn about this new resource and FHA can provide an overview of what can be provided through this service. Additionally, these meet and greets allow for continued relationship building

between the clinic and the clinical counsellor 'assigned' to that practice. Details on the number of referrals can be found in the table below:

	Previous Period (P9)	Current Period (P10)	Difference
# of Referrals	26	20	↓
# of Referring Clinics	9	12	↑

Indigenous Related Supports

As one of the partner organizations, Kwikwetlem First Nation worked to identify the supports needed in the community to support increased attachment and access to primary care services for the community population. Through the planning process, it was identified that 1.5 FTE support workers and 52 FP sessionals could support access to continued primary care services for the community. As a signing partner in the PCN, Kwikwetlem First Nation is underway in implementation of their PCN resources. A partnership table is being established on the Nation inclusive of Regional Health Authority, Division, and First Nation leadership. Unanticipated costs include the need to modify the space to support additional practitioners, the need for supplies to be provided, the lack of MOA assistance for the GP, and need to address poor connectivity. Currently a casual home support worker has been hired to provide services to the elderly. The permanent part-time home support worker position has been posted and is in the process of being filled, the full time Community health worker position is scheduled for posting in the new year.

Medication Management Program - *Clinical Pharmacy*

By working collaboratively with community physicians in the New Westminster and Tri-Cities the FHA Medication Management Program works to optimize medication regimens by working with family physicians' patients through providing home visits that aim to have patients on the fewest medications and fewest dosing times with maximum benefit/least toxicity. Feedback from the Clinical Pharmacist who works with this program notes the changes over the last 2 years have resulted in the following:

	December 2017	December 2019	Difference
# of referrals	21	27	↑
Referral Sources (*where the referrals are coming from)*	100% - Home Health	41% - Home Health 15% - Family Physicians 33% - PCCRN's 11% - Other	↑ **Increase in referrals from FPs*

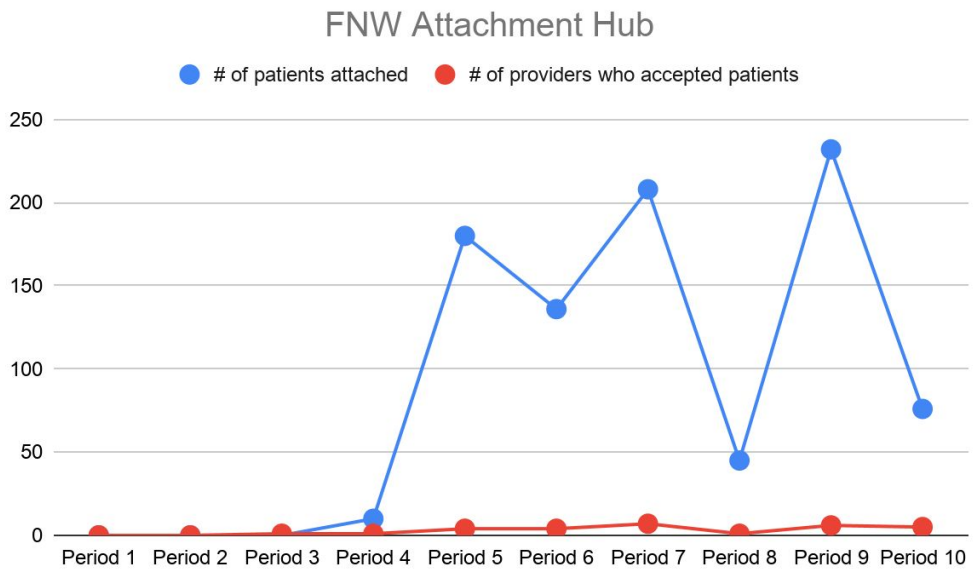
The Clinical Pharmacist reported that, on average, home visits can be approximately 1.5 hours. The pharmacist covers all medications, non-prescription medications and herbal medications are reviewed and all indications are covered for patients. The pharmacist reviews available EMR data, consultation notes, discharge summaries, and

any available labs to support a fulsome medication review with the family, caregivers, patients' dispensing pharmacy, their family physician and other healthcare team members as needed.

Attachment

During this reporting period, the FNW Division Attachment Coordinator continued to support the attachment between the public seeking a FP and family physicians accepting new patients. Table 3 details a breakdown of the attachment work currently taking place:

	New Westminster	South Coquitlam	Port Coquitlam	Port Moody, Anmore, Belcarra, North Coquitlam
# of providers who accepted patients	1 FP, 1 NP	2 FP	-	1 FP
# of patients attached	35	35	-	6
# of patients waiting to be attached	72	2	5	10



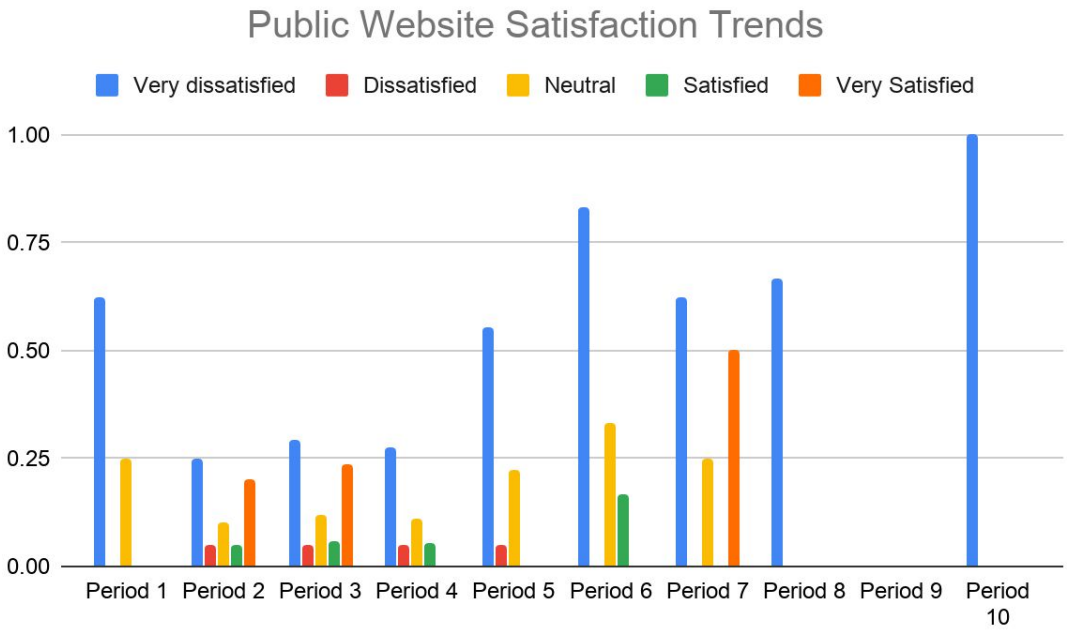
This role is to work in conjunction with the HealthConnect Provincial Registry which has not yet launched - originally the launch date was set for early July. Once launched, this role will continue to support and facilitate connecting patients with doctors; however, rather than being directly contacted by patients, they will utilize the registry which will house all attachment requests.

Feedback from the Community

The FNW Division previously introduced an opportunity for the public to share feedback through the public facing division website. Themes from this data collection largely focused on the need for attachment to FPs in the community with additional feedback inquiring about finding either a FP or an NP in the community. Responses

and feedback compiled from April-December 2019 show the most common words used by visitors, as shown by the word cloud below (Figure 5).

There was one new response for the online survey for period 10. Analytic analysis of the FNW division website indicated that 50% of visitors to the website first entered through the “finding a family doctor” link. The graph below details the satisfaction trends over time



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

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

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

Physician Feedback and Engagement

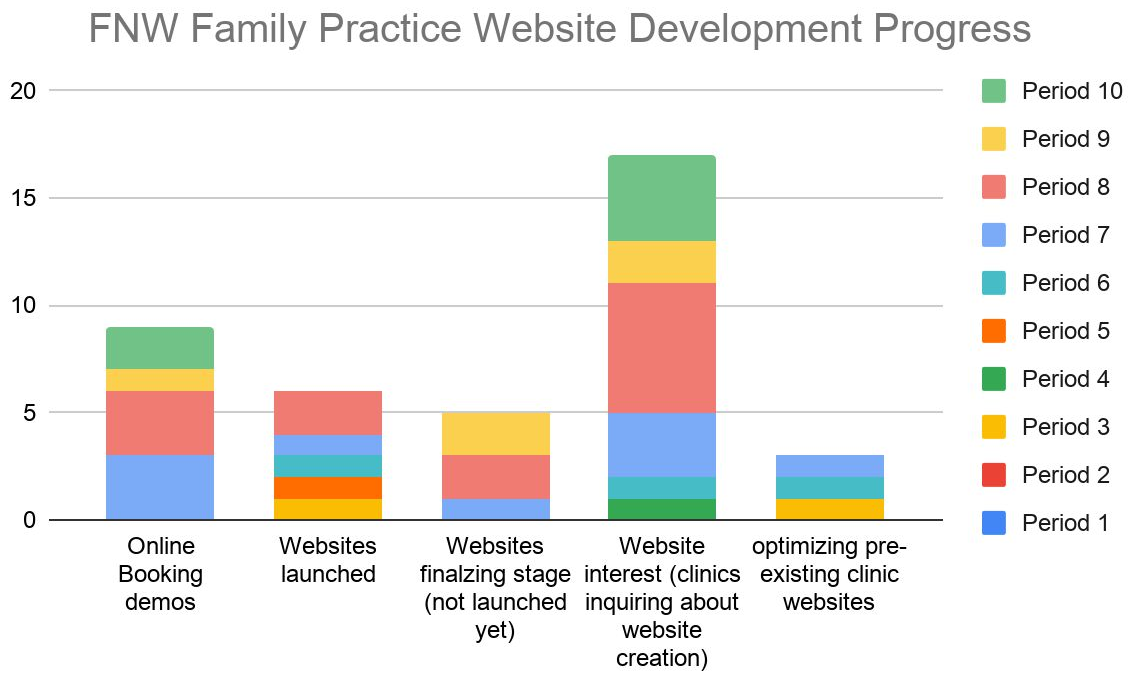
In period8 , the Division hosted an update event for members to attend and learn more about the available PCN services in the FNW communities. Before this event took place, physicians across the community were engaged with and asked a similar question, what does a Primary Care Network mean to you? Physicians were also asked how primary care services have evolved in the FNW. At this engagement event, attending members (including both physicians and NPs) shared what allied healthcare provider they'd like to work with.

Feedback from physicians, partner organizations, internal and external stakeholders has also been collected and key themes from this reporting period that have emerged include:

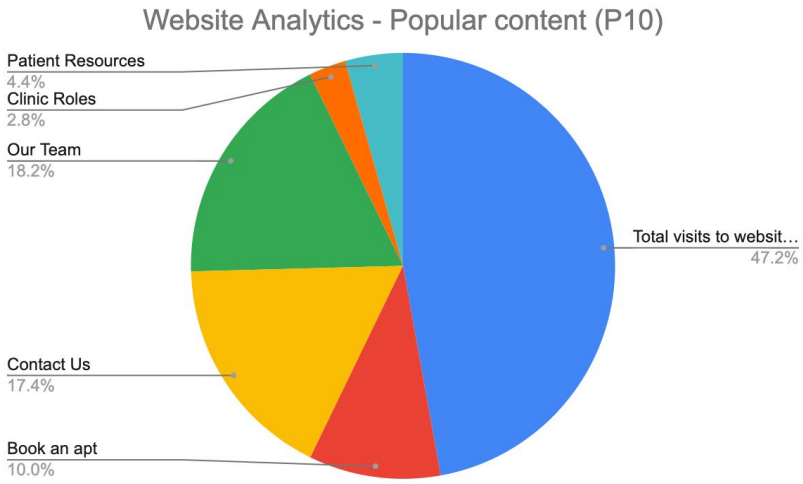
- In relation to FP/NP contracts:
  - Clarification from a physician on billing FFS outside of contracted hours
  - A few clinics reached out and inquired about the onboarding an NP.
- In relation to the RN in Practice:
  - Feedback from a clinic stating that mandated Occupational Health & Safety assessments performed by the Health Authority disrupt workflow given the number of HA staff present as well as are perceived as being intrusive to the clinic while physicians and practice staff are still seeing patients.
  - In period 9, a maternity leave position was filled by adjusting an RN attached to another clinic as the onboarding for maternity leave position was not successful. The family practice that was slated to get this new nurse was collaborative and understanding of the circumstances and supported this coverage adjustment. In period 10, there has been further feedback, conversations and work taking place in order to onboard a nurse into the clinic setting. As of the end of period 10, the clinic still does not have a nurse.
  - As the employment organization, FHA has been asked - and agreed - to provide weekly hiring updates to allow for further collaboration and information sharing between partner organizations.
  - Billing rejections from MSP related to the RN encounter codes continue to occur. A consequence of this leads to increased work in the clinic setting. Feedback from MoH noted that RNs need to route encounters through physician payee number - this is added work to the providers and can take away from providers seeing patients.

Physician engagement for this reporting period includes:

Additional engagement supports provided to FNW physicians is the website development as supported by a Digital Content Coordinator. To date, there have been 6 new clinic websites launched, 17 separate clinics have expressed interest in this service and work is underway to identify and evaluate incorporating online booking into both new and pre-existing clinic websites. A full list of the clinics in the FNW and their associated websites can be found by clicking here. The chart below details the main steps in clinic website developments period by period.



Website analytics that looks at the total page views and visits from the public on popular links from each clinic website and approximately 10% of the total 'clicks' were on Booking an Appointment.



One clinic shared that around 10% of their total appointment bookings are done online. Further work is underway to get more information from multiple clinics across the FNW as well as monitor how recent website launches that have an online booking option affect the total bookings. A patient shared their experience with booking appointments at their doctor's office online and noted:

> *"In the past, I used to dread calling the doctor's office to book an appointment. I always panicked and would take the first appointment they would give me, then look at my calendar and stress because I would have to adjust work schedule or call back and rebook going through the same process, my guess is they would just tell me the next appointment and then sometimes they would ask what I was coming for. Now that my doctor's office has online booking, I feel so calm, I can go online and look at what appointments are coming up that fit with my schedule and based on how urgent, I get to decide if it needs to be tomorrow, this week or can wait a week. I feel more in control and helps me reflect on the urgency of my health needs. I also know if I need to see someone urgently, I can call and the office will squeeze me in."*

As part of onboarding additional primary care providers, the GPSC Minor Tenant Improvement Program was introduced. Clinics across the FNW communities are able to submit applications for funds dedicated to enhancing team-based care by incorporating an additional allied health professional and/or primary care provider. Three clinics have received approval (2 in Period 8, 1 in Period 9) for these funds which can cover up to 85% up to a maximum of 2 rooms and $41k/room. The approximate total costs covered for those clinics $38,700. Completed Payment for these clinics will be reported on in Period 11. In addition to these 3 clinics being approved, 3 additional clinics in the FNW have submitted applications for remuneration - more details will be reported in period 11.

PCN Lessons Learned

1. The role of the Registered Nurse in Practice is new and defining the scope of the role, workload, and workflow processes may differ slightly depending on the practice setting. This flexibility is key to supporting the individual family physicians and practice staff at a family practice.

2. Identifying how PCN partner organizations share communications internally and externally with stakeholders and to support a vetting process that ensures all organizations are aware of what information is communicated out.
3. With the introduction of PCNs across the province, it is inherent that any organizational involvement is invited in by the local PCN governing leadership. Having clear and concise collaborative local leadership supports:
    a. Solution-finding as opposed to only identifying problems within the current system
    b. Clear communication to stakeholders about what the intent of the PCN is and supporting a strengthened understanding around PCN perceptions and 'misperceptions'
4. The intent of the PCN supports and initiatives in FNW family practices is to increase efficiencies, decrease redundancies and obstacles in the health system and ultimately increase attachment, access and improve health outcomes for the population in the FNW. With that being said, the introduction of PCN related supports has required physicians to provide a level of documentation that is an increase compared to what was provided previously. The FNW works collaboratively with physicians, partners and stakeholders to ensure that these supports do not create additional burden (i.e. costs, time, stress) to community physicians.
5. Access and ownership to data is an ongoing conversation between PCN partners and stakeholders. With diverse organization structures, the conversation around data sharing, access, and frequency are aspects that interact and it's important to acknowledge that the data sharing process is not always clear and straightforward.
6. Identifying gaps and opportunities for improvement in the established cash flow and funding definitions, specifically as they relate to required operational non-labour expenses.
7. Information sharing from different partners and working within the varying timelines can be an ongoing process which results in delays at the community level when waiting on information sharing at the regional or provincial level.
8. It was identified that the overhead payment processes to FNW family practices differ across the FNW PCN initiatives and collaborative work is underway between partner organizations and stakeholders to streamline payment processes moving forward.
9. The unanticipated costs of supplies for the RNs in Practice is an ongoing dialogue between partner organizations. Funds for supplies were not originally built into the PCN funds; however, specific supplies required by the employer (FHA) for the RNs may be needed. These supplies were not built into the clinic overhead and funding for them is coming out of a different budget; despite these being specific PCN resources.
10. Accountability of contracts can be complex given multiple partner organizations. The oversight provided for contracts held by one organization, but the impacts are on community physicians requires a dynamic approach by both partner organizations and contracted agencies.
11. Developing a process for coverage for the RNs in Practice where the RNs are slated to go on leave is an emerging matter. Multiple systems are factors in this change; however, ultimately if sufficient coverage isn't provided, there is a risk around the impact that this would have on the family practice that may not have a nurse for this coverage. This risk was identified by family physicians at the beginning of this initiative and it's paramount that partner organizations collaboratively work together to ensure the coordination of these resources to support the clinic providing seamless primary care services.
12. The development of an MOU between clinics and FHA to expedite and automate PCN related overhead payments (i.e. RN in Practice related overhead) is ongoing. Work is underway between partner organizations and stakeholder organizations to develop this. Given how PCN resources may not be specific to local communities, the development MOU may have applicability to other Wave 1 PCN communities across the province.

13. ***New*** As mentioned in LL 11 above (noted in Period 8), identifying a contingency plan for coverage is paramount as in the case of a FNW family practice which was approved to onboard an RN in the Fall; however, delays in identifying a leave coverage for another RN meant that the RN which was slated for this clinic was reassigned to cover the leave coverage. This clinic has been without an RN since the EOI approval process (occured in early October) and has an effect on the clinic flow. Miscommunication between FHA (the RN employer) and the Division contributes to a fragmented approach around this initiative - continued miscommunication may lead to fragmented relationships and partnerships with the RN in Practice operations team.

FNW Primary Care Networks Geography & Demographics

New Westminster: New Westminster has seen an increasing population growth over the years with a current population of approximately 76,800 (2018 BC Statistics). With this growth, there is an increasing need for attachment and access to primary care services. This PCN does have one large tertiary hospital - Royal Columbian Hospital - which supports in serving access to acute and urgent care for the FNW communities. Currently, there are 10 family practice clinics in the community with a total number of 57 FPs practicing across the community in a variety of clinic/acute settings. With the proposed additional PCN supports, there are resources for an additional 3 FPs, 4 NPs, 5.5 RNs, and 1 clinical pharmacist.

Port Coquitlam: Much like New Westminster, Port Coquitlam continues to see population growth with a current population of approximately 62,800 (2018 BC Statistics). There is currently no hospital located in this community, but there are 9 family practice clinics in the community with a total number of 46 FPs practicing across the community in a variety of clinic/acute settings. With the proposed additional PCN supports, there are resources for an additional 2 FPs, 2 NPs, 7.5 RNs, and 1 clinical pharmacist.

South Coquitlam: For the purposes of the PCN, the city of Coquitlam has been split between north and south - simply due to the large population. Within South Coquitlam, there is a population of approximately 100,000 (2018 BC Statistics). Like Port Coquitlam, there is no hospital located in this geographic boundary, but there are 22 family practice clinics in the community with a total number of 83 FPs practicing across the community in a variety of clinic/acute settings. With the proposed additional PCN supports, there are resources for an additional 4 FPs, 4 NPs, 9 RNs, and 1 clinical pharmacist.

Port Moody/Anmore/Belcarra/North Coquitlam: The fourth PCN is comprised of Port Moody, Anmore, Belcarra and North Coquitlam and makes up an approximate population of 88,000 (2018 BC Statistics). This PCN also has a hospital, although smaller than RCH, Eagle Ridge Hospital resides within Port Moody and is a smaller acute site. Currently, there are 4 family practice clinics in the community with a total number of 31 FPs practicing across the community in a variety of clinic/acute settings With the proposed additional PCN supports, there are resources for an additional 3 FPs, 2 NPs, 10 RNs, and 1 clinical pharmacist.