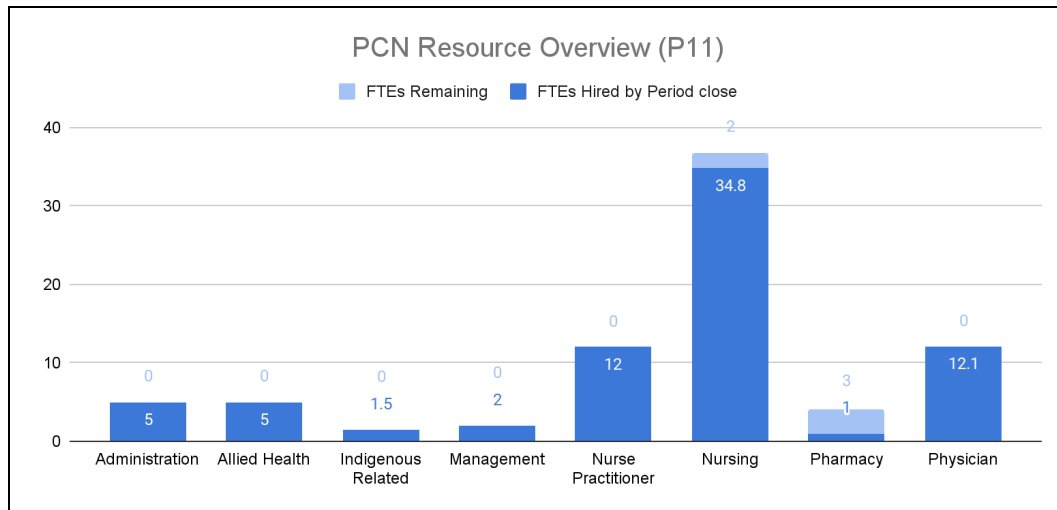


Fraser Northwest Primary Care Network

Period 11 Addendum Report



Patient Medical Home Snapshot

| Provider Types | # in FNW |
|-----------------------------------|----------|
| FFS Longitudinal Family Physician | 147 |
| PCN funded FP | 12 |
| PCN funded NP | 12 |
| Community NP | 8 |

| PMH Types | # in FNW |
|---------------------|----------|
| Family Practice | 32 |
| Hybrid (FP/Walk-in) | 20 |
| Walk-in | 2 |
| Community Services | 3 |
| U&PCC | 1 |

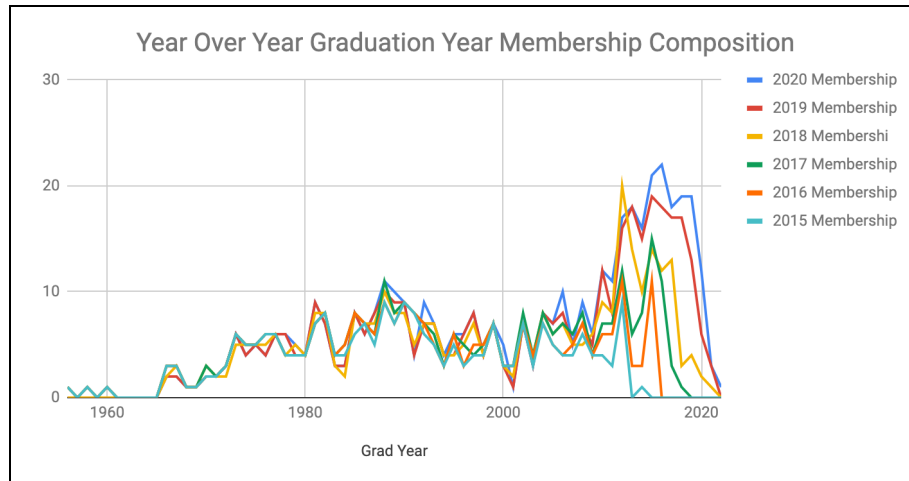
The FNW population surpasses 327,000 people. With 169 primary care providers currently working in these communities, for all people to become attached, that would result in an average panel size of 1934 people/provider



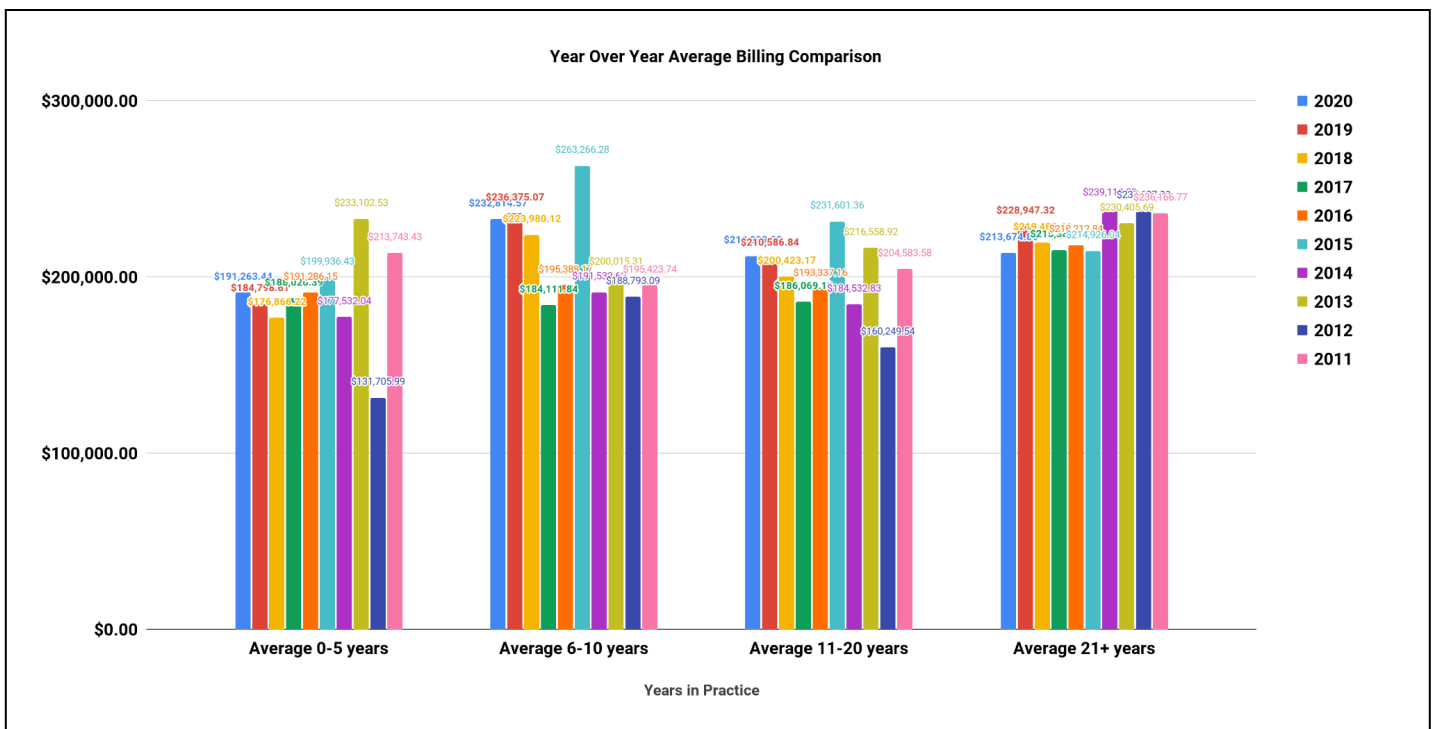
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FNW Community Overview

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 below represents the year over year membership composition based on members' graduation year:



The average Blue Book Listings for Physicians in the FNW from 2011-2020 are represented in the chart below. It's important to note that these numbers reflect Physicians in a variety of roles and providing primary care services in a number of different practice types - i.e. Family Practice, Walk-In Clinic, Hybrid, Locum, Long Term Care, Hospitalist, Maternity, Addictions and a number of others practice types.



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

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



Overview: Primary Care Provider Community Adds & Losses

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

| | 2019 | 2020 | 2021 | 2022 | Total |
|---|------|--------|------|------|---|
| Provider Adds | 12 | 18 | 18 | 2 | -8 providers since PCN inception |
| Provider Losses | 27 | 13 | 15 | 3 | |
| Net Loss/Gain | -15 | +5 | +3 | -1 | |
| # of Patients attached through <i>FNW Attachment Hub</i> | 856 | 2792 | 6783 | 657 | |
| # of Patients registered through the FNW Attachment Hub | NA | 5564 | 8677 | 887 | |
| MoH \$0 Fee Code Attachment | NA* | 73,742 | 6980 | NA | |

*MoH Data not available for 2019

Data was updated to reflect currently known retirements, moves and leaves for the table above. Previous data did not account for a clinic relocation in 2019 and upcoming retirements for 2021. Although 2021 reflects the highest attachment numbers to date, it's important to note that the patients whose providers are leaving/retiring may not have a longitudinal primary care provider any longer. Furthermore, there are approximately 4 longitudinal Primary Care Providers set to retire in early 2022.

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

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

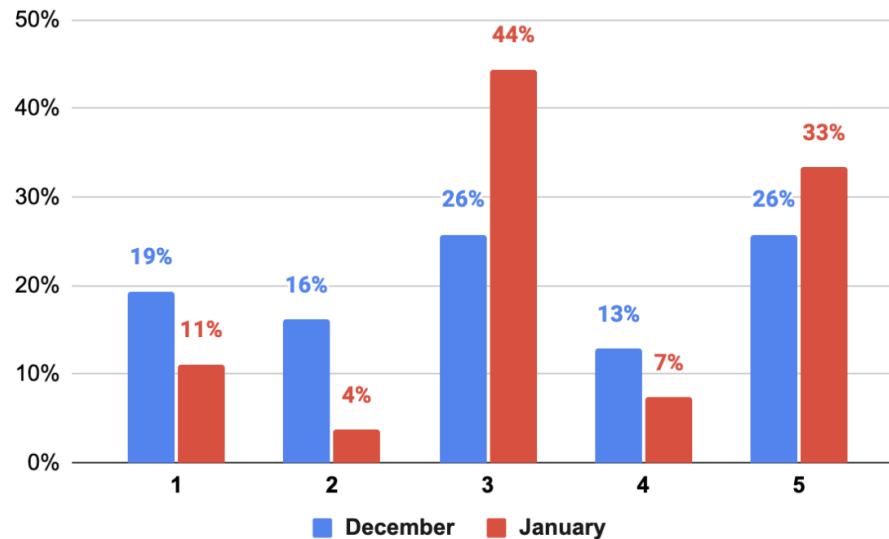
An anecdote from a community family physician noted the deflated feeling in continuing to support community primary care when the larger public system is funded at a higher cost to support less patients, and ultimately not having the same obstacles that community Family Physicians have in struggling to pay rent, staff, office costs, etc.

Another provider, retired for 2 years, shared *"I am very happy in retirement. I was ready to retire from practice. It wasn't as much fun as it used to be, and I found being on-call stressful; I never knew when the phone would ring. I miss working with people skilled in their jobs, discussions about patients and treatments, and the sense of community. I was so lucky to work with amazing colleagues my whole career. I didn't find anyone to take over my office practice, but my patients got absorbed by colleagues. I don't think that would happen today. There are so many reasons for the situation we are in, mostly systemic and governmental, and no simple solutions. The existence of Divisions has provided a central hub in each area, and a province-wide structure for communication. It is probably frustrating at times, but we all appreciate you all. Keep up the good work!"*

Recently, providers shared feedback regarding how providing after-hours call services impacts their decision to provide longitudinal primary care. As noted by the visual below, the significant majority of providers noted that after-hours call **does** impact their decision to provide longitudinal care.

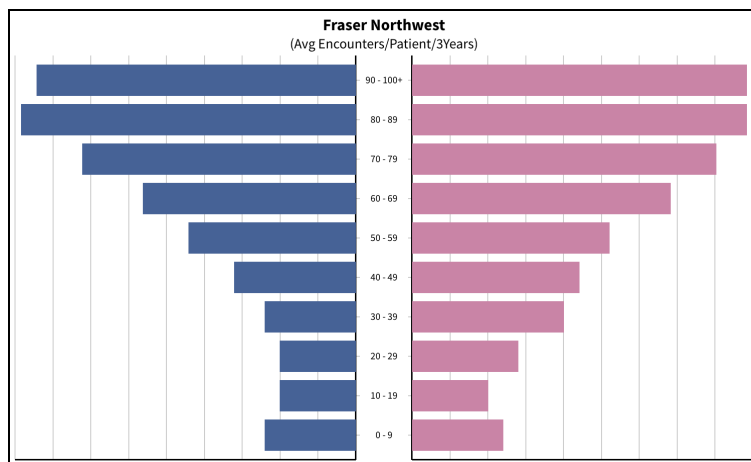
On a scale of 1-5, how does after hours call impact your decision to provide longitudinal care?

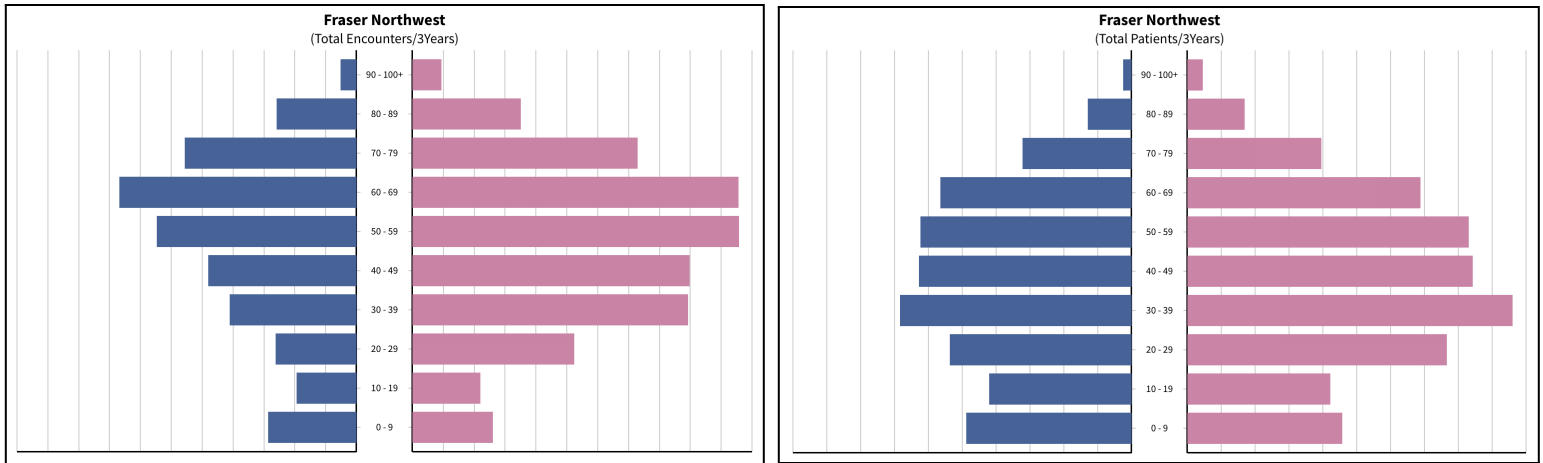
(1= does not impact my decision whatsoever, 3= somewhat impacts my decision, 5 = significantly impacts my decision)



Overview: FNW Population Summary

The population in the New Westminster and Tri-Cities communities has steadily been growing over the past few years with a high increase in young families moving to these communities. The [Health Data Coalition](#) (HDC) provides population based summaries based on the panels of PMHs who use HDC in their practice. Below is a visual representation of the population in the FNW and average encounters/patient/3 years, total encounters/3 years, and total patients/3 years:





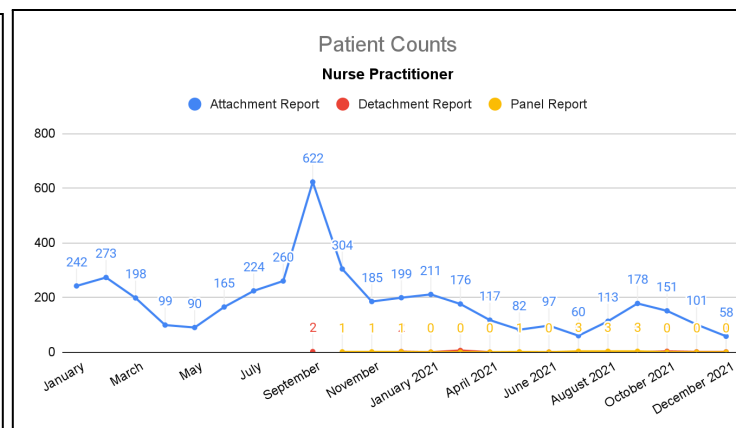
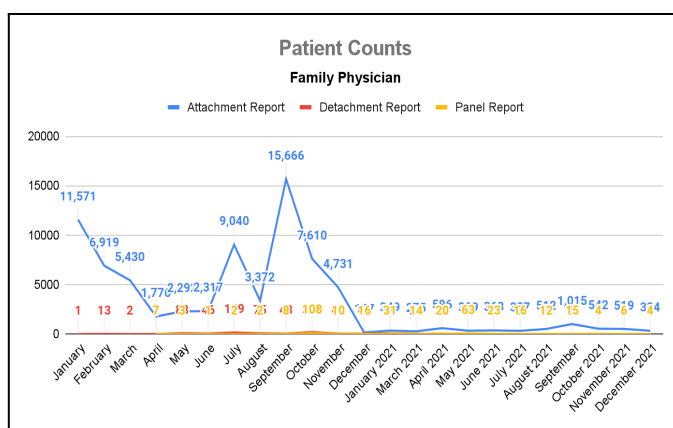
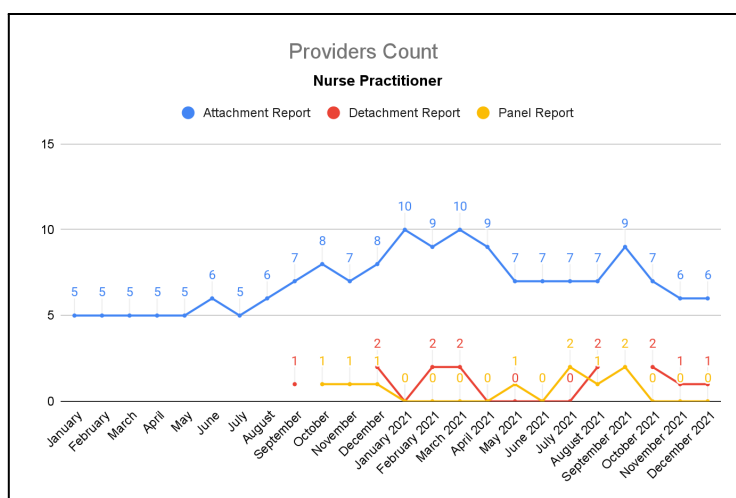
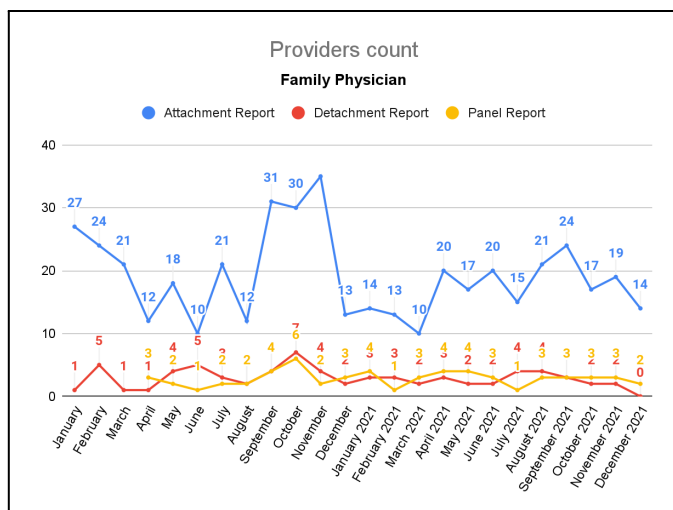
Attachment

Measuring true attachment continues to be a conversation at all stakeholder and partner organization levels. Attachment level data through the use of the O\$ fee code provides a distinction between types of providers and patient counts. A challenge with implementing support for all PMHs to incorporate the use of these codes has been consistency in education across a variety of PMHs who utilize differing EMRs. 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. This data is shared by the MoH out to FNW PCN partner organizations.

In tandem with the O\$ 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 Coding (MoH)

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 and # of times that the specific encounter code was used. The visuals below reflect the month over month trends for both distinct providers (Family Physicians and Nurse Practitioners) and distinct patients (that are attached/unattached to a Family Physician or a Nurse Practitioner):

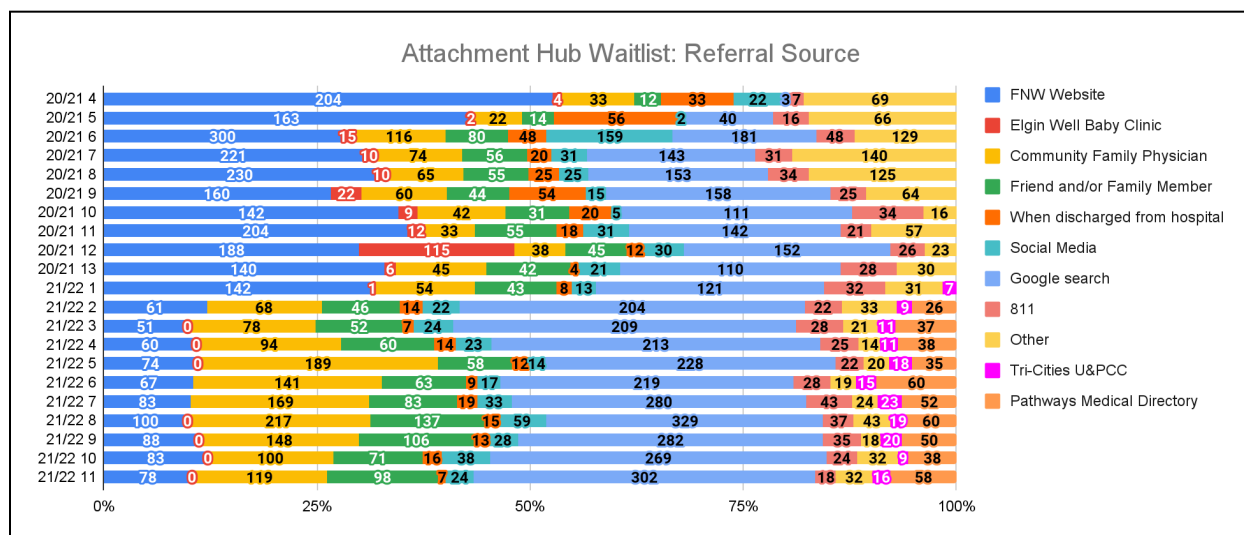


FNW Attachment Hub Waitlist

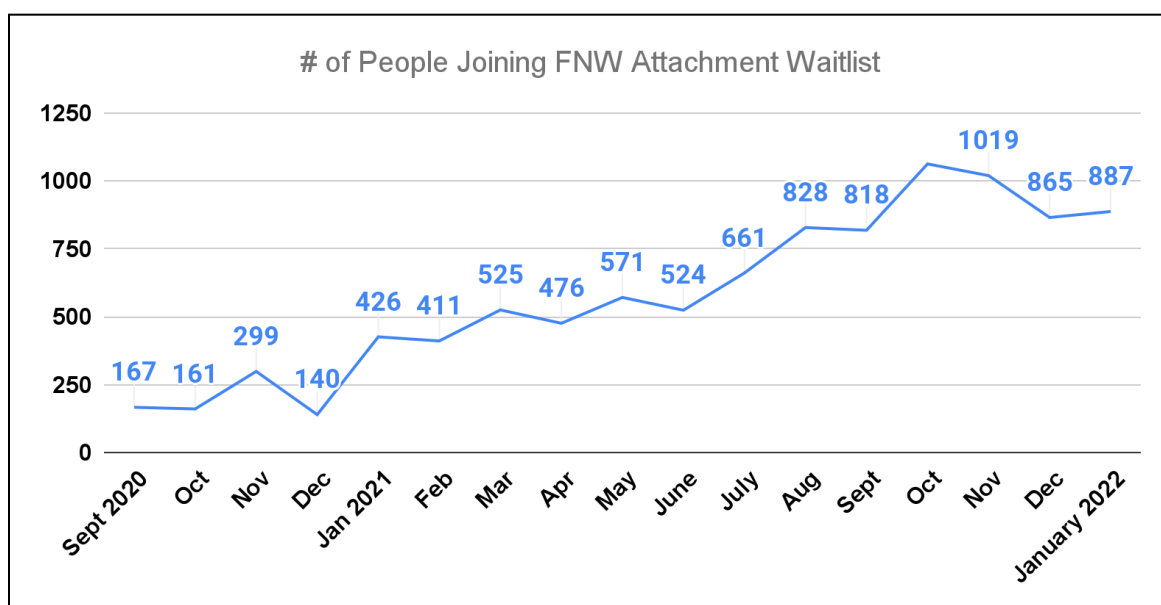
The FNW Division Attachment Coordinator continues to support the attachment between the public seeking primary care providers accepting new patients. It is important to note that these numbers do not capture the full scope of the community attachment taking place as there are primary care providers attaching patients without connecting with the Attachment Hub. True attachment data may be reflected in the 0\$ MSP fee codes; however, work to implement those across the region is an ongoing process between partners. Since the inception of this dedicated resource to the community in Summer 2019, the waitlist for patients continues to grow and recent data provides an indication of the average wait time of those who have been attached broken down by community:

| Community | Average Wait Time (days) |
|-----------------|--------------------------|
| New Westminster | 191 |
| Port Moody | 244 |
| Coquitlam | 174 |
| Port Coquitlam | 102 |

Since early FY 20/21, when people join the Attachment Hub Waitlist the referral source is also collected, below is a breakdown of the main referral sources by period:



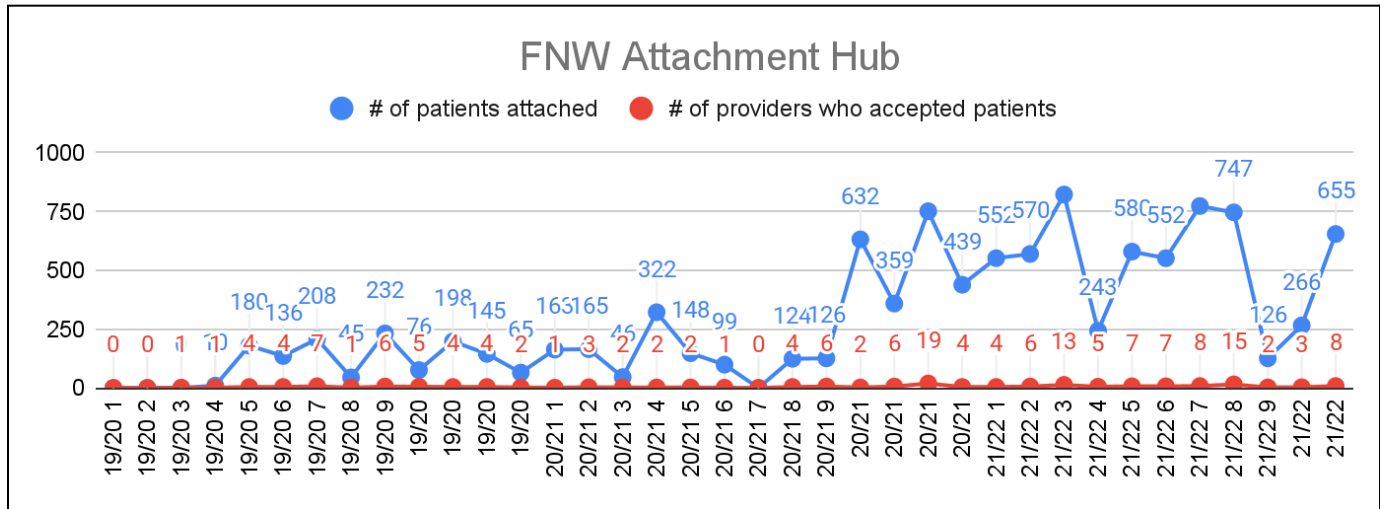
Month over month, the demand to find a longitudinal primary care provider by members of the FNW communities continues to grow. Since Fall 2020, data has been collected to reflect the month over month increase in attachment requests. The table below reflects the ongoing need and high demand for primary care providers:



During this reporting period, the table below details a breakdown of the attachment work that took place by the Attachment Hub:

| | New Westminster | South Coquitlam | Port Coquitlam | Port Moody, Anmore, Belcarra, North Coquitlam |
|--------------------------------------|-----------------|-----------------|----------------|---|
| # of providers who accepted patients | 1 | 5 | 1 | 1 |
| # of patients attached | 108 | 300 | 183 | 66 |
| Total Attachments to date | 10,323 | | | |

| | | | | |
|-------------------------------------|------------------------------|------------------------------|-----------------------------|------------------------------|
| # of people waitlisted | 2170 <i>7% ↑ from P10</i> | 2569 <i>5% ↑ from P10</i> | 74 <i>57% ↓ from P10</i> | 1677 <i>5% ↓ from P10</i> |
| Total people waiting to be attached | 6490 | | | |



A recent quote from a local Family Physician identified that *“unattachment opens up jobs in other areas like UPCC and walk in clinics where I work. However these places can only provide episodic care, or temporary longitudinal care. I think it's not the same.”* This statement reflects the complexity of attachment and the effects of unattachment on access to primary care services in the community.

Program Impacts: RN In Practice Attachment

As part of the FNW PCN Service Agreement, attachment targets per provider were shared in association with PCN funded provider resources. For RNs, it was identified that the addition of this provider could support up to 500 new attachments in PMHs. Recently, reach outs between Division staff, and PMH practice staff took place to identify net new attachments since PCN inception. Below is a breakdown of the net new attachments reported by PMHs:

| Clinic | RN in Practice since | # of providers | # of net new attachments (since April 2019) |
|----------|----------------------|----------------|---|
| Clinic A | January 2020 | 5 | 84 |
| Clinic B | July 2020 | 2 | 109 |
| Clinic C | December 2019 | 5 | 494 |
| Clinic D | October 2019 | 6 | 2402 |
| Clinic E | October 2020 | 4 | 63 |
| Clinic F | August 2020 | 4 | 1543 |
| Clinic G | September 2019 | 5 | 406 |

| | | | |
|----------|----------------|-----|------|
| Clinic H | September 2019 | 4 | 1030 |
| Clinic I | October 2020 | 10+ | 2100 |
| Clinic J | June 2020 | 8 | 592 |
| Clinic K | December 2019 | 4+ | 2166 |
| Clinic L | March 2020 | 1 | 24 |
| Clinic M | December 2019 | 2 | 1420 |

**Please note, the # of providers does not reflect the total # of providers at a clinic, it reflects the # of providers who were able to provide attachment numbers.*

Of the 13 clinics that reported back with their attachment numbers, the average community level attachment/PMH is well above 500 net new attachments. Incorporating an RN into a practice not only enables attachment, but increased coordination, communication and quality of care between providers, patients, and health care services.

Patient Impacts: Impact of Unattachment

Knowing the depth of the unattachment rates in the communities is one thing; however, 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 take 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."

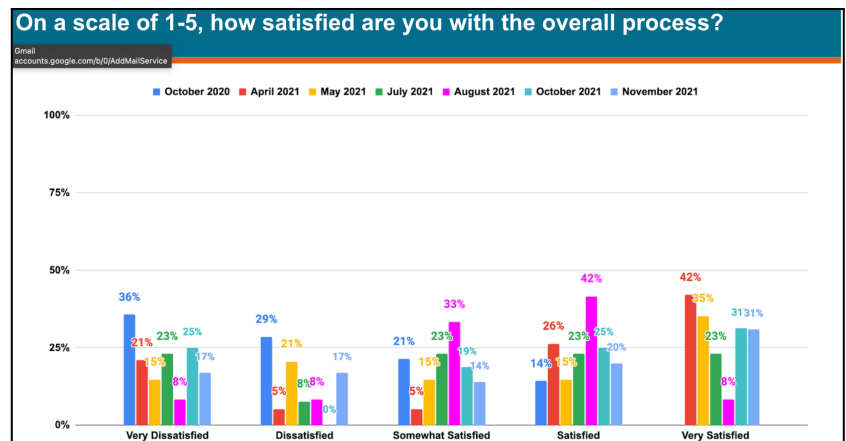
A patient shared the complexities in accessing care with complex medical needs.

"I am a cancer survivor with complex medical needs. I have been diagnosed with hypermobile Ehlers-Danlos syndrome, celiac, and have suspected mast cell activation disorder. My life is significantly impacted by my health issues... After several failed attempts to make appointments on several occasions, I decided to start using the Telus MyCare app (well before the COVID-19 pandemic), and never went to her again, even though transcripts of my Telus MyCare visits were sent to [my doctor]. [My Doctor] ended up

retiring early, so I am searching for a new family doctor. While the Telus MyCare app is great, I do not have continuity of care. I have to retell my entire medical history frequently, which can be tiring and triggering.”

Patients also have identified the importance to have 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.

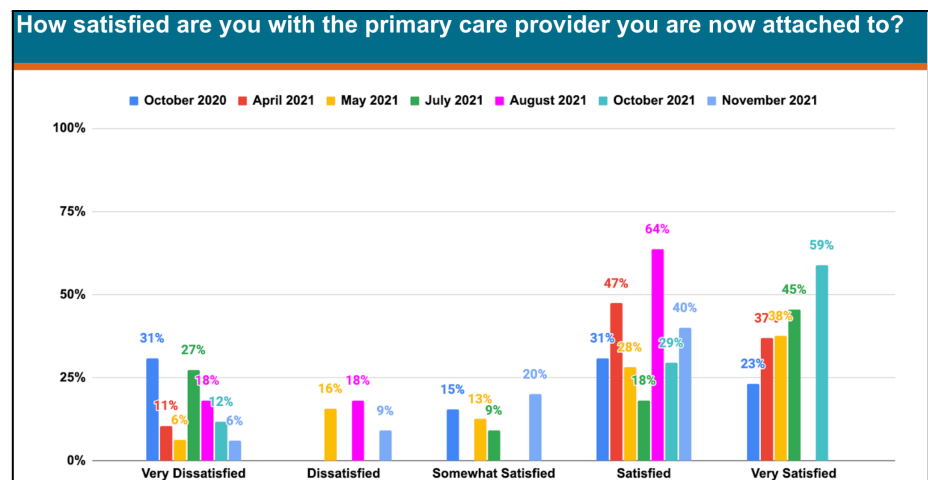
Another patient and their family identified the importance of finding the right ‘fit’ with their longitudinal primary care provider as well as the importance of having a positive interaction from the initial phone call with clinic staff. This illustrates the complexity of finding and building a relationship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

Unfortunately, stories such as these that reflect the need for longitudinal attachment are not unheard of and to ensure an ongoing understanding of these impacts, the Division has launched a Patient Attachment Survey that is distributed to patients 6 weeks after matching with a primary care provider in the community. This survey has run for a number of cycles and the visual below reflects the diversity in satisfaction levels. Themes from this scaling question noted:

- Patients weren't contacted by the providers
- The wait time to be attached was extensive
- Patients found their own provider by calling clinics or through friends
- Patients requesting a specific type of doctor - i.e. male, female.



Once attachment was completed, satisfaction levels with the longitudinal provider certainly is weighted towards a higher and more positive satisfaction level; however, there continues to be diversity in patients satisfaction.

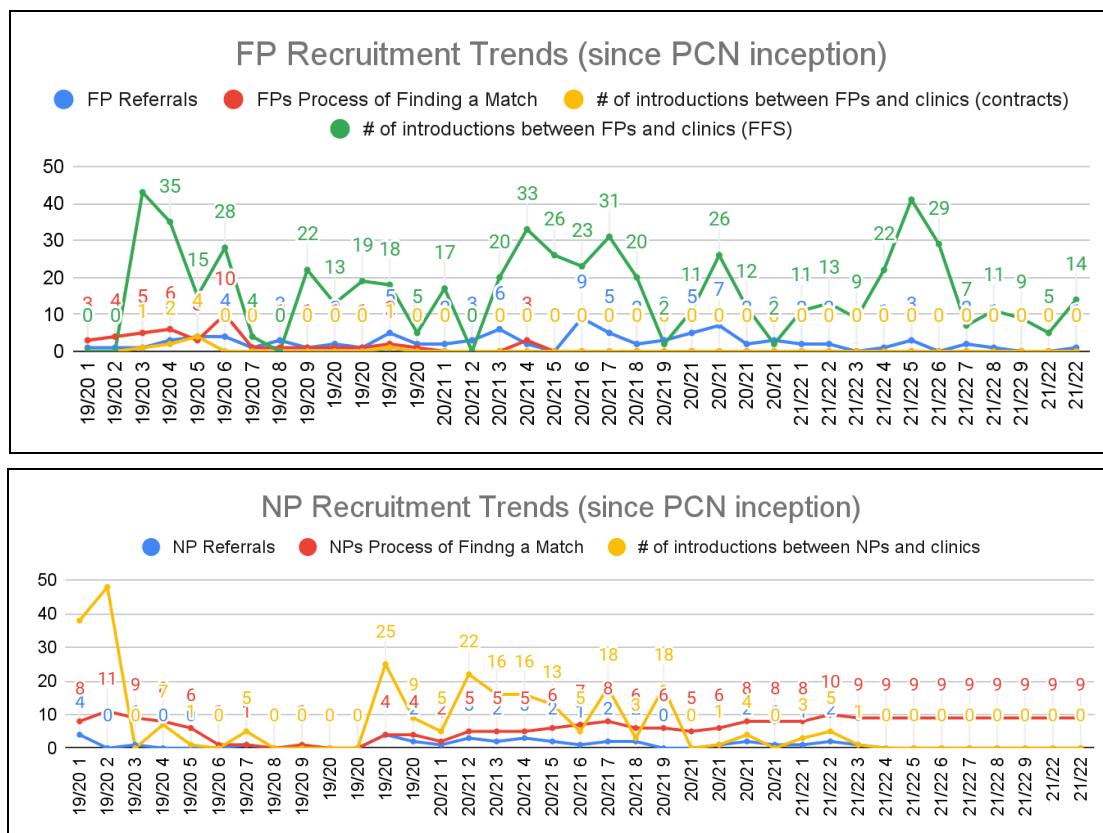
Patient feedback stories such as the ones shared above will continue to be collected and shared through this report as well as work is underway to establish a reporting metric on the number of patients who return for re-attachment.

Family Physician and Nurse Practitioner Contracts

Collaborative work between the FNW, FHA, HealthMatch and the Ministry of Health is vital in order to support increased FP and NP resources in the FNW communities. In Period 10, clinic openings decreased slightly to 7.58 FTE. Table 1 below provides a status overview and update on the breakdown of the NP and FP contracts by PCN within the FNW:

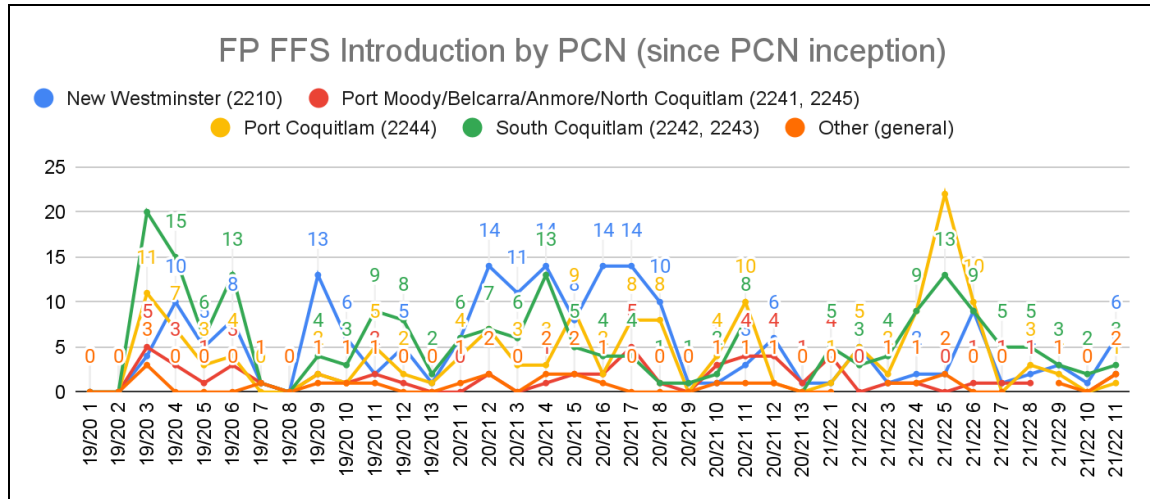
| | Referrals | | # in the process of finding a match | # of introductions between provider and clinics (<i>FFS & Contract</i>) | # of contracts signed |
|---------------------|--------------------|---|-------------------------------------|---|--------------------------------|
| | # of New Referrals | Running Total of Referrals since PCN Launch | | | |
| Family Physician | 1 | 100 | 0 | 14 | 2 Current PCN contracts: 12 |
| Nurse Practitioners | 0 | 46 | 9 | 0 | 0 Current PCN contracts: 12 |

In Period 8 and 10, 3 Family Physicians terminated contracts; however, in both Period 10 and 11, those 3 contracts were re-filled by other Family Physicians bringing the total FP contracts back up to 12 by period close.



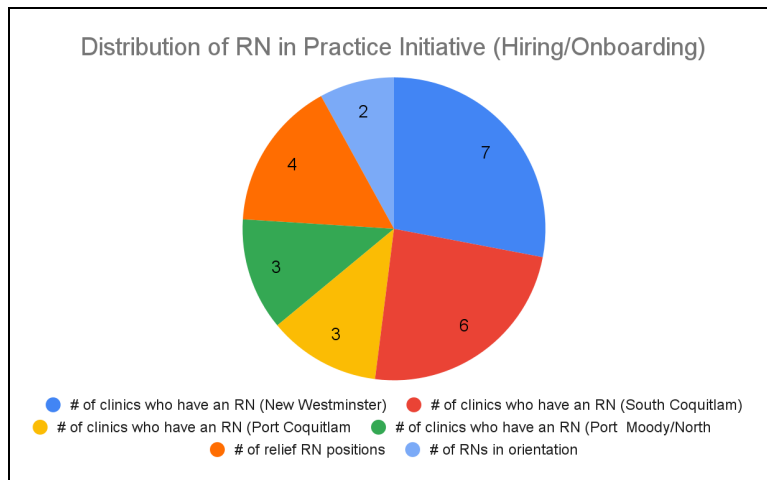
The number of active postings on HealthMatch BC for FPs for both FFS or contract positions decreased to 52 active postings by period close. Opportunities for these postings include: locum and permanent part-time and permanent full-time in the FNW.

Fee For Service (FFS) opportunities and engagement efforts are underway on an ongoing basis and in this period, there were 14 new introductions between FPs and practices for FFS opportunities such as locum, permanent part-time and permanent full-time.

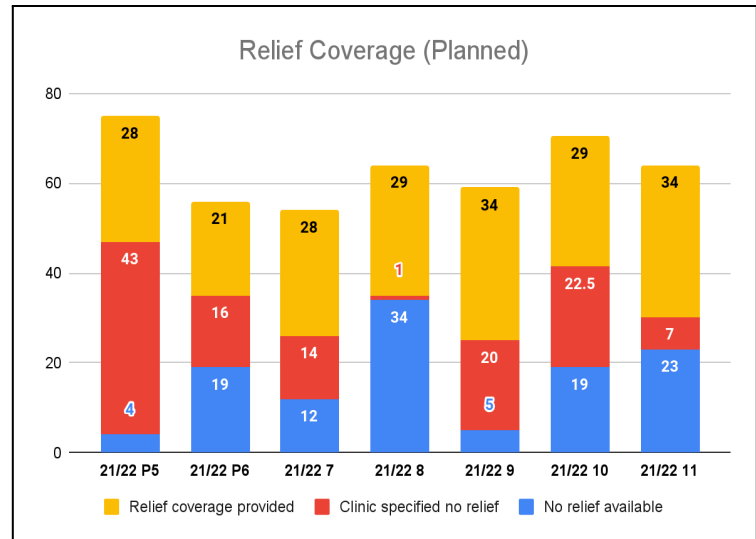
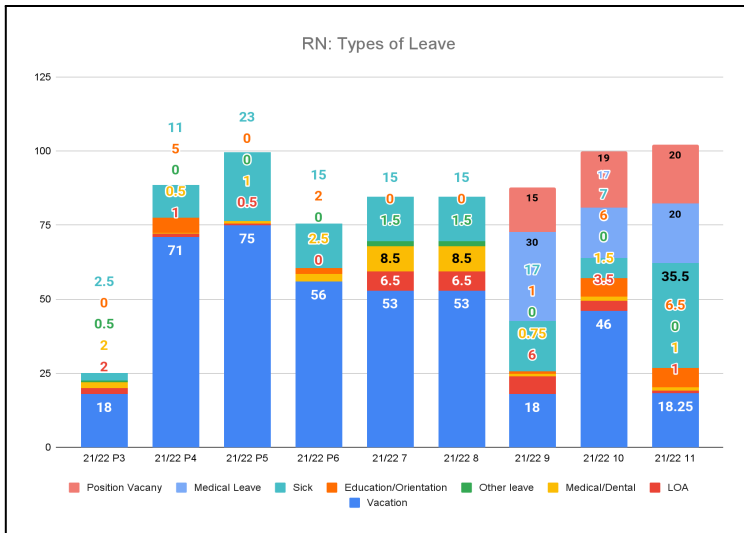


Registered Nurse in Family Practices

At the end of this period, there are 19 clinics in this program with permanent RN in practices, 5 additional clinics with temporary coverage, 1 clinics who are actively recruiting and additional relief positions. Out of the 9 relief positions, 7 are active with the remaining 2 being held for the Return of Incumbent. The period distribution across the PCN's are:



Recently, reporting on the number of days that RNs are out of practice has began and the Period over period distribution for the number of days away are included in the graph below alongside the breakdown of planned coverage:

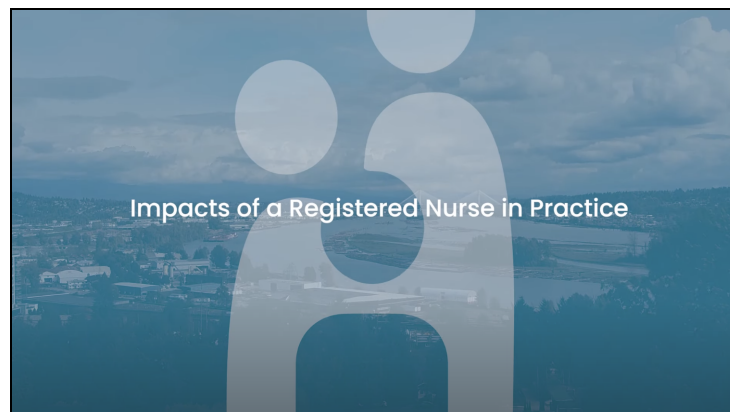


Onboarding and orientation for RNs are a combined effort of partner organizations to ensure proper knowledge and tools are shared to support seamless transition into PMHs. Currently, EMR training for RNs is being supported by the FNW Division; however, the hope is that the Practice Support Program may be able to extend its ability to support EMR specific training for the RNs in this initiative.

Discussions are occurring at the local, regional and provincial level around the process for incorporating practice agreements into this initiative (and similar initiatives in other communities). Currently, these agreements are not signed at the local level and currently there are implications to signing and not signing that directly impacts patient access to care. FHA is not able to place new RNs into clinics without a clinic practice agreement being signed; however, anecdotal feedback from clinics indicates a level of risk to the private business if these agreements are signed. Work is underway between partner organizations and funders to develop a provincial agreement to support seamless placement and continued access to primary care resources within the PMH setting.

RN In Practice Impact Stories

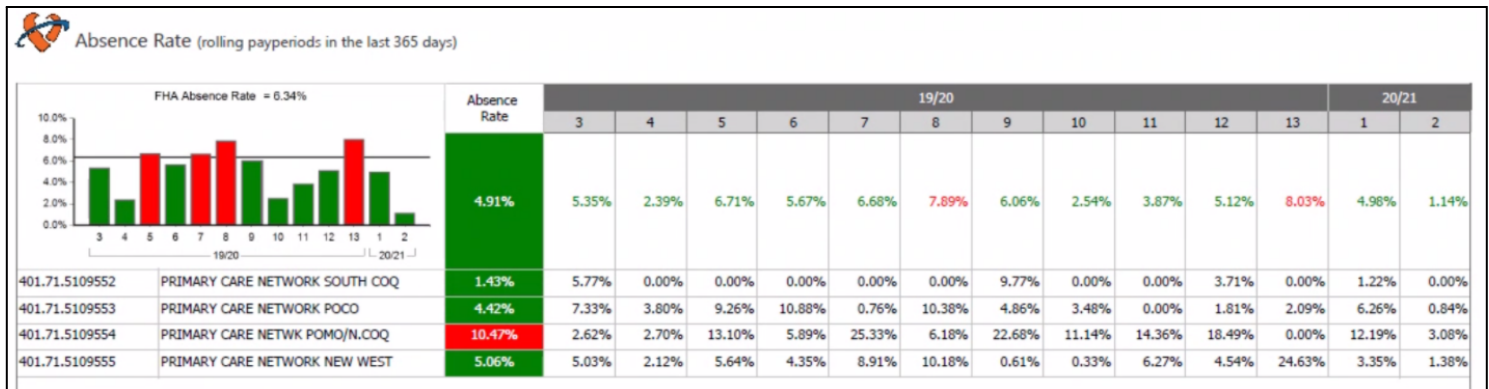
A number of providers shared their experiences of having a RN in practice as an extension of team based care within the PMH. The short video below shares these firsthand experiences and benefits of having an RN working in clinics as an extension of primary care.



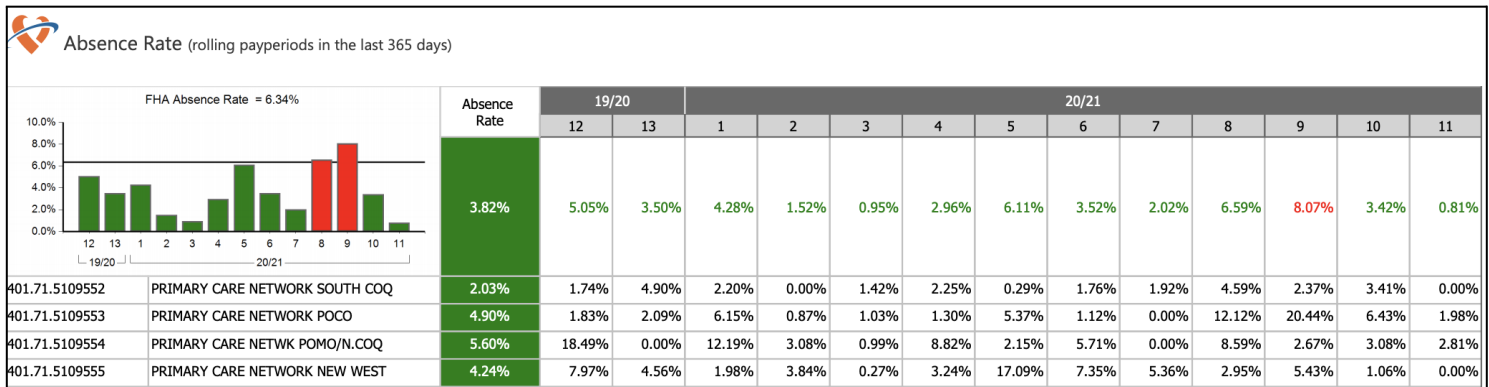
Recently, it was shared that a new Family Physician has started to practice at one of the FNW community maternity clinics. In citing reasons why they began to practice in maternity care - which traditionally in this community has seen challenges in recruitment and retention- they cited the capacity created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

Program Impacts: Absence Rate Analysis

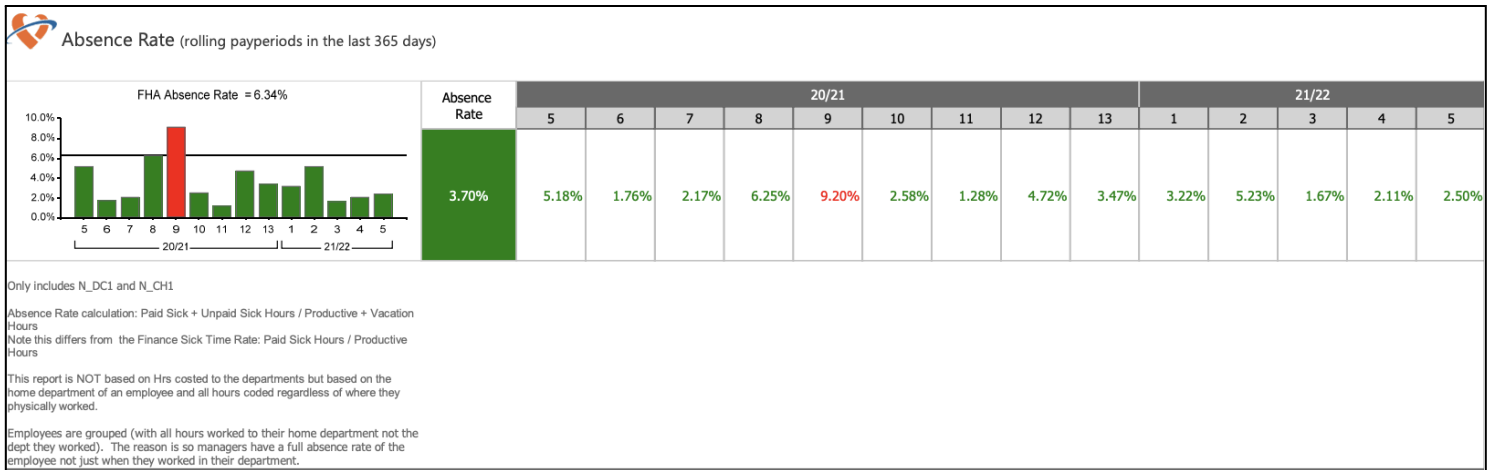
Aggregate level program reports on the absentee rate of RNs in this program compared to other HA settings - acute and community are shown below. The images below are a snapshot of the absence rate by period and PCN since FY 19/20 P3. In FY 19/20, on average the absence rate shown by this program is 4.91% which is below the FHA average of 6.34%.



By FY 20/21 P11, on average the absence rate shown by this program is 3.82% which is below the FHA average of 6.34%. This rate is a decrease of 1.09% from the previous report (image above)

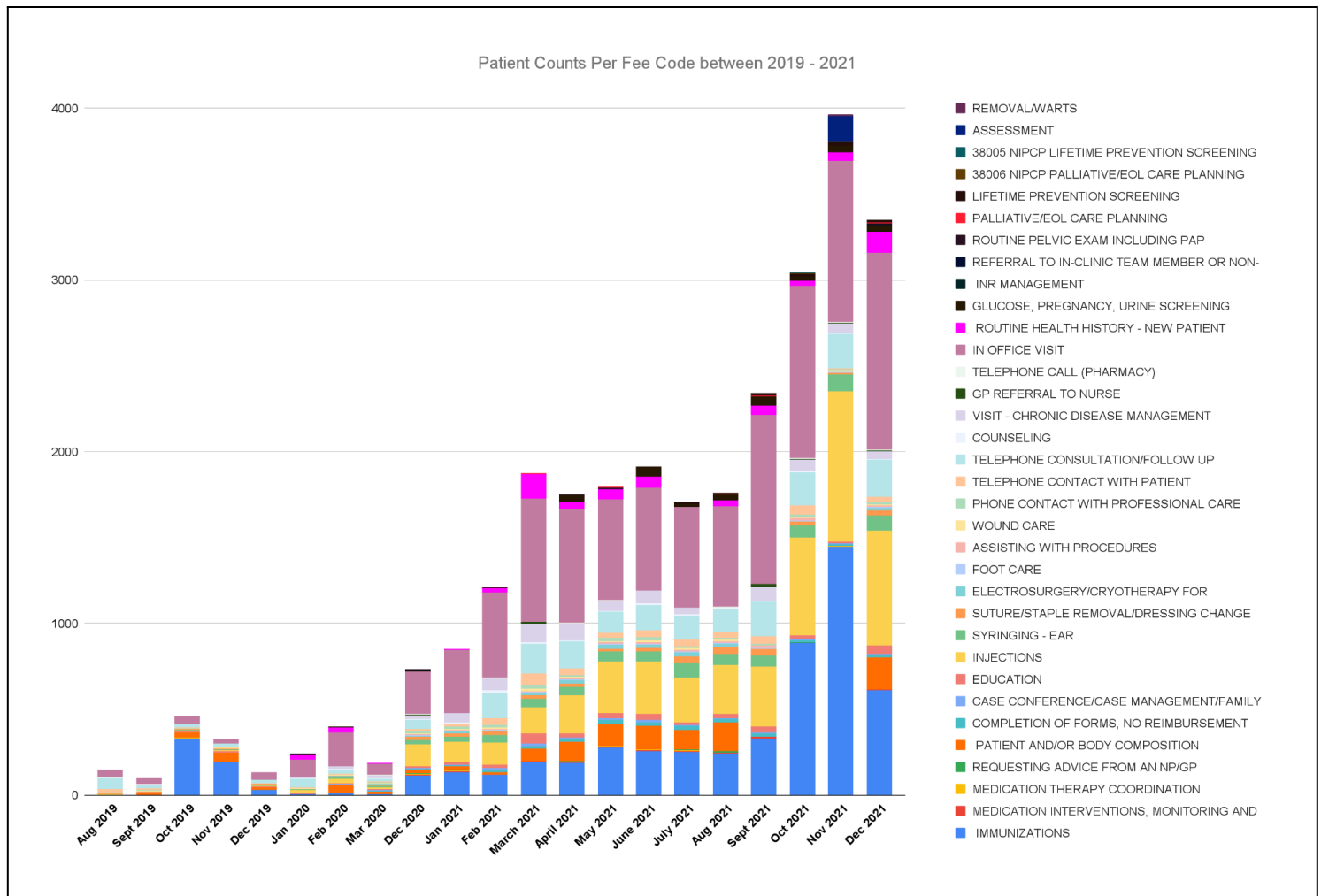


By FY 21/22 P5 (current period), on average the absence rate shown by this program is 3.7% which is below the FHA average of 6.34%. This rate is a decrease of .12% from the previous report (image above).



RN Encounter Coding

Accurate encounter code data is vital to the ongoing implementation of the RN in Practice Initiative 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. The continued rejections have been affecting the Family Physicians, Nurse Practitioners, RNs and practice staff in these clinics and some rejections date back to the summer. Collaborative work is underway between the FNW Division, FHA, Doctors of BC, PSP and the MoH to provide support for the PMHs and providers who are encountering these rejections. MSP generated a monthly encounter code report which reflects the encounter codes that have been accepted, unfortunately the provider count was still low providing an indication that rejections are ongoing and this continues to be a burden on providers. A break in the available data between March 2020 and December 2020 indicates the time period where providers were advised to stop submitting encounter coding as the rejections continued. This data will need to be submitted; however, hesitancy around submitting this is evident given the experience with rejections from practices.

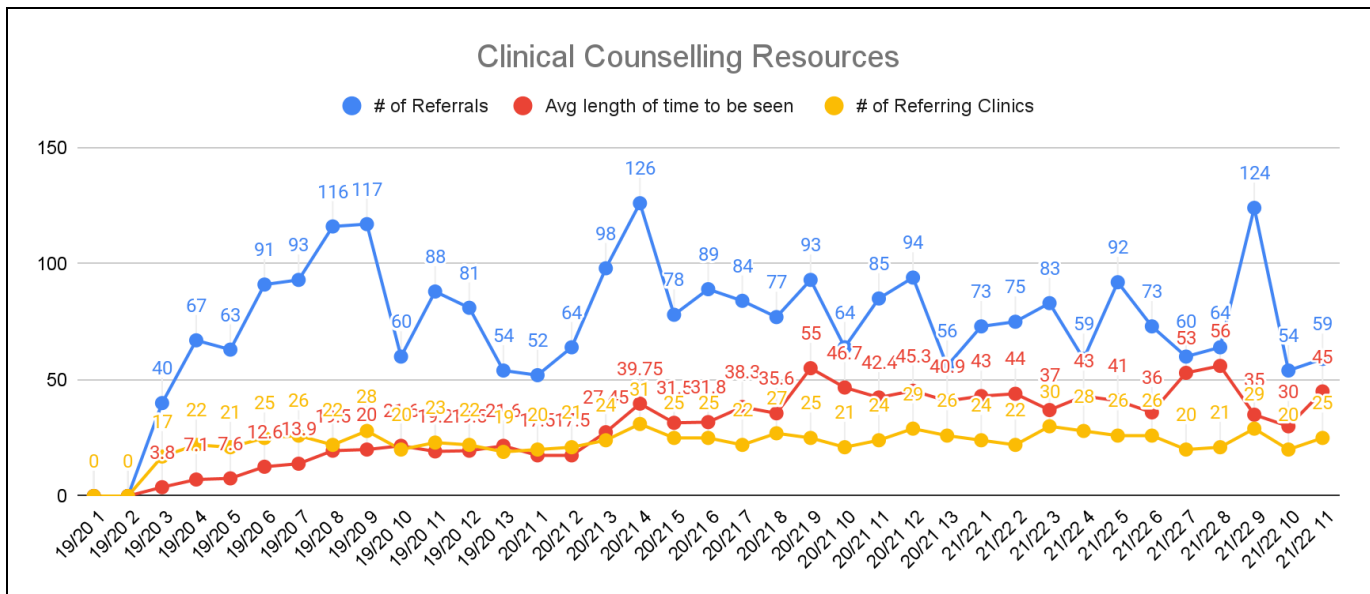


Allied Health (Clinical Counsellors) Supports - Contracted Agency

The number of referrals, number of referring clients, average length of time to be seen, the number of appointments open and number of clients seen all increased during this reporting period. The table below details the change over the last period to the current period:

| | Previous Period (P10) | Current Period (P11) | Difference |
|--|-----------------------|----------------------|------------|
| # of Referrals | 54 | 59 | ↑ |
| # of Referring Clinics | 20 | 25 | ↑ |
| Average length of time for patients to be seen (<i>days</i>) | 30 | 45 | ↑ |
| # of clients seen | 140 | 198 | ↑ |
| # of appointments scheduled | 223 | 371 | ↑ |
| # of cases open | 326 | 322 | ↓ |

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 since PCN inception.



A few clients shared recent testimonial around the impacts and importance of this resource:

"I am grateful for the service at a time when it was really needed. PCN is an awesome program. I especially appreciated the 'no fee'"

"The counsellor was wonderful. At the time I was not there yet, was not ready to open up, it was on me not the counsellor"

Allied Health (Clinical Counsellors) Supports - FHA MHSU

A FHA resource developed to support access to mental health and substance use supports for FNW community physicians 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. Details on the number of referrals can be found in the table below:

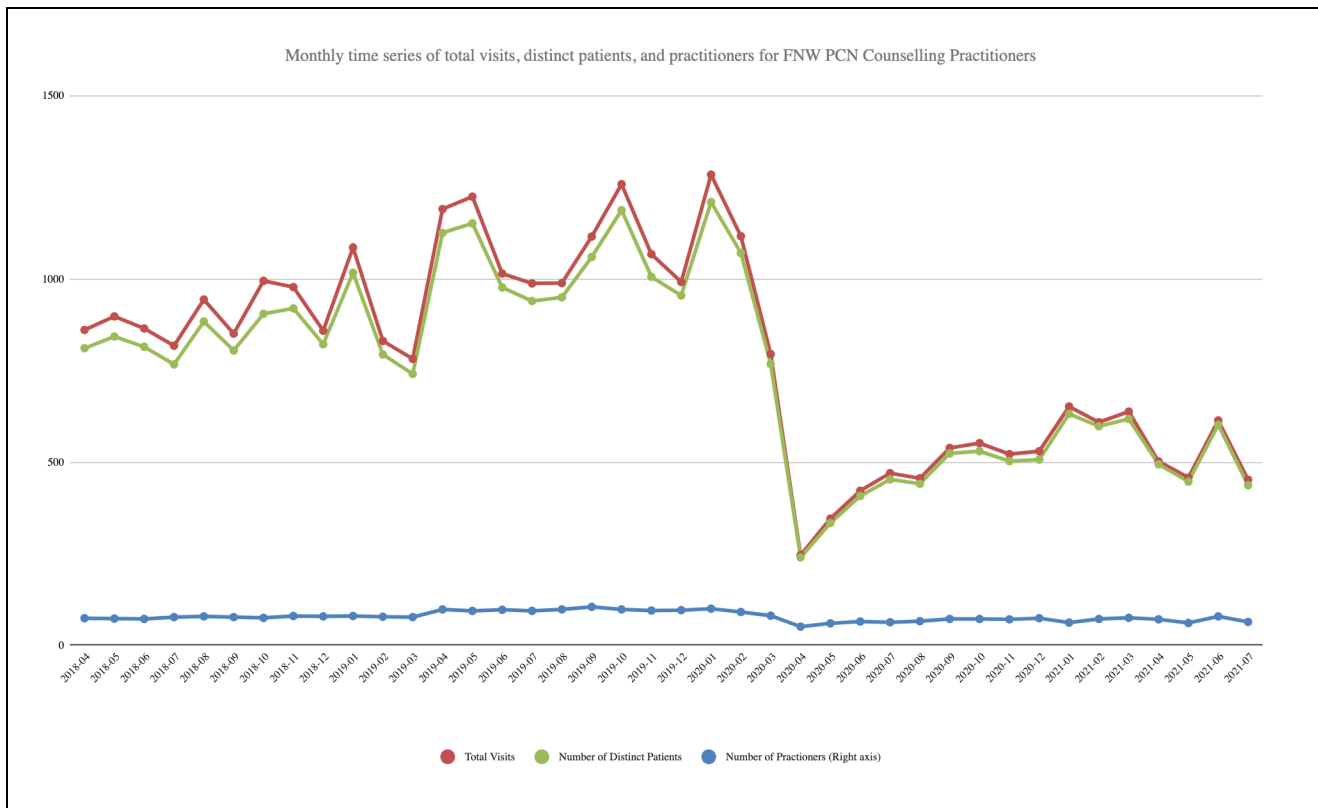
| | Previous Period (P10) | Current Period (P11) | Difference |
|-----------------------------|-----------------------|----------------------|------------|
| # of Referrals | 32 | 58 | ↑ |
| # of Referring Clinics | 17 | 27 | ↑ |
| Avg. caseload/Clinician | 24 | 23 | ↓ |
| # of appointments scheduled | 187 | 195 | ↑ |

Mental Health Program Impact

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. As a note, the MSP data is not fully complete until after 90 days. The tables below shows the year over year comparison broken down by month for:

- The # of practitioners billing for counselling fees
- The # of patient visits from the counselling fees
- The # of distinct patients



Indigenous Related Supports

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

The Kwikwetlem Primary Care clinic opened mid-October 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 soft opening has been a great success according to the team and the community members accessing services. The Physicians are in on Tuesdays. There is also a Nurse Practitioner in the clinic on alternate Fridays. The Community Health Nurse is in 2 days/week to do drop-in for Kwikwetlem First nations members for injections, medical assessments, referrals,

wellness checks, blood pressure, blood glucose checks, wound care and assisting with the Physician of the day’s phone calls.

The elder home support worker is serving three elders and has 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.

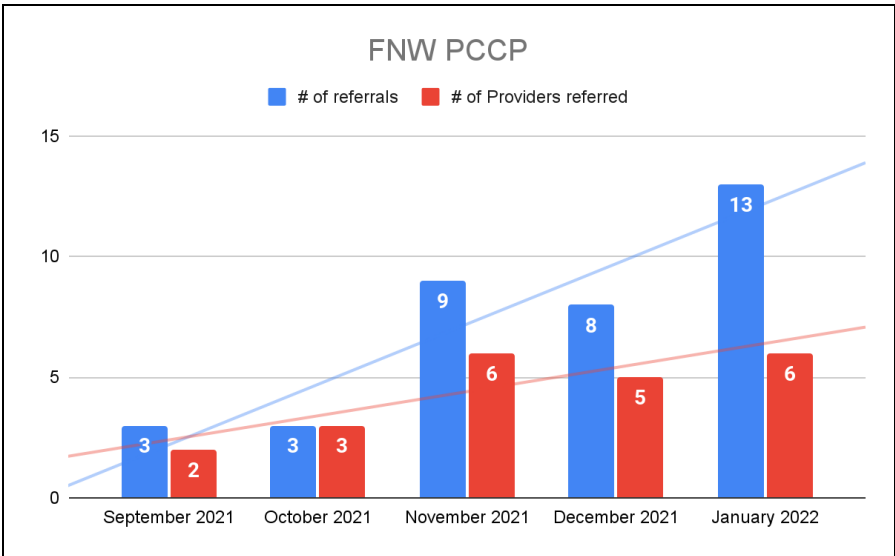
The Aboriginal wellness advisor has assisted the Director of health to assess the wellness needs of the community. They are currently working on meeting the needs of the community by seeking community partnerships with local organizations. In addition, the wellness team is actively seeking grants for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

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.

Primary Care Clinical Pharmacists (PCCP)

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 Frasernorthwest region. 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 Period 5 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 an ongoing discussion 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. Referral data shared by the program reflects an upward trend of usage and referrals for the PCCP.

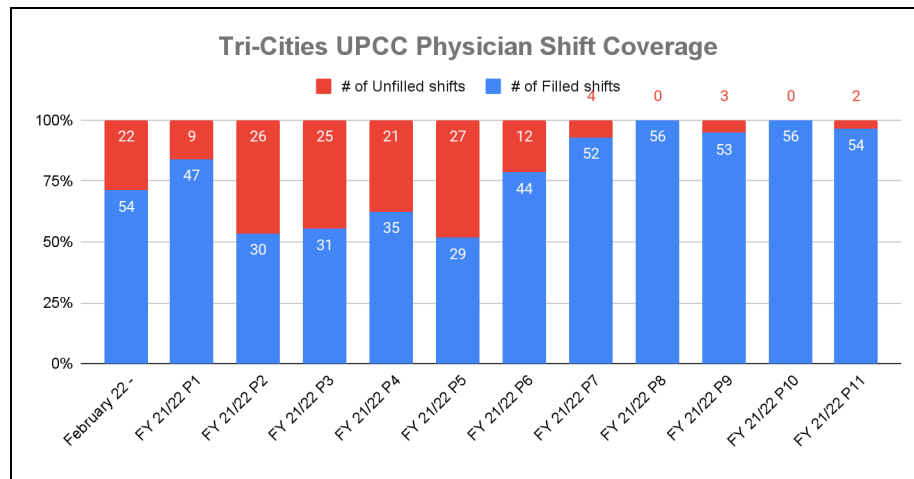


Urgent & Primary Care Centre: Tri-Cities

In February, the Tri-Cities Urgent and Primary Care Centre (UPCC) opened its temporary location at Eagle Ridge Hospital. The UPCC is meant to provide primary care access to patients in the community who are unattached or attached and potentially seeking care outside of regular clinic office hours. The UPCC currently operates from 1pm-8pm 7 days a week.

| | Period 10 | Period 11 | Difference |
|-------------------------------|-----------|-----------|------------|
| # of In-person patient visits | 277 | 324 | ↑ |
| # of virtual patient visits | 263 | 419 | ↑ |
| # of new attachments | 79 | 62 | ↓ |
| Total # of attachments | 225 | 366 | ↑ |

Physician shift coverage has traditionally been a challenge at this site as shown by the visual below comparing the total number of available shifts by breaking down those which were filled and those shifts where there was no Physician at the UPCC.



Program Impact: Accessible Primary Care

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.

FNW Practice Support Program

The Practice Support Program (PSP) provides family physicians the opportunity to “*practice more efficiently, focus on providing proactive care, and work towards adopting attributes of the Patient Medical Home.*” As reported by PSP, most of the PMH/PCN work that is taking place relates to:

- Panel Management
- Panel Maintenance

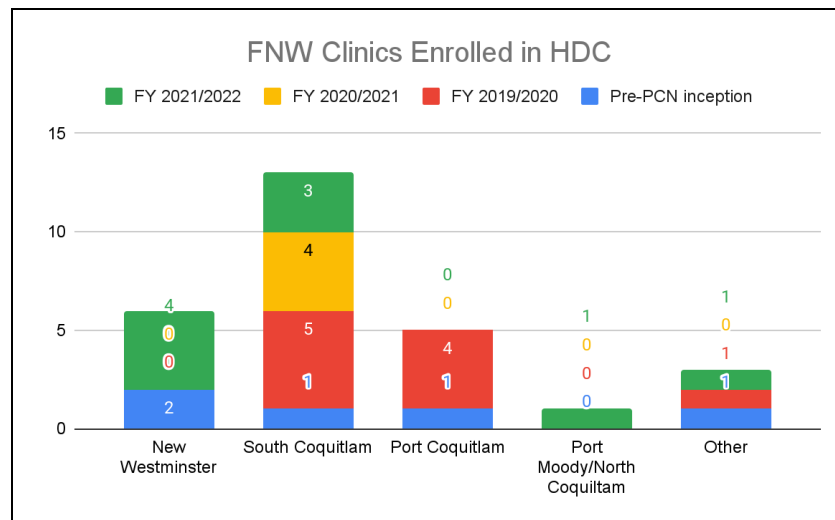
- Patient Experience Tools
- EMR Skills Assessments

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

| | # of MSOC Physician | # of PMH Assessments completed | % started Panel (MSOC) | % Completed Panel (MSOC) | Started Panel | Working on Phase 1 | Working on Phase 2 | Working on Phase 3 | Workbook Complete |
|---------------------------|---------------------|--------------------------------|------------------------|--------------------------|---------------|--------------------|--------------------|--------------------|-------------------|
| Previous month (December) | 180 | 116 | 66% | 54% | 119 | 15 | 3 | 4 | 97 |
| Current month (January) | 179 | 116 | 66% | 55% | 118 | 12 | 3 | 4 | 99 |
| | ↓ | = | = | ↑ | ↓ | ↓ | = | = | ↑ |

Health Data Coalition (HDC)

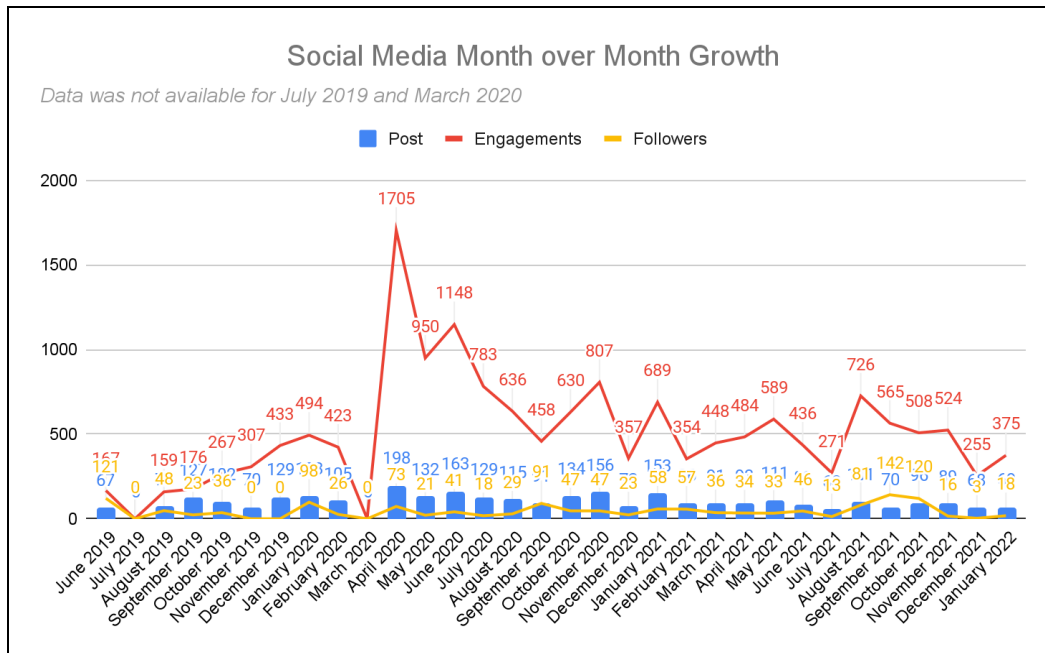
The [Health Data Coalition](#) is a non-profit organization funded by GPSC that “is a physician-led data sharing network that encourages self-reflect and practice improvement in patient care. HDC provides access to a secure, core set of anonymized aggregate data” for physicians and practices. HDC representatives are working alongside FNW Division staff and Physician leadership to identify opportunities for integration into FNW led engagement events for members. This tool will provide practical and tangible solutions to specific topic areas that events are centered around.



Feedback from the Community

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. In January they’ve recorded the following changes in public engagement through the social media platforms:

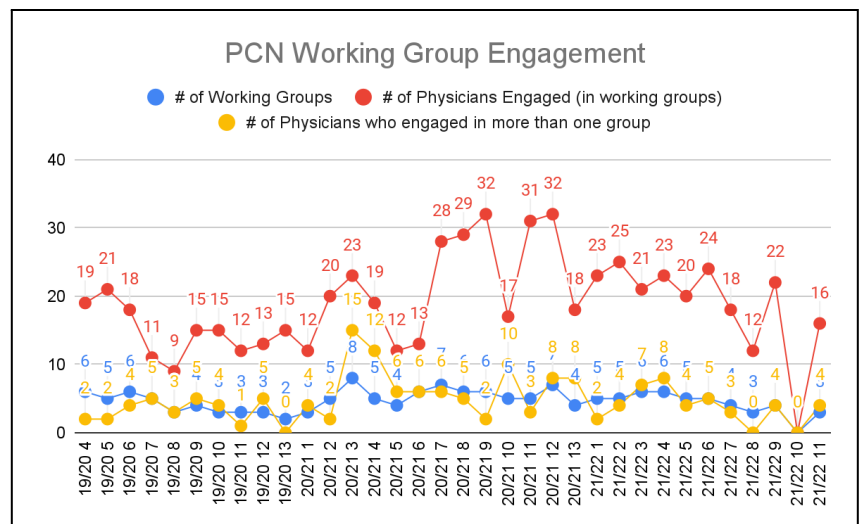
| Channel | # of Posts | Engagements | Followers (+/-) |
|---|------------|-------------|-----------------|
| All Channels (Facebook, Instagram, Twitter, LinkedIn) | +69 | 375 | +18 |



Each quarter, a newsletter is distributed to patients in the communities who have signed up or agreed 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% |

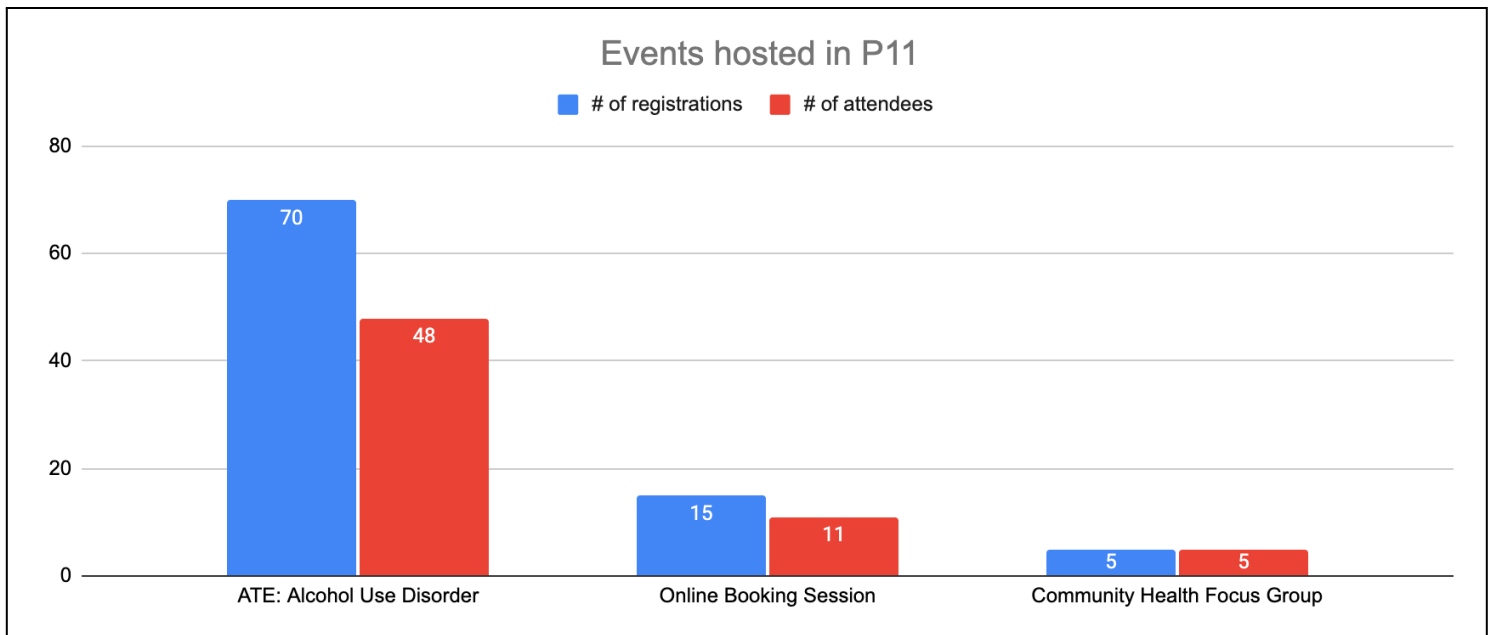
Work is underway to develop a PCN related public engagement strategy that collects feedback and stories from patients to better understand what primary care healthcare supports are integral to their continued access and overall health. Engagement work is currently underway to identify opportunities for people in the community to provide feedback on accessing healthcare services for their needs. Recently, through the distribution of the patient newsletter, people were asked to share their perspectives and experiences related to virtual care. A



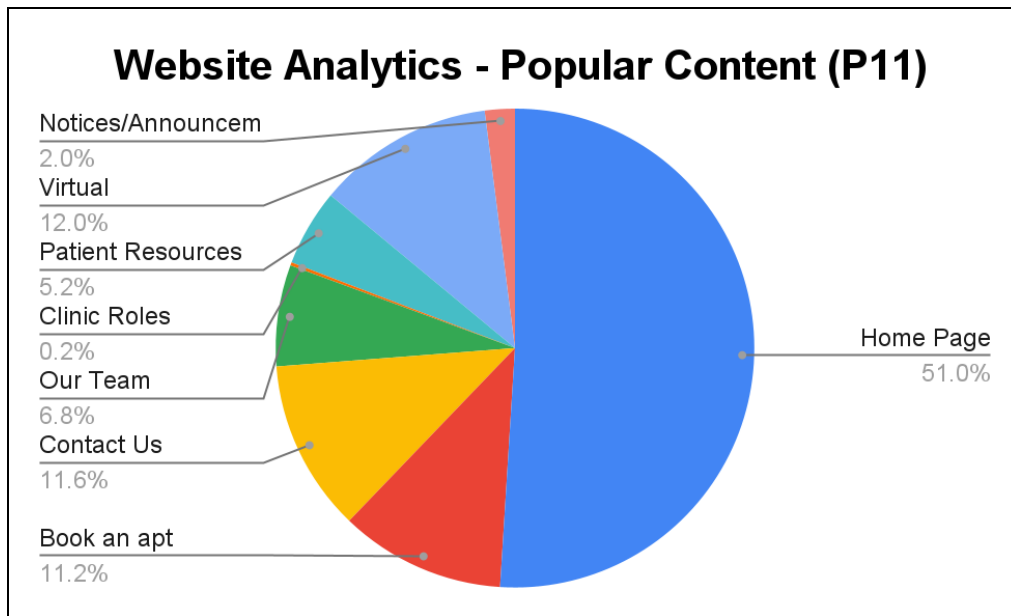
reflected through a number of provider working groups and advisory committees which include:

- 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 is comprised 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.

The following events were hosted for members in this reporting period:



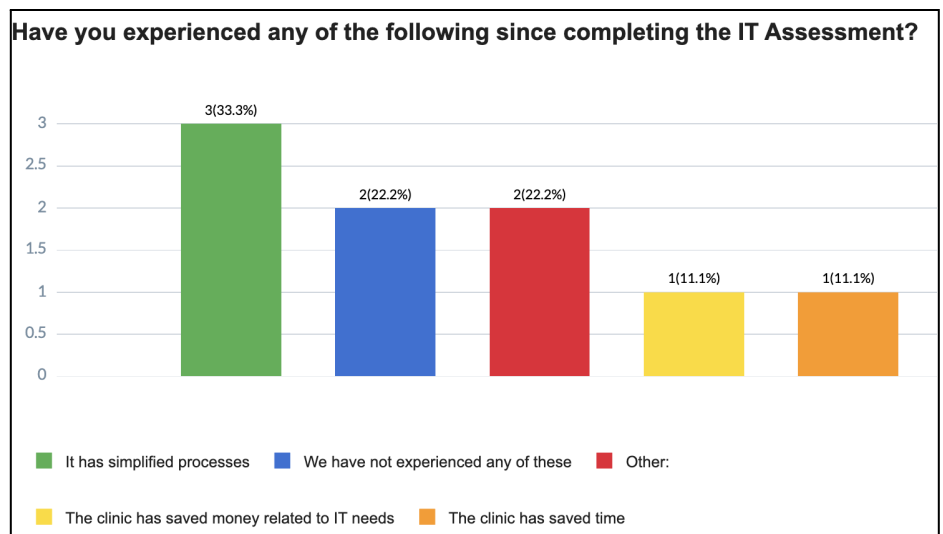
Additional engagement support provided to FNW physicians is the website development. The move to providing primary care services in a virtual setting continues to grow and expand. A full list of the clinics in the FNW and their associated websites can be found by [clicking here](#). Analytic data provided below from websites provides an overview of patient navigation based on popular content and searches for all clinic websites.



Physician Engagement: FNW Information Technology Supports

An internal FNW Division IT Program was established in late 2019, and more recently in 2021, an IT inventory support project has been launched to help facilitate and support FNW clinics in understanding their privacy and security needs and offering support in the implementation and management of these needs. This is an example of an area of work or business

management that many Longitudinal Primary Care Providers may not have the background knowledge or experience in navigating and the hope is that by having the Division support this work, this alleviates the pressure and strain many providers face. Customized support can be provided to clinics after completing a detailed checklist outlining their current state IT infrastructure allowing the Division staff to identify what resources and supports are needed.



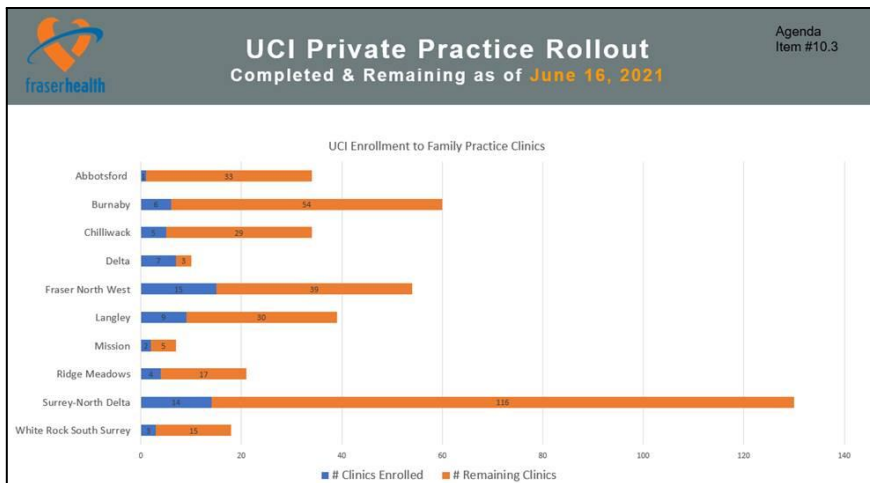
Physician Engagement: Virtual Care

The influx of virtual care over the last 18 months has been significant, largely due to the impacts of the Covid-19 pandemic; however, it's opened up opportunities for access in a quick and convenient manner for patients for certain concerns. 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*).



Physician Engagement: UCI and/or CareConnect Access

The ability for PMHs to incorporate either UCI or CareConnect to enable access of patient information between acute and community settings is vital in enabling coordination of care across care providers and settings. Recently, FHA provided a snapshot of the number of clinics who have access to UCI across the region.



So far, approximately 28% of FNW clinics have enrolled with UCI. UCI is developed by FHA whereas CareConnect was developed by VCH, but can be used across regions.

Community Gaps in Obtaining PCN Core Attribute 5/6

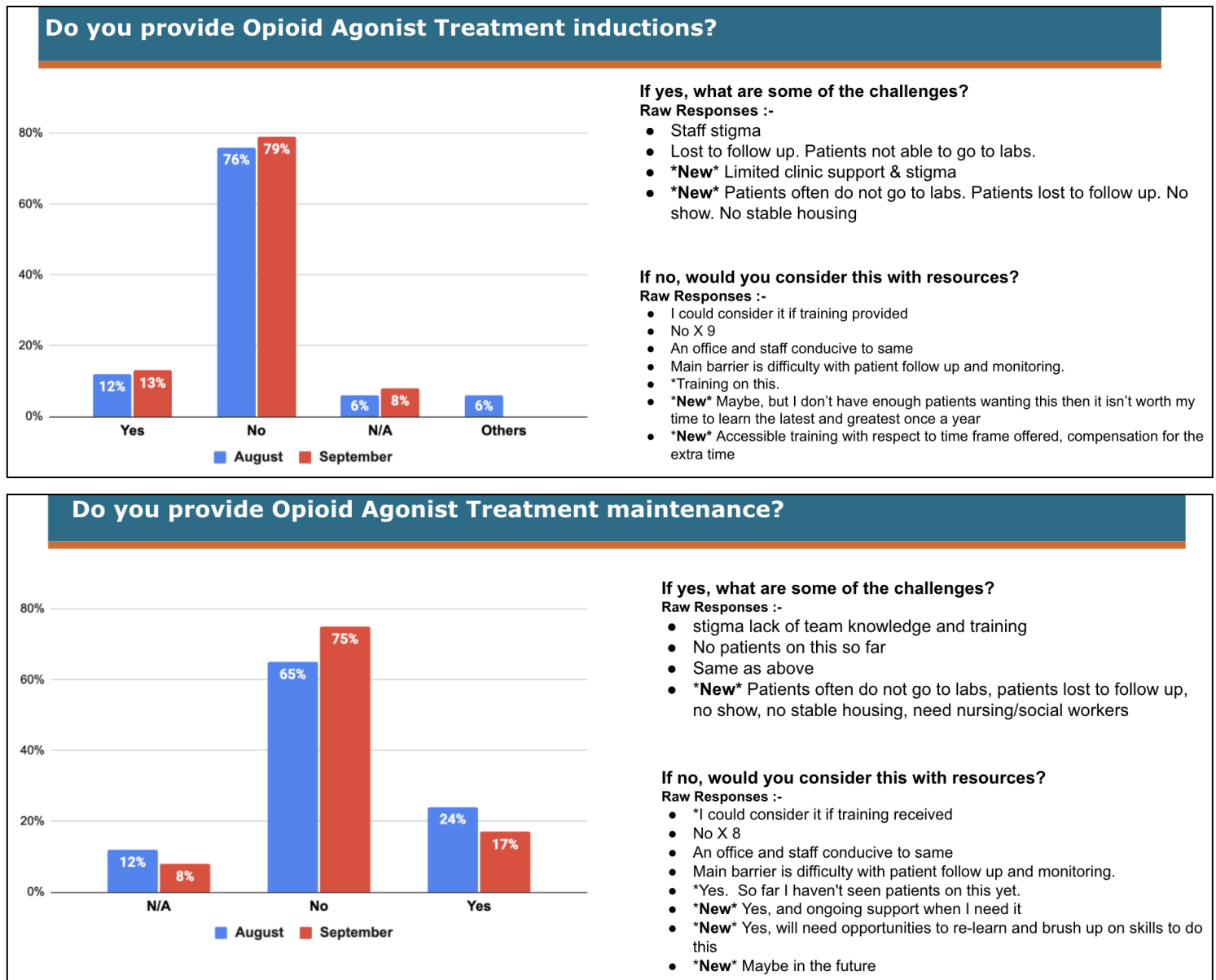
Attribute #5: Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.

Attribute #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 the community.

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 identified 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 |

Maternity Care

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 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?

Raw Responses:

- 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.
- confidence in it
- 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
- Lack of training
- Lack of interest
- Liability
- Comfort
- Accessibility to timely support if things get complicated or urgent care required
- Not sure
- On-call and hours. Training and loss of experience from not practicing it.
- Schedule and I lack skills
- Time limitations. Usually take 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 aware that they are compensated less compared to other visits that doesn't take as long.
- Everything feel 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 to do night and evening shifts due to being on the brink of burnout, already burned out, or recovering from burnout.
- TIME MANAGEMENT
- DIFFICULT TO LEAVE PTS IN THE OFFICE AND ATTEND A DELIVERY AT HOSPITAL

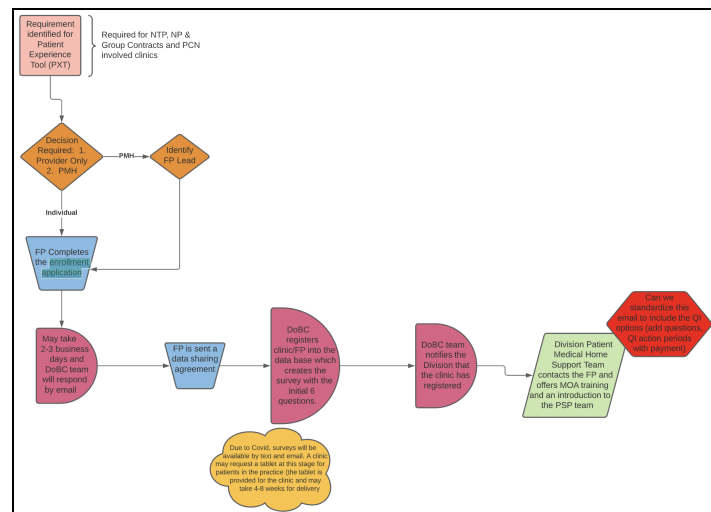
Recently, a Nurse Practitioner attended a prenatal member education event which prompted the provider to engage with the Division team to share that they were accepting new babies and moms as patients and provided details on how to reach out. This example is a reflection of the importance of including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

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.

Patient Engagement

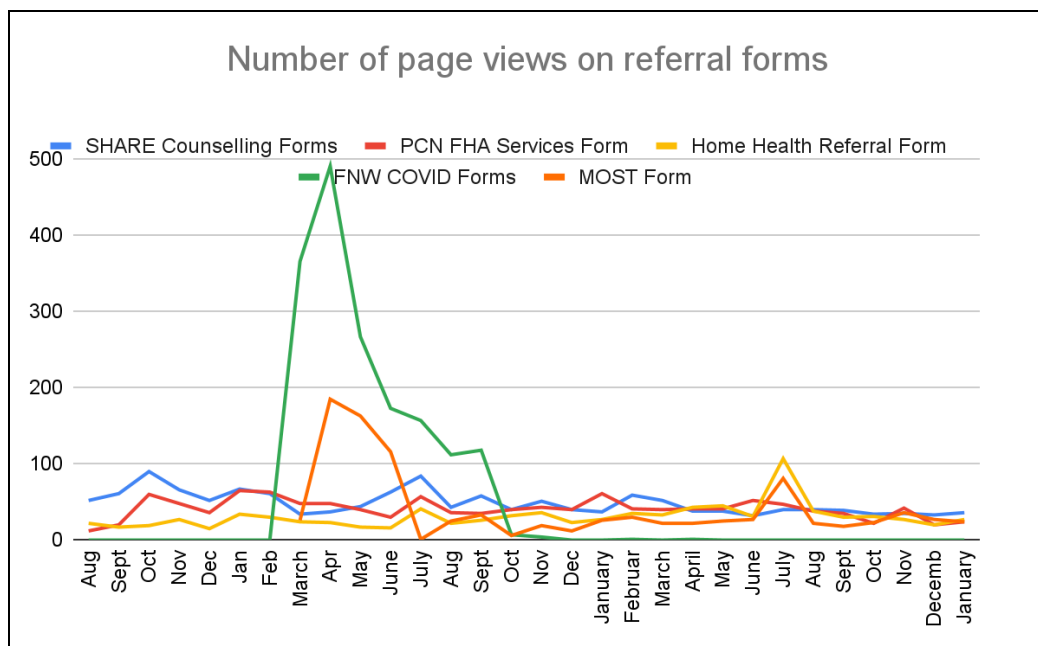
Work is underway to implement the GPSC created Patient Experience Tool (PET) within all practices who have RNs in Practice, or providers on contract. A workflow was developed to share out to PMHs to visually represent the process for implementing the PET into practice. The visual is a draft representation of the workflow process for this tool's implementation.



So far, 2 PMHs within the FNW have signed up for the Patient Experience Tool.

Pathways

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.



PCN Lessons Learned

1. Identifying a process for transition and support related to contract terminations is needed to support the provider as well as how to support the panel of patients.

2. Coordination of care is a core attribute of both the PMH and PCN work. Recent experiences related to colposcopy referrals between primary care providers, provincial organizations and local hospitals highlighted differing processes for referral pathways which have a potential for impacts on patient care and safety.
3. The encounter coding system continues to not work. RNs and FPs at practices that don't have a group payee # continue to receive rejections. Some practices have rejections dating back to late 2019.
 - a. In some practices the rejections are piling up in the 1000s, there needs to be an identification of whose responsibility it is to support this and ensure accuracy
 - b. It's key to have a point person for Physicians to contact to reach out for adequate and clear support as encounter coding issues continue to impede upon these providers' providing patient care.
4. Attachment between priority populations and primary care providers emerged as an obstacle as some processes don't collect certain contact information making it difficult for seamless and expedited attachment between patients and primary care providers.
5. Designated overhead funds for Allied Health positions embedded within PMHs has emerged as a concern from both the PMHs and the HA. There is an unrecognized management role that the Physicians play in creating a workplace for these team members and currently that is covered under the existing overhead amount.
 - a. Additional overhead funds for PMHs include cyber insurance policies which noted a 22% increase for 2021. This reflects another cost for PMHs to successfully continue to provide longitudinal primary care services.
6. For FNW PMHs to be eligible for in-practice allied health support, all members of the PMH must be a member of the Division.