Fraser Northwest Primary Care Network

Period 1 Addendum Report

PCN Resource Overview (P1)

Legend: FTEs Remaining · FTEs Hired by Period close

Category	FTEs Hired by Period close	FTEs Remaining
Administration	5	0
Allied Health	5	0
Indigenous Related	1.5	0
Management	2	0
Nurse Practitioner	10	2
Nursing	24	8
Pharmacy	0	4
Physician	8	4.1
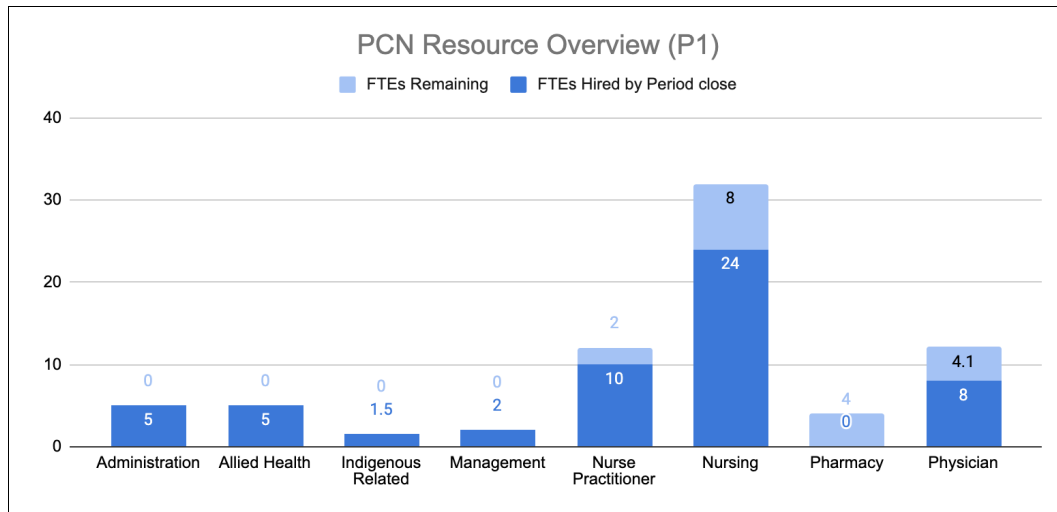
Patient Medical Home Snapshot:

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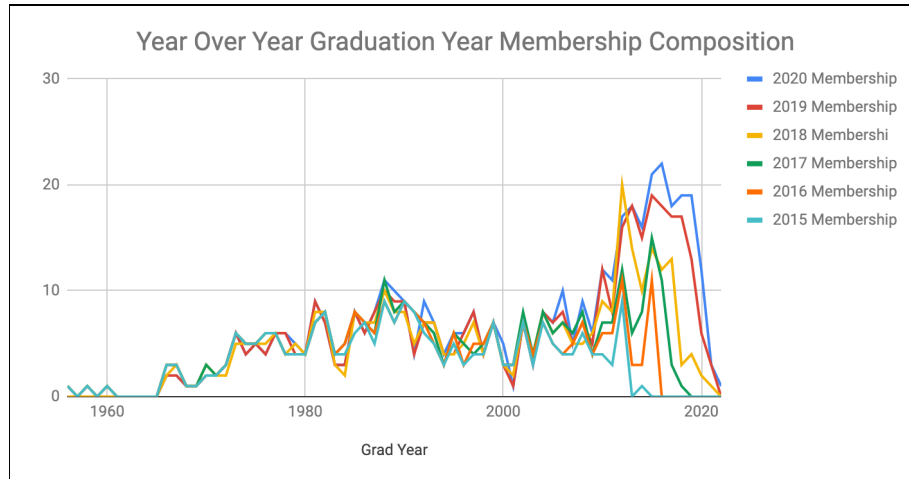
The average Blue Book Listings for Physicians in the FNW from 2011-2020 are represented in the chart below. It's important to note that these numbers reflect Physicians in a variety of roles and providing primary care services in a number of different practice types - i.e. Family Practice, Walk-In Clinic,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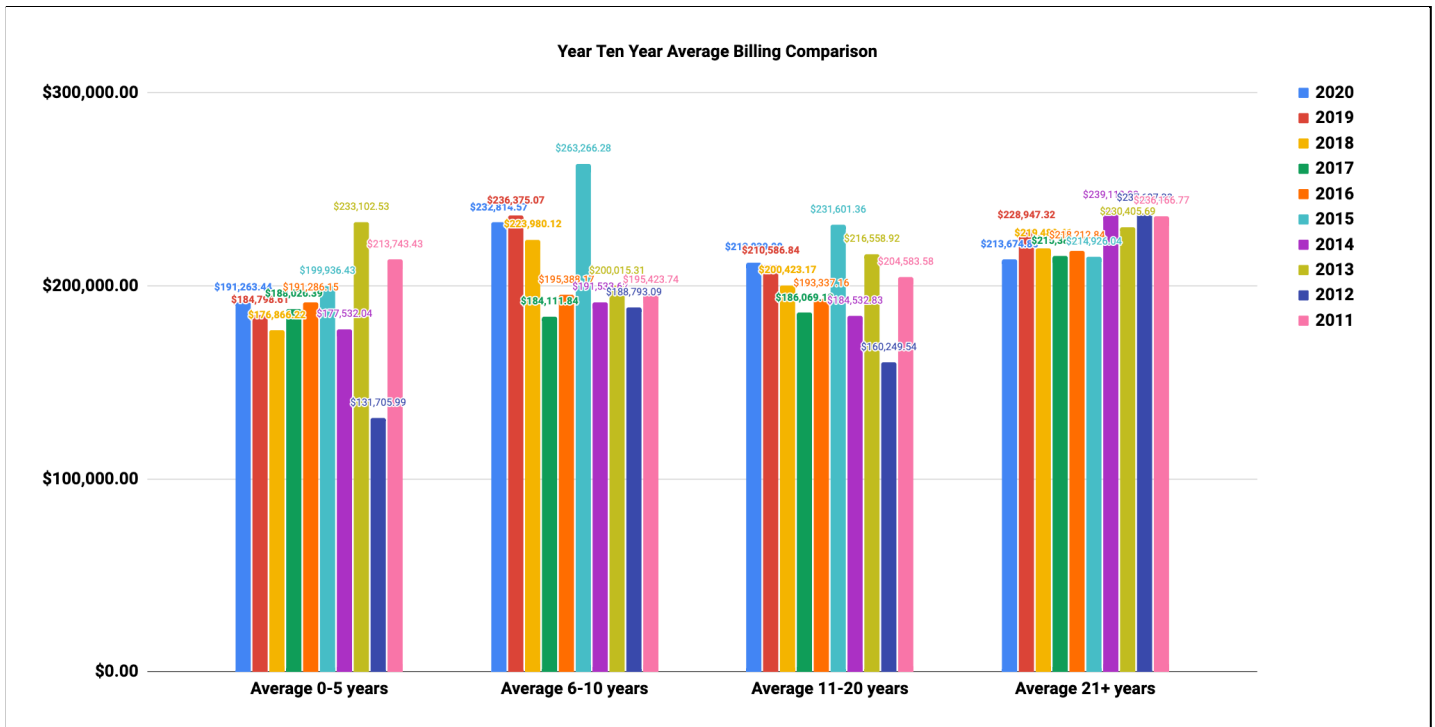
Overview: Primary Care Provider Community Adds & Losses

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	24
Provider Losses	15	22	2
Net Loss/Gain	-5	-14	+22
FNW Attachment Hub #	856	2792	2102
MoH $0 Fee Code Attachment	NA*	73,742	1470

*MoH Data not available for 2019

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.
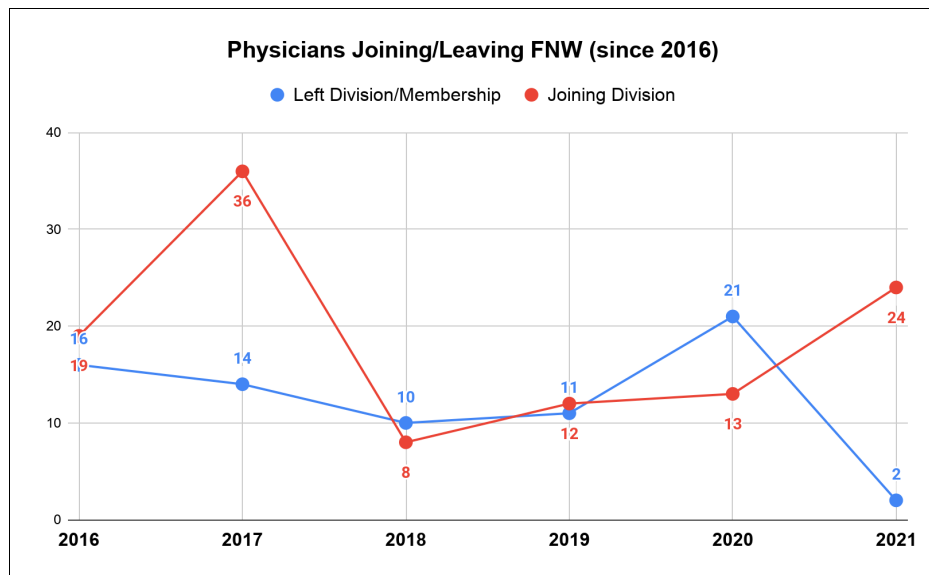
Projected retirements in the next year are set at 7 with a five year forecast of 25 family physicians retiring out of the FNW communities. This projection is an estimate and is based on an estimate that approximately 10% of our members that are 21+ years in practice will retire between 2020-2024 as we 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 1 (April 1 - April 30), clinic openings increased to 21.2 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	82	0	0	1 PCN Launch Total: 8
Nurse Practitioners	1	44	8	3	0 PCN Launch Total: 10

FP Recruitment Trends (since PCN inception)

NP Recruitment Trends (since PCN inception)
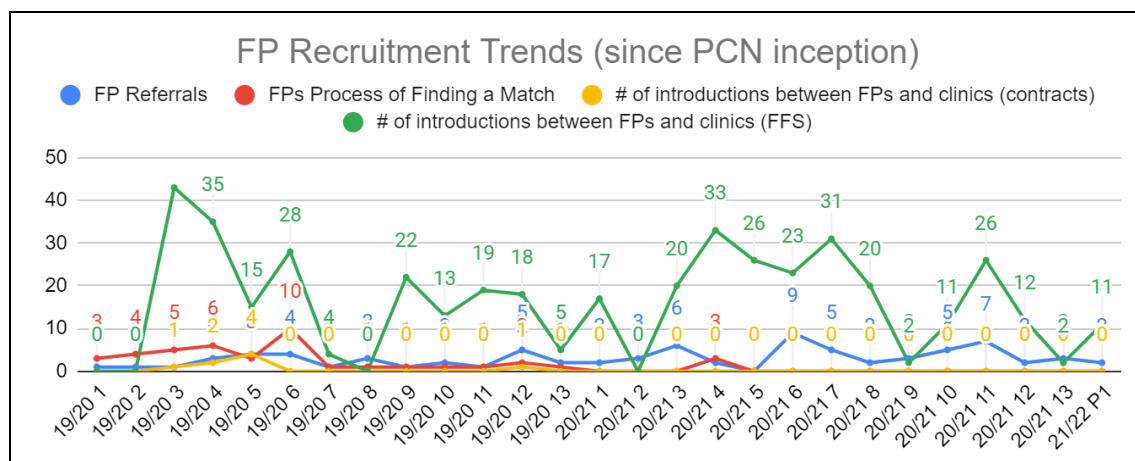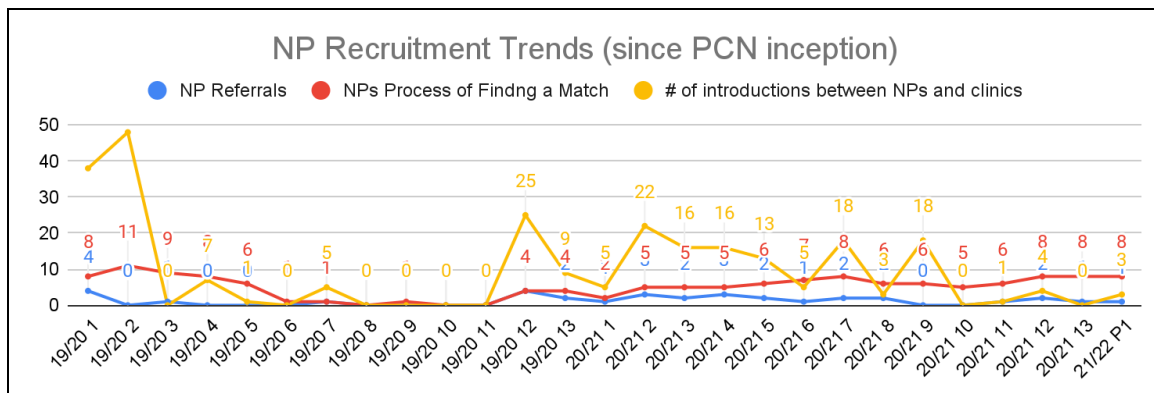
The number of active postings on HealthMatch BC for FPs for both FFS or contract positions increased in this period to 42active postings by period close. Opportunities for these postings include: locum and permanent part-time and permanent full-time in the FNW.

Fee For Service (FFS) opportunities and engagement efforts are underway on an ongoing basis and in this period, there were 11 new introductions between FPs and practices for FFS opportunities such as locum, permanent part-time and permanent full-time.

FP FFS Introduction by PCN (since PCN inception)
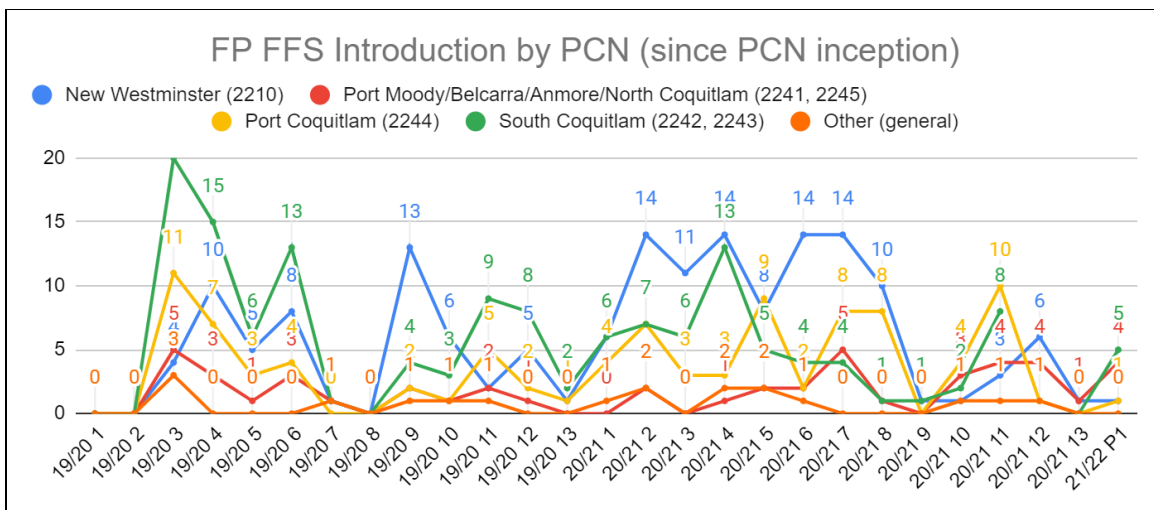
Recently, Division staff created a workflow visual demonstrating the steps required to successfully onboard new contracted providers:
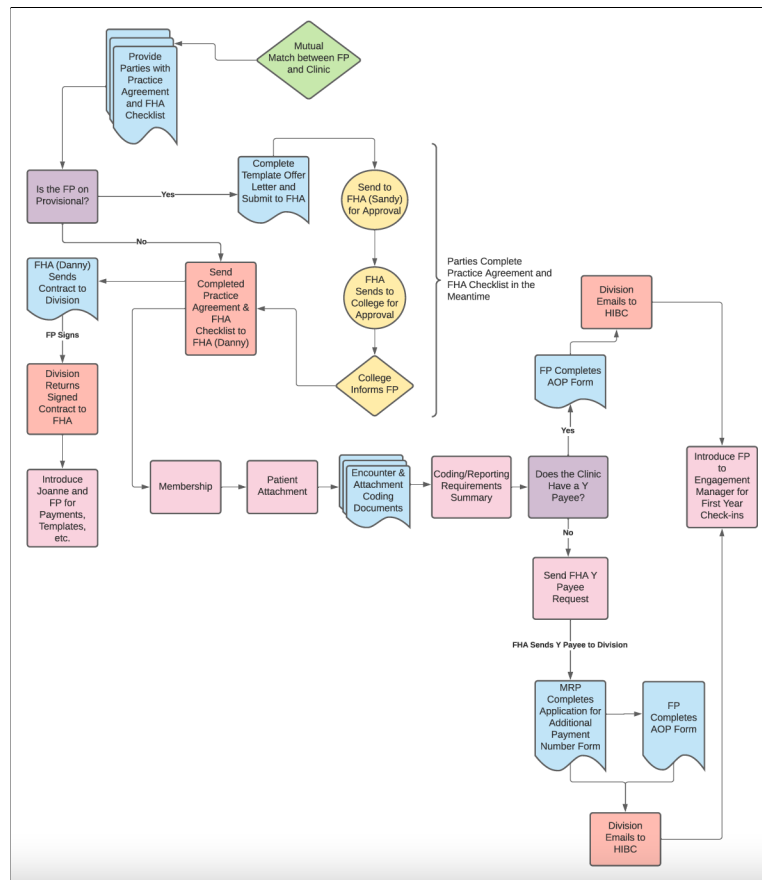
Registered Nurse in Family Practices

This initiative has seen some fluctuations in the number of family practices who have RNs, at the end of this period, there were 20 RNs in practice with 1 relief RN. 3 positions are posted, 1 for a permanent position and 2 relief positions. The period distribution acr=oss the PCN's are:
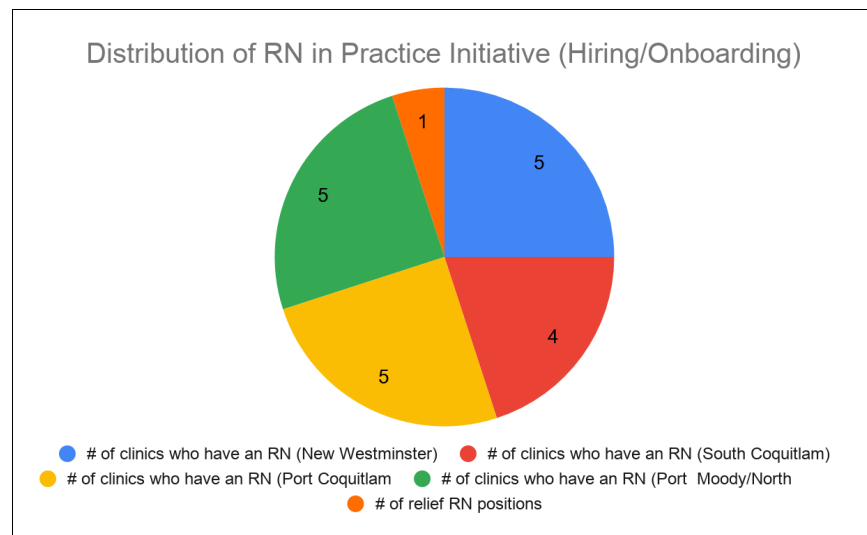
RN In Practice Impact Stories

Recently, Family Physicians have shared their experience around having RNs supporting their practice.

A Family Physician Lead at a practice shared a note of appreciation around their RN. *"We have a complicated patient who is going for surgery and we were all confused about their meds and what to start/stop, especially being as they have been in and out of hospital a few times recently (which happened after her pre-op optimization consult). With limited time, the RN made a number of calls and connects to ensure that the surgeon and the anesthetist were up to date on the patients new meds, and got them to make a new plan for what to do. This patient has waited 2 years for the surgery and was really scared she would have to postpone or cancel the surgery due to the new meds, and because of the RNs work the surgery is a go!"*

Program Impacts: 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

Of the 10 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.

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%.
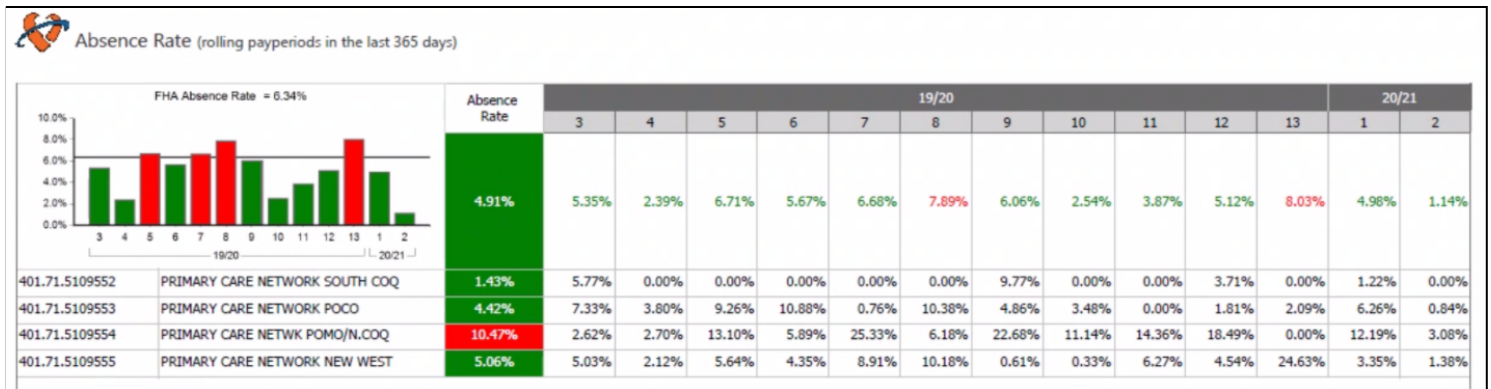
By FY 20/21 P11, on average the absence rate shown by this program is 3.82% which is below the FHA average of 6.34%. This rate is a decrease of 1.09% from the previous report (image above)
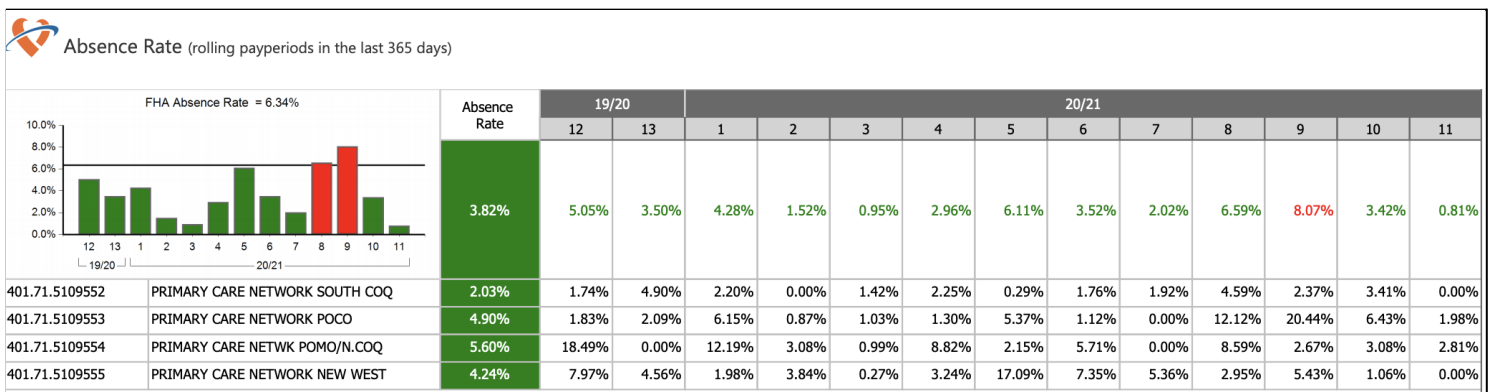
A recent analysis on employment status noted that of the RNs that have worked in the RN in Practice program, 81% are still currently working within this program.

- 81.4% of the staff are still in FNW of which 81.8% are currently active
- 18.5% of staff are not in FNW currently and 100% are active
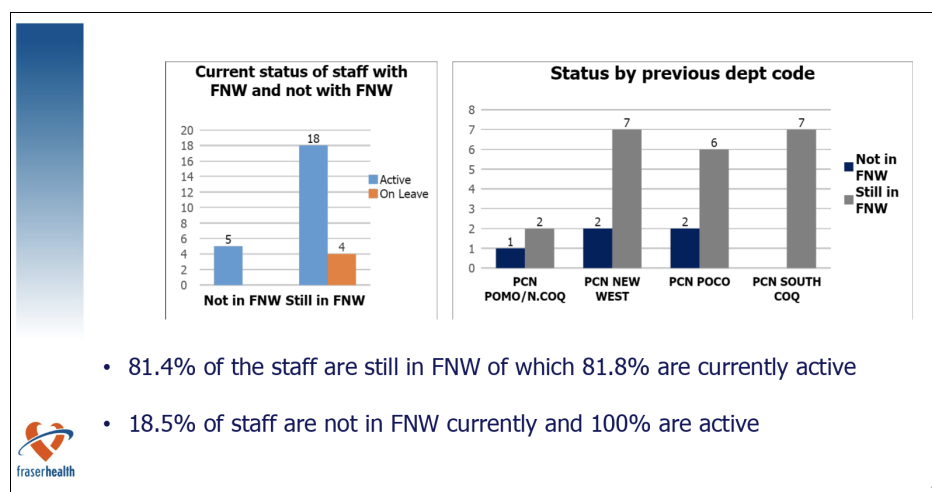
RN Encounter Coding

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.

	Patient Counts												
	08/19	09/19	10/19	11/19	12/19	01/20	02/20	03/20		12/20	01/21	02/21	03/21
38010-38045 IMMUNIZATIONS			71%	59%	22%	2%	2%	3%		14%	15%	10%	10%
38060-38062 AND 38064-38065 MEDICATION INTERVENTIONS, MONITORING AND INFORMATION										1%	1%		1%
38063 MEDICATION THERAPY COORDINATION			1%							1%	1%		
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%	1%	4%
38125 NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT								3%		1%	1%	1%	1%
38130-38135 NIPCP CASE CONFERENCE/CASE MANAGEMENT/FAMILY CONFERENCE							1%	3%		1%	1%	1%	1%
38141-38155 NIPCP EDUCATION		5%	1%	2%	4%	2%	1%	4%		2%	2%	1%	2%
38160-38162 NIPCP INJECTIONS	3%		1%	2%	4%	8%	6%	5%		18%	11%	11%	9%
38168 NIPCP SYRINGING - EAR			1%	2%	4%	3%	3%	4%		3%	3%	4%	3%
38169-39170 NIPCP SUTURE/STAPLE REMOVAL/DRESSING CHANGE	3%	5%	1%	2%	4%	2%	1%	3%		3%	1%	2%	1%
38171 NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS							1%	3%		1%	1%	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%		1%
38180 NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER	3%	5%	1%					3%		3%	1%	1%	1%
38184 NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND	12%	11%	1%	2%	5%	2%	1%	3%		2%	1%	3%	4%
38185-38186 NIPCP TELEPHONE CONSULTATION/FOLLOW UP	47%	18%	4%	6%	12%	19%	5%	9%		8%	9%	13%	11%

	C1	C2	C3	C4	C5	C6	C7	C8		C9	C10	C11	C12
38191-38192 NIPCP COUNSELING		5%				2%	1%	3%		1%	2%	1%	
38195 NIPCP VISIT - CHRONIC DISEASE MANAGEMENT						2%	4%	8%		3%	4%	5%	5%
38073 NIPCP GP REFERRAL TO NURSE										1%			5%
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%	42%	41%
38116 NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT						10%	7%	3%				2%	2%
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, average length of time for patients to be seen, number of clients seen, and number of appointments scheduled for this reporting period increased while the number of referring clinics seen slightly decreased when comparing numbers from the last reporting period. Moving forward, the # of current cases open (i.e. programm caseload) will be reported. The table below details the change over the last period to the current period:

	Previous Period (P13)	Current Period (P1)	Difference
# of Referrals	56	73	↑
# of Referring Clinics	26	24	↓
Average length of time for patients to be seen (*days*)	40.9	43	↑
# of clients seen	171	183	↑
# of appointments scheduled	284	324	↑
# of cases open	N/A	361	

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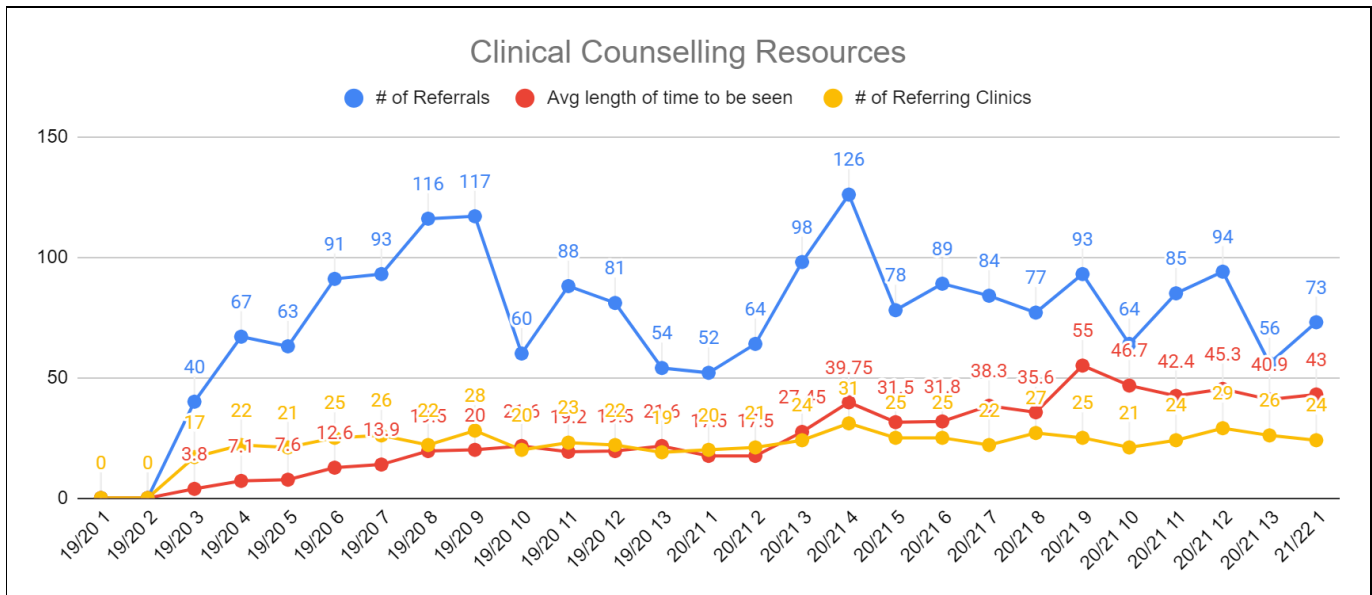
**Allied Health (Clinical Counsellors) Supports -** *FHA MHSU*

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:

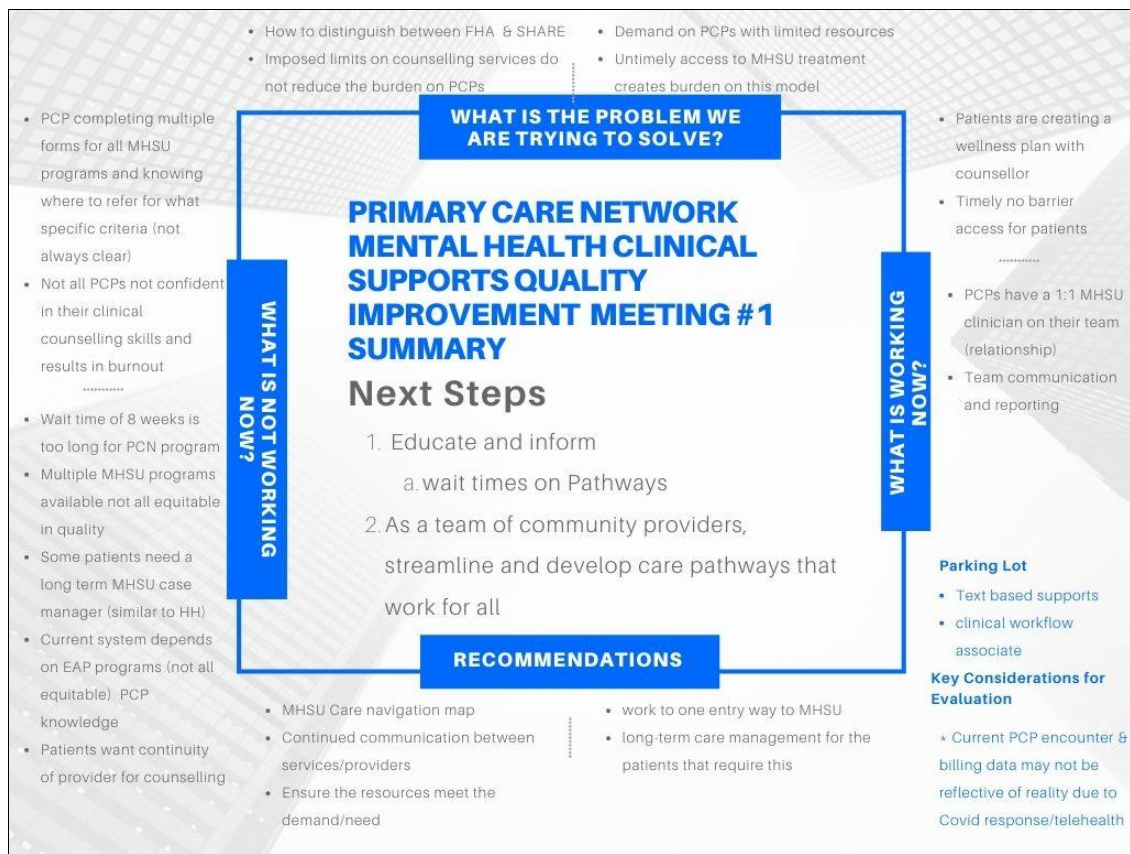|	Previous Period (P13)	Current Period (P1)	Difference
# of Referrals	67	63	↓
# of Referring Clinics	29	28	↓
Avg. caseload/Clinician	40	38	↓
# of appointments scheduled	294	273	↓

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
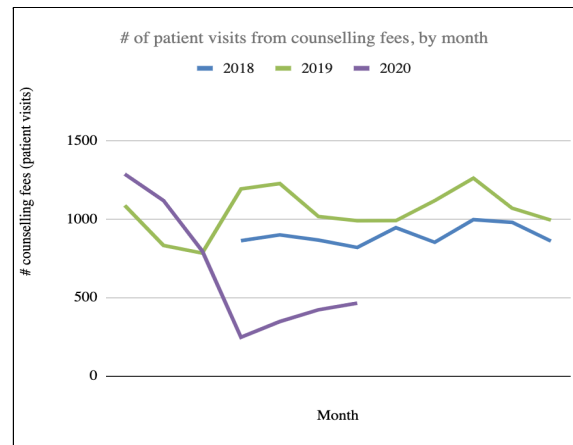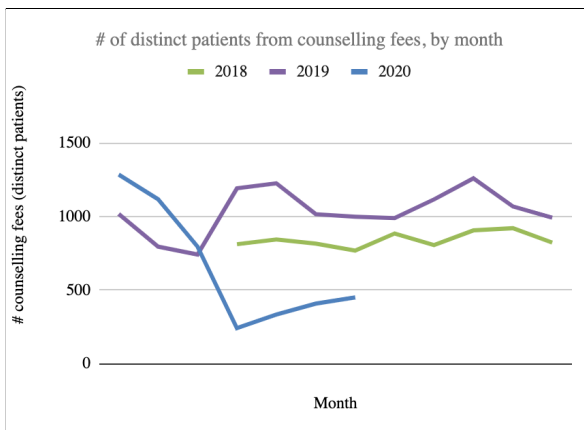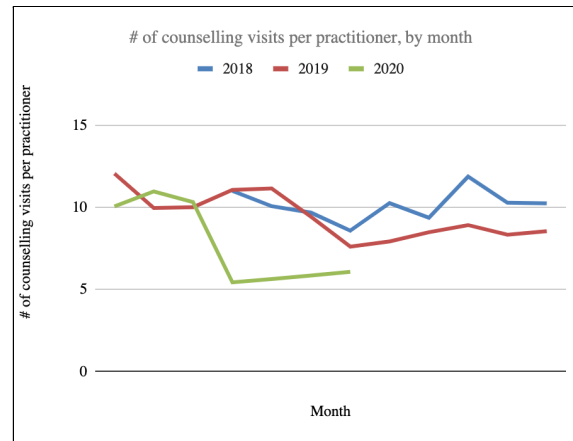
Mental Health Community Physician Engagement

In FY 20/21 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:

- How to distinguish between FHA & SHARE
- Imposed limits on counselling services do not reduce the burden on PCPs
- Demand on PCPs with limited resources
- Untimely access to MHSU treatment creates burden on this model

WHAT IS THE PROBLEM WE ARE TRYING TO SOLVE?

PRIMARY CARE NETWORK MENTAL HEALTH CLINICAL SUPPORTS QUALITY IMPROVEMENT MEETING #1 SUMMARY

WHAT IS NOT WORKING NOW?

- PCP completing multiple forms for all MHSU programs and knowing where to refer for what specific criteria (not always clear)
- Not all PCPs not confident in their clinical counselling skills and results in burnout
  ....
- Wait time of 8 weeks is too long for PCN program
- Multiple MHSU programs available not all equitable in quality
- Some patients need a long term MHSU case manager (similar to HH)
- Current system depends on EAP programs (not all equitable) PCP knowledge
- Patients want continuity of provider for counselling

Next Steps

1. Educate and inform
   a. wait times on Pathways
2. As a team of community providers, streamline and develop care pathways that work for all

RECOMMENDATIONS

- MHSU Care navigation map
- Continued communication between services/providers
- Ensure the resources meet the demand/need
- work to one entry way to MHSU
- long-term care management for the patients that require this

WHAT IS WORKING NOW?

- Patients are creating a wellness plan with counsellor
- Timely no barrier access for patients
  ....
- PCPs have a 1:1 MHSU clinician on their team (relationship)
- Team communication and reporting

Parking Lot
- Text based supports
- clinical workflow associate

Key Considerations for Evaluation

* Current PCP encounter & billing data may not be reflective of reality due to Covid response/telehealth

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*)
New Westminster	206
Port Moody	216
Coquitlam	128
Port Coquitlam	110

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:
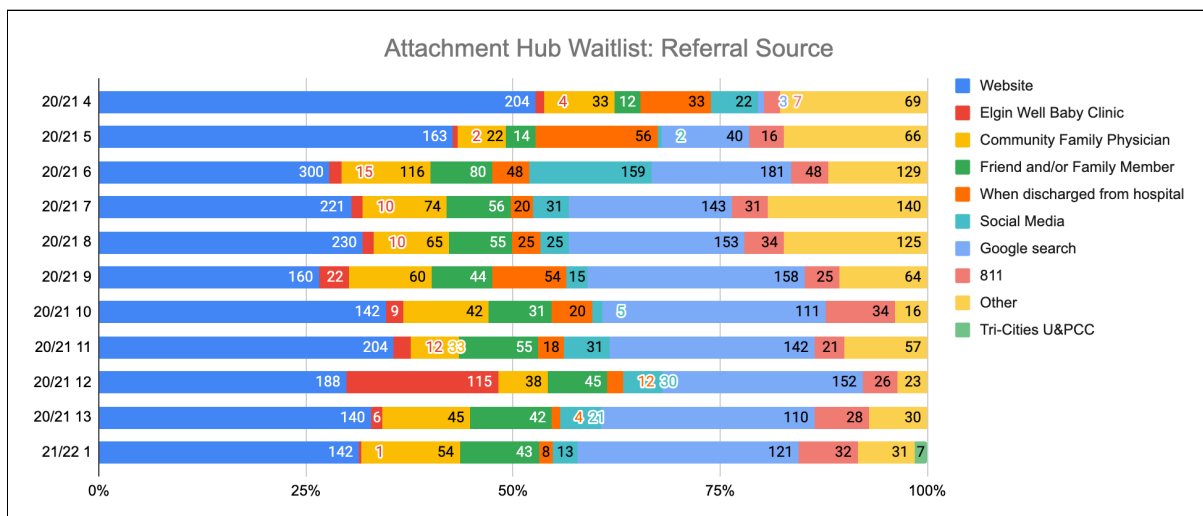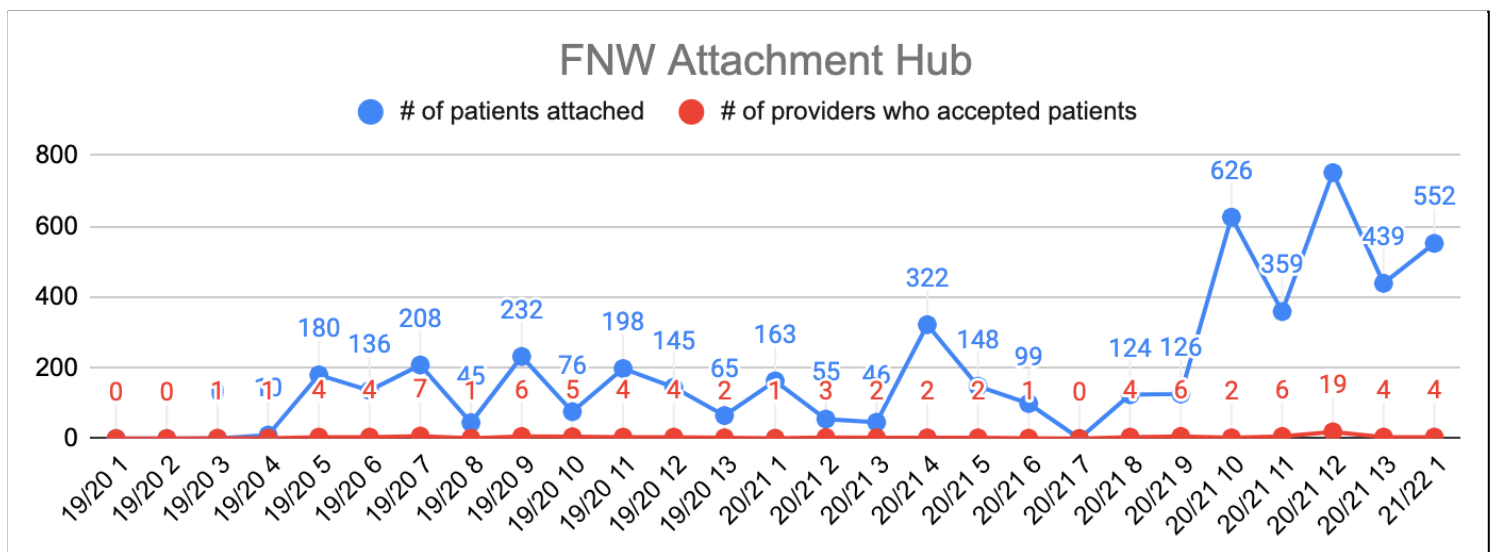
Passive Attachment

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	2	2	0	0
# of patients attached	348	204	0	0
# of people waitlisted	1500 *12.9% ↓ from P13*	1487 *5.2% ↓ from P13*	416 *4.8% ↑ from P13*	1133 *5.3% ↑ from P13*
Total Attachments to date	**4894**			

FNW Attachment Hub

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. There were 7 members of the community who were referred to the FNW Attachment Hub from the U&PCC.

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):
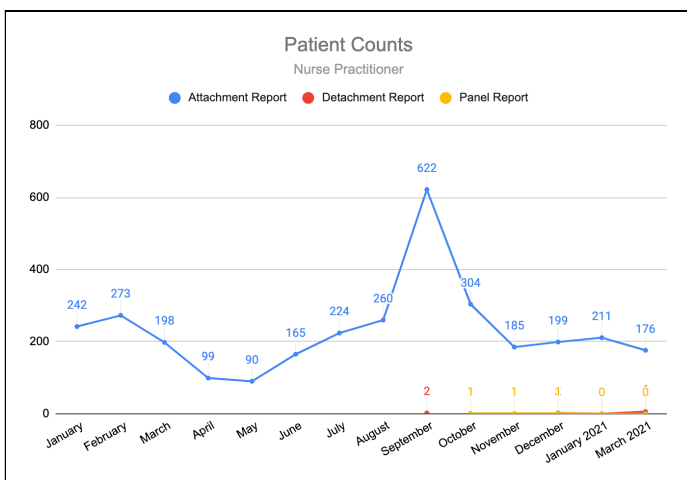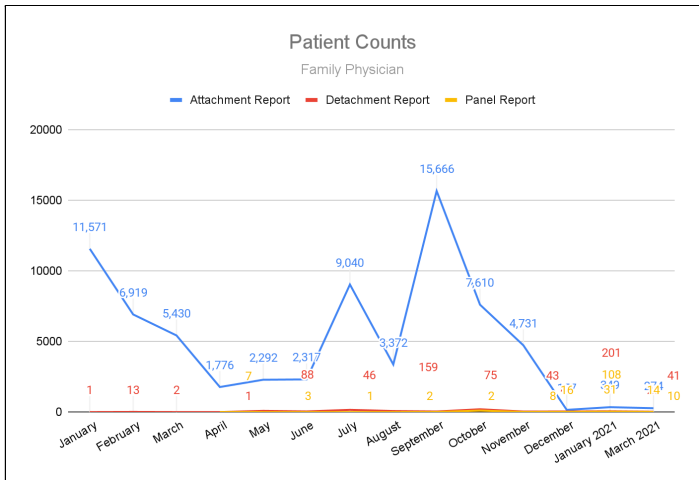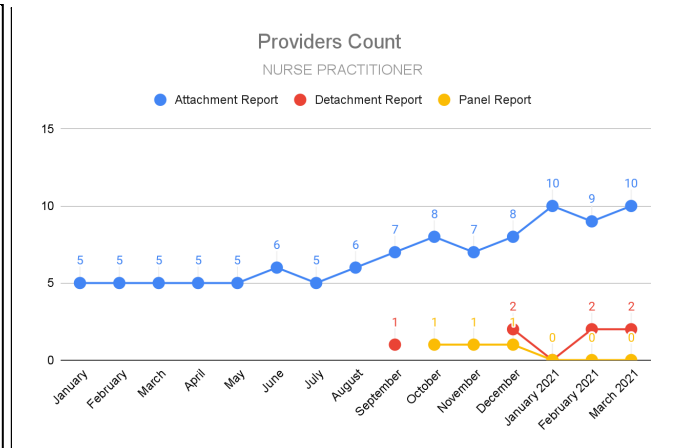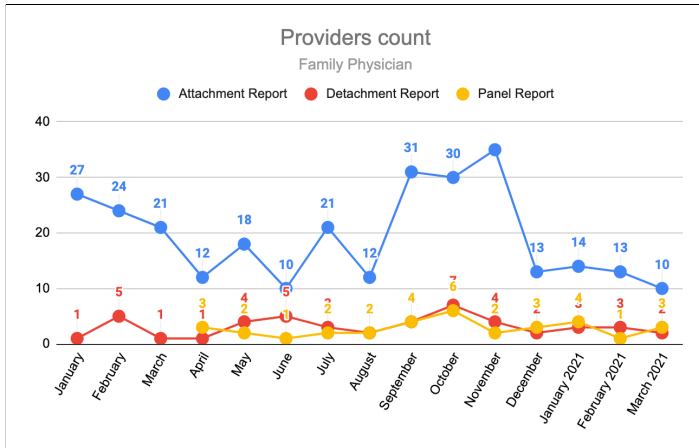
Urgent & Primary Care Centre: Tri-Cities

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 13	Period 1	Difference
# of In-person patient visits	41	139	↑
# of virtual patient visits	197	260	↑

Avg visits/day	8.5	14.2	↑
% of visits by unattached patients	81.5%	7.3%	↓
% of visits by seniors (aged 65+)	18.6%	15.8%	↓
# of new attachments	3	1	↓
Total # of attachments	4	5	↑

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

Opportunities for involvement at the U&PCC from community Family Physicians continues to be an obstacle as a number of barriers were identified in relation to being able to fill shifts at the centre:

1. Training of FPs on the EMR and requirements around references in order to be eligible to take shifts.
   a. Comparing this to the ease of doing shifts at community walk-in clinics, there are a number of additional requirements needed in order for FPs to be eligible to take shifts at the U&PCC
2. Limited resources available as there is a high demand for FPs to support the Covid-19 immunization response.

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 (March)	178	116	61%	51%	108	11	2	4	91
Current month (April)	178	116	62%	51%	110	12	3	4	91
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.
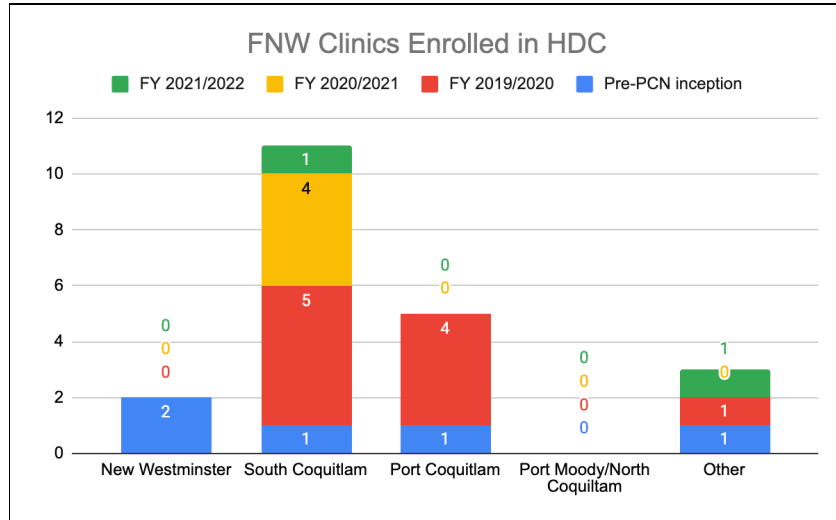
Social Prescribing: CARES Program

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.
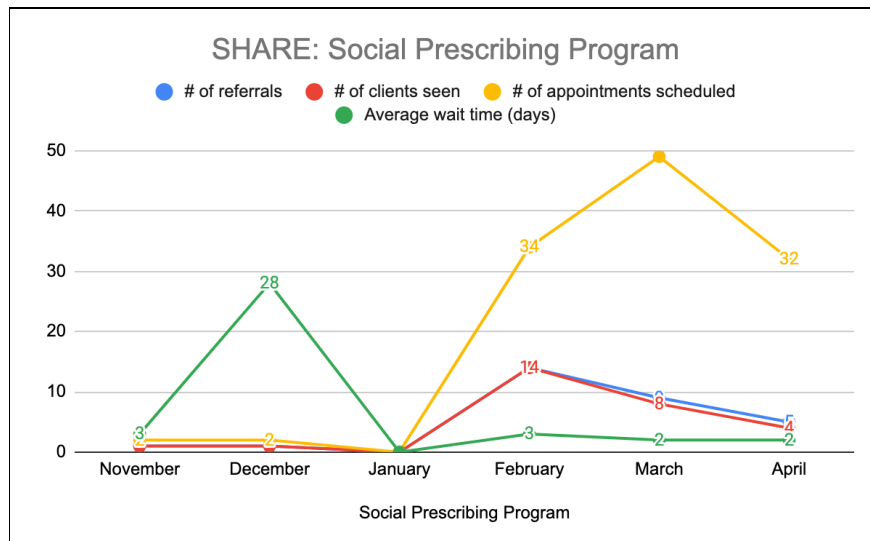
Feedback from the Community

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 April 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)	+93	484	+34
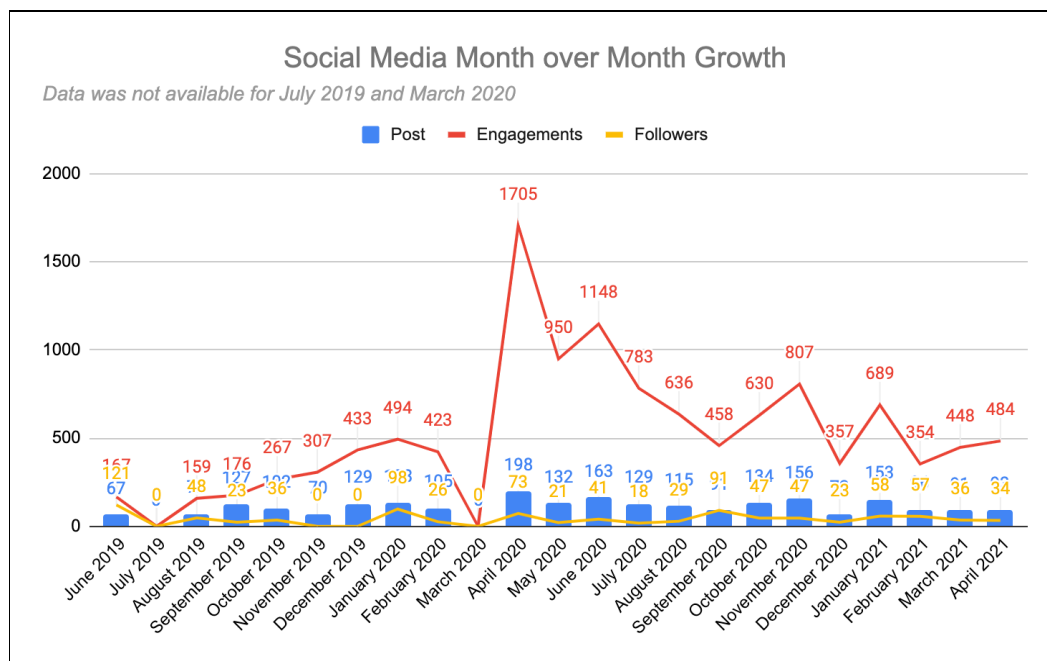
Each quarter, a newsletter is distributed to patients in the communities who have signed up or agreed to receive newsletters from the Division. When this resource launched in May 2020, there were a total of 170 subscribers, whereas in January the subscribers grew by approximately 1800% to a month end total of 3285 subscribers. 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%

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."

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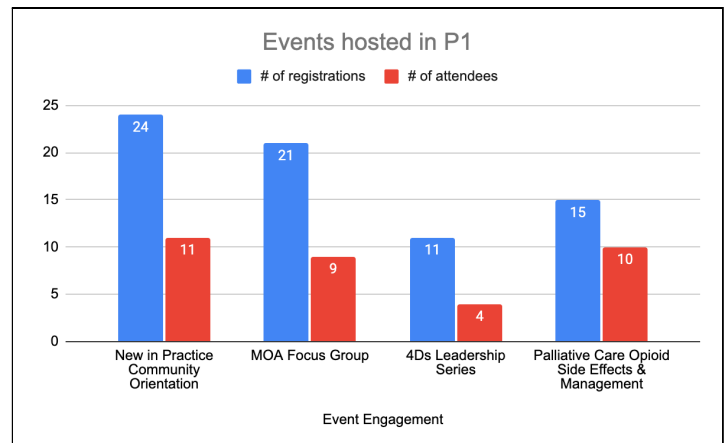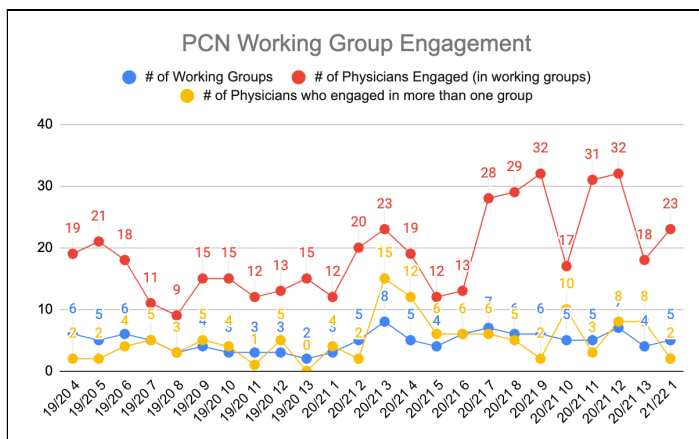
Additional engagement support provided to FNW physicians is the website development. The move to providing primary care services in a virtual setting continues to grow and expand. A full list of the clinics in the FNW and their associated websites can be found by clicking here. The chart below details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

FN PMH Website Development Progress
The total % below is compared to the total PMHs in FNW
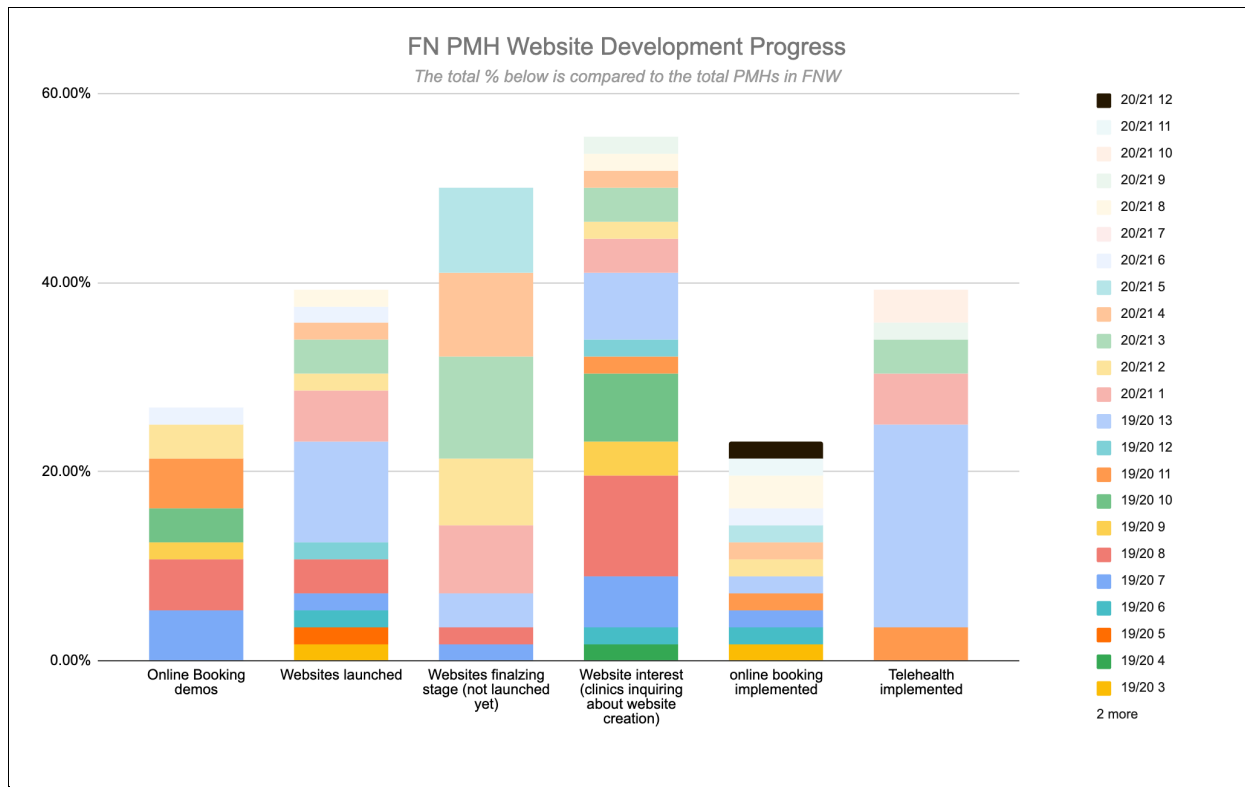
Website analytics that looks at the total page views and visits from the public on popular links from each clinic website and approximately 16% of the 'click's in this period were on Booking an Appointment.

Website Analytics - Popular Content (P1)
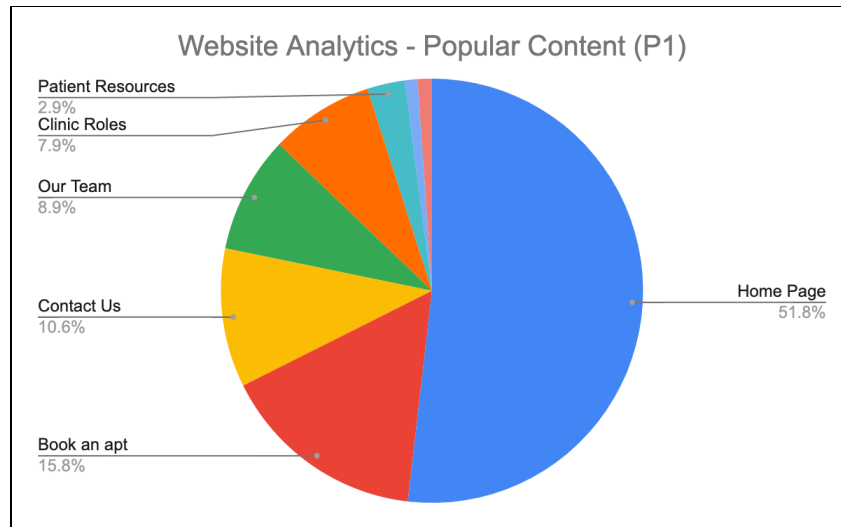
A feedback mechanism that's been implemented in the FNW since 2019 between the Division staff and FPs enables FPs to share 'what frustrates them in practice' with the Division staff in order to collaboratively work to improve coordination of care for continuous improvement. Recently, the impacts of this feedback mechanism yielded positive outcomes when a Physician identified some opportunities for improvement when Colposcopy referrals are made to the acute system. Through collaborative work between the FP, the Division and HA staff, this referral pathway was updated and rectified with the quality of care for patients at the forefront.

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 below is a draft representation of the workflow process for this tool's implementation:
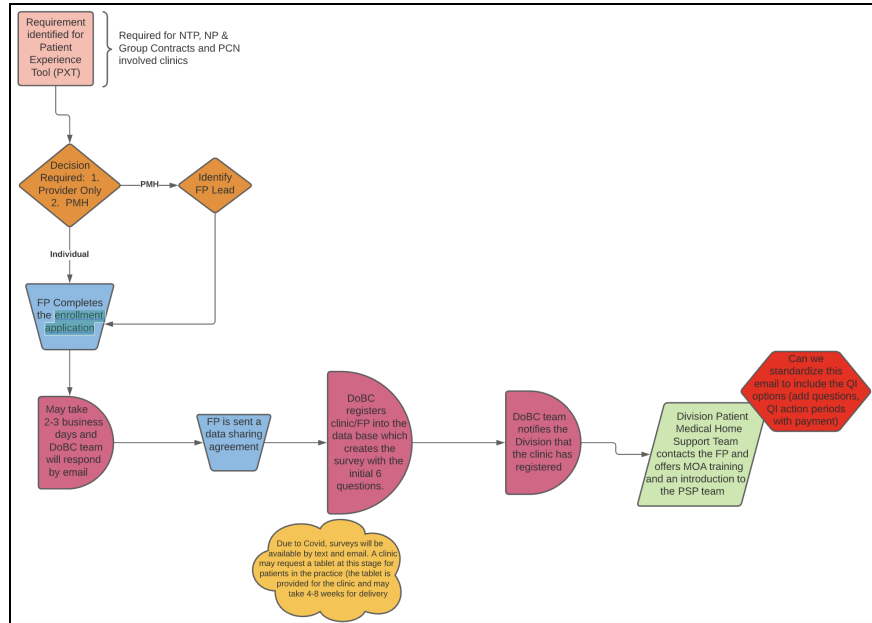
Pathways

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.
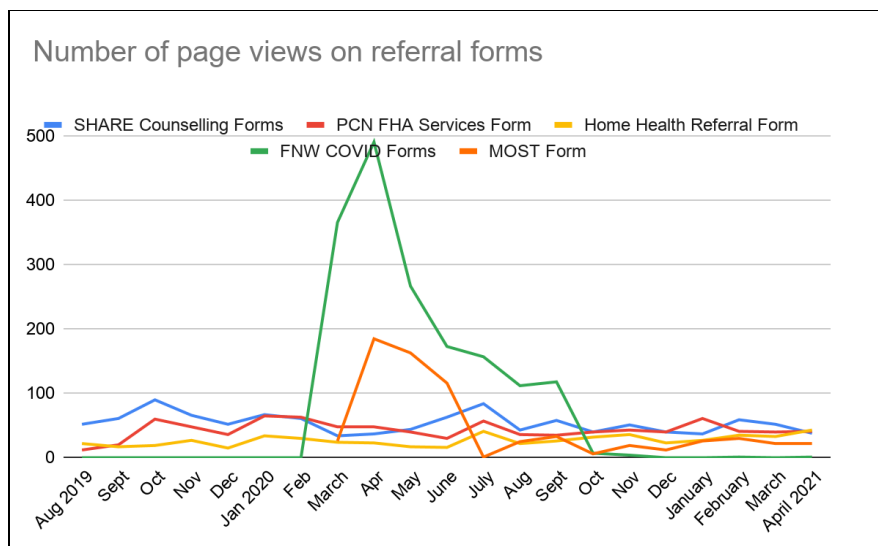
PCN Lessons Learned

1. 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. 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.