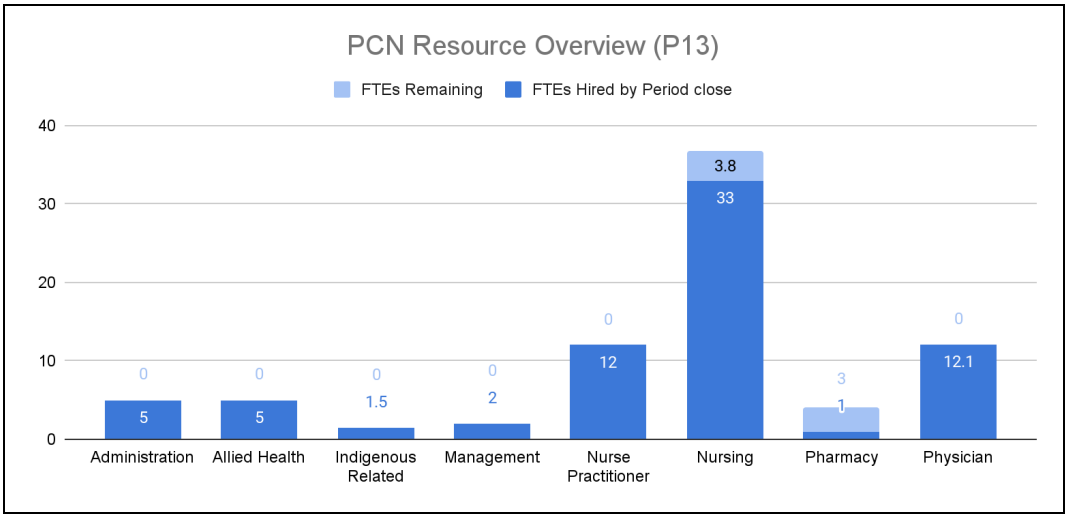
Fraser Northwest Primary Care Network

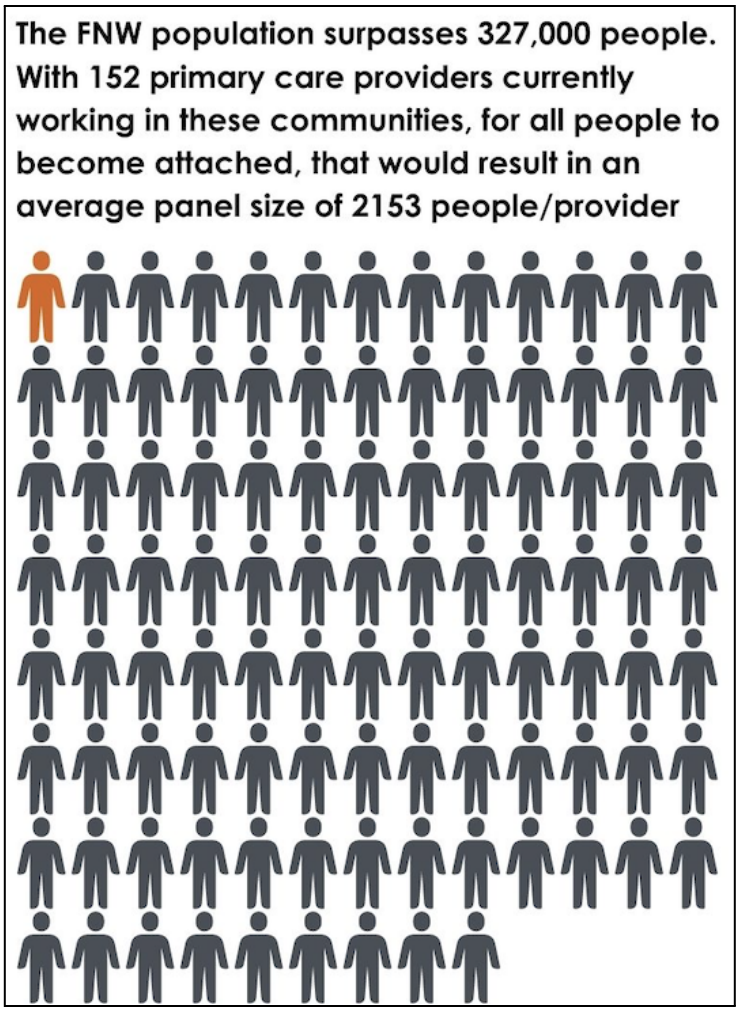
Period 13 Addendum Report



Patient Medical Home Snapshot

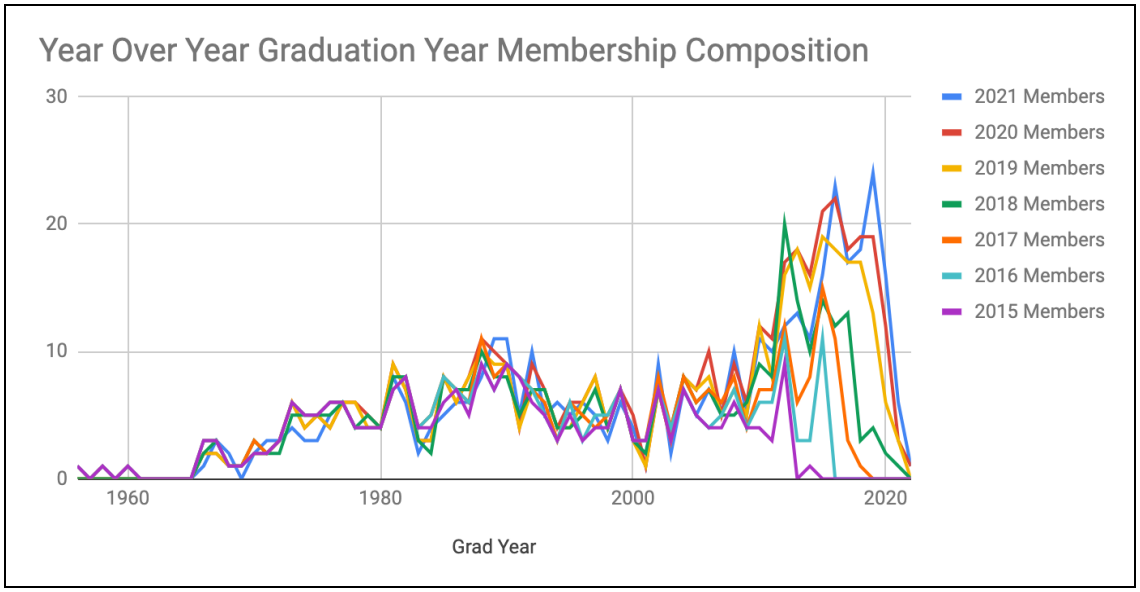
Provider Types	# in FNW
FFS Longitudinal Family Physician	152
PCN funded FP	12
PCN funded NP	12
Community NP	23

PMH Types	# in FNW
Family Practice	29
Hybrid (FP/Walk-in)	21
Walk-in	2
Community Services	4
U&PCC	1

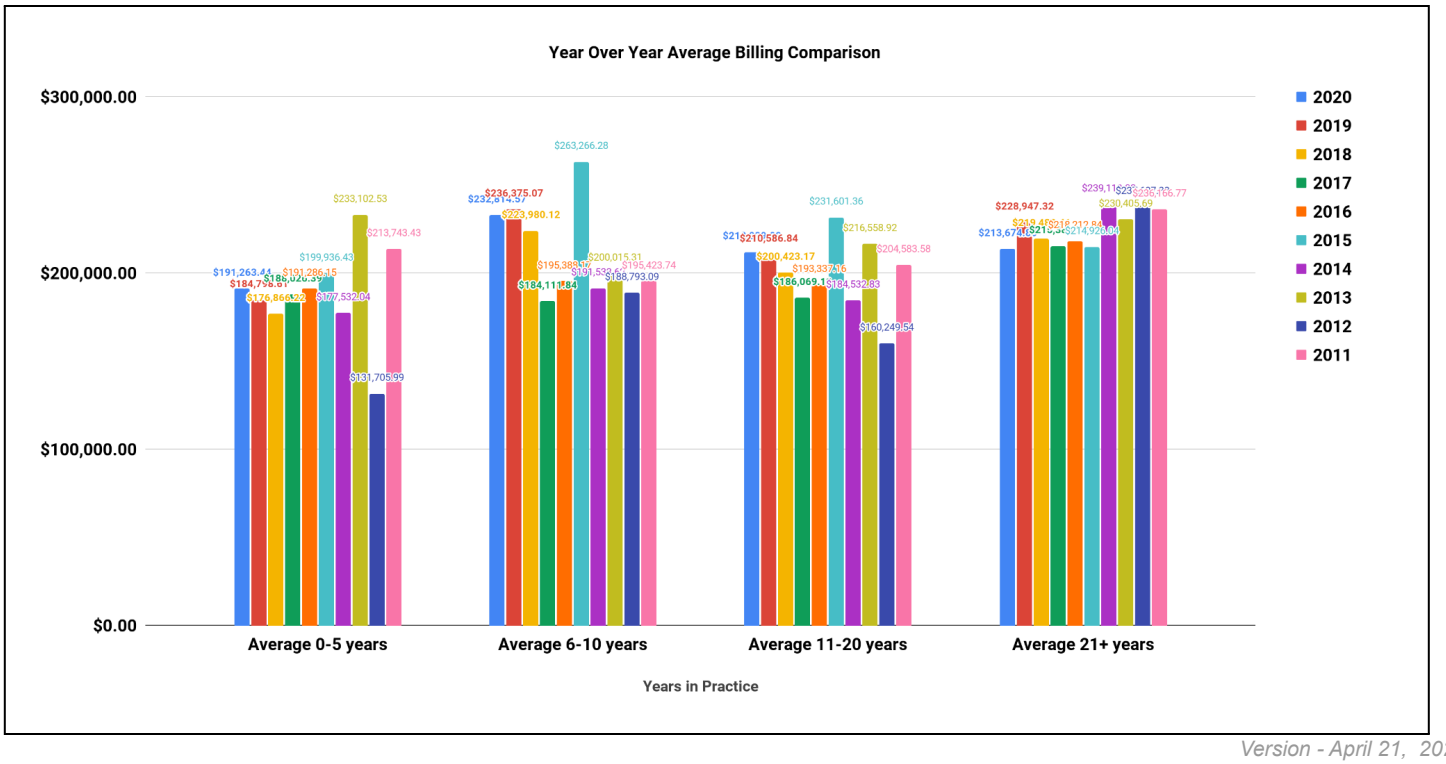


FNW Community Overview

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.

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	3	**-16 providers since PCN inception**
Provider Losses	27	13	15	12	
Net Loss/Gain	-15	+5	+3	-9	
# of Patients attached through *FNW Attachment Hub*	856	2792	6783	1023	
# of Patients registered through the FNW Attachment Hub	NA	5564	8677	3017	
MoH $0 Fee Code Attachment	NA*	73,742	6980	1573	

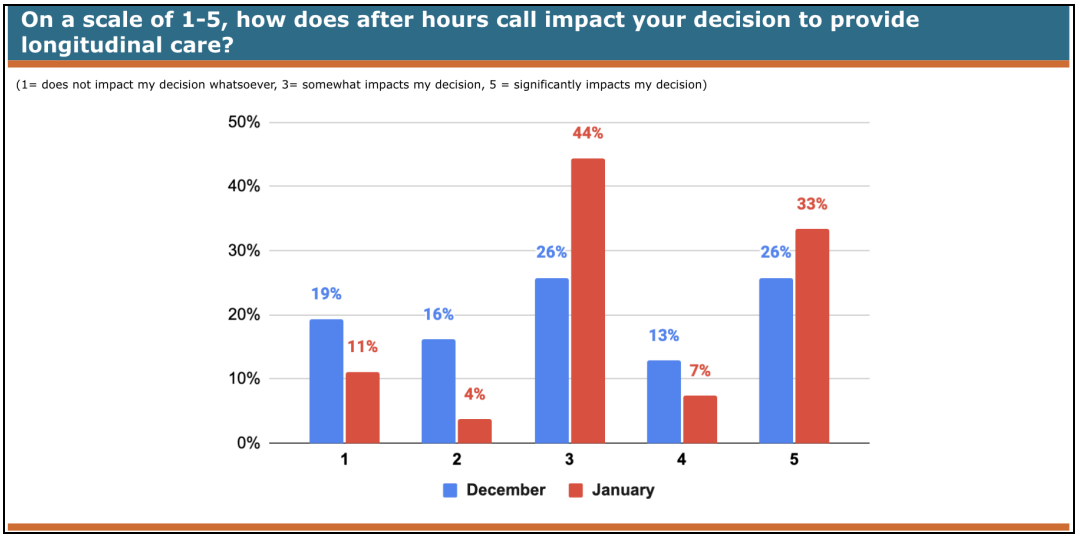
**MoH Data not available for 2019*

There are approximately 10 longitudinal Primary Care Providers set to retire or leave Family Practice in 2022. 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.

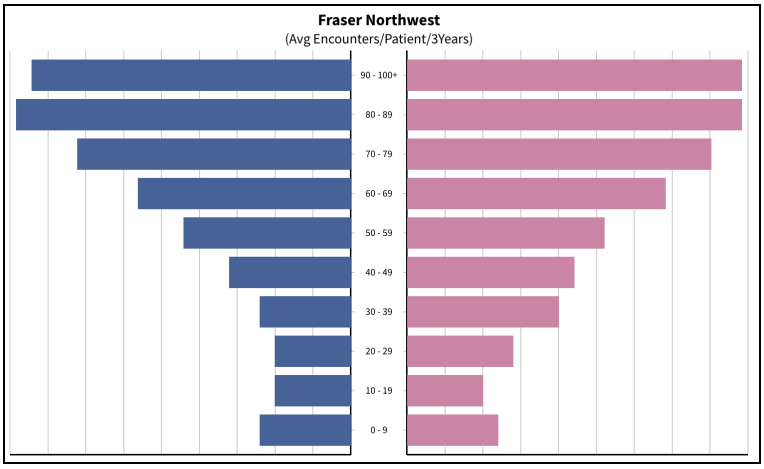


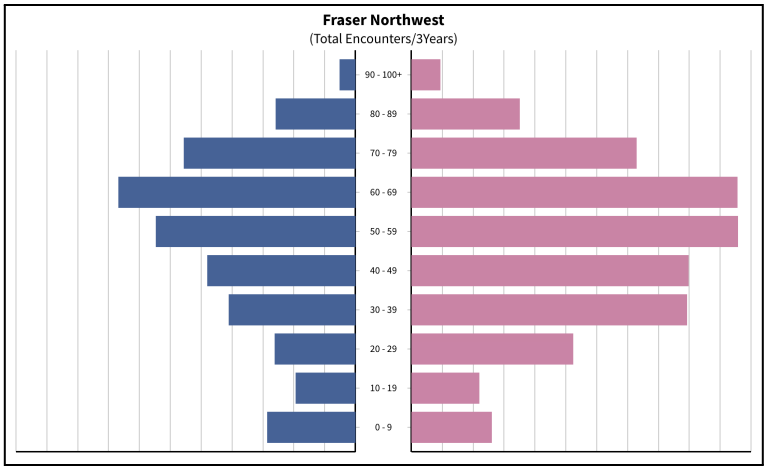
Despite high demand, Locum availability is limited in the community. In February 2022, data has been collected to document the number of locum opportunities currently available in the community, including vacancies and filled

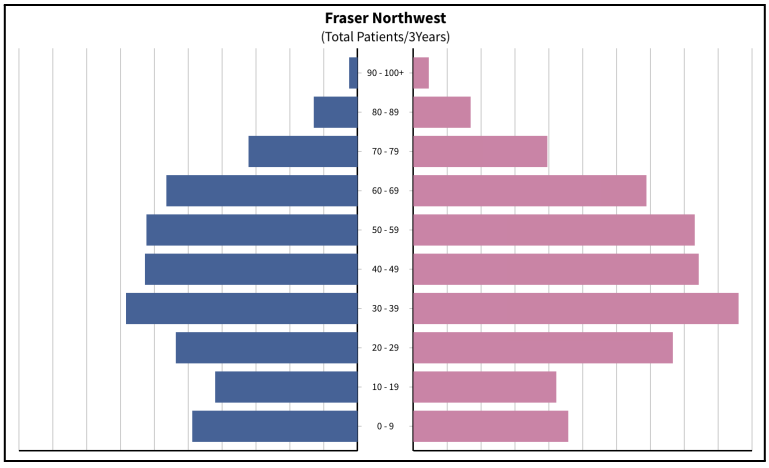
vacancies and unfilled positions. In Period 13, vacancies remained consistent for most of the period at 18 and decreased to 16 by period close. The decrease was due to one vacancy being successfully filled.

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:







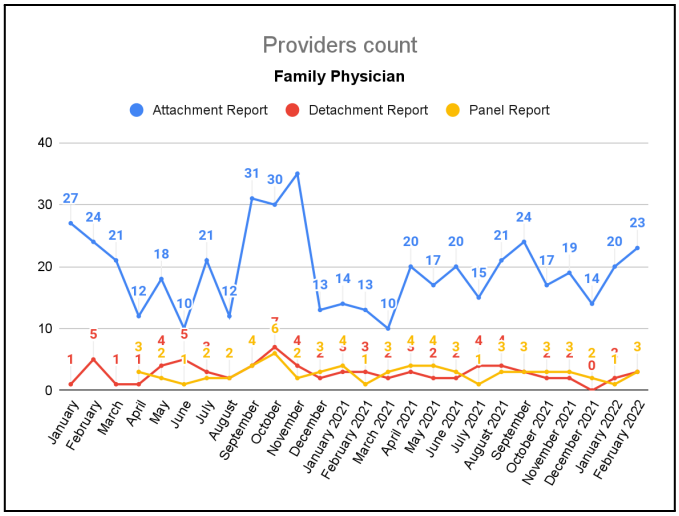
Attachment

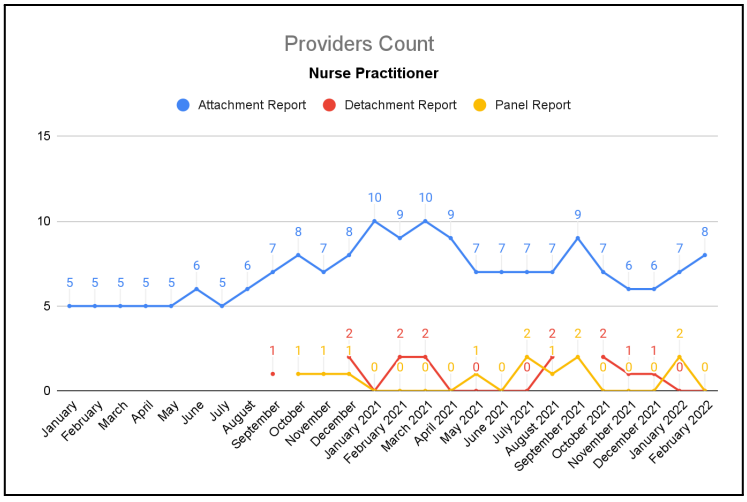
Measuring true attachment continues to be a conversation at all stakeholder and partner organization levels. Attachment level data through the use of the 0$ fee code provides a distinction between types of providers and patient counts. A challenge with implementing support for all PMHs to incorporate 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.

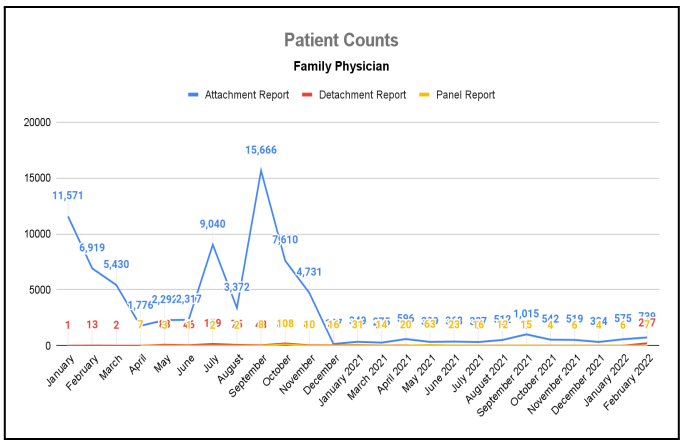
In tandem with the 0$ fee code, the FNW Division has an internal Attachment Hub mechanism which supports patients in the FNW seeking a primary care provider to be attached to primary care providers accepting new patients in the FNW communities.

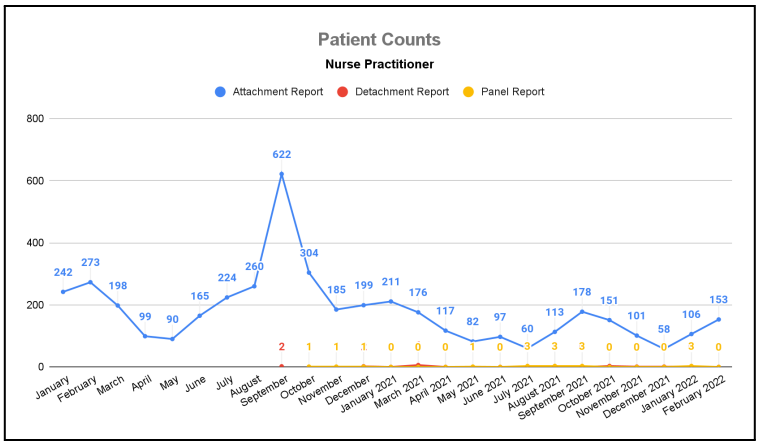
Attachment Coding (MoH)

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):









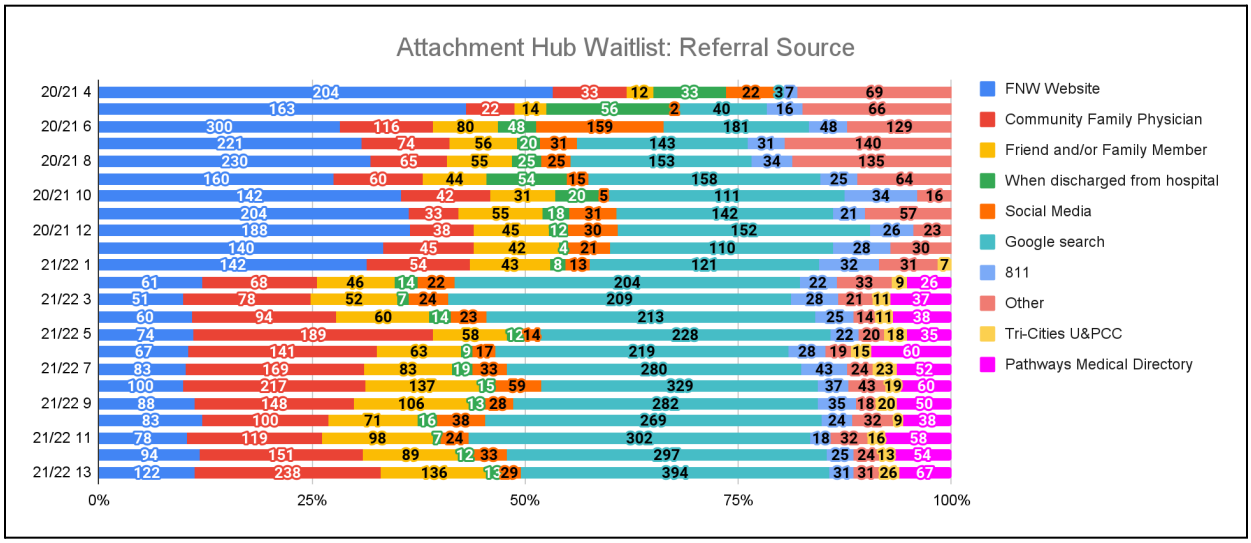
FNW Attachment Hub Waitlist

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

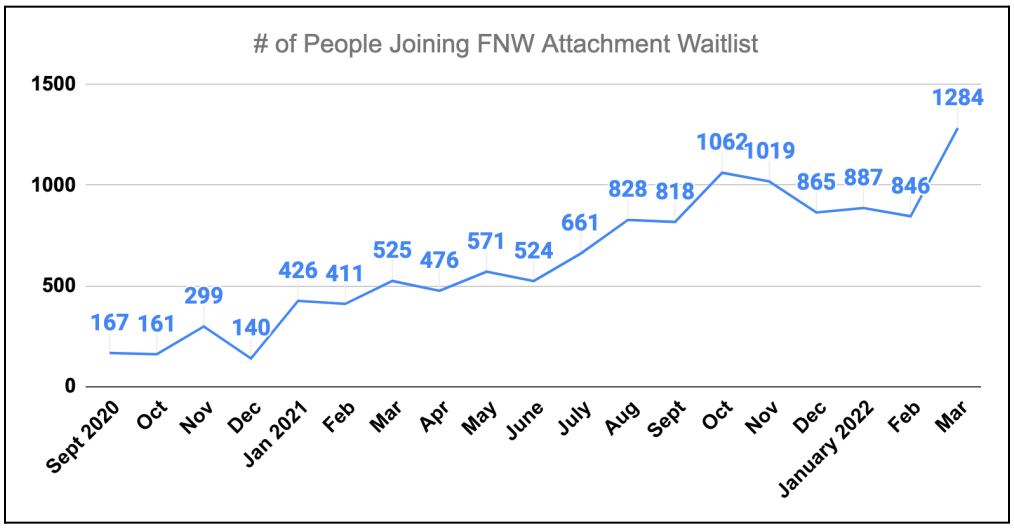
dedicated resource to the community in Summer 2019, the waitlist for patients continues to grow and recent data provides an indication of the average wait time of those who have been attached broken down by community:

Community	**Average Wait Time (*days*)**
New Westminster	191
Port Moody	244
Coquitlam	174
Port Coquitlam	103

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:

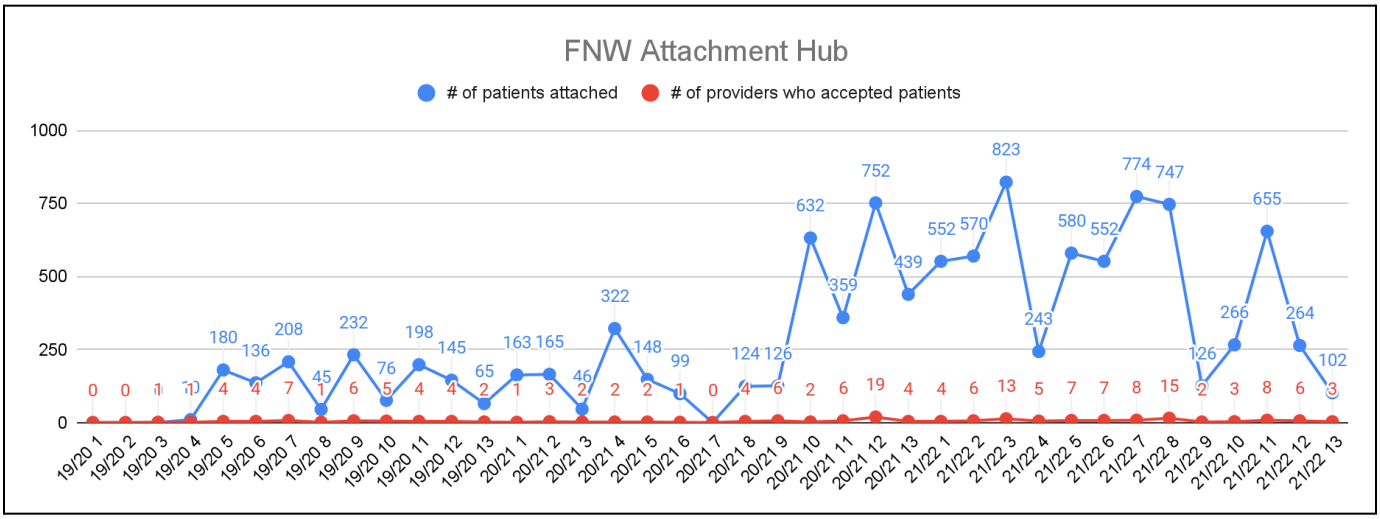


Month over month, the demand to find a longitudinal primary care provider by members of the FNW communities continues to grow. Since Fall 2020, data has been collected to reflect the month over month increase in attachment requests. The table below reflects the ongoing need and high demand for primary 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	0	2	1	0
# of patients attached	94	4	0	4
Total Attachments to date	**10,687**			
# of people waitlisted	2373 ***9% ↑ from P11***	2747 ***7% ↑ from P11***	156 ***53% ↑ from P11***	1745 ***4% ↑ from P11***
Total people waiting to be attached	**6490**			



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.

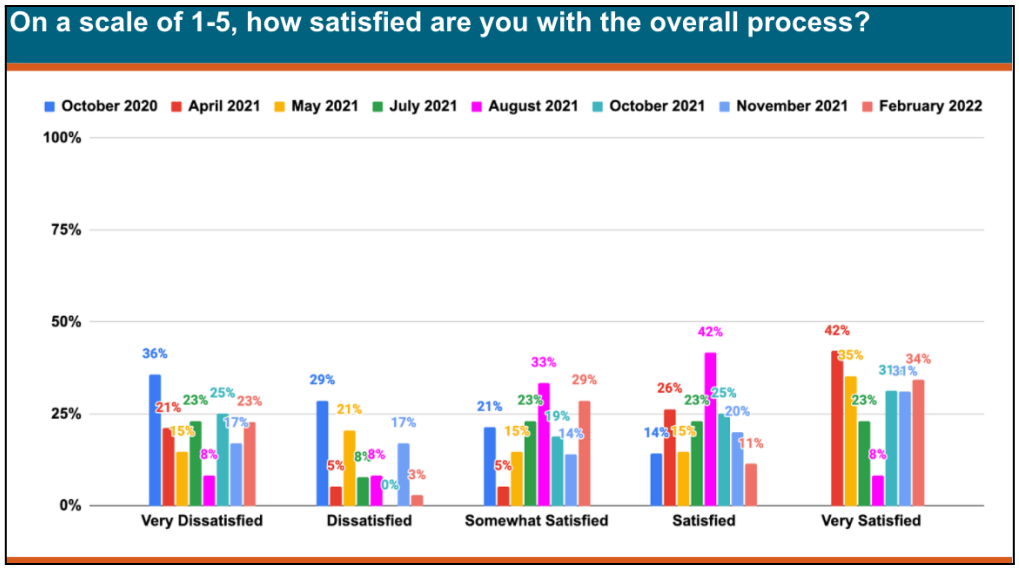
Patient Impacts: Impact of Unattachment

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.

> *A patient who was recently attached to a primary care provider noted the impacts of communication. After being attached, they noted not having heard from the clinic and mentioned their need to speak with their primary care provider to provide accurate dosage for their existing mental health concerns.*
>
> *Patients receiving letters from their existing providers that note that the provider is no longer practicing (i.e. retiring, moving, closing the clinic) can result in distress as patients and their families begin the search for a new provider.*
>
> *A patient who was attached to a provider, but also wasn't contacted by the attaching provider noted the importance of the immediate contact given ongoing health related testing that this patient requires.*
>
> *A patient and their family sought care elsewhere from their primary care provider as they weren't satisfied with the care; upon seeking support elsewhere, they were directed that because they currently have a provider, they were unable to see another one. This reflects the difficulty and **importance** in finding a primary care provider where patients and their families feel safe, and a part of their health care journey.*

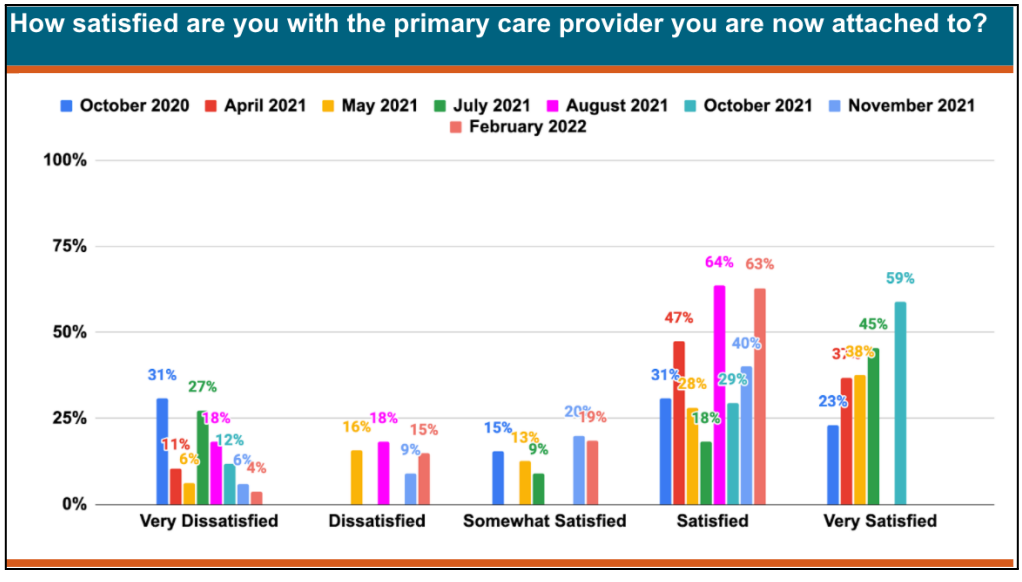
Patients who previously had a primary care provider and are now unattached also may have ongoing health concerns and needs which may be complex to support through alternative means of access such as walk-in clinics, the U&PCC and telehealth. Examples of these include patients who have chronic pain needs 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.

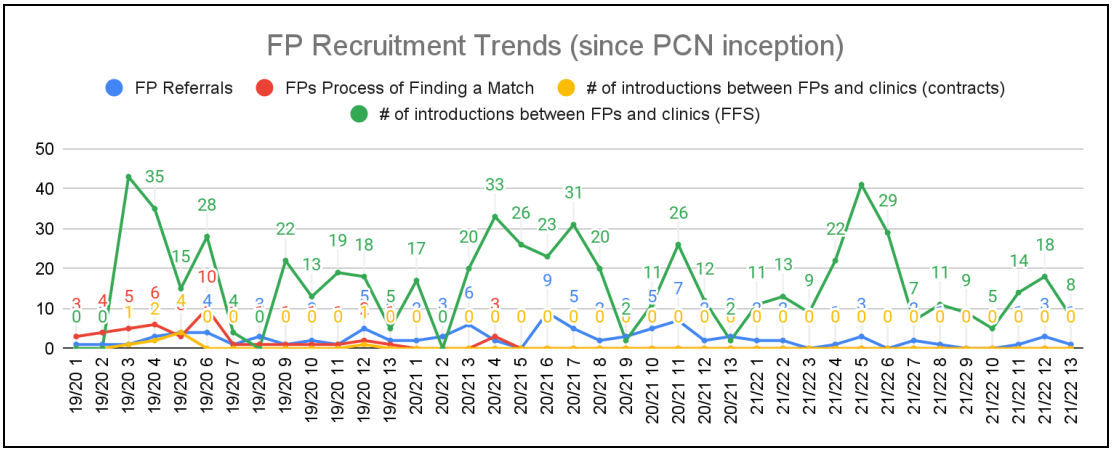


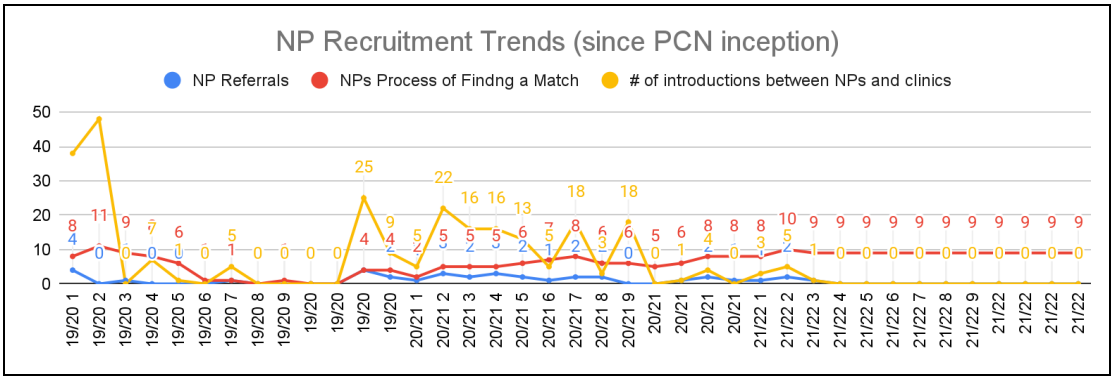
Patient feedback stories such as the ones shared above will continue to be collected and shared through this report as well as work is underway to establish a reporting metric on the number of patients who return for re-attachment.

Family Physician and Nurse Practitioner Contracts

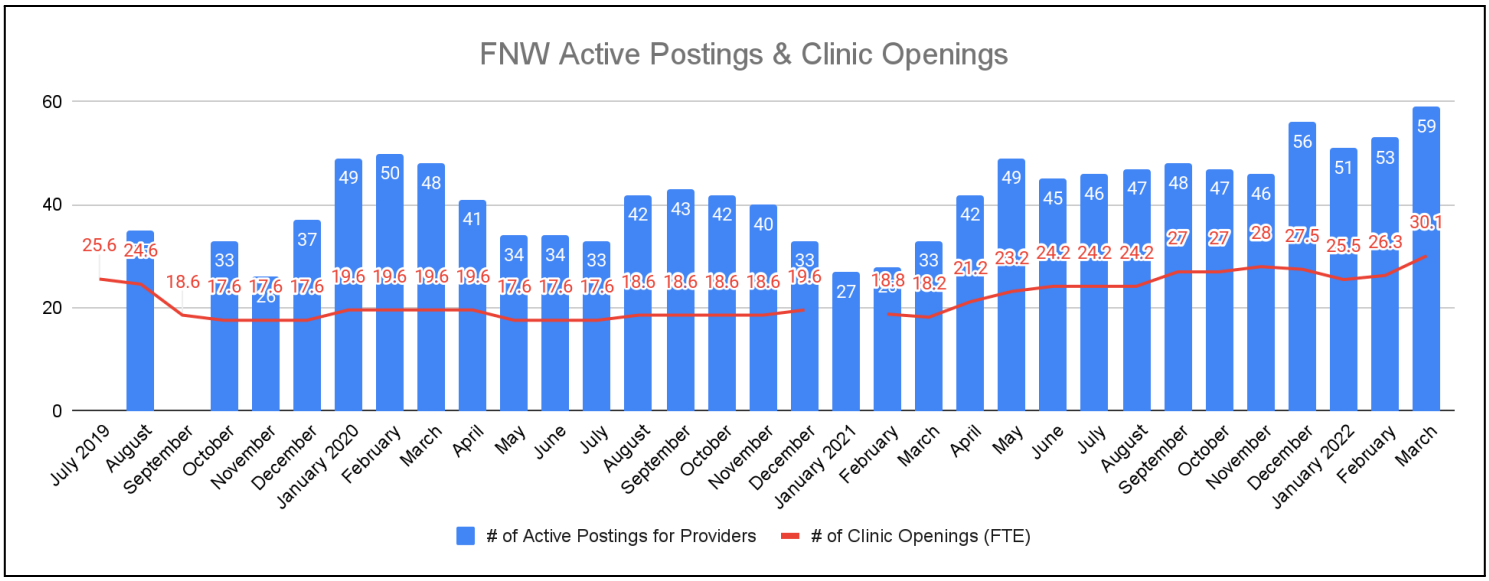
Collaborative work between the FNW, FHA, HealthMatch and the Ministry of Health is vital in order to support increased FP and NP resources in the FNW communities. Table 1 below provides a status overview and update on the breakdown of the NP and FP contracts by PCN within the FNW:

	Referrals		# of introductions between provider and clinics (*FFS & Contract)*	# of contracts signed
	# of New Referrals	Running Total of Referrals since PCN Launch		
Family Physician	1	104	8	0 Current PCN contracts: 12
Nurse Practitioners	0	46	0	0 Current PCN contracts: 12

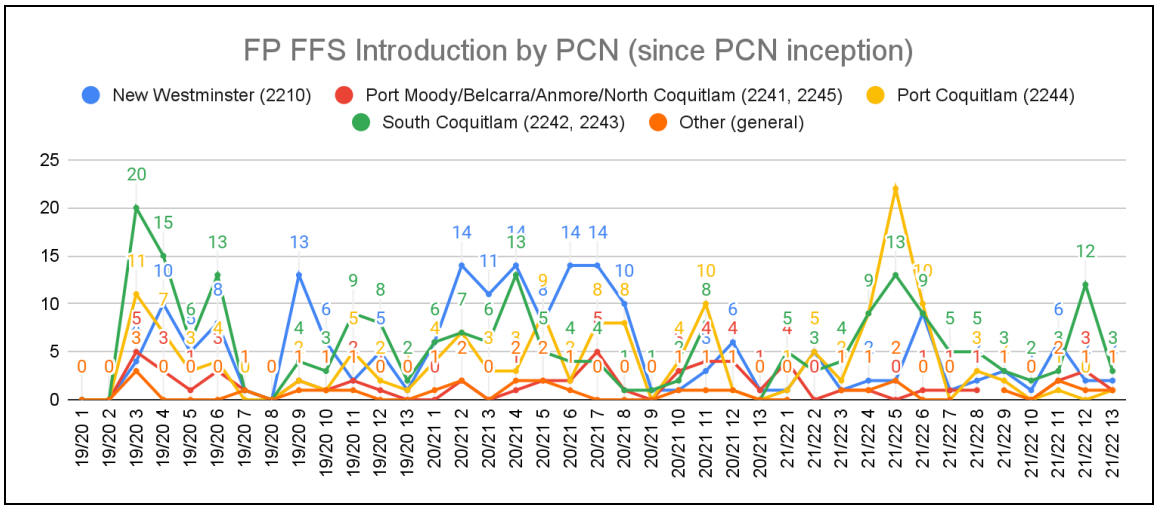




The number of active postings on HealthMatch BC for FPs for both FFS or contract positions increased to 59 active postings by period close. Opportunities for these postings include: locum and permanent part-time and permanent full-time in the FNW. The table below shows the overall number of active postings and clinic openings available in the FNW communities since data tracking began in July 2019.

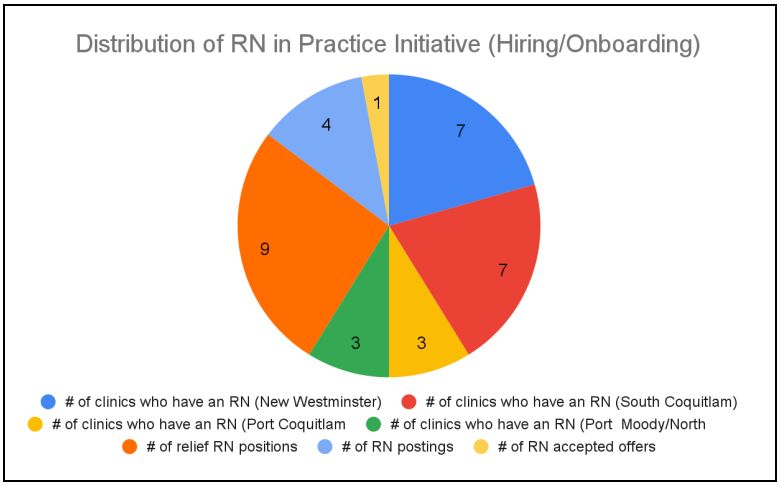


Fee For Service (FFS) opportunities and engagement efforts are underway on an ongoing basis and in this period, there were 8 new introductions between FPs and practices for FFS opportunities such as locum, permanent part-time and permanent full-time.

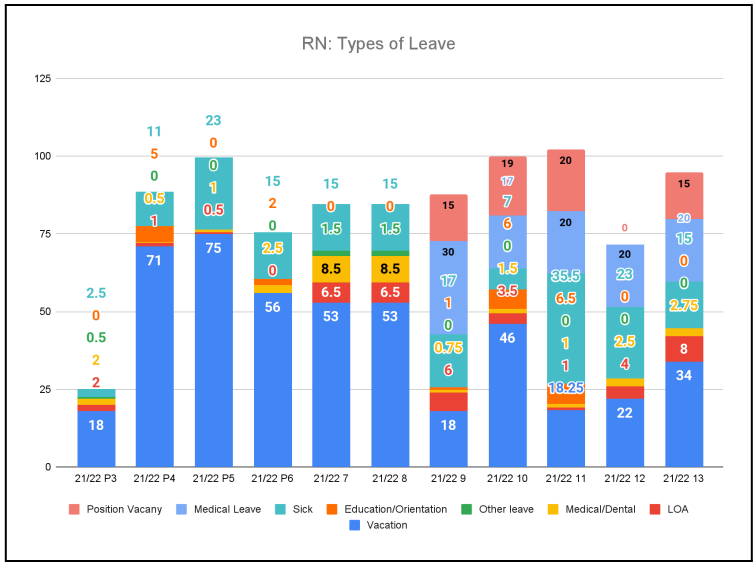


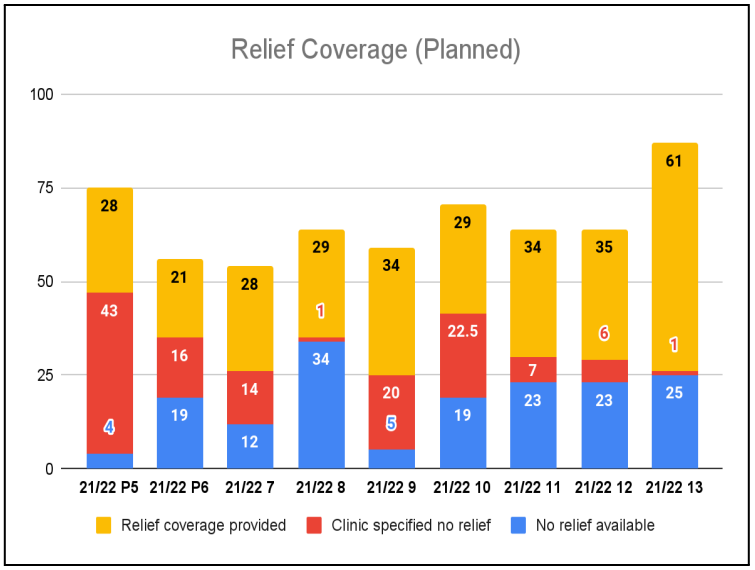
Registered Nurse in Family Practices

At the end of this period, there remain 20 clinics in this program with permanent RN in practices, 4 additional clinics with temporary coverage, 1 clinic who is actively recruiting and additional relief positions. Out of the 9 relief positions, all are active and 2 new positions (a CRN and a Clinical Resource RN) have been posted with one position slated to start in April 2022. The period distribution across the PCN's are:



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:





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.

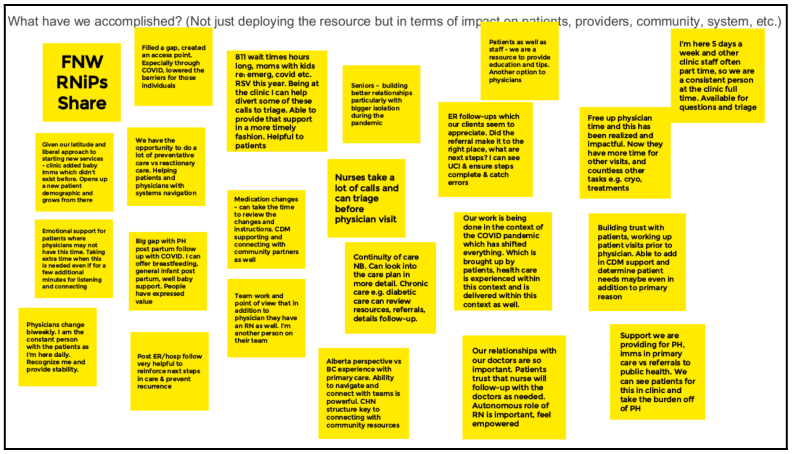
RN In Practice Impact Stories

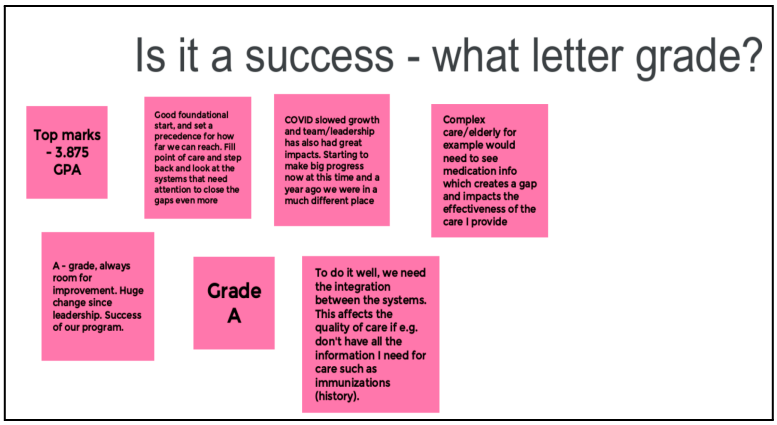
A number of providers shared their experiences of having a RN in practice as an extension of team based care within the PMH. **The short video below** shares these firsthand experiences and benefits of having an RN working in clinics as an extension of primary care.

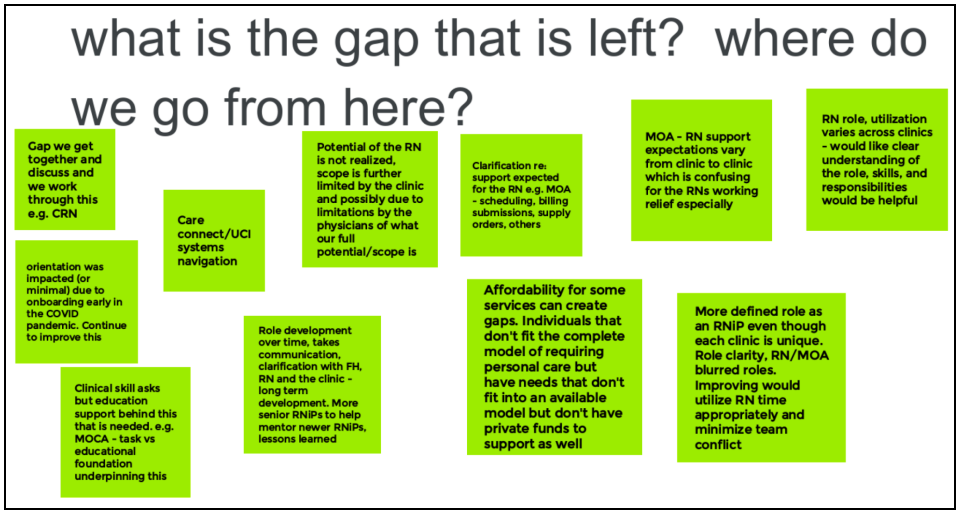
Recently, it was shared that a new Family Physician has started to practice at one of the FNW community maternity clinics. In citing reasons why they began to practice in maternity care - which traditionally in this community has seen challenges in recruitment and retention- they cited the capacity created 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.

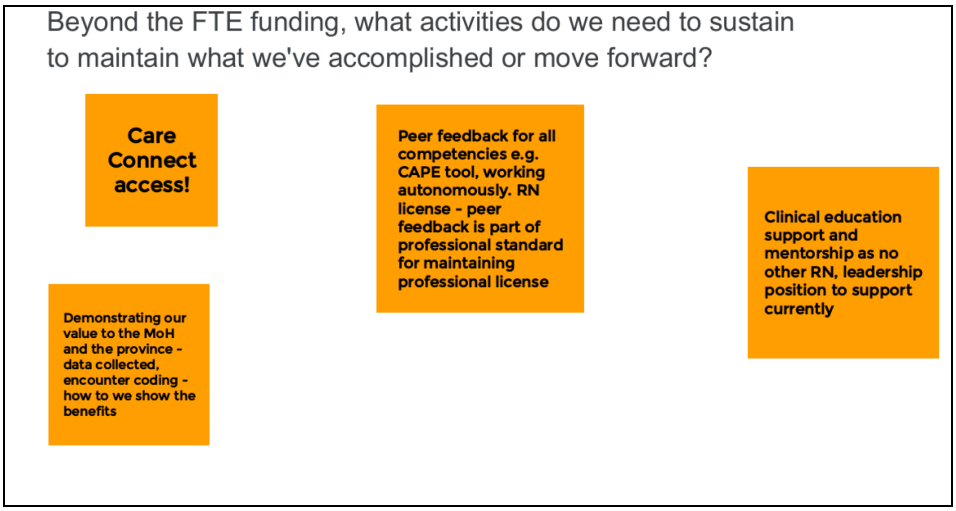
Program Impacts: RN Team Feedback

A tool often used to generate discussion and collect feedback for the purposes of brainstorming challenges, successes and solutions is JamBoard. The RN in Practice team engaged in a discussion surrounding a thorough overview of their experiences in being a part of this PCN initiative and their feedback is shared below:



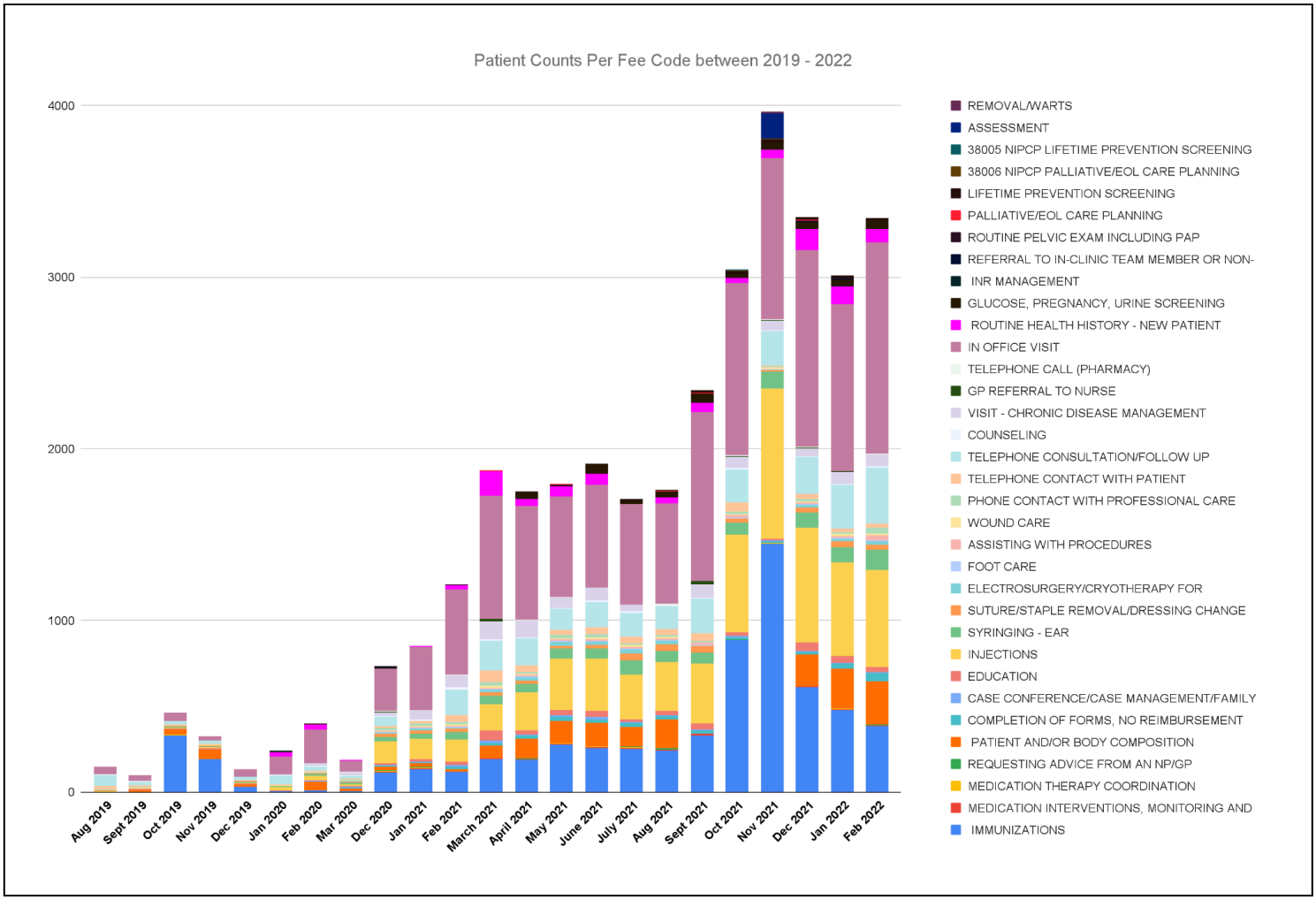






RN Encounter Coding

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.

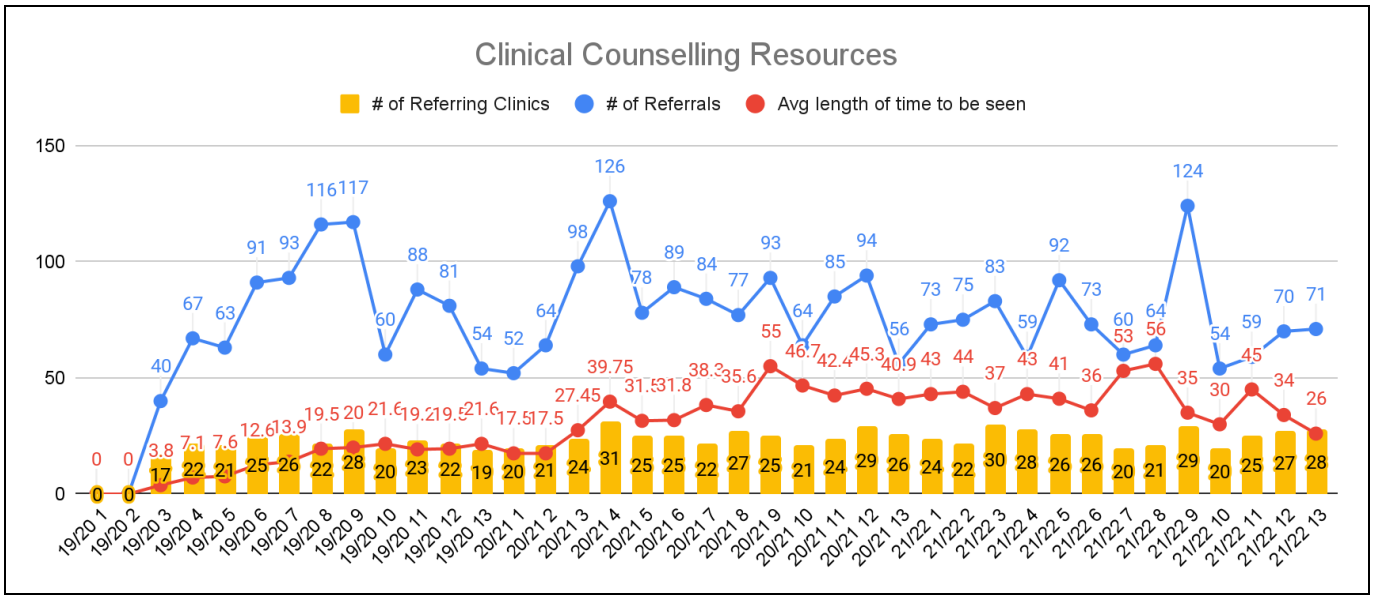


Allied Health (Clinical Counsellors) Supports - *Contracted Agency*

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

	Previous Period (P12)	**Current Period (P13)**	**Difference**
# of Referrals	70	71	↑
# of Referring Clinics	27	28	↑
Average length of time for patients to be seen (*days)*	34	26	↓
# of clients seen	185	178	↓
# of appointments scheduled	332	345	↑
# of cases open	308	277	↓

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:

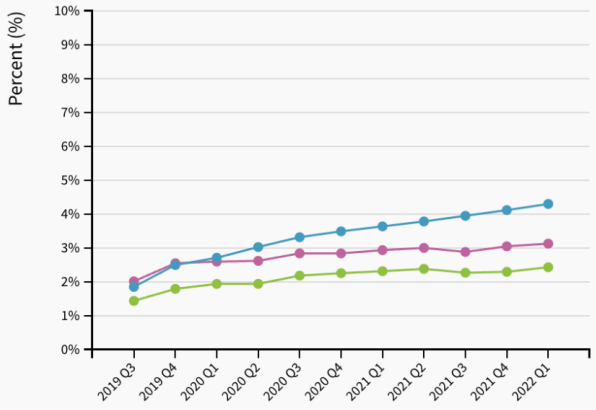
	Previous Period (P12)	Current Period (P13)	Difference
# of Referrals	57	72	↓
# of Referring Clinics	23	32	↑
Avg. caseload/Clinician	25	30	↑
# of appointments scheduled	207	285	↑

Mental Health Program Impact: HDC

HDC offers demographic data based on aggregated patient data coded into the platform from participating PMHs EMRs. One coded measurement if the prevalence on patient with **anxiety and fear-related disorders** and compares quarterly data from 1 year, 3 year or 5 years across all FNW clinics, Fraser Health and BC. The visual below is a snapshot of the trending increase in prevalence for anxiety and fear-related disorders across FNW clinics. Data such as this reflects the ongoing, and growing, need for rapid access mental health supports for mild-moderate MH concerns.

The percentage of active patients with anxiety and fear-related disorders (including phobias) based on the problem list as recorded in the EMR.

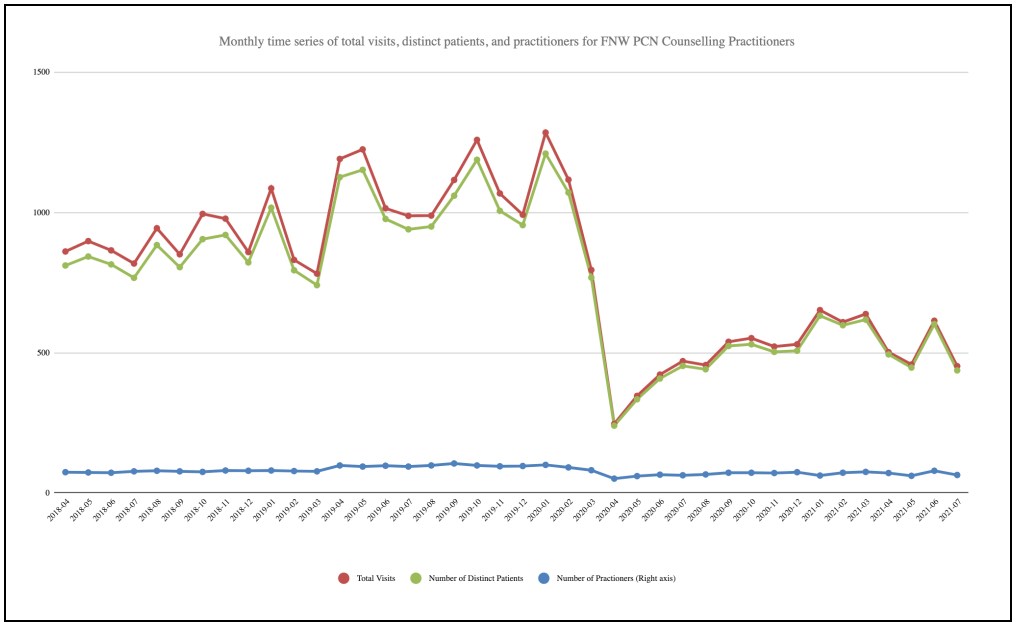
Legend	Data Source	Ratio	Data as of
	British Columbia	99286 / 2307078 (4.30%)	2022 Q1
	Fraser Health	27351 / 873567 (3.13%)	2022 Q1
	Fraser Northwest	4470 / 183677 (2.43%)	2022 Q1



Mental Health Program Impact: MoH

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.

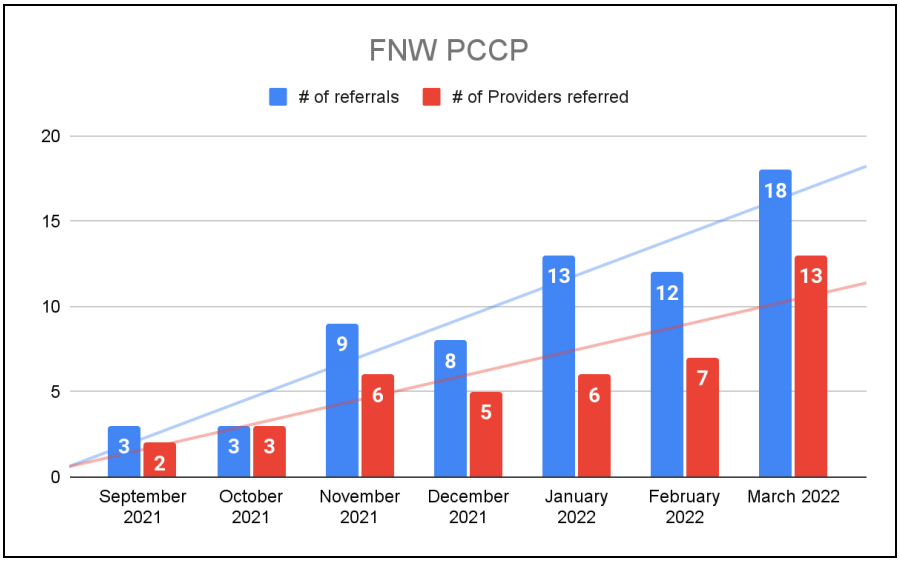
The Aboriginal wellness advisor has assisted the Director of health to assess the wellness needs of the community. They are currently working on meeting the needs of the community by seeking community partnerships with local organizations. In addition, the wellness team is actively seeking grants for 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 2021, 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. Period 13 data was not available at the time of writing this report and it is anticipated that moving forward, all UPCC reporting will take place on the MoH PCN web portal.

	Period 11	Period 12	Difference
# of In-person patient visits	324	418	↑
# of virtual patient visits	419	510	↑
# of new attachments	62	57	↓
Total # of attachments	366	531	↑

Program Impact: Accessible Primary Care

A Physician 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

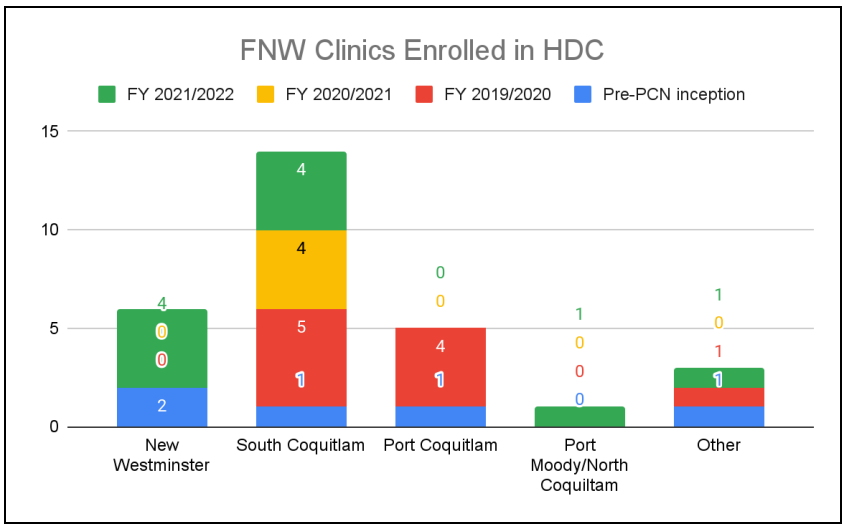
- Patient Experience Tools
- EMR Skills Assessments

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 (January)	179	116	66%	55%	118	12	3	4	99
Current month (February)	182	118	66%	55%	121	13	3	4	101
	↑	↑	=	=	↑	↑	=	=	↑

Health Data Coalition (HDC)

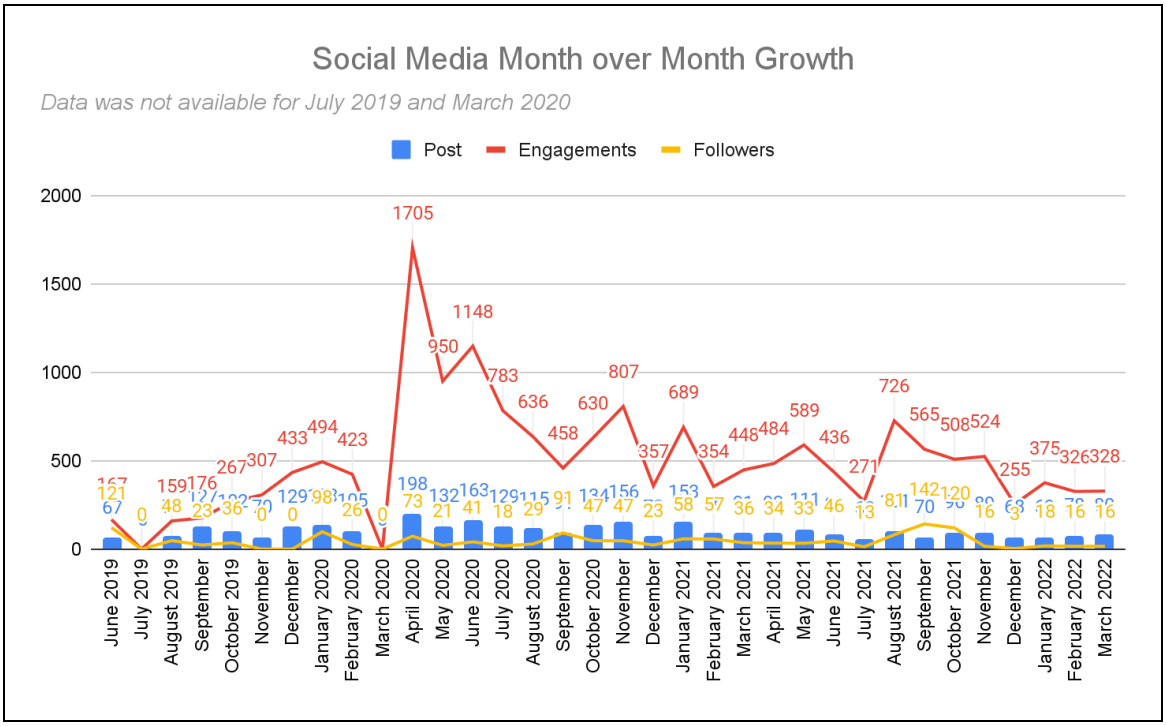
The Health Data Coalition is a non-profit organization funded by GPSC that "*is a physician-led data sharing network that encourages self-reflect and practice improvement in patient care. HDC provides access to a secure, core set of anonymized aggregate data"* for physicians and practices. HDC representatives 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 March 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)	+80	328	+16



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%
February 2022	3473	1942	56%

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 number of responses came in highlighting the diversity of access to the health system when asked the following questions:

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

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

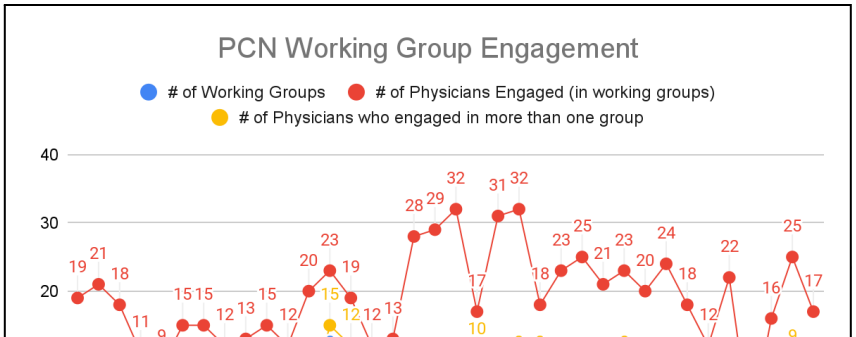
> *"We've been in the lower mainland for three years, we'd be happy to *get* a family doctor, virtual or otherwise. Myself and two daughters use walk-in clinics because we have not found a physician accepting patients. It has materially affected how we seek out and receive care. Fortunately, we are moving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

Public Engagement: Feedback Collection

Members of the public are encouraged to provide ongoing feedback on the public facing division website. This method of feedback collection was introduced in 2019 and has been ongoing. Themes from this data collection largely focus on the need for attachment to FPs in the community with additional feedback inquiring about finding either a FP or an NP in the community. These themes continue to be consistent with what was heard when this mechanism was initially launched and is a reflection of the ongoing need for access to primary care despite the addition of the PCN Primary Care Provider resources.

Physician Feedback and Engagement

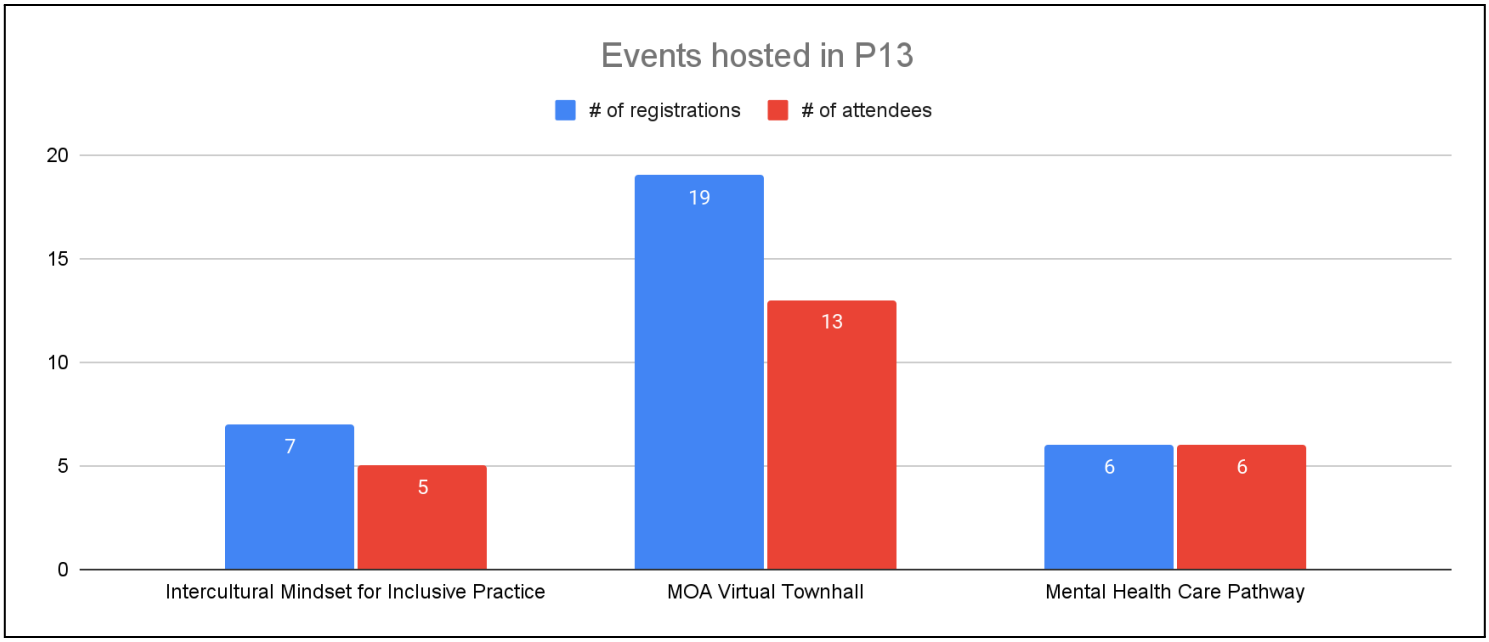
Physician engagement for this reporting period includes a breakdown of both the PCN Working group engagement as well as the PMH team engagement events. As part of the FNW PCN, Primary Care Provider engagement and leadership is integral to the successful



development and delivery of community services and resources. This engagement is reflected through a number or provider working groups and advisory committees which include:

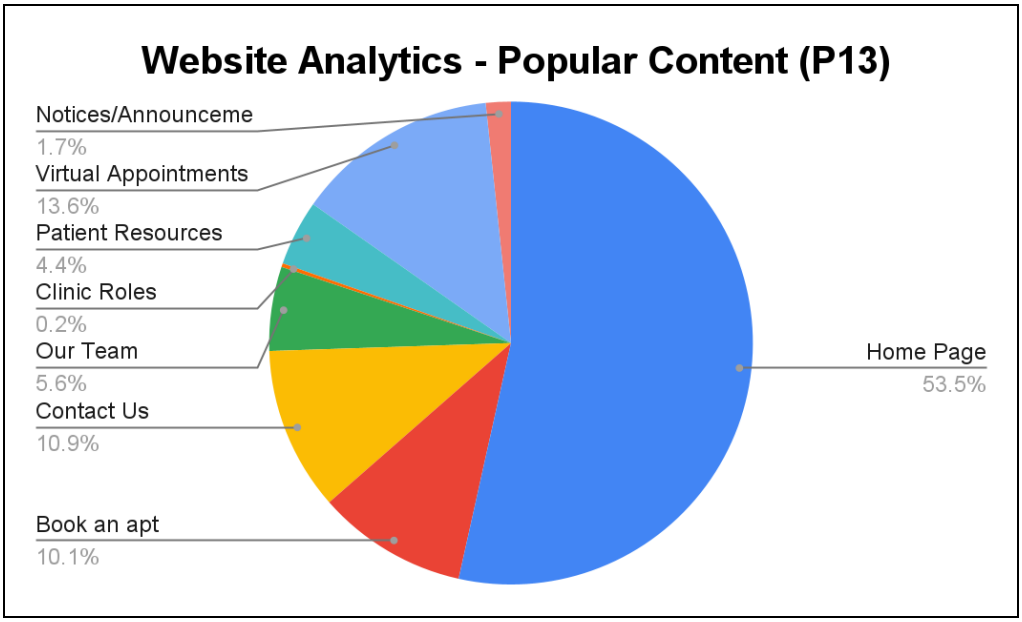
- PCN Steering Committee
  - *The purpose of the FNW PCN Steering Committee is to provider governance and leadership to te activities, working groups and strategic planning for the FNW PCNs*.
  - *Membership is comprised of PCN partner organizations, community family physicians, hospitalists, administrative 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:



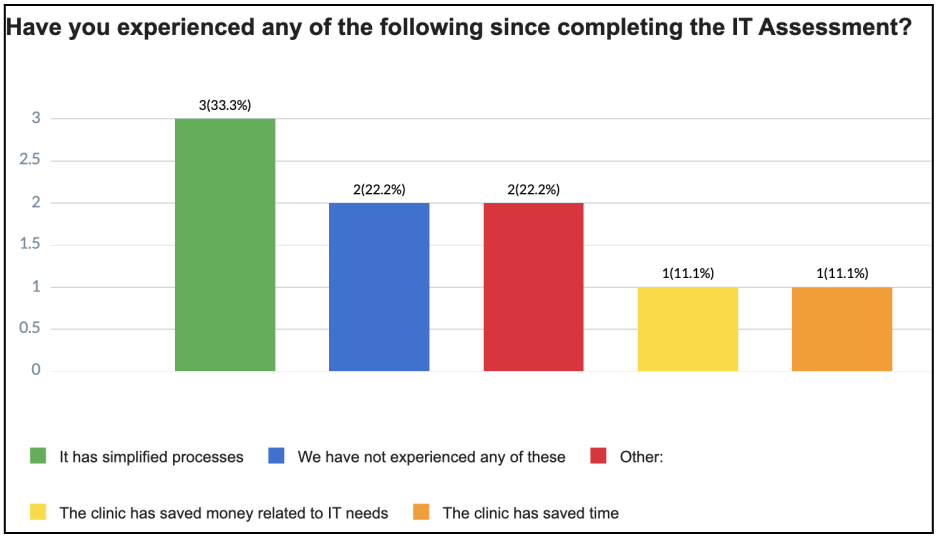
Additional engagement support provided to FNW physicians is the website development. The move to providing primary care services in a virtual setting continues to grow and expand. A full list of the clinics in the FNW and

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.



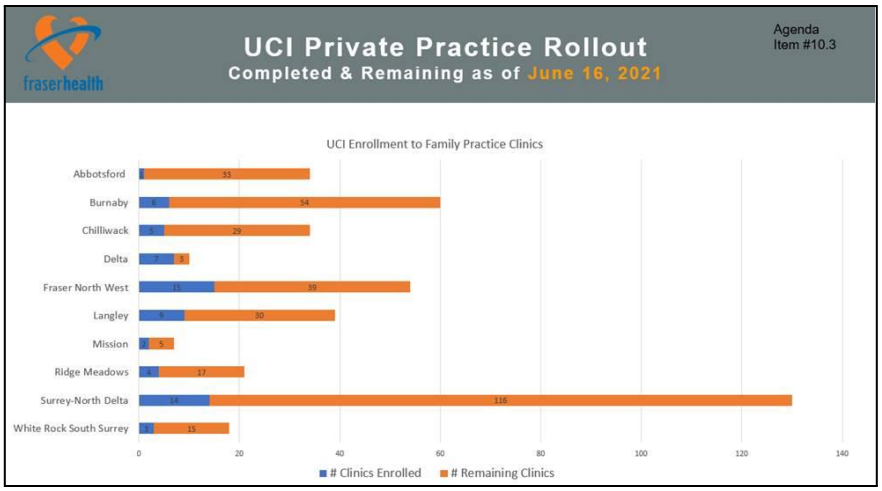
Physician Engagement: Virtual Care

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.

The PCN Steering Committee discussed key aspects and principles related to working towards attaining these two PCN attributes within the community. The Committee identified 5 Key Principles related to Coordination of Care.

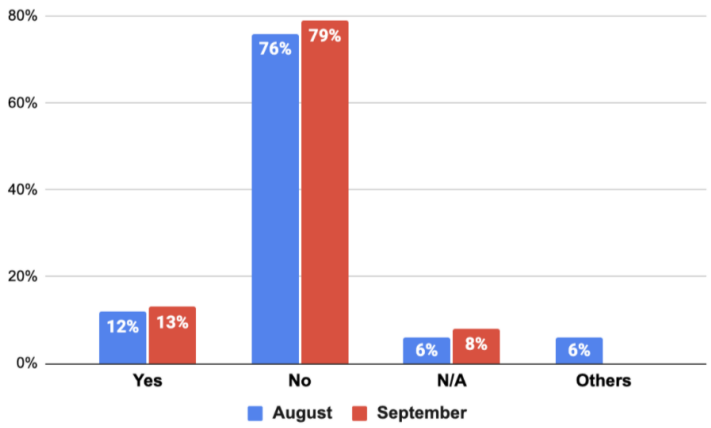
Principle	Description
Patient Centered	○ Care coordination in the system would mean, a patient at the center, the family and their care providers can find an answer effortlessly when a question arises in the life/health journey from birth to death. ○ Recognition that patients have differing needs and beliefs. i. Personalized and individualized. ○ All services report back to the PMH after a referral for services and supports. ○ Holistically recognizing the patient as a whole rather than a condition, they have a body, mind and spirit. ○ The business side of healthcare does not impact the focus on patient care ○ Advocacy and support in navigating when needed, all patients are VIP when they actually need healthcare ○ System recognition of number of patients served along with balanced budget
Easily Accessible	○ Patient records are available anywhere the patient gets medical care and that provider can easily access all their information. i. Shared communication platform ○ Every patient has one clinic/PMH where they can get all their health needs and only truly specialized services require the patient to go elsewhere. i. Every resident living in the community has their own PMH. ○ Transparent wait times to manage patient and provider expectations and interim care strategies
Team-Based Care	○ The patient is part of their own care team and provided education to have a proactive role in their health. i. Empowerment of patient and family ○ Help patients along to the right place at the right time. i. Patients provided the information of what to expect along their journey and who will be their support team. ○ Care teams are whole person and may include but are not limited to: i. Patient ii. Family Members iii. Primary Care Provider iv. Affordable or no cost counseling v. Specialists vi. Diagnostics vii. Surgical iii. RNs ix. Allied Health x. Hospitalists ○ Care teams: i. Are transparent in their capacity and limitations ii. Will find ways to reduce wait times iii. Will ensure smooth transitions for patients between providers and health care settings iv. Will keep the primary care provider updated on patient health changes and find ways to improve communication ● Warm handshakes between transitions and team members

	● Using technology to improve team care conferencing (virtual) v. Will seek out meaningful ways to build relationships amongst the team they work with ● Caring about the wellbeing of all care team members (reducing burnout) vi. Will focus on patient transitions rather than referrals (not sending patients away but asking for expertise and help to care for patient) vii. Will understand and recognize their own individual biases and will work to understand and break down barriers, impacts, stigmas and meet all patients where they are at. iii. Are excited about continuous improvement ● Reduce bottlenecks in the system
Relationships	○ Patients have one primary care provider that they know and have a relationship with. i. Providers have time to build relationships
Safe Care	○ All healthcare providers create a safe and respectful environment for all patients. i. PMH and network based tailored engagement opportunities (i.e. cultural safety, leadership development, communication, conflict resolution) ○ Patients never feel vulnerable in the healthcare setting, they feel cared for. ○ Quality transitions in care, no patient slips through a crack i. Patient information follows the patient back to the PMH and into care supports (one record)

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:

Do you provide Opioid Agonist Treatment inductions?



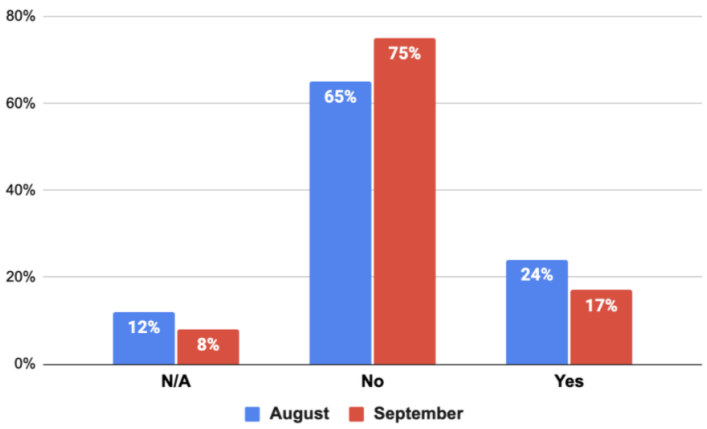
If yes, what are some of the challenges?
Raw Responses :-

- Staff stigma
- Lost to follow up. Patients not able to go to labs.
- ***New*** Limited clinic support & stigma
- ***New*** Patients often do not go to labs. Patients lost to follow up. No show. No stable housing

If no, would you consider this with resources?
Raw Responses :-

- I could consider it if training provided
- No X 9
- An office and staff conducive to same
- Main barrier is difficulty with patient follow up and monitoring.
- *Training on this.
- ***New*** Maybe, but I don't have enough patients wanting this then it isn't worth my time to learn the latest and greatest once a year
- ***New*** Accessible training with respect to time frame offered, compensation for the extra time

Do you provide Opioid Agonist Treatment maintenance?



If yes, what are some of the challenges?
Raw Responses :-

- stigma lack of team knowledge and training
- No patients on this so far
- Same as above
- ***New*** Patients often do not go to labs, patients lost to follow up, no show, no stable housing, need nursing/social workers

If no, would you consider this with resources?
Raw Responses :-

- *I could consider it if training received
- No X 8
- An office and staff conducive to same
- Main barrier is difficulty with patient follow up and monitoring.
- *Yes. So far I haven't seen patients on this yet.
- ***New*** Yes, and ongoing support when I need it
- ***New*** Yes, will need opportunities to re-learn and brush up on skills to do this
- ***New*** Maybe in the future

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

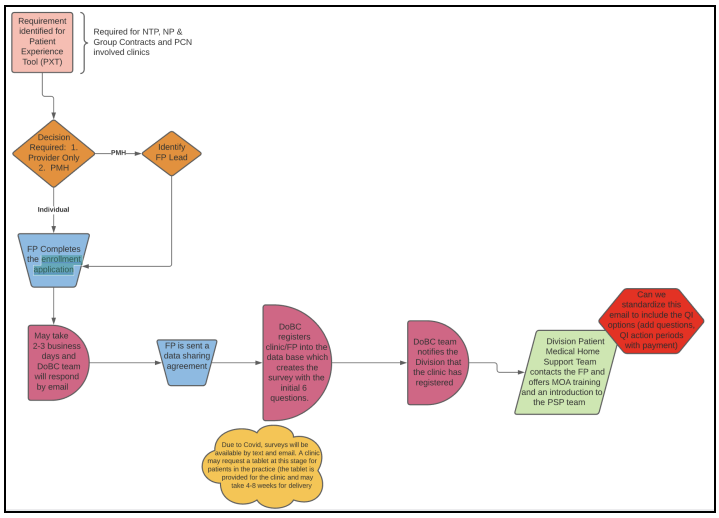
Recently, a Nurse Practitioner attended a prenatal member education event which prompted the provider to engage with the Division team to share that they were accepting new babies and moms as patients and provided details on how to reach out. This example is a reflection of the importance of including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

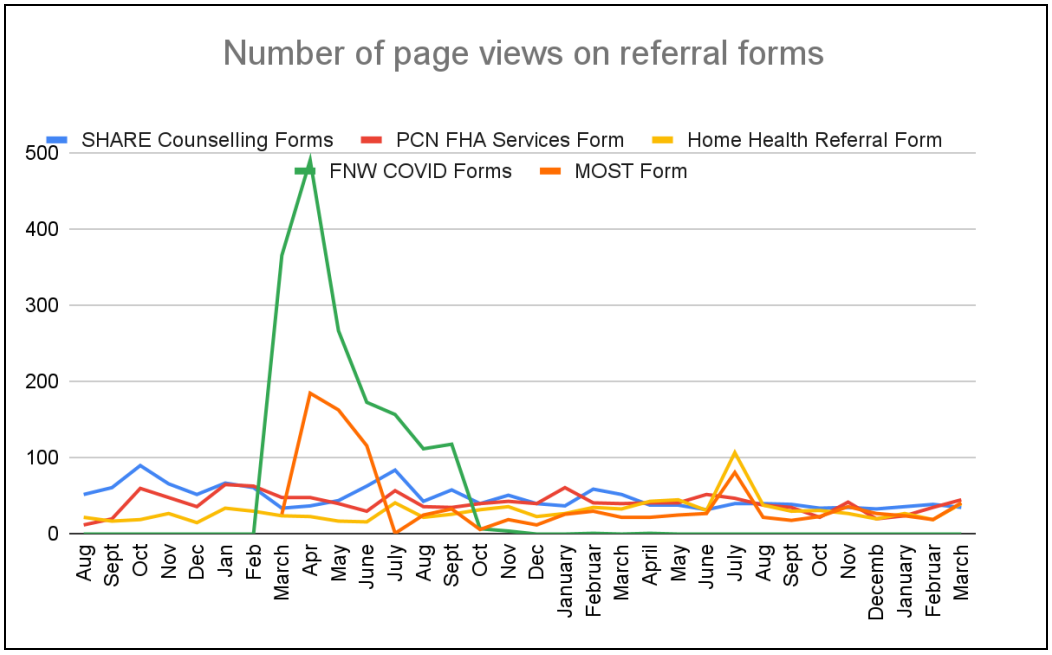
Work is underway to implement the GPSC created Patient Experience Tool (PET) within all practices who have RNs in Practice, or providers on contract. A workflow was developed to share out to PMHs to visually represent the process for implementing the PET into practice. The visual is a draft representation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