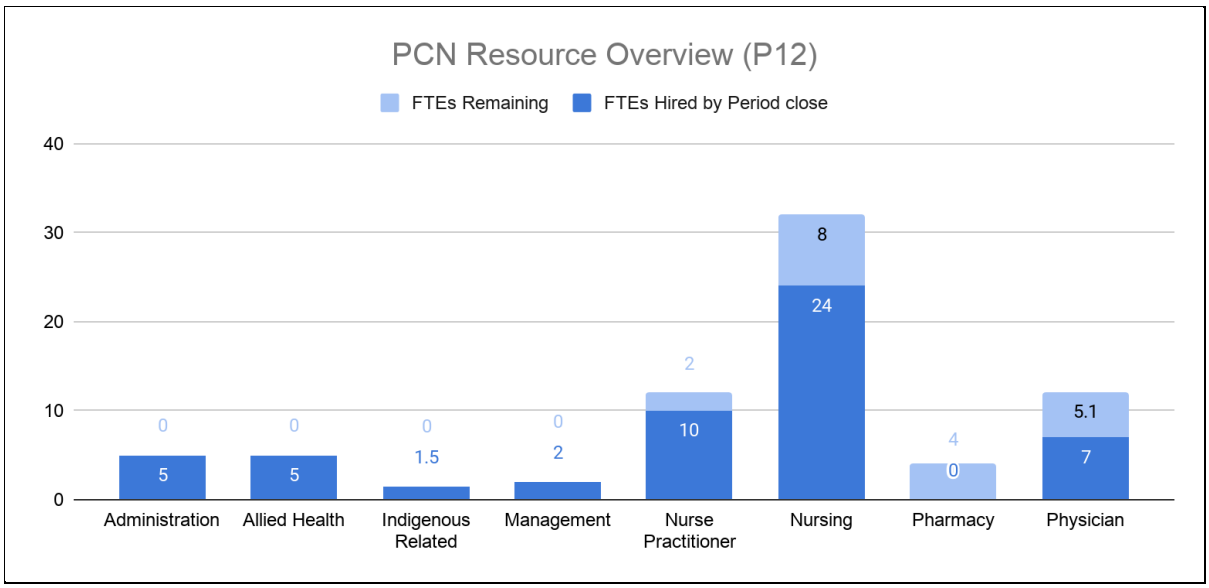
Fraser Northwest Primary Care Network

Period 12 Addendum Report



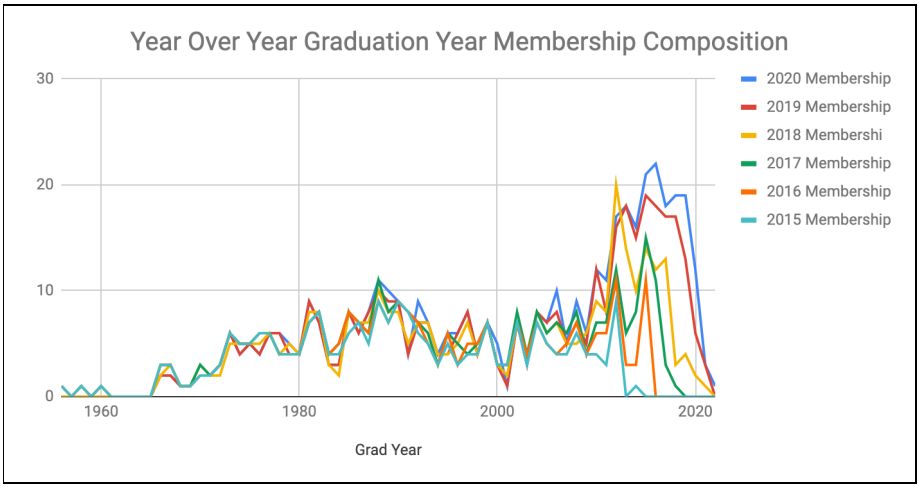
Patient Medical Home Snapshot:

Provider Types	# in FNW
FFS Family Physician	228
PCN funded FP	7
PCN funded NP	10
Community NP	8

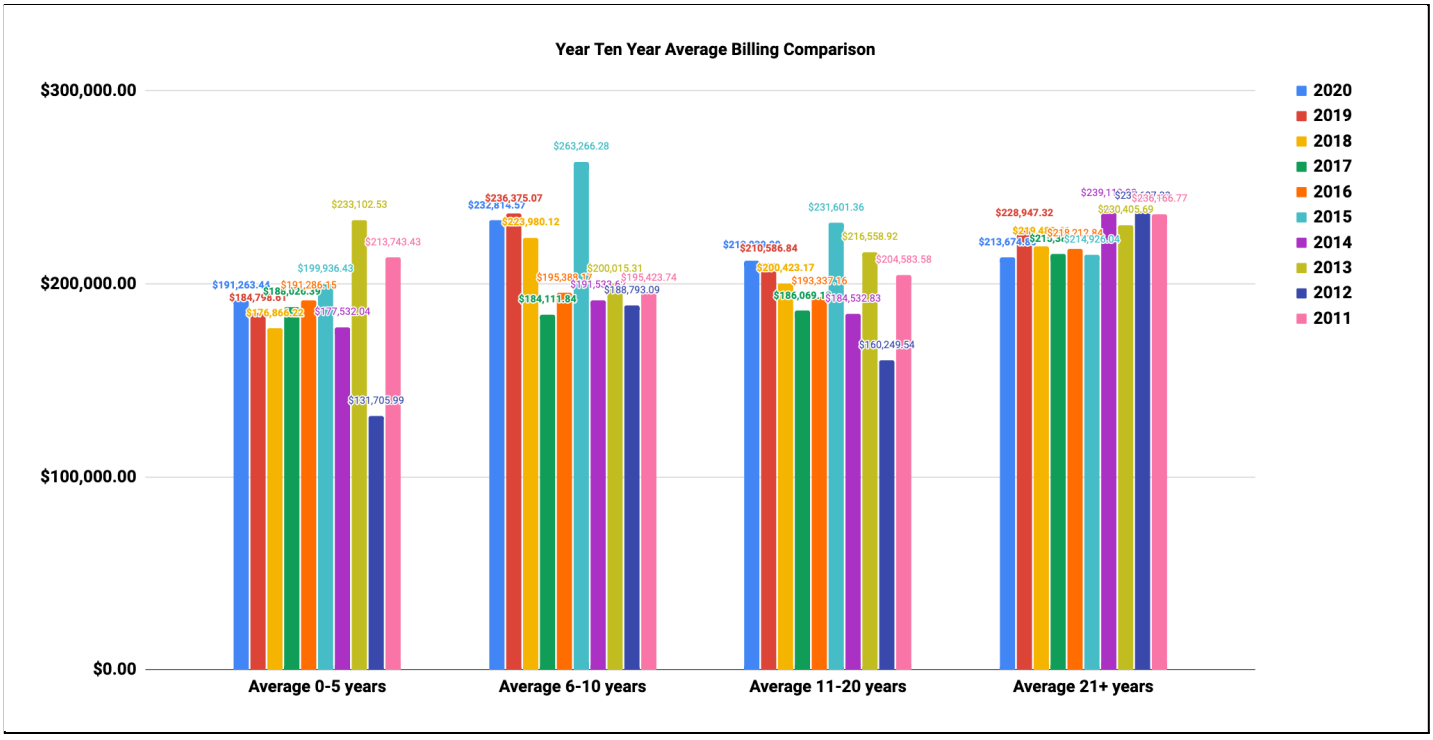
PMH Types	# in FNW
Family Practice	32
Hybrid (FP/Walk-in)	20
Walk-in	2
Community Services	3
U&PCC	1

FNW Community Overview

FNW Division membership comprises approximately 450 physician and provider members. Although this number is large, 40% of FNW members have been in practice for 20+ years. This is 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.



Overview: Primary Care Provider Community Adds & Losses

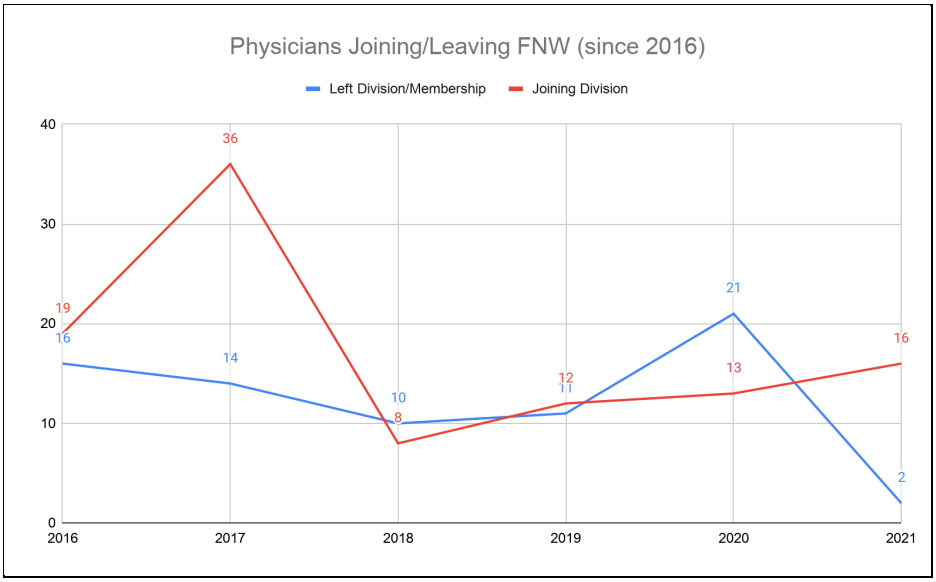
Since the inception of the FNW PCN in April 2019, there continues to be primary care providers joining and leaving the community. The visual below denotes the addition of primary care providers (including both Family Physicians and Nurse Practitioners) to the FNW communities; the leaves of primary care providers (including retirements and other leaves); and the correlating attachment based on data collected from the FNW Attachment Hub. A detailed breakdown of the projected retirements can be found later in this section.

	2019	2020	2021
Provider Adds	10	8	16
Provider Losses	15	22	2
Net Loss/Gain	-5	-14	+14
FNW Attachment Hub #	856	2792	1111
MoH $0 Fee Code Attachment	NA*	73,742	652

**MoH Data not available for 2019*

Work is underway to welcome potential International Medical Graduates (IMGs) Return of Service (ROS) from the UBC program and the Practice Ready Assessment (PRA) program into community practices to take on a panel for longitudinal practice. 2 Physicians from the PRA program were matched with FNW communities with the clinical assessment commencing in Spring 2021. Unfortunately, recently 1 of the 2 Physicians withdrew their application and so the FNW will welcome 1 Physician from the PRA program into the community in the Spring.

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 77 physicians leaving the community with 11 physicians leaving in 2019 and an additional 21 leaving in 2020 already. The graph below shows the distribution of Physicians leaving the community compared to those joining the community since 2016.



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.

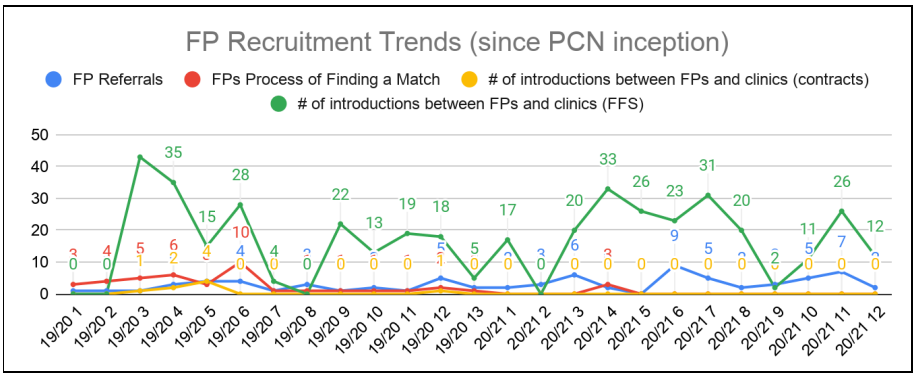
Approximately 30.4% of PMHs in the FNW offer childhood immunizations in practice, an aggregate PCN level breakdown of that data is below:

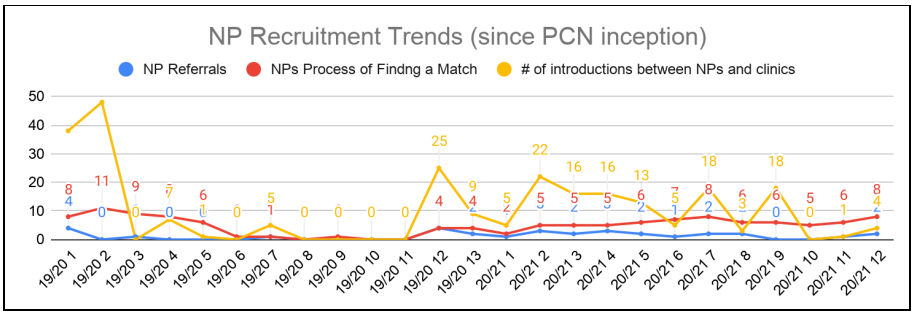
	Yes	No	N/A	Total
New Westminster	4	6	4	**14**
Port Coquitlam	2	6	1	**9**
South Coquitlam	8	8	11	**27**
Port Moody/ Belcarra/ Anmore/ North Coquitlam	3	2	1	**6**
Total	**17**	**22**	**17**	**56**

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 12 (February 5 - March 5), clinic openings decreased slightly to 18.8 FTE. Table 1 below provides a status overview and update on the breakdown of the NP and FP contracts by PCN within the FNW:

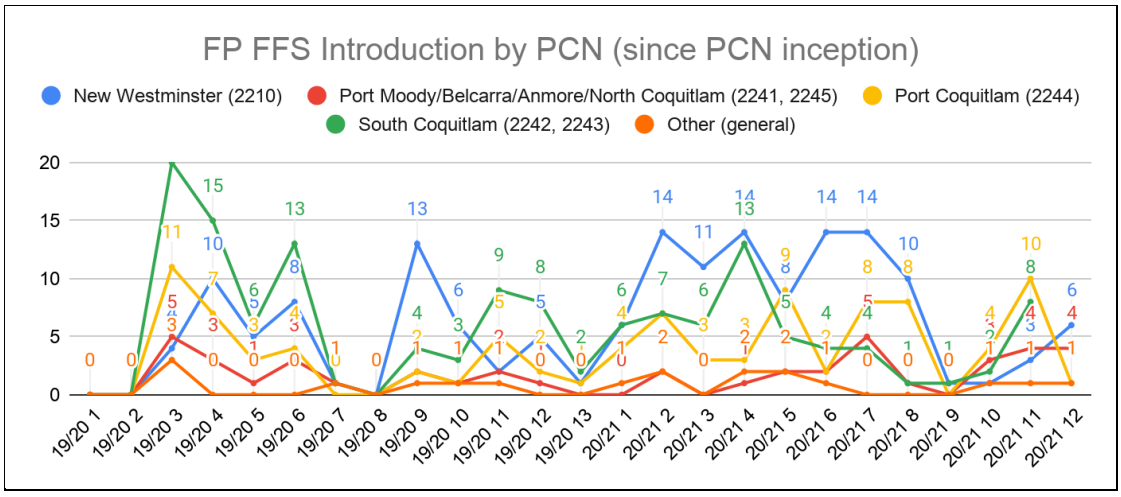
	Referrals		# in the process of finding a match	# of introductions between provider and clinics	# of contracts signed
	# of New Referrals	Running Total of Referrals since PCN Launch			
Family Physician	2	77	0	0	1 PCN Launch Total: 7
Nurse Practitioners	2	42	8	4	0 PCN Launch Total: 10



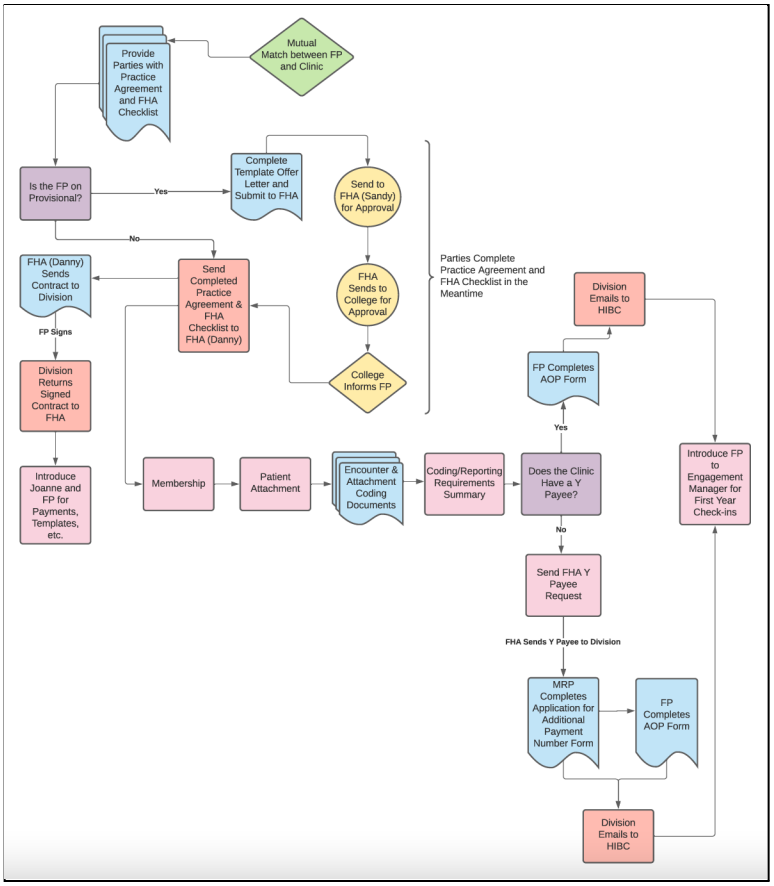


The number of active postings on HealthMatch BC for FPs for both FFS or contract positions increased in this period to 28 active postings by period close. Opportunities for these postings include: locum and permanent part-time and permanent full-time in the FNW.

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

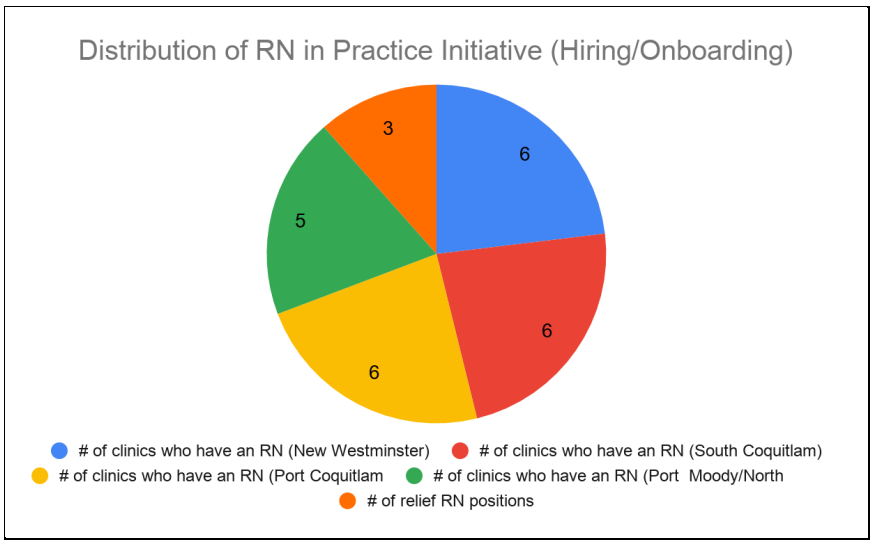


Recently, Division staff created a workflow visual demonstrating the steps required to successfully onboard new contracted providers:



Registered Nurse in Family Practices

In Period 12, there are 22 family practices that now have a nurse. Two clinics who previously had RNs now have vacancies which partner organizations are working to fill. There are currently 3 positions posted for clinic RNs. In addition to the 22 currently in family practices, there are an additional 3 RNs who provide relief/coverage. The YTD distribution across the PCN's are:



RN In Practice Impact Stories

Recently, Family Physicians have shared their experience around having RNs supporting their practice. One Physician indicated that when the RN began doing influenza vaccination clinics in the practice, this reduced a lot of pressure and ultimately burnout for Physicians. This Physician shared that they "*didn't realize we were burning out until someone else took the burden off us*." That being said, the same Physician shared the pressures and fear of having another provider providing these to their patients. This Physician felt that it was their obligation as they were patients' Family Doctor and it is their job to take care of them fully. Ultimately, this Physician identified that they were *"doing more disservice to my patients by spreading myself too thin - when I let this go, I found that I was a better doctor, and could spend more time with patients instead of worrying about the flu shot."*

The biggest aha moment for this Physician when recognizing the contributions of the RN and extension of the Physician's work was when *"I realized that there is someone else that can help me, and report back to me and have that shared care [for my patients]. Seeing happiness from patients afterwards and that they felt they were being well taken care of. Patients [have] said 'I really appreciated the nurse'... I felt like it was an extension of the way we practice and that it was good care - and it didn't have to come from me...I realized that I can release control and there can still be good care for my patients."*

A second Family Physician who shared their experience spoke around the impacts of the RN on providing childhood immunizations and - more recently - well-baby checks. Since joining the practice, one of the goals for the RN was to incorporate them into administering the childhood vaccines.

> *"This role developed from just vaccine administration to a more comprehensive visit: the RN will go in and meets with the family first, answers any questions about nutrition and growth, provides education and reviews all of the developmental milestones. The RN then reviews this with the Physician and the Physician will go in and complete the remainder of the check with the families...This has been a huge value add to the patients as patients feel like they have ample time to ask questions, get education, and the patient leaves feeling more satisfied with their visit."*

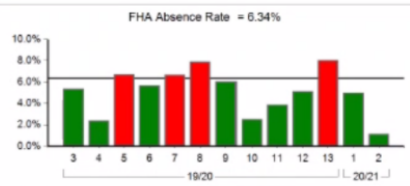
Another Family Physician indicated the opportunities for improvement for this program and the importance of identifying an RN who fits with the clinic and who feels the clinic fits with them. Incorporating a probationary period for both parties allows for relationships to build and support efficiency within the PMH so as to allow for increased access for patients and providers. The change of pace in a clinic environment may also be new to RNs and so ensuring they have the time and support to incorporate and adjust to the new environment is key to a successful match.

A fourth Family Physician shared similar themes that the previous FP had shared; however, they have had a few experiences with different RNs and reinforced how important 'fit' is to both the FP and the RN within the PMH. Having an RN who is familiar with the system provides an advantage for primary care providers as they may know how to navigate the larger health system to benefit both the primary care providers and their 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 is 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%.

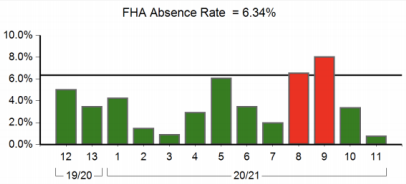
Absence Rate (rolling payperiods in the last 365 days)



		Absence Rate	19/20										20/21	
			3	4	5	6	7	8	9	10	11	12	13	1	2
		4.91%	5.35%	2.39%	6.71%	5.67%	6.68%	7.89%	6.06%	2.54%	3.87%	5.12%	8.03%	4.98%	1.14%
401.71.5109552	PRIMARY CARE NETWORK SOUTH COQ	1.43%	5.77%	0.00%	0.00%	0.00%	0.00%	0.00%	9.77%	0.00%	0.00%	3.71%	0.00%	1.22%	0.00%
401.71.5109553	PRIMARY CARE NETWORK POCO	4.42%	7.33%	3.80%	9.26%	10.88%	0.76%	10.38%	4.86%	3.48%	0.00%	1.81%	2.09%	6.26%	0.84%
401.71.5109554	PRIMARY CARE NETWK POMO/N.COQ	10.47%	2.62%	2.70%	13.10%	5.89%	25.33%	6.18%	22.68%	11.14%	14.36%	18.49%	0.00%	12.19%	3.08%
401.71.5109555	PRIMARY CARE NETWORK NEW WEST	5.06%	5.03%	2.12%	5.64%	4.35%	8.91%	10.18%	0.61%	0.33%	6.27%	4.54%	24.63%	3.35%	1.38%

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)

Absence Rate (rolling payperiods in the last 365 days)



		Absence Rate	19/20		20/21										
			12	13	1	2	3	4	5	6	7	8	9	10	11
		3.82%	5.05%	3.50%	4.28%	1.52%	0.95%	2.96%	6.11%	3.52%	2.02%	6.59%	8.07%	3.42%	0.81%
401.71.5109552	PRIMARY CARE NETWORK SOUTH COQ	2.03%	1.74%	4.90%	2.20%	0.00%	1.42%	2.25%	0.29%	1.76%	1.92%	4.59%	2.37%	3.41%	0.00%
401.71.5109553	PRIMARY CARE NETWORK POCO	4.90%	1.83%	2.09%	6.15%	0.87%	1.03%	1.30%	5.37%	1.12%	0.00%	12.12%	20.44%	6.43%	1.98%
401.71.5109554	PRIMARY CARE NETWK POMO/N.COQ	5.60%	18.49%	0.00%	12.19%	3.08%	0.99%	8.82%	2.15%	5.71%	0.00%	8.59%	2.67%	3.08%	2.81%
401.71.5109555	PRIMARY CARE NETWORK NEW WEST	4.24%	7.97%	4.56%	1.98%	3.84%	0.27%	3.24%	17.09%	7.35%	5.36%	2.95%	5.43%	1.06%	0.00%

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 the 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.

	Patient Counts										
	08/19	09/19	10/19	11/19	12/19	01/20	02/20	03/20		12/20	01/21
38010-38045 IMMUNIZATIONS			71%	59%	22%	2%	2%	3%		14%	15%
38060-38062 AND 38064-38065 MEDICATION INTERVENTIONS, MONITORING AND INFORMATION										1%	1%
38063 MEDICATION THERAPY			1%							1%	1%

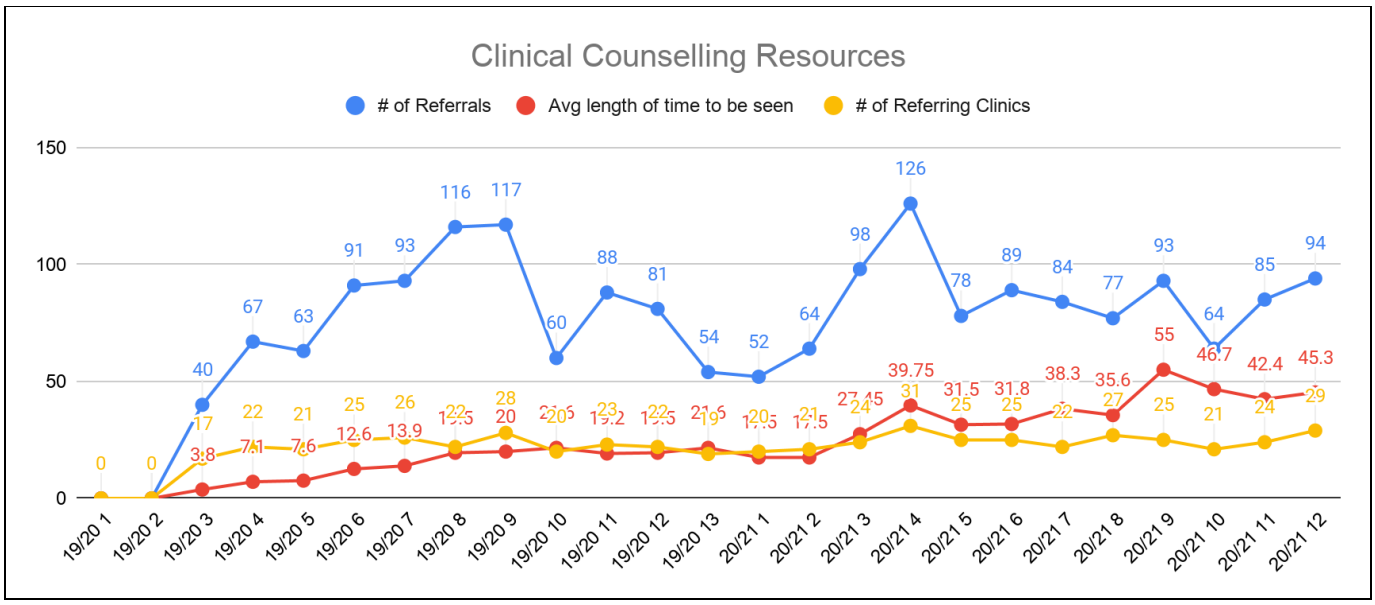
COORDINATION											
38070 NIPCP REQUESTING ADVICE FROM AN NP/GP										1%	1%
38117-38119 NIPCP PATIENT AND/OR BODY COMPOSITION ASSESSMENT		9%	6%	17%	11%		13%	8%		3%	2%
38125 NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT								3%		1%	1%
38130-38135 NIPCP CASE CONFERENCE/CASE MANAGEMENT/FAMILY CONFERENCE							1%	3%		1%	1%
38141-38155 NIPCP EDUCATION		5%	1%	2%	4%	2%	1%	4%		2%	2%
38160-38162 NIPCP INJECTIONS	3%		1%	2%	4%	8%	6%	5%		18%	11%
38168 NIPCP SYRINGING - EAR			1%	2%	4%	3%	3%	4%		3%	3%
38169-39170 NIPCP SUTURE/STAPLE REMOVAL/DRESSING CHANGE	3%	5%	1%	2%	4%	2%	1%	3%		3%	1%
38171 NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS							1%	3%		1%	1%
38172 NIPCP FOOT CARE										1%	1%
38174 NIPCP ASSISTING WITH PROCEDURES										1%	1%
38175 NIPCP WOUND CARE		5%		2%		2%	1%	3%		1%	1%
38180 NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER	3%	5%	1%					3%		3%	1%
38184 NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND	12%	11%	1%	2%	5%	2%	1%	3%		2%	1%
38185-38186 NIPCP TELEPHONE CONSULTATION/FOLLOW UP	47%	18%	4%	6%	12%	19%	5%	9%		8%	9%
38191-38192 NIPCP COUNSELING		5%				2%	1%	3%		1%	2%
38195 NIPCP VISIT - CHRONIC DISEASE MANAGEMENT						2%	4%	8%		3%	4%
38073 NIPCP GP REFERRAL TO NURSE										1%	
38188 NIPCP TELEPHONE CALL (PHARMACY)	3%							3%		1%	
39080-38085 NIPCP VISIT - IN OFFICE VISIT	27%	36%	11%	7%	35%	42%	50%	33%		30%	43%
38116 NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT						10%	7%	3%			
38165-38167 NIPCP GLUCOSE, PREGNANCY, URINE SCREENING						2%	1%			1%	
38173 NIPCP SUTURING MINOR LACERATIONS						2%					
38123 NIPCP COMMUNICABLE DISEASE FOLLOW UP										1%	
38176 NIPCP INR MANAGEMENT										1%	

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

The number of referrals, number of referring clinics and average length of time for patients to be seen for this reporting period increased while the number of patients seen and number of appointments scheduled slightly decreased when comparing numbers from the last reporting period. The table below details the change over the last period to the current period:

	Previous Period (P11)	Current Period (P12)	Difference
# of Referrals	85	94	↑
# of Referring Clinics	24	29	↑
Average length of time for patients to be seen (*days)*	42.4	45.3	↑
# of clients seen	163	154	↓
# of appointments scheduled	279	273	↓

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.



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:

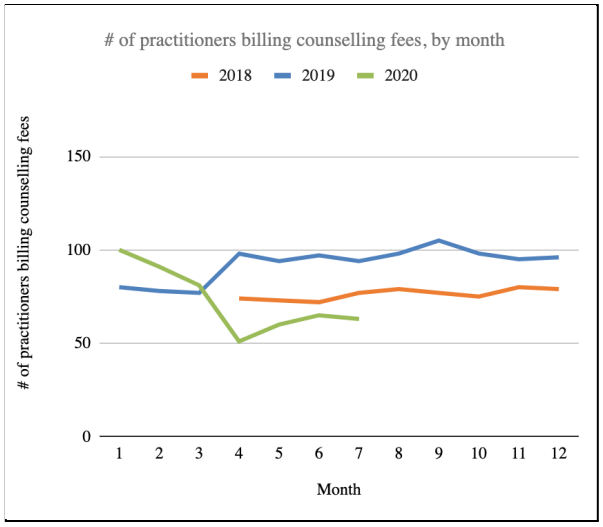
	Previous Period (P11)	Current Period (P12)	Difference
# of Referrals	90	87	↓
# of Referring Clinics	34	36	↑
Total current caseload	NA	183	-
# of appointments scheduled	NA	274	-

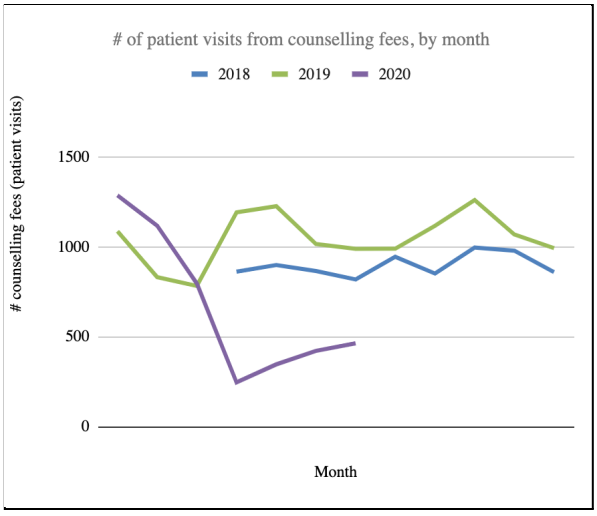
This resource is working closely alongside the other clinical counselling resources in the above section to support the demand for services, approximately 8% of the referrals for this period were from the other service provider.

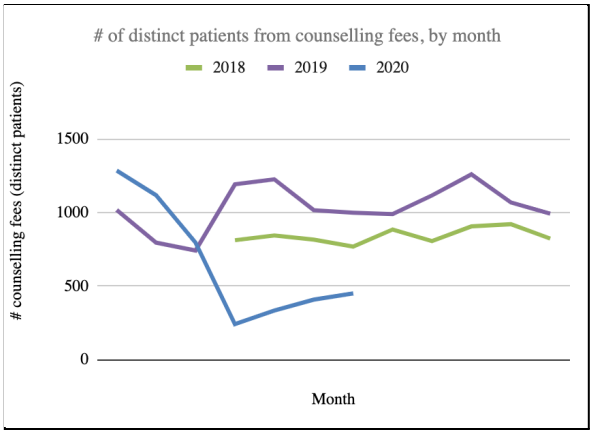
Mental Health Program Impact

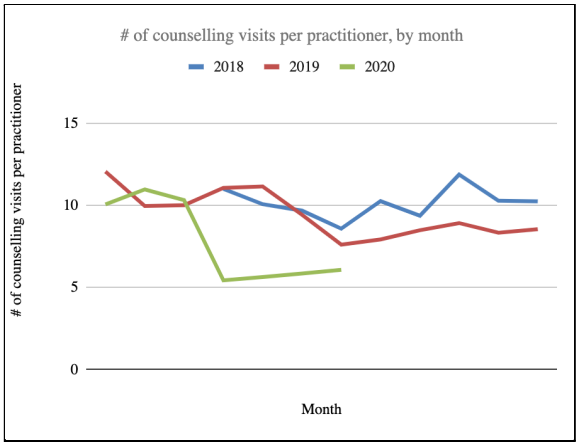
Through the co-development of these programs, the intention was to increase patient and physician access to rapid counselling supports given the high waitlist for existing community supports. This intent in turn decreases the burden in caring for these patients that is placed on family physicians which 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. 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
- The # of counselling visits/provider



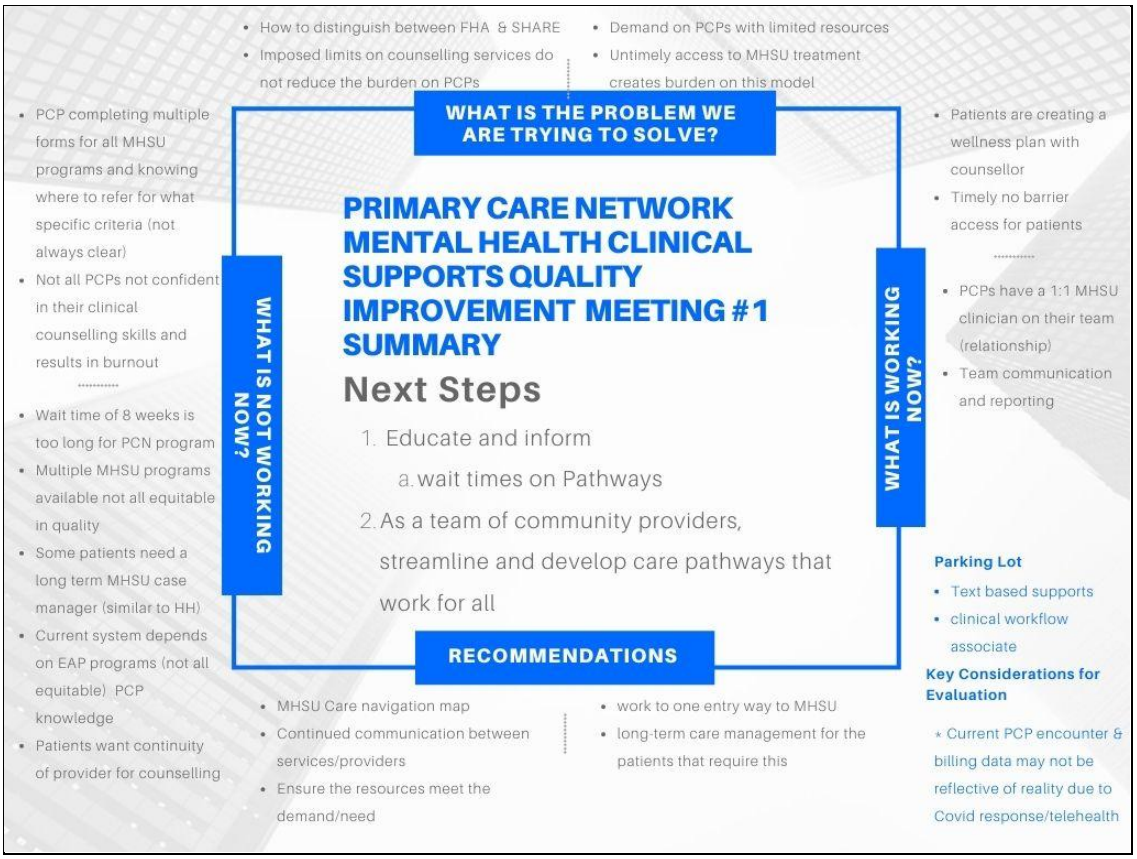






Mental Health Community Physician Engagement

In Period 12, the first PCN Mental Health Clinical Supports Quality Improvement meeting took place where representatives from both community support agencies, local family physicians and FHA and FNW Division support staff came together to engage in a discussion about ensuring continued access to patients in the community seeking support for mild to moderate mental health concerns. An overview of the discussion and identified next steps is shared below:



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.

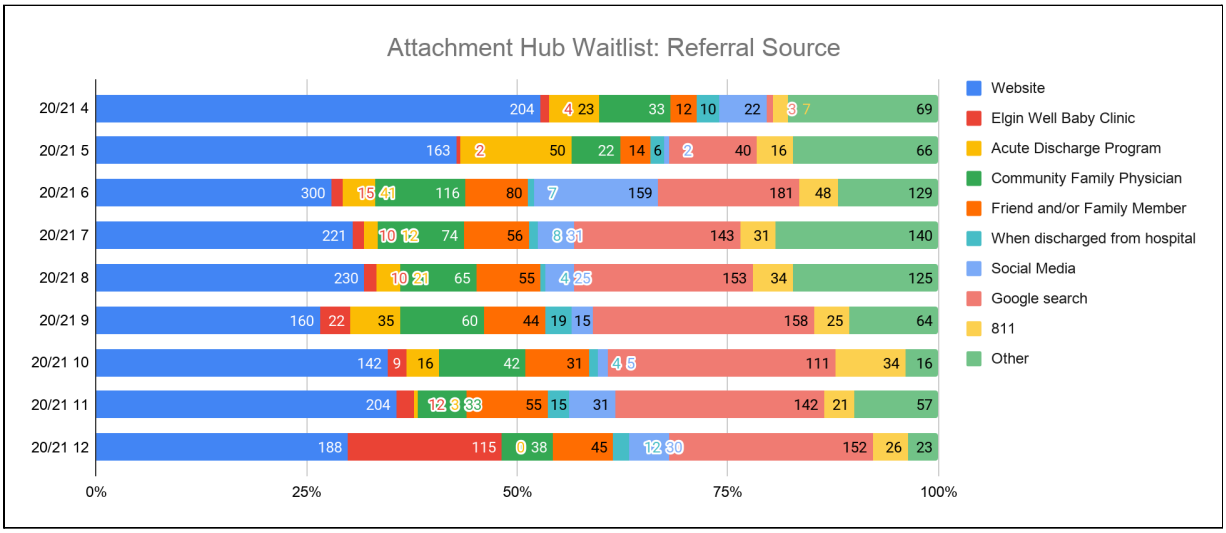
Attachment

Attachment Hub Waitlist

The FNW Division Attachment Coordinator continues to support the attachment between the public seeking a FP and family physicians 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)*	Total # of people attached
New Westminster	132	427
Port Moody	216	154
Coquitlam	108	818
Port Coquitlam	109	759

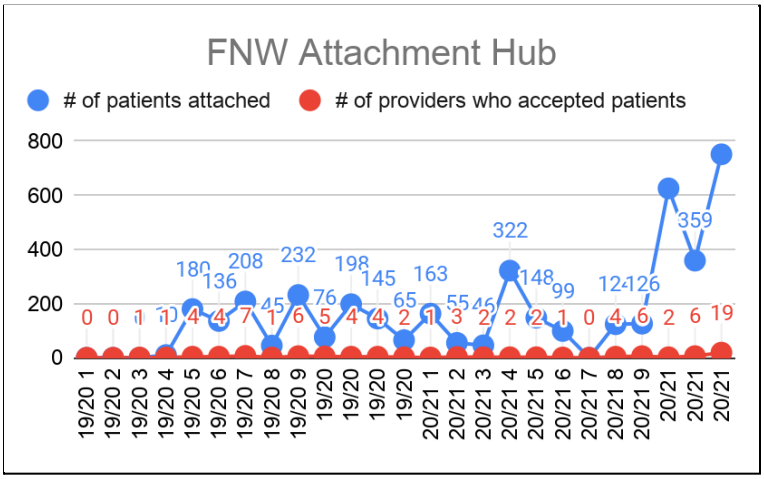
When people join the Attachment Hub Waitlist the referral source is also collected, below is a breakdown of the main referral sources by period since FY 20/21 Period 4 as a data is currently available for these periods:



Passive Attachment

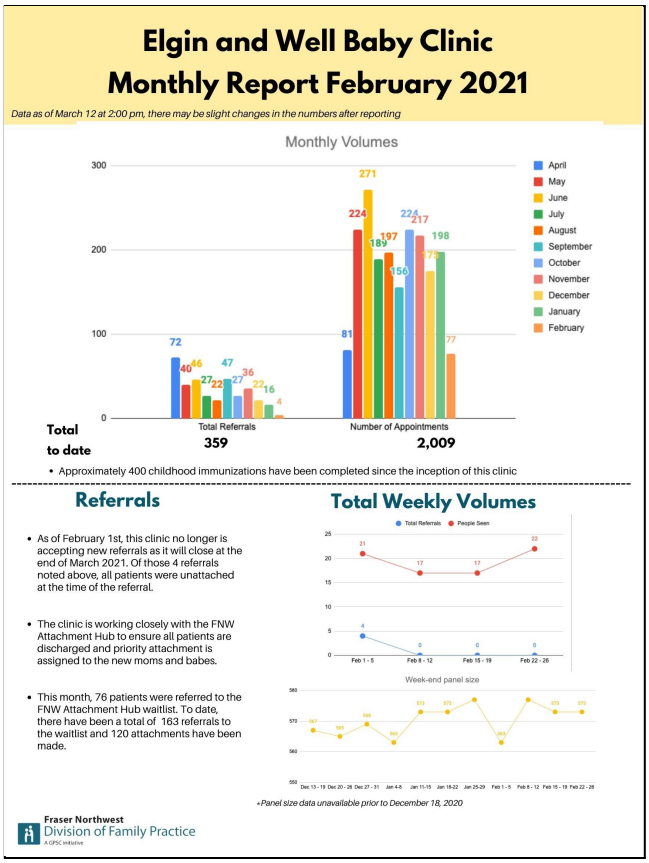
During this reporting period, the table below details a breakdown of the attachment work that took place by the Attachment Hub:

	New Westminster	South Coquitlam	Port Coquitlam	Port Moody, Anmore, Belcarra, North Coquitlam
# of providers who accepted patients	6	9	4	0
# of patients attached	46	457	249	0
# of people waitlisted	1787 *1.8% ↓ from P11*	1474 *2.1% ↑ from P11*	404 *2% ↑ from P11*	1036 *10.6% ↑ from P11*



Active Attachment

The FNW Virtual Hub (including the Acute Discharge program) referrals recently transitioned to the Tri-Cities Urgent & Primary Care Centre which opened on February 22nd to the public. Further reporting details on this in the section below; however, data specific to the Virtual Hub is included in the general U&PCC report. The FNW New Mom/Well Baby Clinic (stationed at a local clinic in Port Coquitlam) will close at the end of March 31st and work is underway to provide priority attachment to all unattached moms and babies seeking care in the FNW. The visual below reflects the New Mom/Well Baby program's February referral data:



Recently, referring providers from an acute site shared the following sentiment about the impacts of the acute discharge program and its transition to the U&PCC:

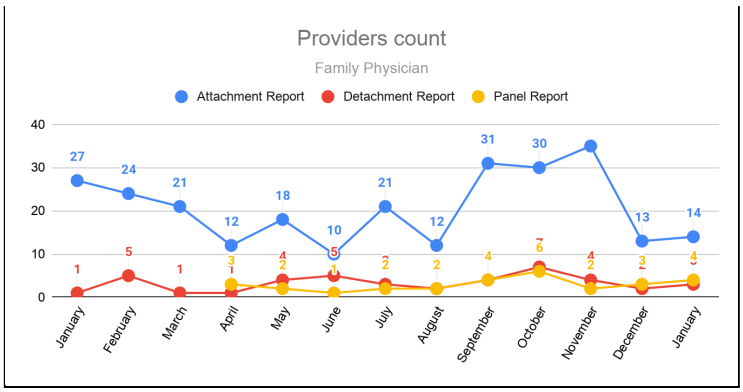
> *"The program is so great and I want to encourage others to keep doing it. I can't explain how much better my life is telling patients someone will call to follow up with you for this complicated issue compared to the old days of saying 'well good luck finding a gp or a walk in clinic.'"*

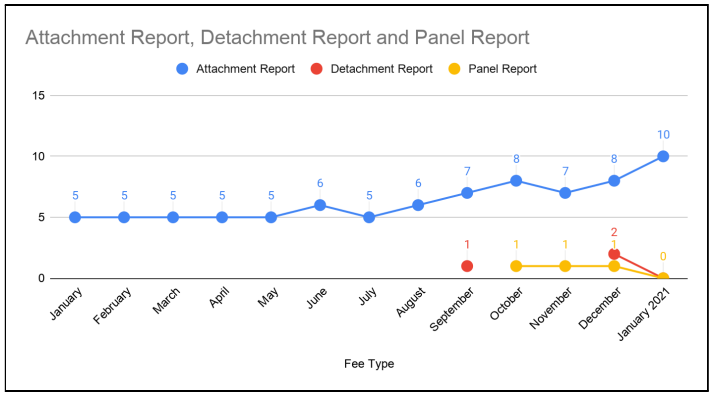
> *"I have utilized the Fraser Northwest Division of Family Practice for many of my clients over the past few months and with GREAT success and happiness for my clients! Medical office assistant, T was a huge help and deserves a lot of kudos for her efforts as she went above and beyond to assure my clients were looked after. I am often at ERH seeing clients and will come by the new clinic location to introduce myself soon. I worked at ERH for a number of years in every ward but, mostly the ED. I have wonderful relationships with staff there and am well connected in the ERH community. I look forward to working together to achieve health and wellness for my/our clients."*

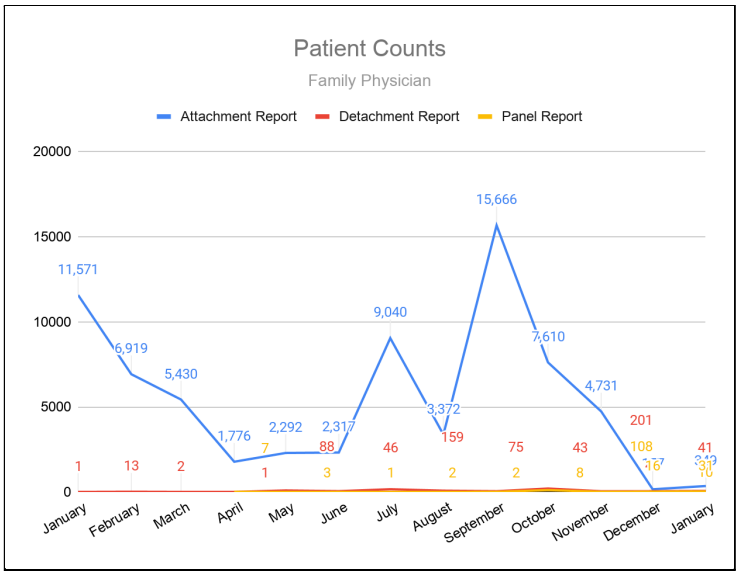
"I'm so glad that you've started this wonderful initiative and our patients have somewhere to go instead of getting lost in the void. It's been a tough year and the Acute Discharge program has undoubtedly made many lives that much better."

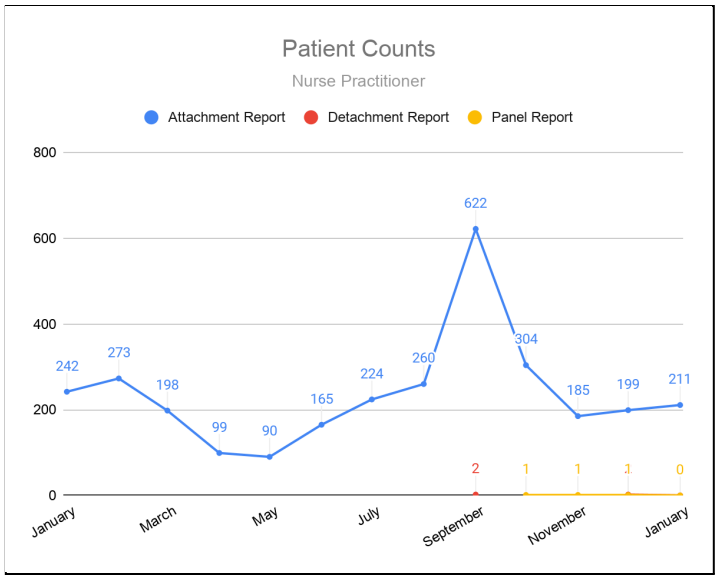
Attachment Coding (MoH)

Attachment data from the MoH has recently become available providing 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):









Urgent & Primary Care Centre: Tri-Cities

On February 22nd, 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 12
# of In-person patient visits	25
# of virtual patient visits	24
Avg visits/day	3
% of visits by unattached patients	68%
% of visits by seniors (aged 65+)	12.5%
# of new attachments	1
Total # of attachments	1

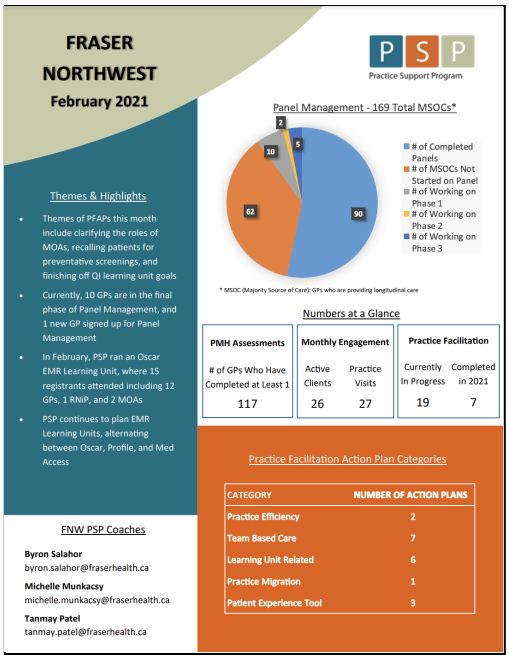
Work is underway between partner organizations to expand the reporting indicators based on feedback from Physician Leadership in the community.

A Physician working at the U&PCC highlighted the importance of access to patient medical records when patients are unable to connect with their primary care provider due to after-hours access. Simplified access of patient medical records for Physicians at the U&PCC allows for a coordinated and collaborative care approach for the patient seeking care.

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



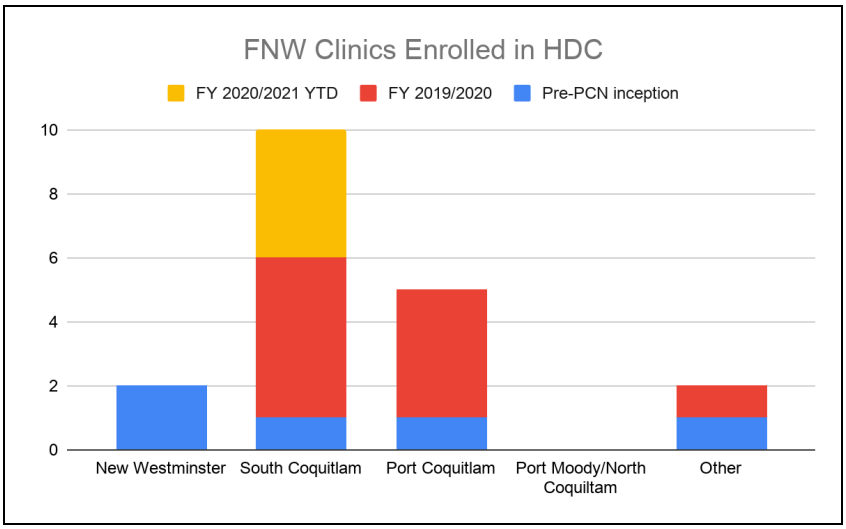
Below is the month over month comparison from the previous report shared:

	# 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 (January)	172	117	62%	53%	107	9	1	5	92

Current month (February)	169	117	63%	53%	107	10	2	5	90
Change	↓	=	↑	=	=	↑	↑	=	↓

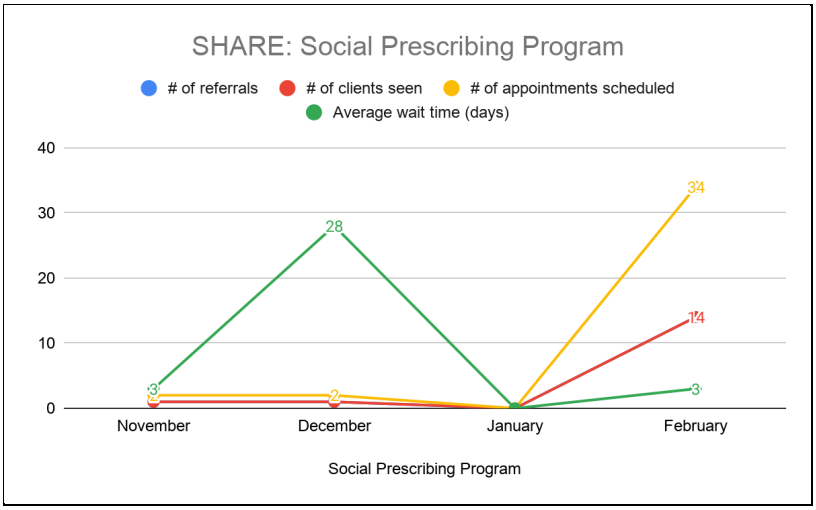
Health Data Coalition (HDC)

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.



Social Prescribing: CARES Program

CARES (Community Actions and Resources Empowering Seniors) is a primary care Frailty management program that helps primary care providers support their patients to prevent further frailty. In the FNW this social prescribing program to SHARE Society launched in November 2020. Below is the referral data since this program launched. The increase in wait time in December was subject to the holiday closures and the referral was immediately followed up on after the agency reopened.

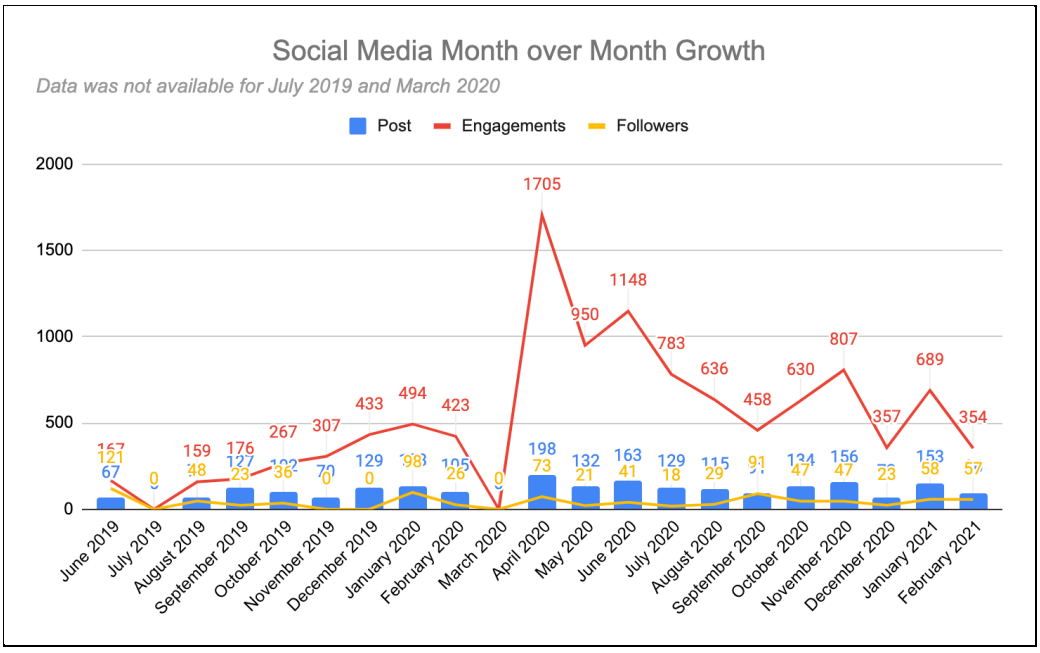


Feedback from the Community

Preliminary 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.

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 February 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)	+96	354	+57



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 January the subscribers grew by approximately 1800% to a month end total of 3285 subscribers. Newsletter subscribers are coming from the following sources:

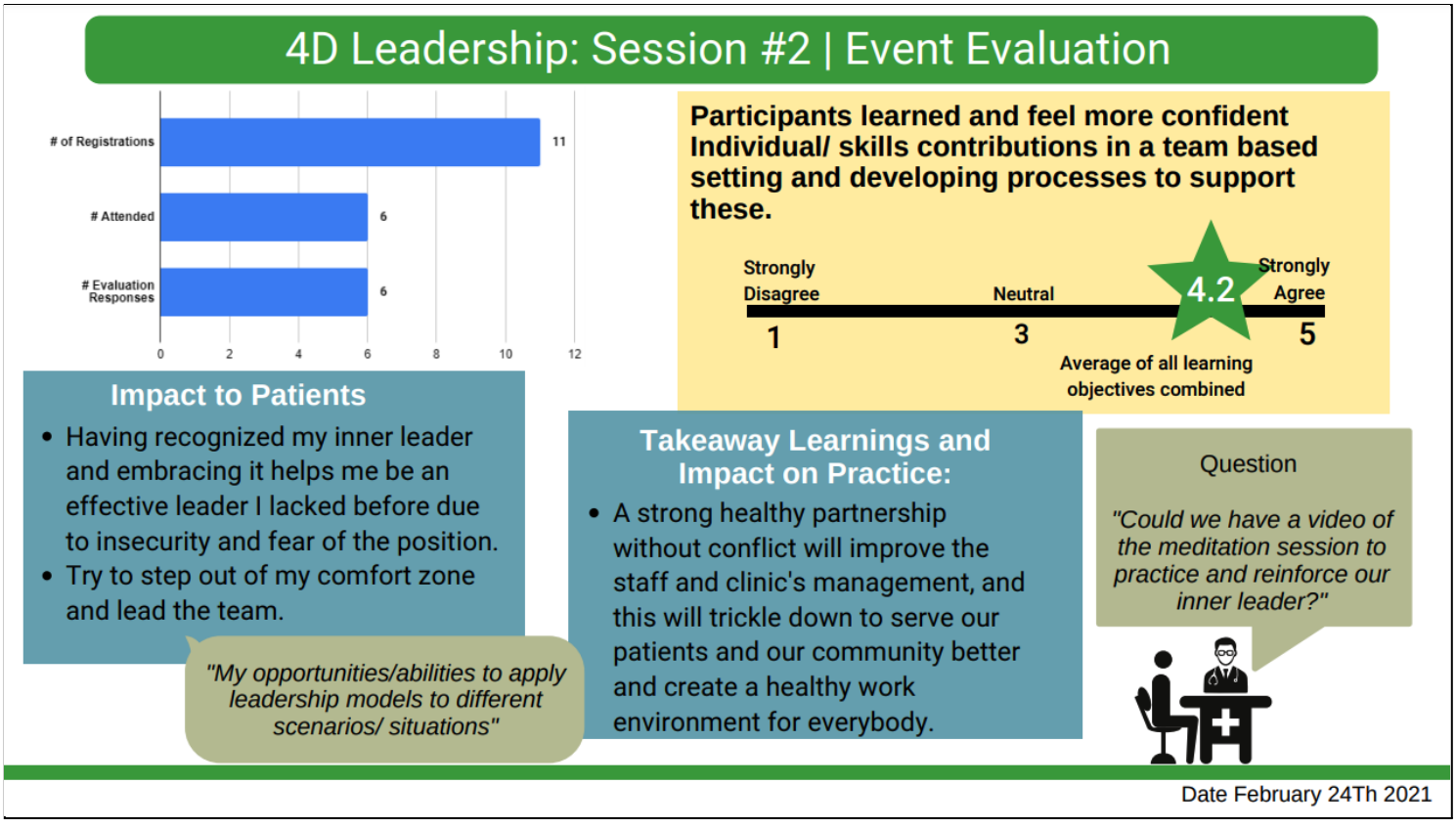
- 2k from FNW Attachment Hub
- 1K from FNW Community Influenza clinica
- The remaining subscribers came from a combination of public survey interest, the Virtual Hub, and clinic and/or FNW website signups.

Physician Feedback and Engagement

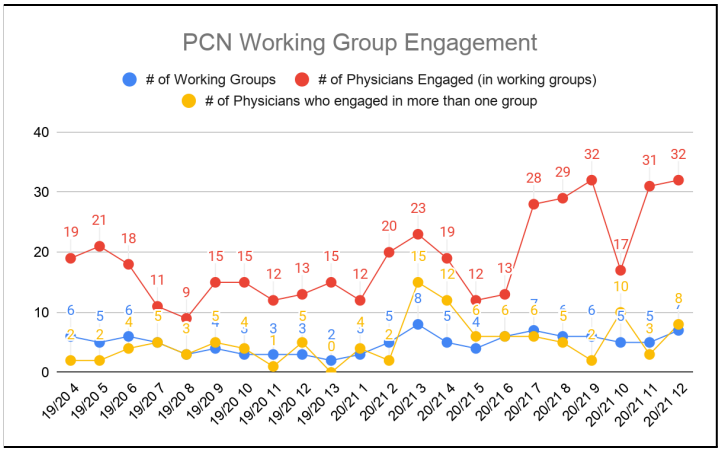
A Physician shared an experience around the impacts of supporting a patient in an Advance Care Planning conversation that is a reflection of the impacts that patients can have on Family Physicians and the importance of building relationships to support longitudinal primary care:

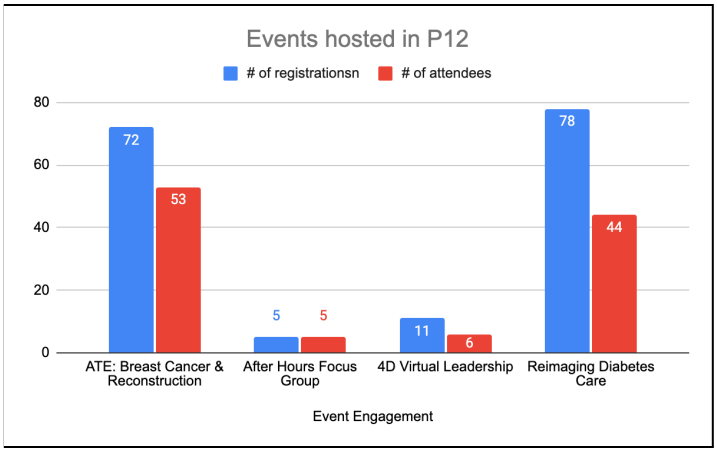
"I saw a 74 yo male today who was concerned about worsening cognition… He needed a baseline mental state exam, and then we delved into advance care planning. That was the bulk of our 45 min visit. And we aren't even finished yet as he has "homework" to do... When the task is complete, I will probably save the system $1000's at the "end of life" stage of his care....I heard a very fascinating life story from this patient, and will be sure to meet his needs, as his life situation changes going forward. Guess you can't really put a price on that."

Feedback from physicians taking part in a Leadership training cohort identified how important team based care and physician leadership are. The visual below details the summarized feedback from the event:

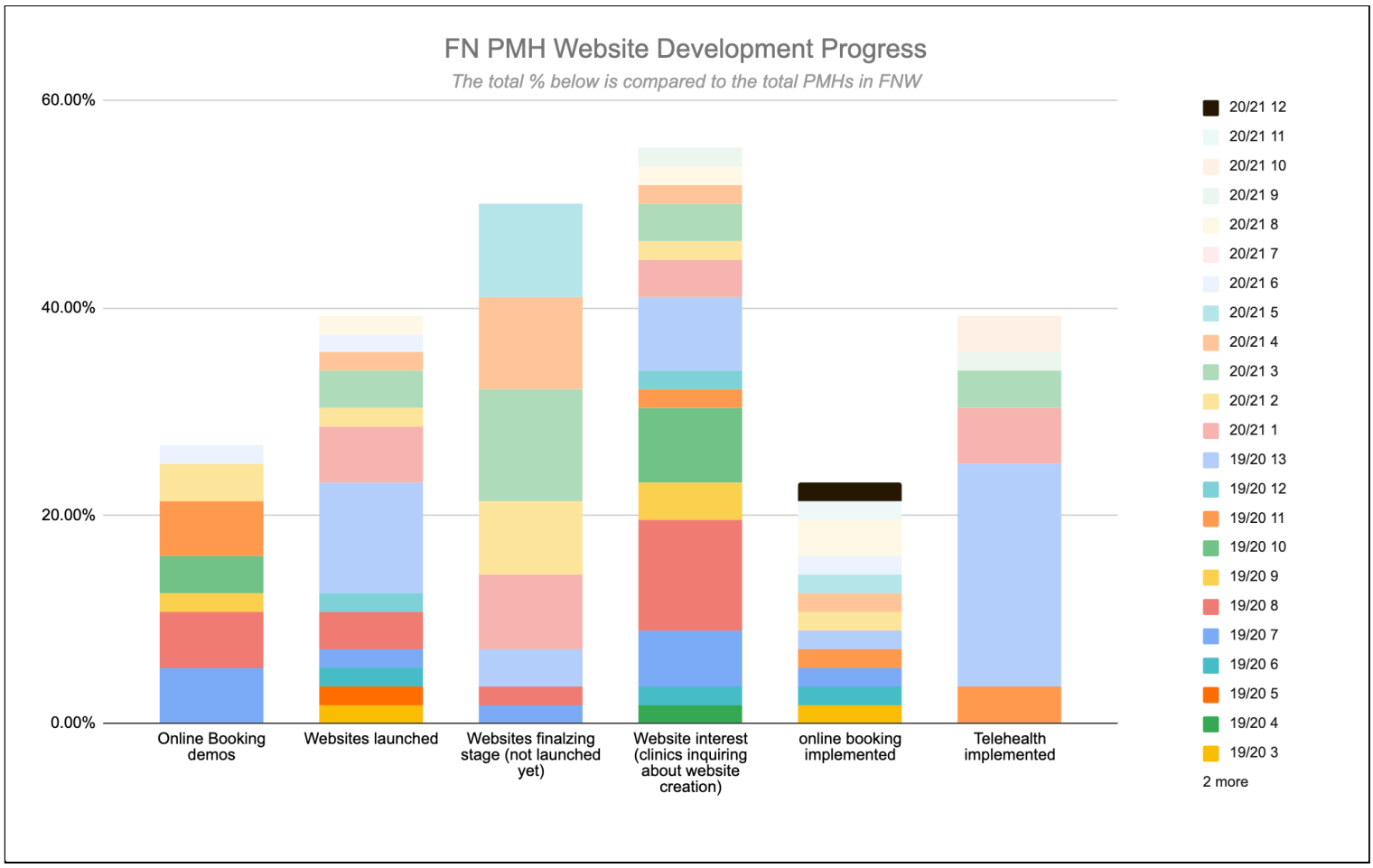


Physician engagement for this reporting period includes:

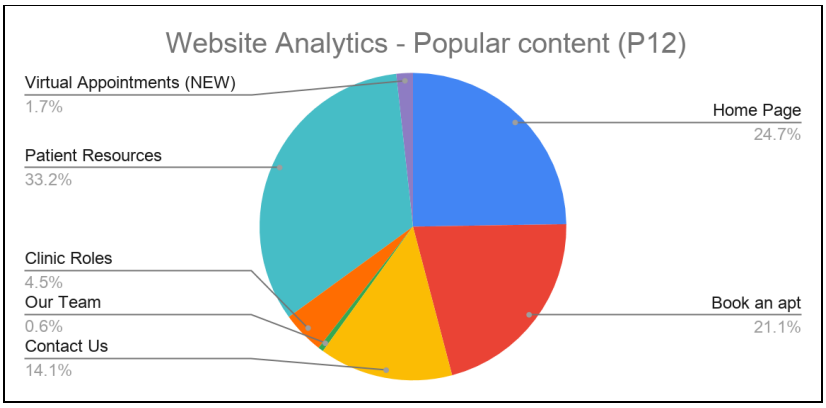




Additional engagement support provided to FNW physicians is the website development. The move to providing primary care services in a virtual setting continues to grow and expand. A full list of the clinics in the FNW and their associated websites can be found by clicking here. The chart below details the main steps in clinic website developments period by period as a comparison to the total PMHs in the FNW.

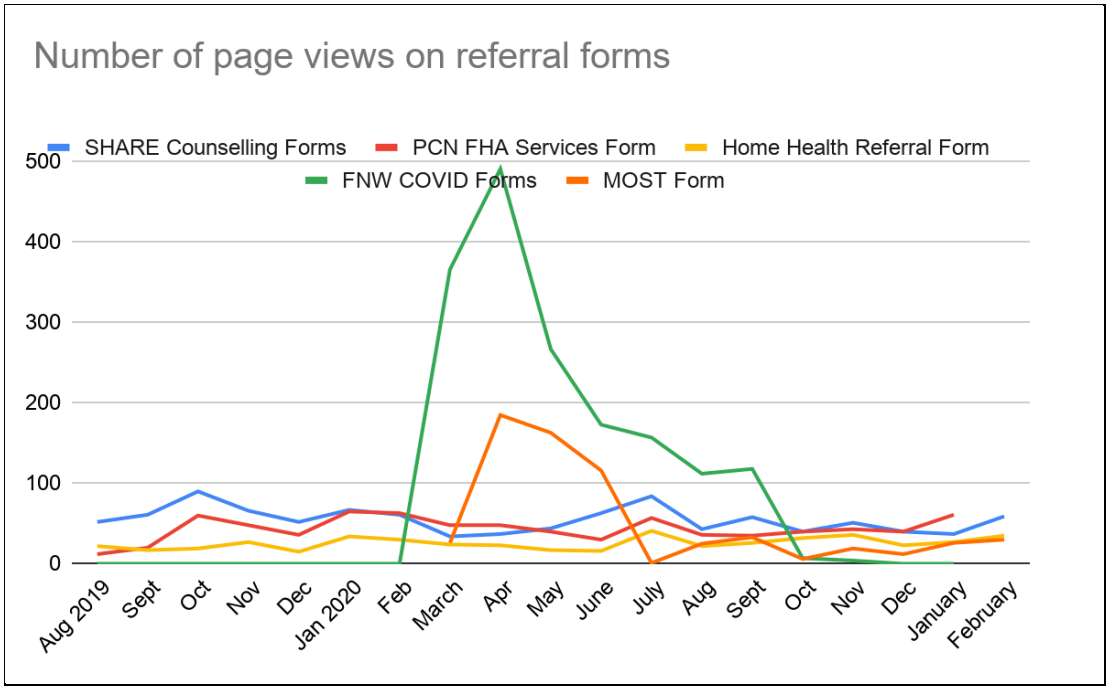


Website analytics that looks at the total page views and visits from the public on popular links from each clinic website and approximately 21.1% of the total 'clicks' were on Booking an Appointment.



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. ***New***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.
2. ***New***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.
3. 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.
4. For FNW PMHs to be eligible for in-practice allied health support, all members of the PMH must be a member of the Division.
5. Work is underway between partner organizations to develop and identify information required to set up Clinic Payee information as it relates to RN in Practice encounter code reporting.