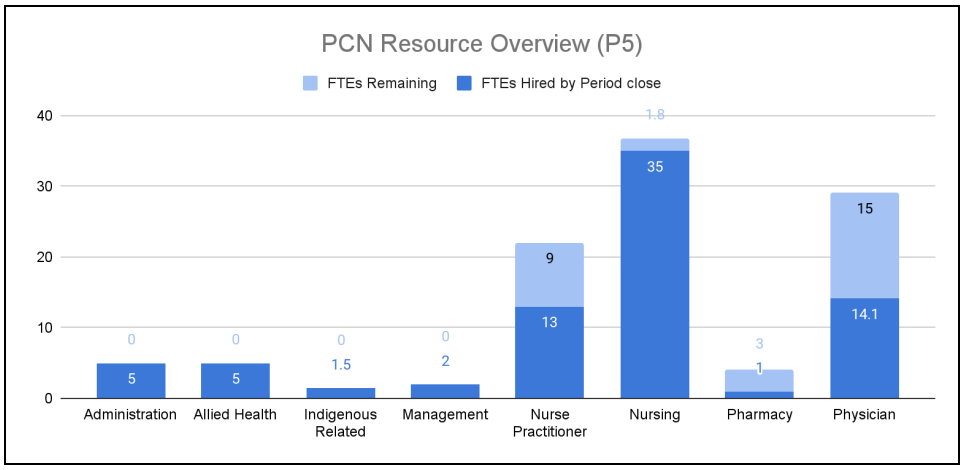
# Fraser Northwest Primary Care Network

Period 5 Addendum Report




## Patient Medical Home Snapshot

| Provider Types | # in FNW |
|---|---|
| FFS Longitudinal Family Physician | 155 |
| PCN funded FP | 14 |
| PCN funded NP | 14 |
| Community NP | 23 |

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

**The FNW population surpasses 327,000 people. With 155 primary care providers currently working in these communities, for all people to become attached, that would result in an average panel size of 2153 people/provider**

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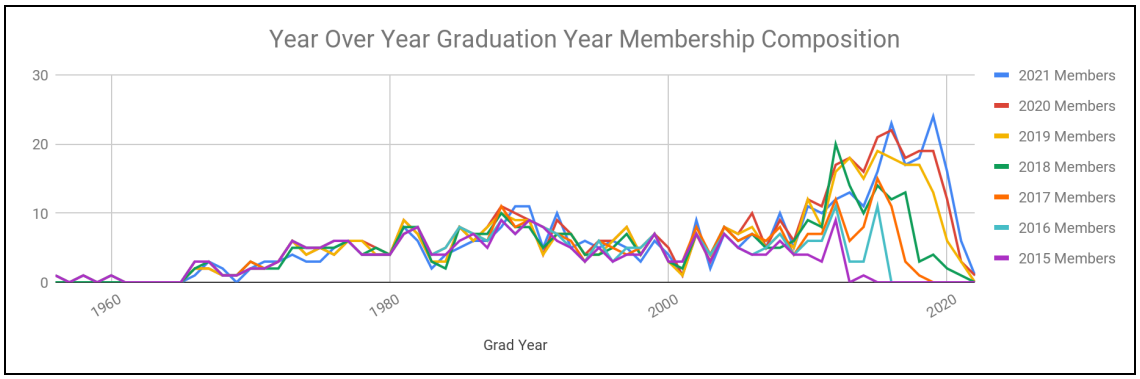
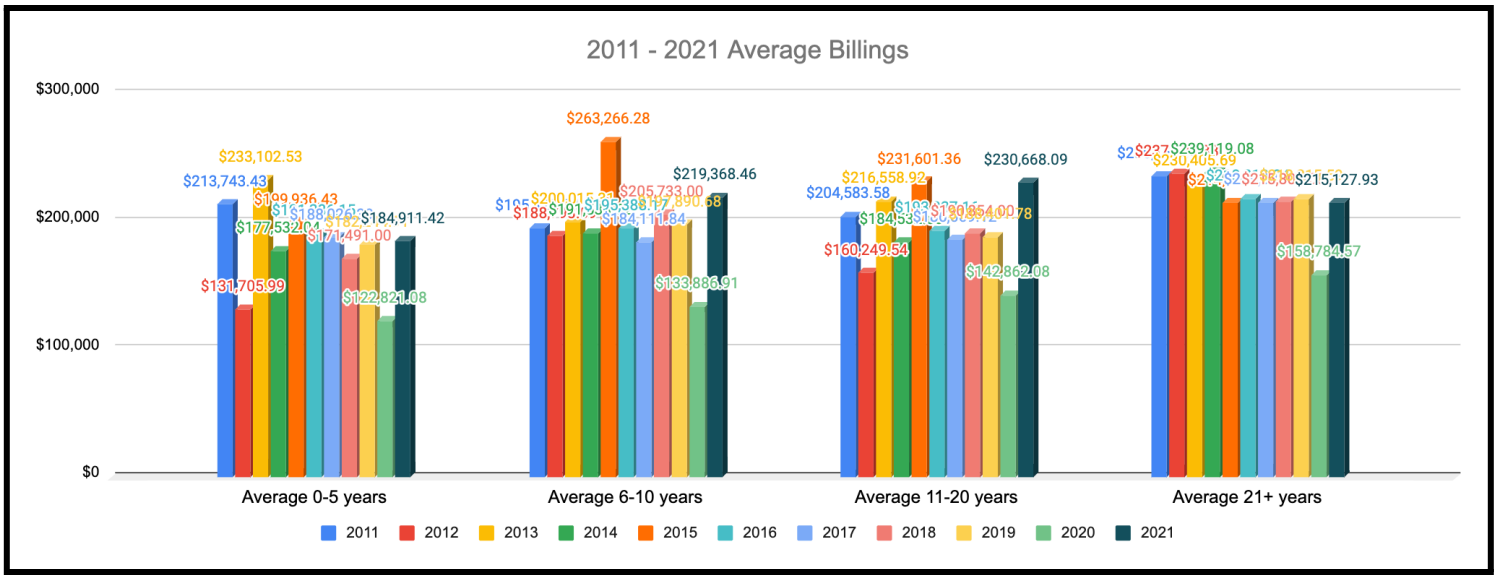
## FNW Community Overview

FNW Division membership comprises approximately 500 physician and provider members. Although this number is large, almost 40% of FNW members have been in practice for 20+ years, making up a significant portion of the membership of FNW. Membership is, not surprisingly, largely made up of community Family Physicians with a similar number of locums and hospitalists comprising the bulk of the members. Year over year membership composition continues to show strong numbers for Physicians in their first 10 years of practice, the graph below represents the year over year membership composition based on members' graduation year:




The average Blue Book Listings for Physicians in the FNW from 2011-2021 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 | 13 | **-12 providers since PCN inception** |
| **Provider Losses** | 27 | 13 | 16 | 17 | |
| **Net Loss/Gain** | -15 | +5 | +2 | -4 | |
| **# of Patients attached through *FNW Attachment Hub*** | 856 | 2792 | 6783 | 1544 | |
| **# of Patients registered through the FNW Attachment Hub** | NA | 5564 | 8677 | 8760 | |
| **MoH $0 Fee Code Attachment** | NA* | 73,742 | 6980 | 4509 | |

**MoH Data not available for 2019*

There are approximately 2 longitudinal Primary Care Providers set to retire or leave Family Practice in the remainder of 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!"*

A quote emerged from a recent dialogue between two Physicians in which identified sentiments causing concern in the FNW:

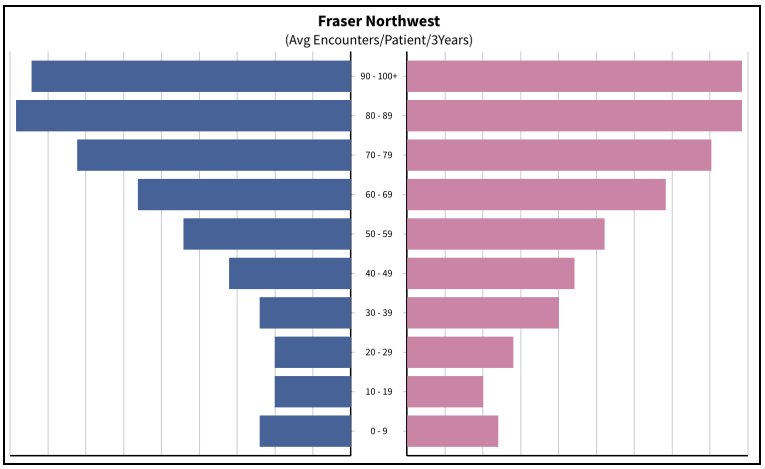
> "Dr 1*: If we practice medicine to have zero liability, no one will get anything done (as we see in FHA).*
>
> Dr 2: *I agree with you; it's these small things that show no one cares about our valued time and our expertise. As long as the health authority and gov't treats us as a dumping ground, we will all leave practice -- I myself am looking to move out of practice, there was recently a RCMP job posting that I am now exploring.*
> *I will also write my concerns to DofBC as well (if THEY even care...)"*

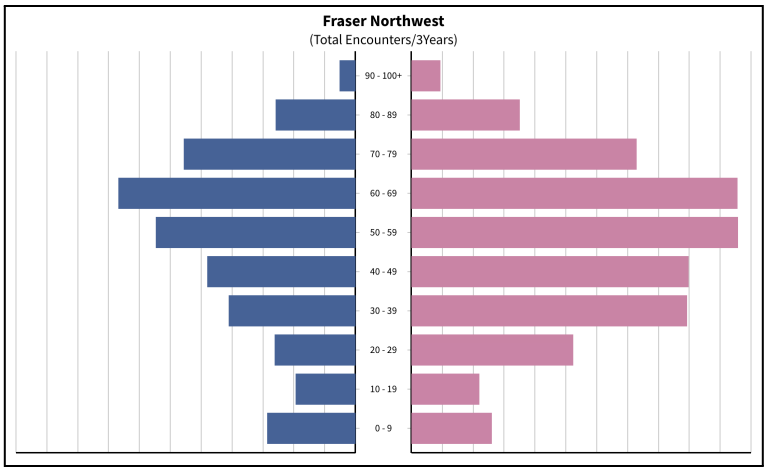
Since April 2022, 4 FNW PMHs and 1 specialized clinic have come forward and identified that they are in a critical state of closure. With primary care provider resources moving out of clinics or retiring, and no new providers joining the clinics, this has a profound impact on the remaining providers' ability to provide the same level of overhead support to the clinic. ***The Primary Care Providers at these PMHs support approximately 55,000 people and to suffer this significant loss in clinics would have a dramatic impact on the FNW communities' access to primary care.***

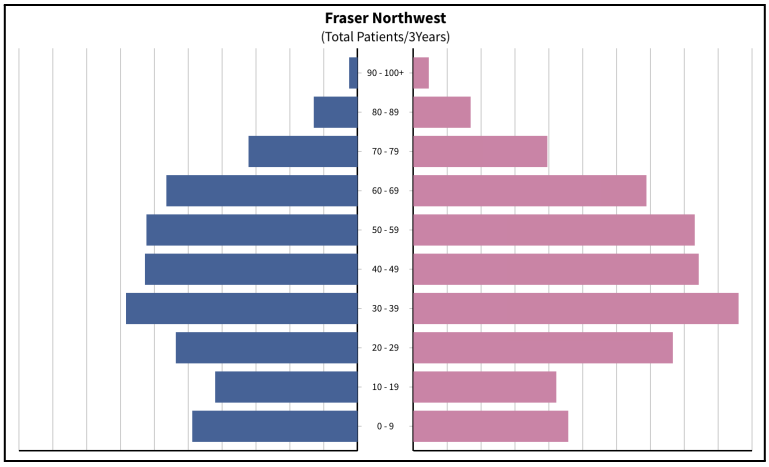
Despite high demand, Locum availability is limited in the community. In February 2022, data was collected to document the number of locum opportunities currently available in the community, including vacancies and filled vacancies and unfilled positions. In Period 5, vacancies dropped from the previous period to an average of 21 openings during this period.

### 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:



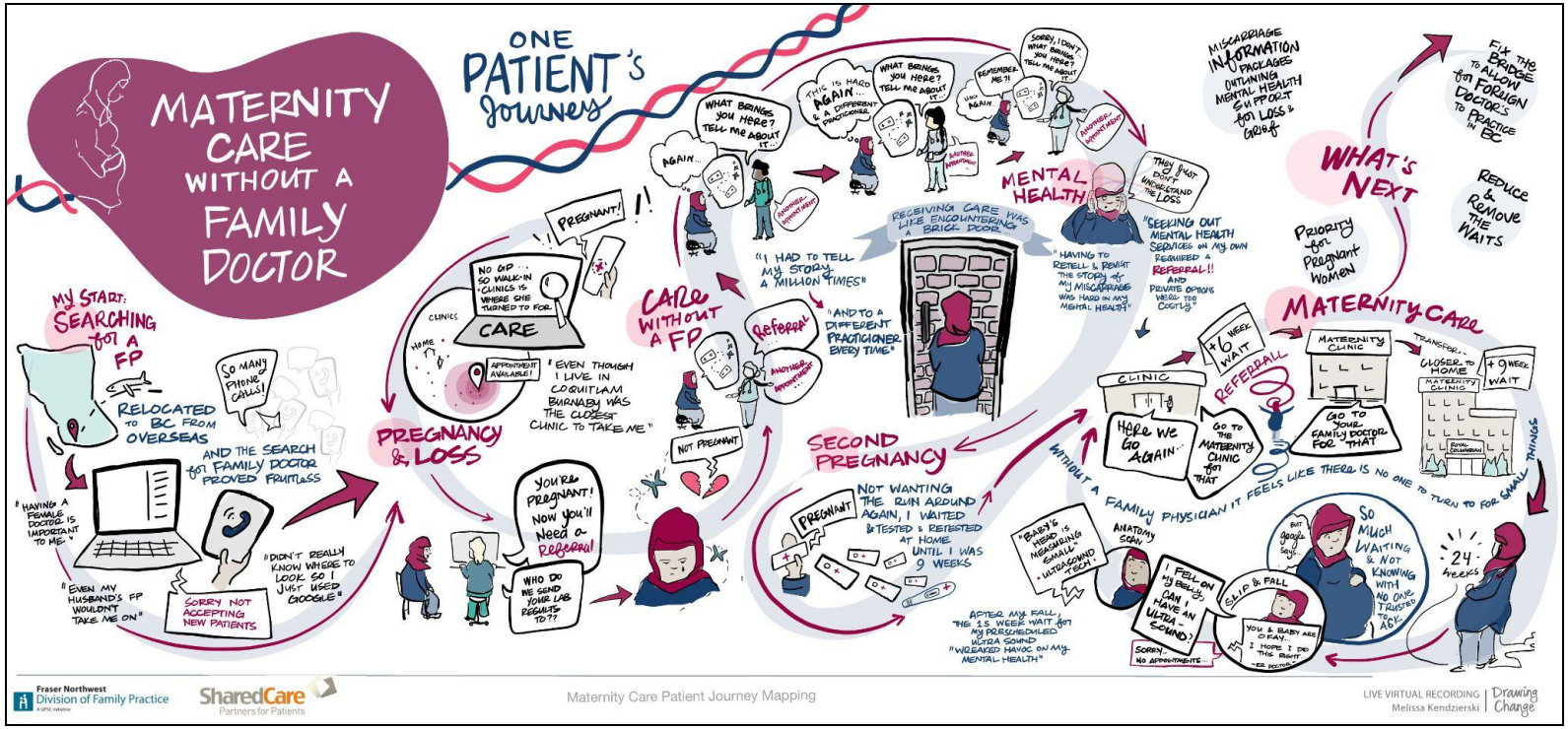



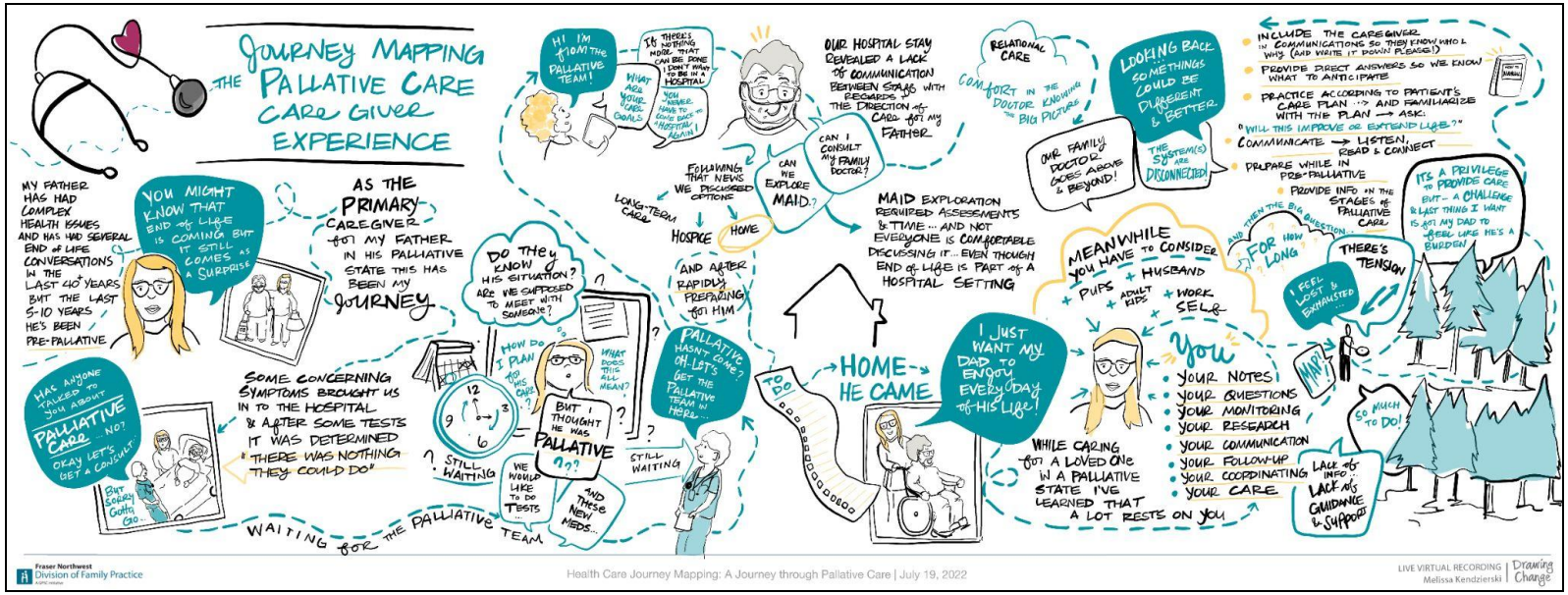

## Overview: Community Journey Mapping

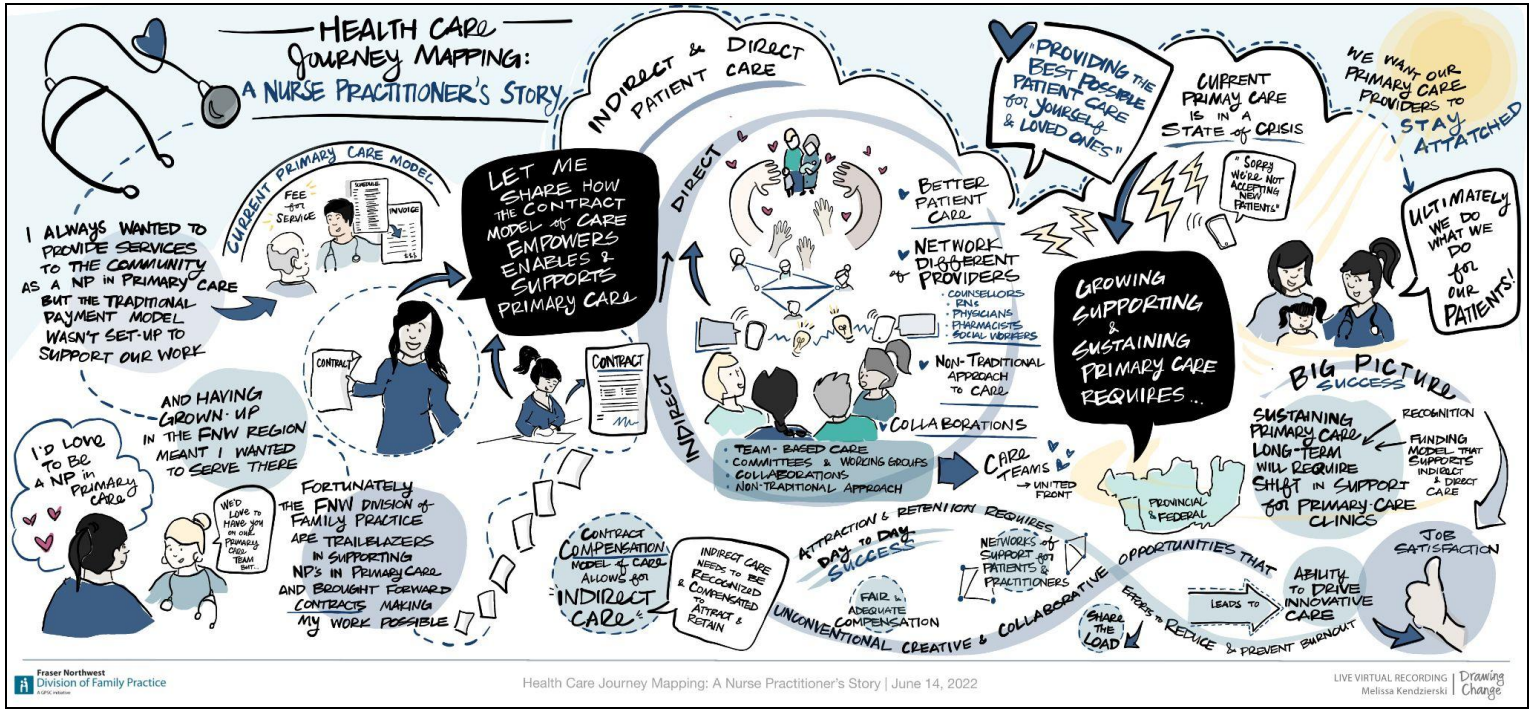
Recently, a number of patient and provider journey maps have been created to better understand the experiences and impacts that the health care system has had, and continues to have on members of the community. At the time of writing this report, 4 journey maps have been created which look at experiences such as:

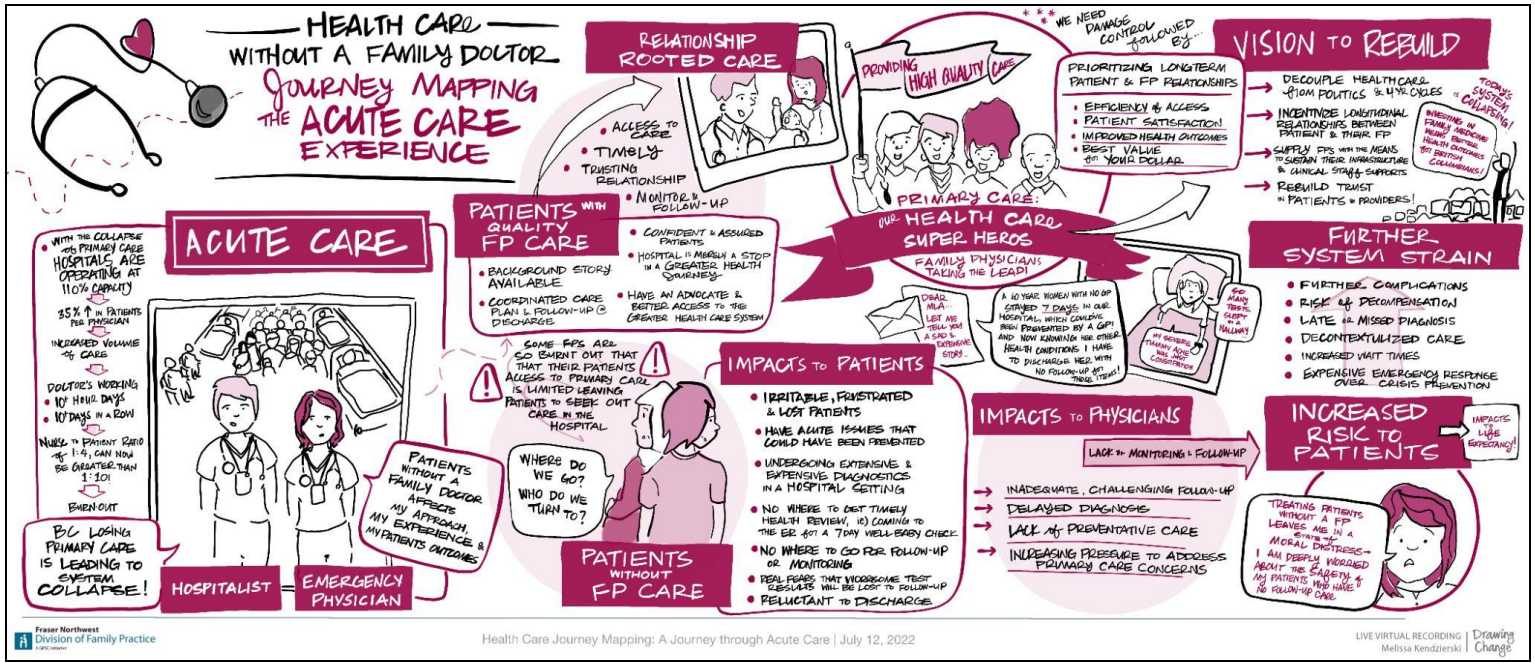
- Unattached Prenatal patient journey
- Palliative Caregiver journey
- Community Nurse Practitioner experience
- Acute Care Physicians experience' during this primary care crisis

The images on the pages below showcase these stories collected.


MATERNITY CARE WITHOUT A FAMILY DOCTOR
ONE PATIENT'S Journey
MY START: SEARCHING for a FP
RELOCATED to BC FROM OVERSEAS
AND THE SEARCH for FAMILY DOCTOR PROVED FRUITLESS
"HAVING A FEMALE DOCTOR IS IMPORTANT TO ME"
"EVEN MY HUSBAND'S FP WOULDN'T TAKE ME ON"
SORRY NOT ACCEPTING NEW PATIENTS
"DIDN'T REALLY KNOW WHERE TO LOOK SO I JUST USED GOOGLE"
SO MANY PHONE CALLS!
PREGNANCY & LOSS
PREGNANT!
NO GP... SO WALK-IN CLINICS IS WHERE SHE TURNED TO FOR CARE
CLINICS
HOME
APPOINTMENT AVAILABLE!
"EVEN THOUGH I LIVE IN COQUITLAM BURNABY WAS THE CLOSEST CLINIC TO TAKE ME"
NOT PREGNANT
YOU'RE PREGNANT! NOW YOU'LL NEED a Referral
WHO DO WE SEND YOUR LAB RESULTS TO??
CARE WITHOUT A FP
WHAT BRINGS YOU HERE? TELL ME ABOUT IT...
AGAIN...
ANOTHER APPOINTMENT
THIS IS HARD AGAIN... & A DIFFERENT PRACTICIANER
ANOTHER APPOINTMENT
Referral
ANOTHER APPOINTMENT
"I HAD TO TELL MY STORY A MILLION TIMES"
"AND TO A DIFFERENT PRACTICIANER EVERY TIME"
RECEIVING CARE WAS LIKE ENCOUNTERING A BRICK DOOR
MENTAL HEALTH
SORRY, I DON'T... WHAT BRINGS YOU HERE? TELL ME ABOUT IT...
REMEMBER ME?!
WHY AGAIN...
ANOTHER APPOINTMENT
THEY JUST DON'T UNDERSTAND THE LOSS
"HAVING TO RETELL & REVISIT THE STORY OF MY MISCARRIAGE WAS HARD ON MY MENTAL HEALTH"
"SEEKING OUT MENTAL HEALTH SERVICES ON MY OWN REQUIRED A REFERRAL!! AND PRIVATE OPTIONS WERE TOO COSTLY"
MISCARRIAGE INFORMATION PACKAGES ONTAINING MENTAL HEALTH SUPPORT for LOSS & GRIEF
WHAT'S NEXT
FIX THE BRIDGE TO ALLOW FOREIGN DOCTOR'S TO PRACTICE IN BC
REDUCE & REMOVE THE WAITS
Priority for Pregnant Women
MATERNITY CARE
MATERNITY CLINIC
TRANSFER
CLOSER TO HOME
+9 WEEK WAIT
MATERNITY CLINIC
ROYAL COLUMBIAN
+6 WEEK WAIT
CLINIC
REFERRAL
Here We Go Again...
GO TO THE MATERNITY CLINIC for THAT
GO TO YOUR FAMILY DOCTOR FOR THAT
SECOND PREGNANCY
PREGNANT
NOT WANTING THE RUN AROUND AGAIN, I WAITED & TESTED & RETESTED AT HOME UNTIL I WAS 9 WEEKS
AFTER MY FALL, THE 15 WEEK WAIT for MY RESCHEDULED ULTRA SOUND "WREAKED HAVOC ON MY MENTAL HEALTH"
"BABY'S HEART IS NEGLIGIBLE EMAIL" - ULTRASOUND TECH
ANATOMY SCAN
I FELL ON MY BELLY, CAN I HAVE AN ULTRA-SOUND?
SORRY, NO APPOINTMENTS...
SLIP & FALL
YOU & BABY ARE OKAY... I HOPE I DO THIS RIGHT
-ER DOCTOR
WITHOUT A FAMILY PHYSICIAN IT FEELS LIKE THERE IS NO ONE TO TURN TO FOR SMALL THINGS
SO MUCH WAITING & NOT KNOWING WITH NO ONE TRUSTED TO ASK
BUT google SAYS...
24 weeks
Fraser Northwest Division of Family Practice
SharedCare Partners for Patients
Maternity Care Patient Journey Mapping
LIVE VIRTUAL RECORDING Melissa Kendzierski | Drawing Change


Journey Mapping the PALLATIVE CARE CARE GIVER EXPERIENCE
MY FATHER HAS HAD COMPLEX HEALTH ISSUES AND HAS HAD SEVERAL END OF LIFE CONVERSATIONS IN THE LAST 40+ YEARS BUT THE LAST 5-10 YEARS HE'S BEEN PRE-PALLATIVE
YOU MIGHT KNOW THAT END OF LIFE IS COMING BUT STILL COMES AS A SURPRISE
AS THE PRIMARY CAREGIVER for MY FATHER IN HIS PALLATIVE STATE THIS HAS BEEN MY JOURNEY
HAS ANYONE TALKED TO YOU ABOUT PALLATIVE CARE... NO? OKAY LET'S GET A CONSULT
SOME CONCERNING SYMPTOMS BROUGHT US IN TO THE HOSPITAL & AFTER SOME TESTS IT WAS DETERMINED "THERE WAS NOTHING THEY COULD DO"
WAITING for THE PALLATIVE TEAM
HI! I'M TIM THE PALLATIVE TEAM!
IT THERE'S NOTHING MORE THAT CAN BE DONE I DON'T WANT TO BE IN A HOSPITAL
WHAT ARE YOUR CARE GOALS?
YOU WANTED HAVE TO COME BACK TO HOSPITAL AGAIN!
DO THEY KNOW HIS SITUATION? ARE WE SUPPOSED TO MEET WITH SOMEONE?
HOW DO I PLAN for HIS CARE?
WHAT DOES THIS ALL MEAN?
BUT I THOUGHT HE WAS PALLATIVE ???
WE WOULD LIKE TO DO TESTS...
AND THESE NEW MEDS...
STILL WAITING
PALLATIVE HASN'T COME OH-LET'S GET THE PALLATIVE TEAM IN HERE...
STILL WAITING
OUR HOSPITAL STAY REVEALED A LACK OF COMMUNICATION BETWEEN STAFF WITH REGARDS TO THE DIRECTION OF CARE for MY FATHER
CAN I CONSULT MY FAMILY DOCTOR?
CAN WE EXPLORE MAID?
FOLLOWING THAT NEWS WE DISCUSSED OPTIONS
LONG-TERM CARE
HOSPICE
HOME
AND AFTER RAPIDLY PREPARING for HIM
MAID EXPLORATION REQUIRED ASSESSMENTS & TIME... AND NOT EVERYONE IS COMFORTABLE DISCUSSING IT... EVEN THOUGH END OF LIFE IS PART OF A HOSPITAL SETTING
TO DO
HOME HE CAME
I JUST WANT MY DAD TO ENJOY EVERY DAY OF HIS LIFE!
RELATIONAL CARE
COMFORT IN THE DOCTOR KNOWING THE BIG PICTURE
OUR FAMILY DOCTOR GOES ABOVE & BEYOND!
LOOKING BACK SO MEANINGS COULD BE DIFFERENT & BETTER
THE SYSTEM(S) ARE DISCONNECTED!
MEANWHILE YOU HAVE TO CONSIDER + PUPS + HUSBAND + ADULT KIDS + WORK + SELF
WHILE CARING for A LOVED ONE IN A PALLIATIVE STATE I'VE LEARNED THAT A LOT RESTS ON YOU
You
• YOUR NOTES
• YOUR QUESTIONS
• YOUR MONITORING
• YOUR RESEARCH
• YOUR COMMUNICATION
• YOUR FOLLOW-UP
• YOUR COORDINATING
• YOUR CARE
LACK OF INFO... LACK OF GUIDANCE & SUPPORT
• INCLUDE THE CAREGIVER IN COMMUNICATIONS SO THEY KNOW WHO & WHY (AND WRITE IT DOWN PLEASE!)
• PROVIDE DIRECT ANSWERS SO WE KNOW WHAT TO ANTICIPATE
• PRACTICE ACCORDING TO PATIENT'S CARE PLAN --> AND FAMILIARIZE WITH THE PLAN --> ASK
"WILL THIS IMPROVE OR EXTEND LIFE?"
• COMMUNICATE --> LISTEN, READ & CONNECT
• PREPARE WHILE IN PRE-PALLIATIVE
• PROVIDE INFO IN THE STAGES OF PALLIATIVE CARE
AND THEN THE BIG QUESTION... FOR HOW LONG?
THERE'S TENSION
I FEEL LOST & EXHAUSTED
IT'S A PRIVILEGE TO PROVIDE CARE BUT... A CHALLENGE & LAST THING I WANT IS for MY DAD TO FEEL LIKE HE'S A BURDEN
HAP!
SO MUCH TO DO!
Fraser Northwest Division of Family Practice
Health Care Journey Mapping: A Journey through Palliative Care | July 19, 2022
LIVE VIRTUAL RECORDING Melissa Kendzierski | Drawing Change


HEALTH CARE JOURNEY MAPPING:
A NURSE PRACTITIONER'S STORY
I ALWAYS WANTED TO PROVIDE SERVICES TO THE COMMUNITY AS A NP IN PRIMARY CARE BUT THE TRADITIONAL PAYMENT MODEL WASN'T SET-UP TO SUPPORT OUR WORK
CURRENT PRIMARY CARE MODEL
FEE FOR SERVICE
INVOICE
AND HAVING GROWN-UP IN THE FNW REGION MEANT I WANTED TO SERVE THERE
I'D LOVE TO BE A NP in PRIMARY CARE
WE'D LOVE TO HAVE YOU on OUR PRIMARY CARE TEAM BUT...
FORTUNATELY THE FNW DIVISION of FAMILY PRACTICE ARE TRAILBLAZERS IN SUPPORTING NP'S IN PRIMARY CARE AND BROUGHT FORWARD CONTRACTS MAKING MY WORK POSSIBLE
CONTRACT
LET ME SHARE HOW THE CONTRACT MODEL of CARE EMPOWERS ENABLES & SUPPORTS PRIMARY CARE
INDIRECT & DIRECT PATIENT CARE
DIRECT
INDIRECT
BETTER PATIENT CARE
NETWORK DIFFERENT PROVIDERS
· COUNSELLORS
· RNs
· PHYSICIANS
· PHARMACISTS
· SOCIAL WORKERS
NON-TRADITIONAL APPROACH TO CARE
COLLABORATIONS
· TEAM-BASED CARE
· COMMITTEES & WORKING GROUPS
· COLLABORATIONS
· NON-TRADITIONAL APPROACH
CARE TEAMS
→ UNITED FRONT
CONTRACT COMPENSATION MODEL of CARE ALLOWS for INDIRECT CARE
INDIRECT CARE NEEDS TO BE RECOGNIZED & COMPENSATED TO ATTRACT & RETAIN
ATTRACTION & RETENTION REQUIRES DAY TO DAY SUCCESS
FAIR & ADEQUATE COMPENSATION
NETWORKS of SUPPORT for PATIENTS & PRACTITIONERS
UNCONVENTIONAL CREATIVE & COLLABORATIVE OPPORTUNITIES THAT
SHARE THE LOAD
EFFORTS TO REDUCE & PREVENT BURNOUT
LEADS TO
ABILITY TO DRIVE INNOVATIVE CARE
"PROVIDING THE BEST POSSIBLE PATIENT CARE for YOURSELF & LOVED ONES"
CURRENT PRIMAY CARE IS IN A STATE of CRISIS
"SORRY WE'RE NOT ACCEPTING NEW PATIENTS"
GROWING SUPPORTING & SUSTAINING PRIMARY CARE REQUIRES...
PROVINCIAL & FEDERAL
WE WANT OUR PRIMARY CARE PROVIDERS TO STAY ATTACHED
ULTIMATELY WE DO WHAT WE DO for OUR PATIENTS!
BIG PICTURE SUCCESS
SUSTAINING PRIMARY CARE LONG-TERM WILL REQUIRE SHIFT IN SUPPORT for PRIMARY-CARE CLINICS
RECOGNITION
FUNDING MODEL THAT SUPPORTS INDIRECT & DIRECT CARE
JOB SATISFACTION
Fraser Northwest Division of Family Practice
Health Care Journey Mapping: A Nurse Practitioner's Story | June 14, 2022
LIVE VIRTUAL RECORDING Melissa Kendzierski | Drawing Change


HEALTH CARE WITHOUT A FAMILY DOCTOR
JOURNEY MAPPING THE ACUTE CARE EXPERIENCE
ACUTE CARE
WITH THE COLLAPSE of PRIMARY CARE HOSPITALS ARE OPERATING AT 110% CAPACITY
35% ↑ IN PATIENTS PER PHYSICIAN
INCREASED VOLUME of CARE
DOCTOR'S WORKING
· 10+ HOUR DAYS
· 10+ DAYS IN A ROW
NURSE TO PATIENT RATIO of 1:4, CAN NOW BE GREATER THAN 1:20!
BURN-OUT
BC LOSING PRIMARY CARE IS LEADING TO SYSTEM COLLAPSE!
HOSPITALIST = EMERGENCY PHYSICIAN
PATIENTS WITHOUT A FAMILY DOCTOR AFFECTS MY APPROACH, MY EXPERIENCE, & MY PATIENTS OUTCOMES
RELATIONSHIP ROOTED CARE
· ACCESS TO CARE
· TIMELY
· TRUSTING RELATIONSHIP
· MONITOR & FOLLOW-UP
PATIENTS WITH QUALITY FP CARE
· BACKGROUND STORY AVAILABLE
· COORDINATED CARE PLAN & FOLLOW-UP @ DISCHARGE
· CONFIDENT & ASSURED PATIENTS
· HOSPITAL IS MERELY A STOP IN A GREATER HEALTH JOURNEY
· HAVE AN ADVOCATE & BETTER ACCESS TO THE GREATER HEALTH CARE SYSTEM
SOME FPS ARE SO BURNT OUT THAT THEIR PATIENTS ACCESS TO PRIMARY CARE IS LIMITED LEAVING PATIENTS TO SEEK OUT CARE IN THE HOSPITAL
WHERE DO WE GO? WHO DO WE TURN TO?
PATIENTS WITHOUT FP CARE
IMPACTS TO PATIENTS
· IRRITABLE, FRUSTRATED & LOST PATIENTS
· HAVE ACUTE ISSUES THAT COULD HAVE BEEN PREVENTED
· UNDERGOING EXTENSIVE & EXPENSIVE DIAGNOSTICS IN A HOSPITAL SETTING
· NO WHERE TO GET TIMELY HEALTH REVIEW, IE) COMING TO THE ER for A 7DAY WELL-BABY CHECK
· NO WHERE TO GO FOR FOLLOW-UP OR MONITORING
· REAL FEARS THAT WORRISOME TEST RESULTS WILL BE LOST TO FOLLOW-UP
· RELUCTANT TO DISCHARGE
PROVIDING HIGH QUALITY CARE
PRIMARY CARE: OUR HEALTH CARE SUPER HEROS
FAMILY PHYSICIANS TAKING THE LEAD!
DEAR MLA... LET ME TELL YOU A SAD & EXTENSIVE STORY...
A 40 YEAR WOMEN WITH NO GP STAYED 7 DAYS IN OUR HOSPITAL, WHICH COULD HAVE BEEN PREVENTED BY A GP! AND NOW REMINDED HER OTHER HEALTH CONDITIONS I HAVE TO DISCHARGE HER WITH NO FOLLOW-UP for THESE ITEMS!
MY BEWEEN TRAVEL ALONE & CONSTIPATION
SO MANY TIMES I SLEPT IN A HALLWAY
* * * WE NEED DAMAGE CONTROL FOLLOWED BY...
PRIORITIZING LONGTERM PATIENT & FP RELATIONSHIPS
· EFFICIENCY of ACCESS
· PATIENT SATISFACTION
· IMPROVED HEALTH OUTCOMES
· BEST VALUE for YOUR DOLLAR
VISION TO REBUILD
→ DECOUPLE HEALTH CARE from POLITICS & 4 YR. CYCLES
→ INCENTIVIZE LONGITUDINAL RELATIONSHIPS BETWEEN PATIENT & THEIR FP
→ SUPPLY FPS WITH THE MEANS TO SUSTAIN THEIR INFRASTRUCTURE & CLINICAL STAFF SUPPORTS
→ REBUILD TRUST IN PATIENTS & PROVIDERS!
TODAY'S SYSTEM IS COLLAPSING!
INVESTING IN FAMILY MEDICINE HEALTH OUTCOMES for BRITISH COLUMBIANS!
FURTHER SYSTEM STRAIN
· FURTHER COMPLICATIONS
· RISE of DECOMPENSATION
· LATE or MISSED DIAGNOSIS
· DECONTEXTUALIZED CARE
· INCREASED WAIT TIMES
· EXPENSIVE EMERGENCY RESPONSE OVER CRISIS PREVENTION
IMPACTS TO PHYSICIANS
LACK of MONITORING & FOLLOW-UP
→ INADEQUATE, CHALLENGING FOLLOW-UP
→ DELAYED DIAGNOSIS
→ LACK of PREVENTATIVE CARE
→ INCREASING PRESSURE TO ADDRESS PRIMARY CARE CONCERNS
INCREASED RISK TO PATIENTS
IMPACTS on LIFE EXPECTANCY!
TREATING PATIENTS WITHOUT A FP LEAVES ME IN A STATE of MORAL DISTRESS. I AM DEEPLY WORRIED ABOUT THE SAFETY of MY PATIENTS WHO HAVE NO FOLLOW-UP CARE.
Fraser Northwest Division of Family Practice
Health Care Journey Mapping: A Journey through Acute Care | July 12, 2022
LIVE VIRTUAL RECORDING Melissa Kendzierski | Drawing Change

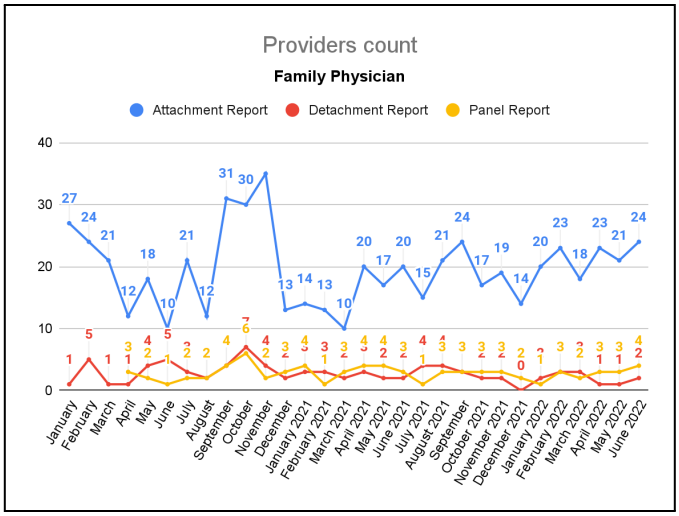
## Attachment

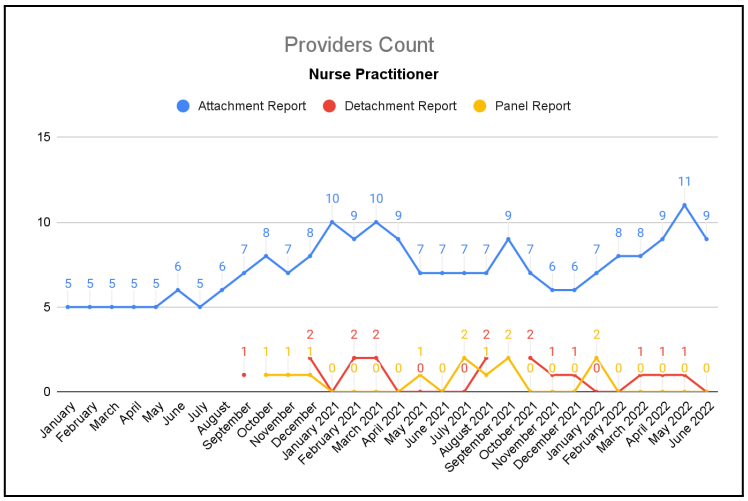
Measuring true attachment continues to be a conversation at all stakeholder and partner organization levels. Attachment level data through the use of the 0$ fee code provides a distinction between types of providers and patient counts. A challenge with implementing support for all PMHs to incorporate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

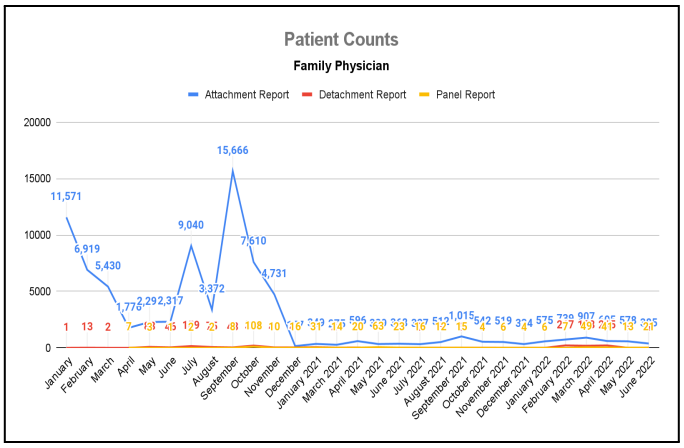
In tandem with the 0$ fee code, the FNW Division has an internal Attachment Hub mechanism which supports patients in the FNW seeking a primary care provider to be attached to primary care providers accepting new patients in the FNW communities.

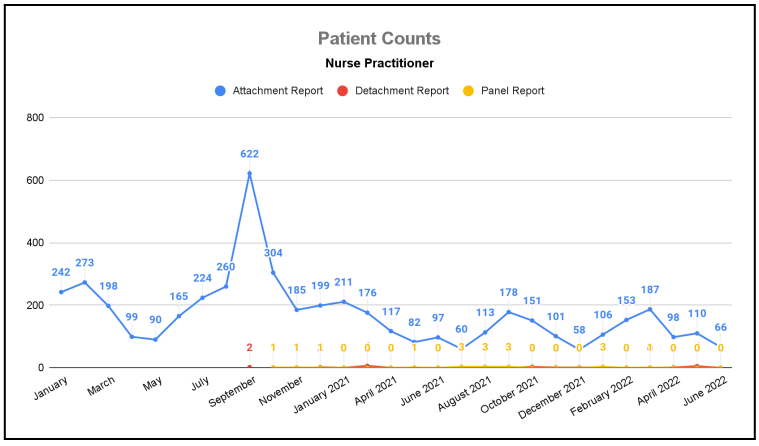
### Attachment Coding (MoH)

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):



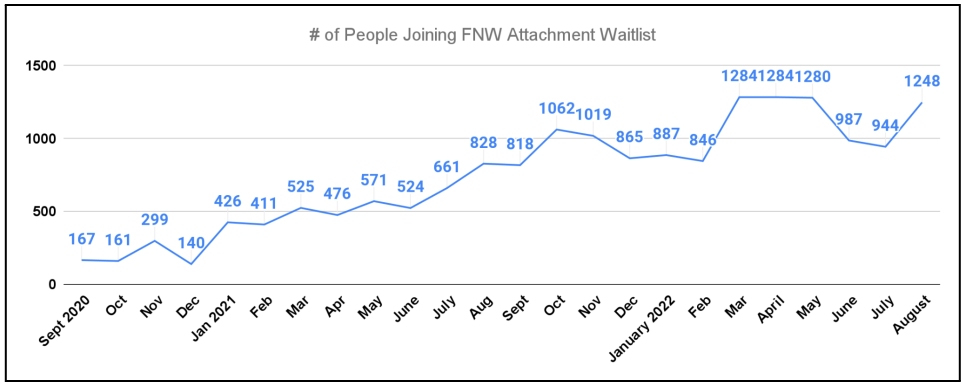



FNW Attachment Hub Waitlist

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:

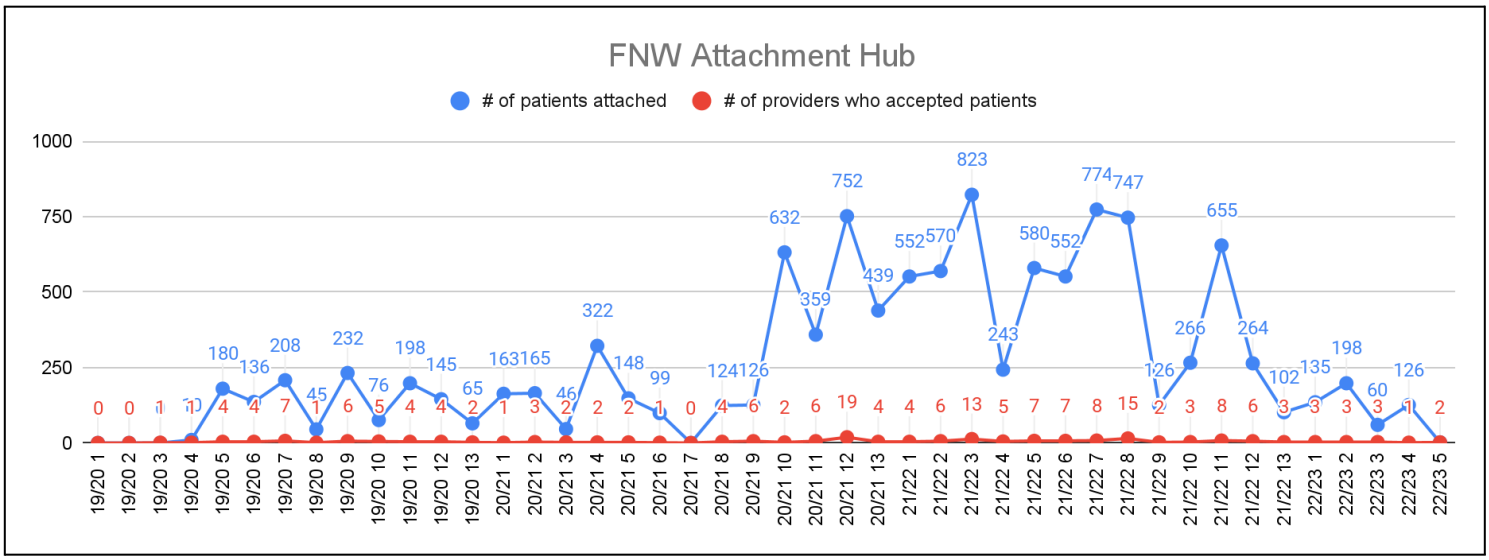
| **Community** | **Average Wait Time (*days*)** |
|---|---|
| New Westminster | 199 |
| Port Moody | 259 |
| Coquitlam | 189 |
| Port Coquitlam | 96 |

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 here reflects the ongoing need and high demand for primary care providers.




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

| | **New Westminster** | **South Coquitlam** | **Port Coquitlam** | **Port Moody, Anmore, Belcarra, North Coquitlam** |
|---|---|---|---|---|
| **# of providers who accepted patients** | 1 | 1 | 0 | 0 |
| **# of patients attached** | 1 | 1 | 0 | 0 |
| **Total Attachments to date** | **11,208** | | | |
| **# of people waitlisted** | 3709<br>***9% ↑ from P4*** | 4968<br>***9% ↑ from P4*** | 1010<br>***17% ↑ from P4*** | 2624<br>***3% ↑ from P4*** |
| **Total people waiting to be attached** | **12,311** | | | |




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 takes for attachment to occur after signing up for the waitlist.

> *A patient is seeking an alternative primary care provider to access medication for their health condition. This reflects the importance of having a primary care provider that is readily available and easily accessible to monitor ongoing health needs.*
>
> *A patient and their family are experiencing difficulty finding a family doctor to oversee their health concerns. Due to the delay in accessing care, this family has been accessing walk-in clinics, while being placed on the waitlist.*
>
> *An unattached patient and their family is seeking a female primary care provider. This reflects the importance of having a primary care provider that patients feel comfortable accessing care from.*

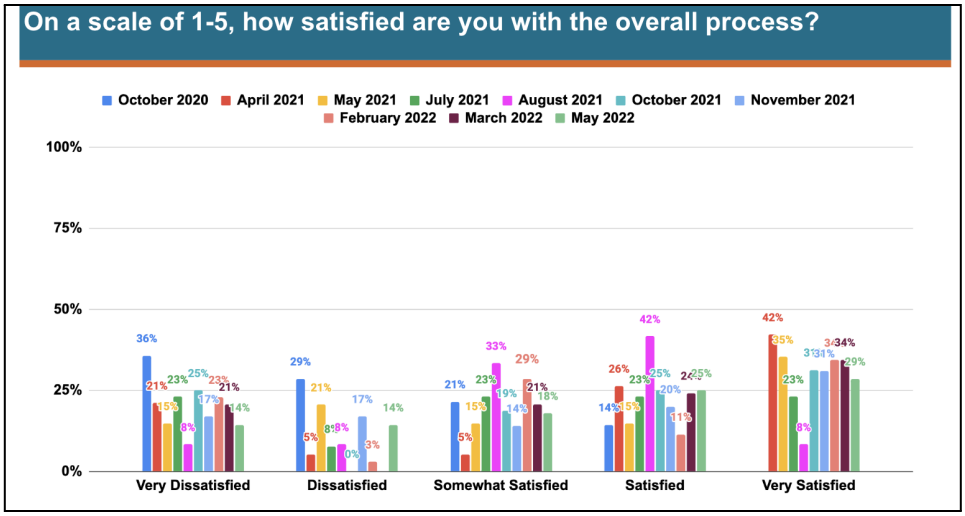
Patients who previously had a primary care provider and are now unattached also may have ongoing health concerns and needs which may be complex to support through alternative means of access such as walk-in clinics, the U&PCC and telehealth. Examples of these include patients who have chronic pain needs where medication for these needs is not easily available through these alternative primary care services.

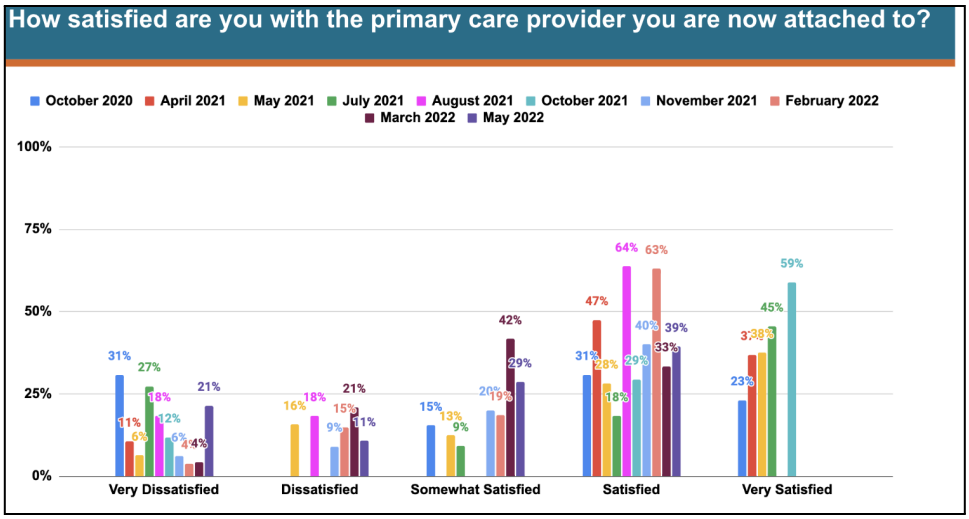
Unfortunately, stories such as these that reflect the need for longitudinal attachment are not unheard of and to ensure an ongoing understanding of these impacts, the Division has launched a Patient Attachment Survey that is distributed to patients 6 weeks after matching with a primary care provider 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.

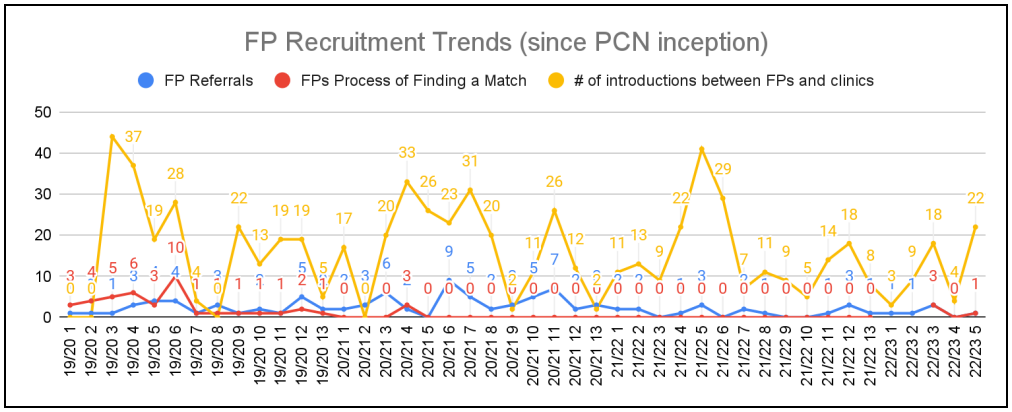


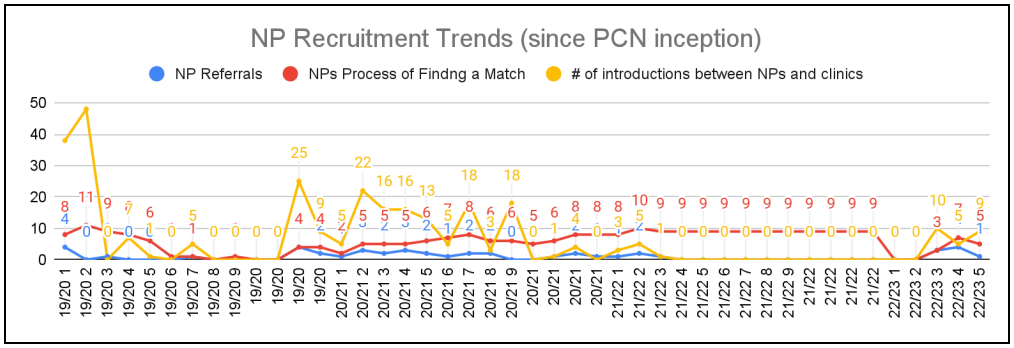




## Family Physician and Nurse Practitioner Contracts

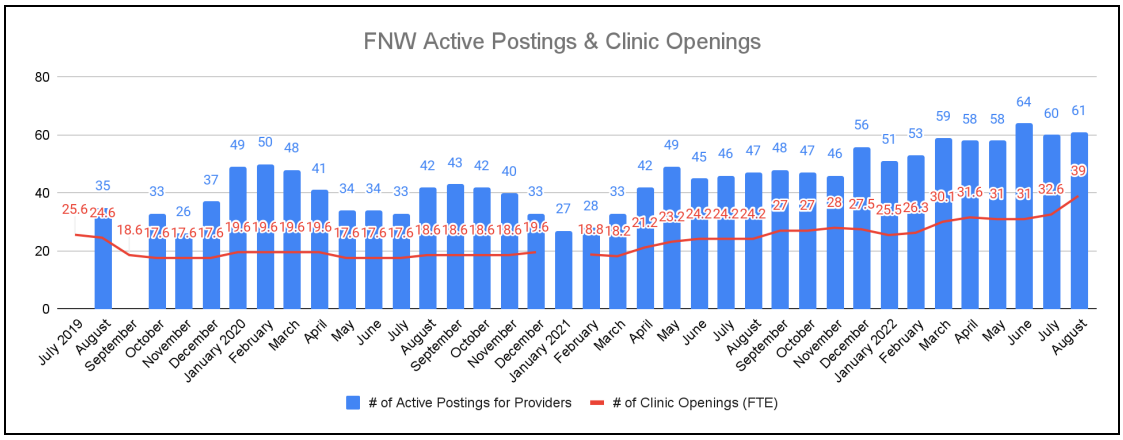
Collaborative work between the FNW, FHA, HealthMatch and the Ministry of Health is vital in order to support increased FP and NP resources in the FNW communities. Table 1 below provides a status overview and update on the breakdown of the NP and FP contracts by PCN within the FNW:

| | 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 | 110 | 22 | 0<br>Current PCN FPs on contract: 15 |
| Nurse Practitioners | 1 | 54 | 9 | 2<br>Current PCN NPs on contract: 14 |

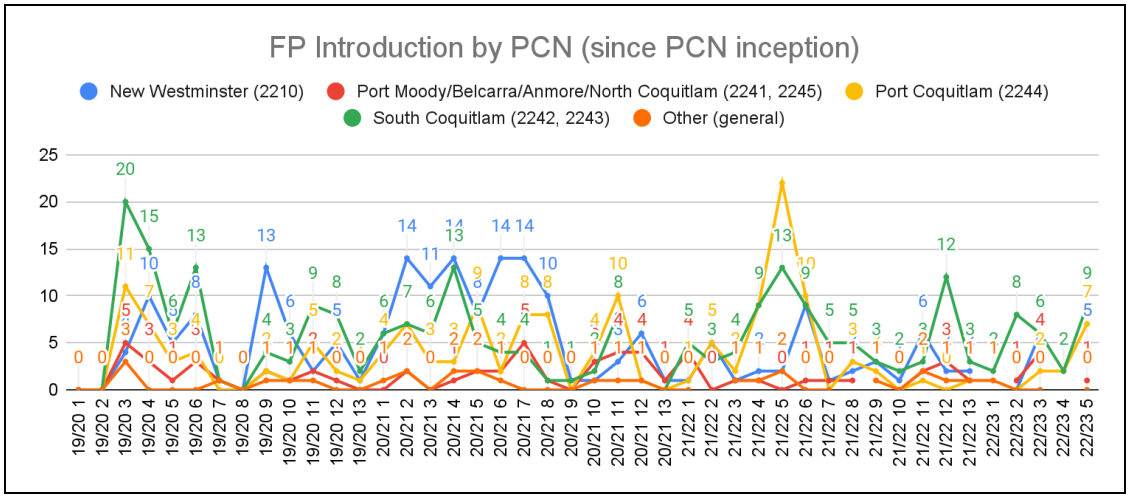



The number of active postings on HealthMatch BC for FPs for both FFS or contract positions decreased to 60 active postings by period close. Opportunities for these postings include: locum and permanent part-time and permanent full-time in the FNW. The table below shows the overall number of active postings and clinic openings available in the FNW communities since data tracking began in July 2019.

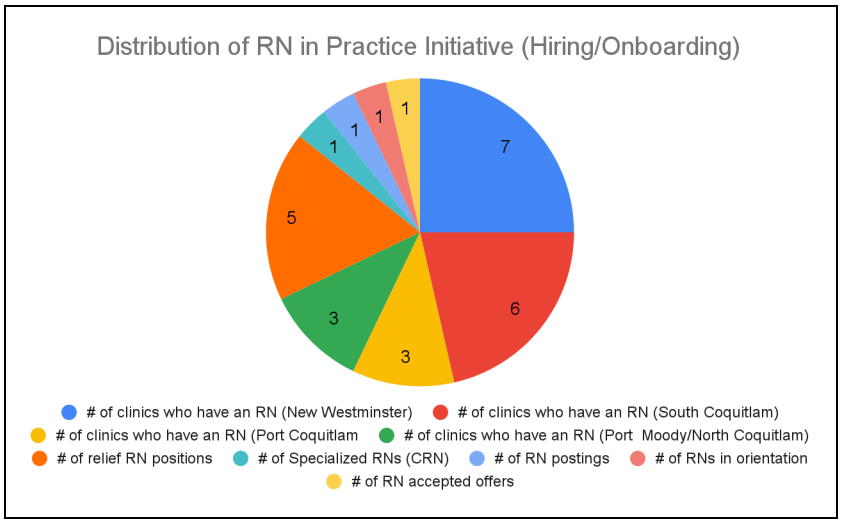



Opportunities and engagement efforts are underway on an ongoing basis and in this period, there were 18 new introductions between FPs and practices for FFS opportunities such as locum, permanent part-time and permanent full-time.

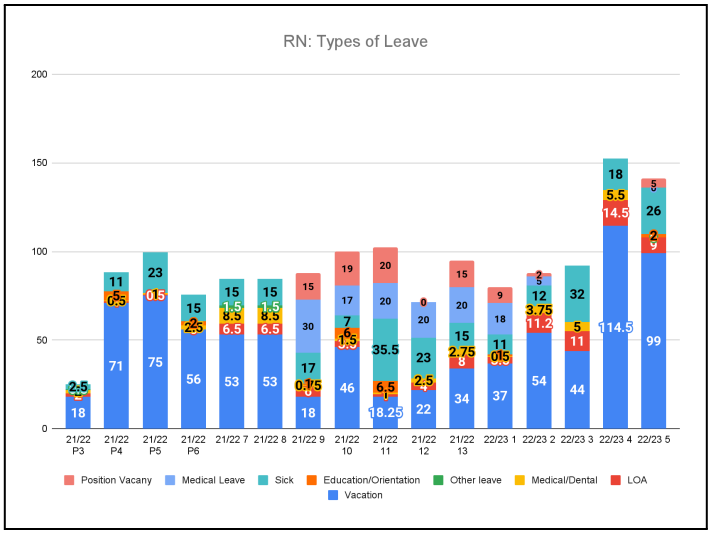


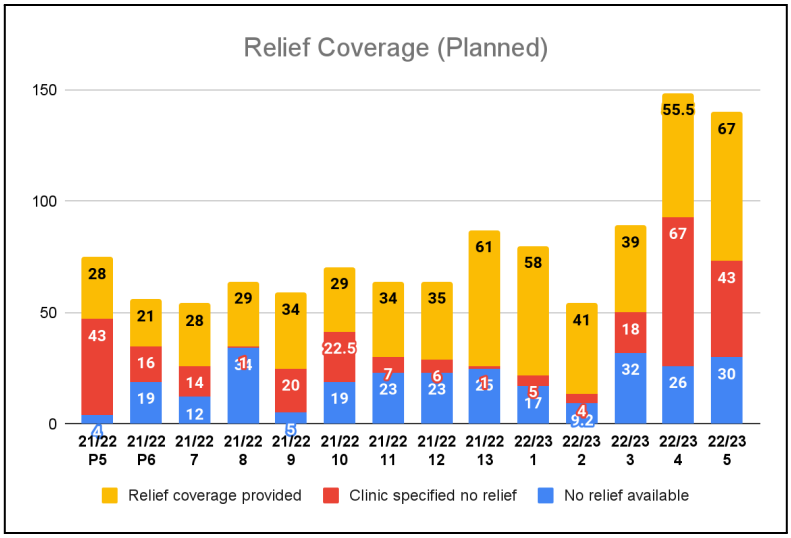

## Registered Nurse in Family Practices

At the end of this period, there 35 RN positions utilized - 8 of which are relief RNs, 1 is a Clinical Resource Nurse and the remaining are at 23 PMHs across the FNW. 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.

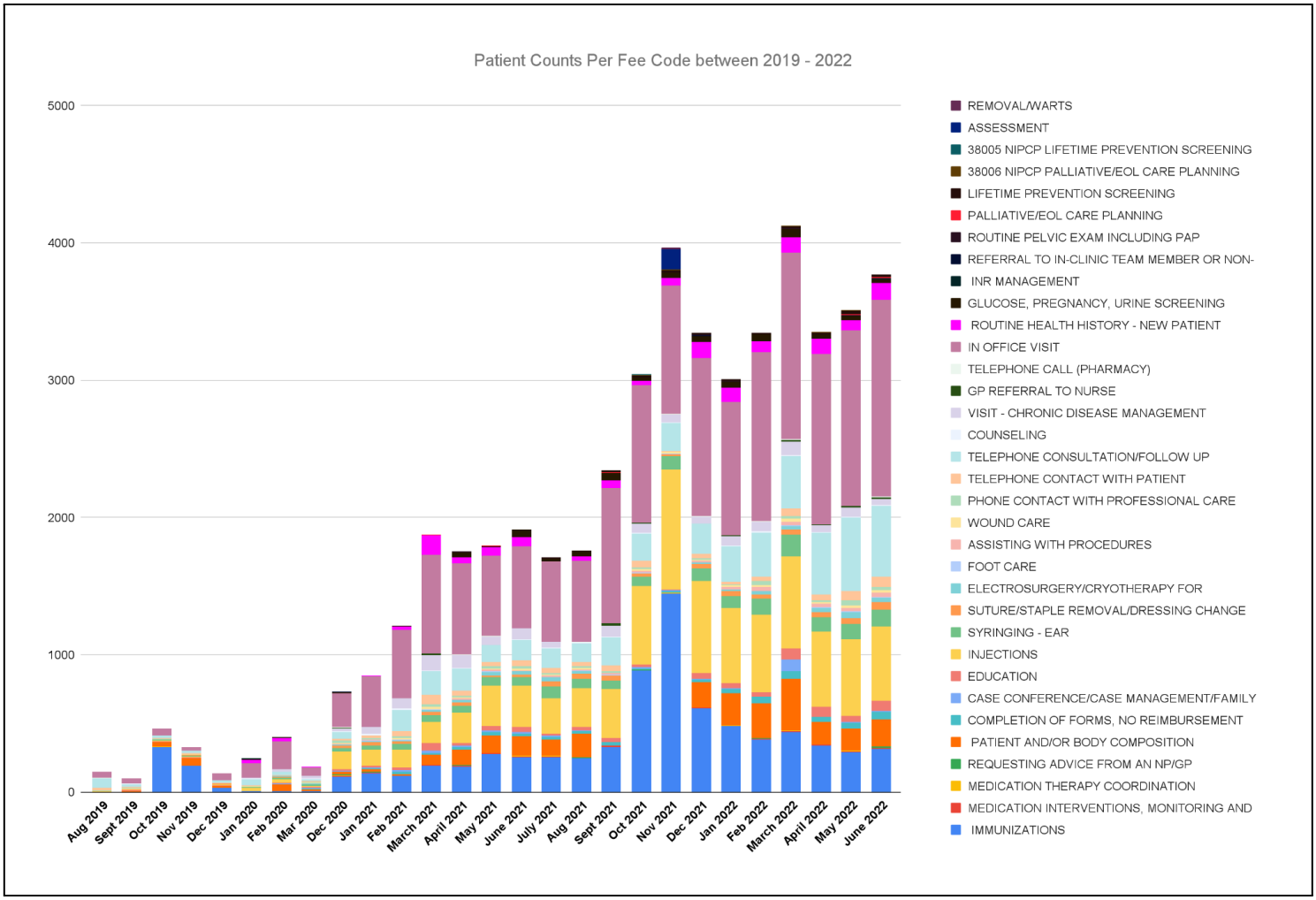
### RN In Practice Impact Stories

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.

### RN Encounter Coding

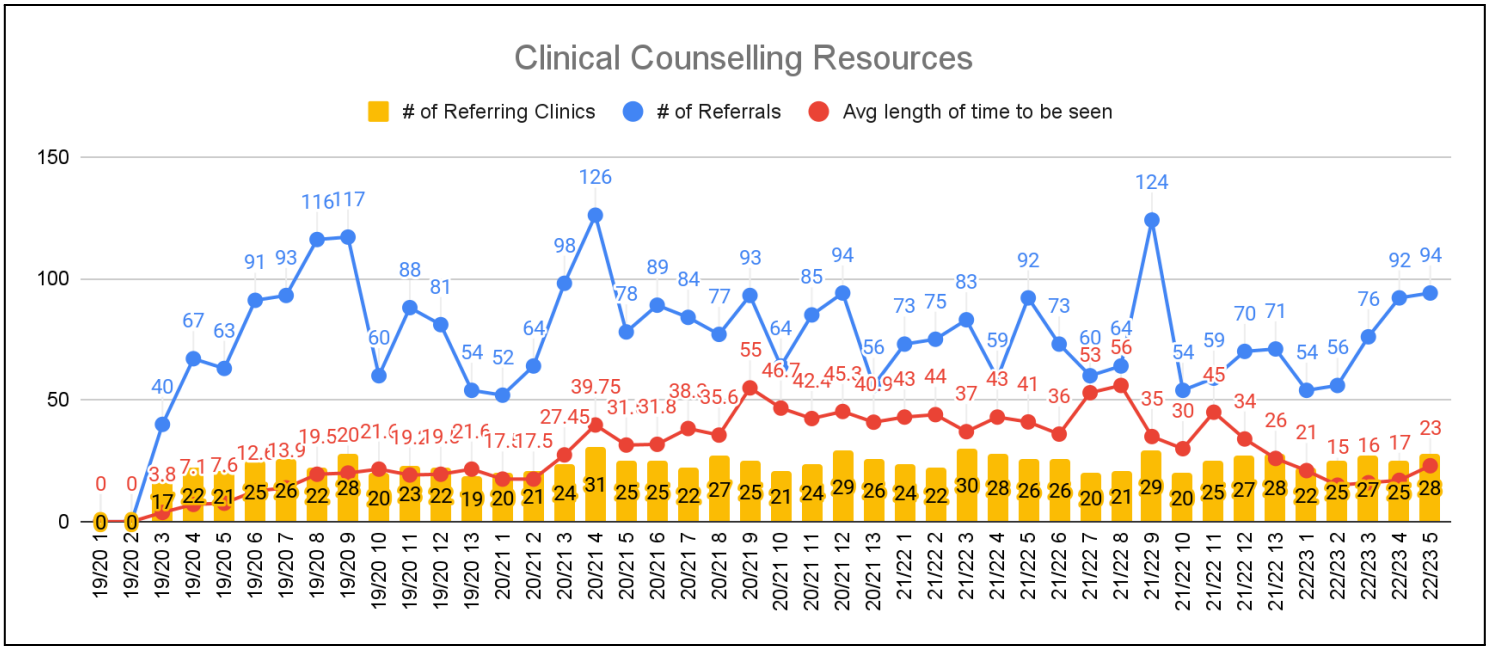
Accurate encounter code data is vital to the ongoing implementation of the RN in Practice Initiative and it's important that PCN funded resources do not add to the workload, but reduce it. Clinics that receive billing rejections have noted that correcting these are increasing the overall workload as 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*

In Period 5, the number of referrals, number of referring clinics, average length of time for patients to be seen and number of cases open increased, while all other metrics show a decrease in usage over the last period. The table below details the change over the last period to the current period:

| | **Previous Period (P4)** | **Current Period (P5)** | **Difference** |
|---|---|---|---|
| # of Referrals | 92 | 94 | ↑ |
| # of Referring Clinics | 25 | 28 | ↑ |
| Average length of time for patients to be seen (*days)* | 17 | 23 | ↑ |
| # of clients seen | 155 | 116 | ↓ |
| # of appointments scheduled | 290 | 182 | ↓ |
| # of cases open | 242 | 255 | ↑ |




## 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:

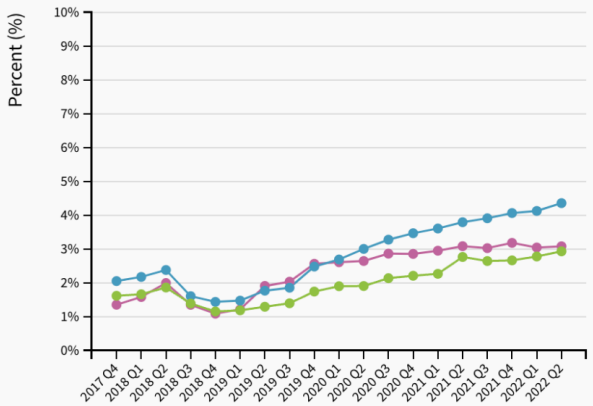
| | **Previous Period (P4)** | **Current Period (P5)** | **Difference** |
|---|---|---|---|
| # of Referrals | 41 | 55 | ↑ |
| # of Referring Clinics | 21 | 26 | ↑ |
| Avg. caseload/Clinician | 26 | 24 | ↓ |
| # of appointments scheduled | 265 | 250 | ↓ |

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 for the last 5 years. 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.

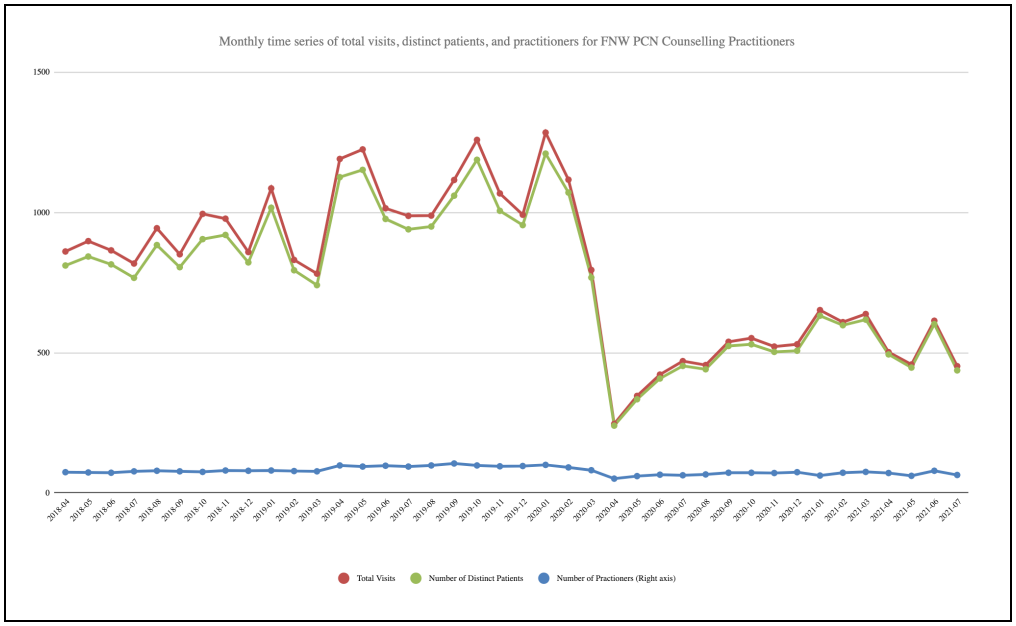
| Legend | Data Source | Ratio | Data as of |
|---|---|---|---|
| | British Columbia | 108965 / 2498336 (4.36%) | 2022 Q2 |
| | Fraser Health | 29371 / 952131 (3.08%) | 2022 Q2 |
| | Fraser Northwest | 6223 / 211952 (2.94%) | 2022 Q2 |




## 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



Mental Health & Acute Care

Recent data pulled from the RCH and ERH acute sites shares data on the number of mhsu patients seeking care at the Emergency departments and left without being seen (LWBS). The total percentage of those who LWBS is 0.5% at RCH and 0.9% at ERH for FY 21/22.

**Royal Columbian Hospital:**

| RP | ER VISITS PER RP | LWBS PER RP | PERCENTAGE % |
|---|---|---|---|
| RP01 | 5651 | 5 | 0.1 |
| RP02 | 6014 | 14 | 0.2 |
| RP03 | 6282 | 25 | 0.4 |
| RP04 | 6741 | 48 | 0.7 |
| RP05 | 6705 | 35 | 0.5 |
| RP06 | 6310 | 19 | 0.3 |
| RP07 | 6010 | 28 | 0.5 |
| RP08 | 6884 | 55 | 0.8 |
| RP09 | 6685 | 35 | 0.5 |
| RP10 | 6159 | 35 | 0.6 |
| RP11 | 5923 | 27 | 0.5 |
| RP12 | 6101 | 19 | 0.3 |
| RP13 | 6281 | 40 | 0.6 |
| **TOTAL** | **81746** | **385** | **0.5** |
| **Average** | **6288** | **30** | **0.5** |
| | | | |
| Average wait time (removing outliers of +> 2 hours) = **57 minutes** | | | |

**Eagle Ridge Hospital:**

| RP | ER VISITS PER RP | LWBS PER RP | PERCENTAGE % |
|---|---|---|---|
| RP01 | 3838 | 9 | 0.2 |
| RP02 | 4241 | 26 | 0.6 |
| RP03 | 4208 | 10 | 0.2 |
| RP04 | 4374 | 69 | 1.6 |
| RP05 | 4399 | 41 | 0.9 |
| RP06 | 4159 | 49 | 1.2 |
| RP07 | 3991 | 51 | 1.3 |
| RP08 | 4114 | 32 | 0.8 |
| RP09 | 4024 | 35 | 0.9 |
| RP10 | 3792 | 36 | 0.9 |
| RP11 | 3646 | 21 | 0.6 |
| RP12 | 3939 | 34 | 0.9 |
| RP13 | 4230 | 41 | 1.0 |
| **TOTAL** | **52955** | **454** | **0.9** |
| **Average** | **4073** | **35** | **0.9** |
| | | | |
| Average wait time (removing outliers of +> 2 hours) = **35 minutes** | | | |

## 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 Physicians are in on Wednesdays. 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 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.

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.

As of July 2022, it was announced by the UBC Program team that all future reporting will be provided and shared with PCN communities on a quarterly basis. FY 22/23 Q1 data is included in the visual here.

**Pharmacists in PCN Program**
**Quarterly Reporting of Local Data**

| | | |
|---|---|---|
| Reporting Period | April 1 – June 30, 2022 | **Description:** These local data reports provide a limited summary of PCCP workload and the complexity of patients receiving care from PCCPs on a quarterly basis. |
| PCN | Fraser Northwest | |
| Next Reporting Period | July 1 – September 30, 2022 | |

**Table 1: Status of PCCPs in PCN**

| Year | # PCCPs Identified | # PCCPs Posted | # PCCPs Hired | # PCCPs Active | # PCCPs Providing Pt Care |
|---|---|---|---|---|---|
| Year 1 | 1 | 1 | 1 | 1 | 1 |
| Year 2 | 3 | 0 | 0 | 0 | 0 |
| **TOTAL** | **4** | **1** | **1** | **1** | **1** |

**Table 2: Patient and Service Counts**

| | PCCP Start Date | Date First Patient Seen | Total Unique Patients[1] | Total Appointments | Appointment Types: Initial[2] | Appointment Types: Follow-Up[3] |
|---|---|---|---|---|---|---|
| New | Sept 7, 2021 | Sept 22, 2021 | 85 | 145 | 44 | 101 |
| Y2 Total | | | n/a | 301 | 112 | 189 |

*[1] Total unique patients may not equal total appointments in the quarter as one patient can be seen multiple times within the quarter for follow up appointments. This adds to the appointment count but not the unique patient count per quarter.*

*[2] Initial Appointments with new patients are ~60 minutes. The PCCP will assess a patient's medication experience, attitudes towards medications, understanding of their medications, and their ability to take medications (prescription, non-prescription, supplements and traditional or alternative medicines). The PCCP will also look for actual or potential drug therapy problems, prioritize the problems and work with patient and care team to resolve them as appropriate.*

*[3] Follow-Up Appointments are scheduled for 30-60 minutes to ensure patients are receiving optimal treatment.*

**Table 3: Patient Complexity Measures**

| Avg Meds/ Pt[2] | Total DTPs Identified | Type of DTP[1]: Adverse Drug Reaction | Different Drug Needed | Dose Too High | Dose Too Low | Needs Additional Drug | Non-Compliance | Unnecessary Drug | Avg DTPs/ Pt |
|---|---|---|---|---|---|---|---|---|---|
| 13.60 | 286 | 32 | 13 | 24 | 8 | 87 | 69 | 53 | 3.36 |

*[1] PCCPs identify and resolve actual and potential drug therapy problems (DTPs) through provision of comprehensive medication management. This data collection process is in early stages of development and actual DTPs may be under-reported.*

*[2] The average number of medications per patient is a proxy measure of the complexity of the patients seen by the PCCPs. This includes prescriptions, over the counter medications, and natural health products.*

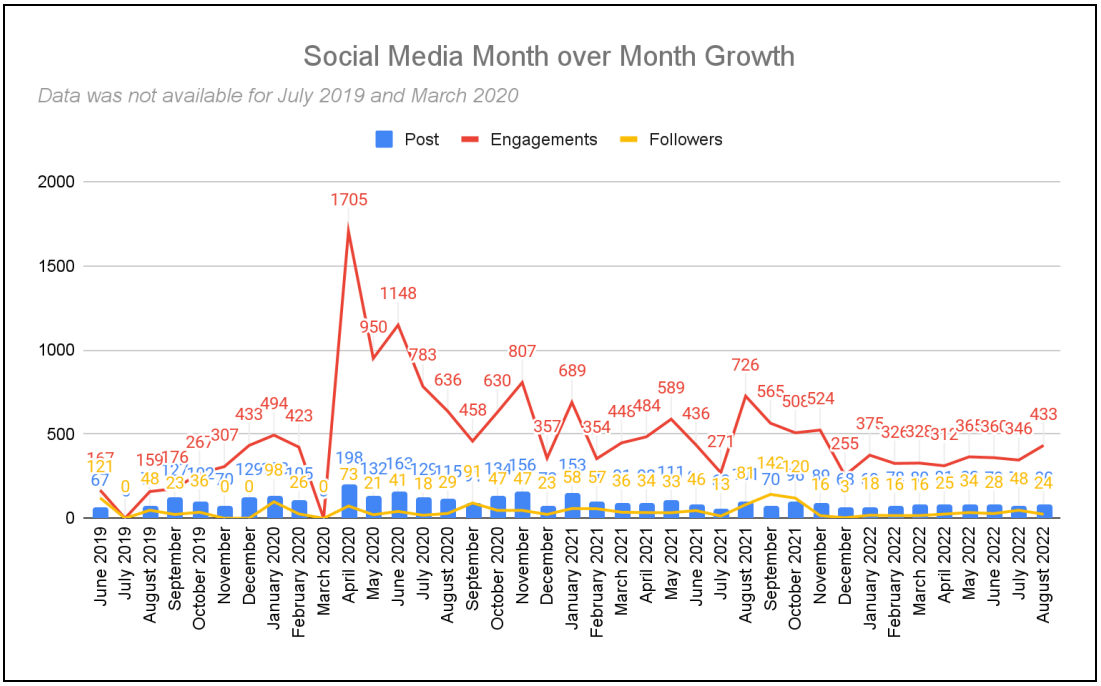
## Urgent & Primary Care Centre: Tri-Cities

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. Data was not available at the time of writing this report and as of Period 1 FY 22/23 all UPCC reporting will take place on the MoH PCN web portal.

## 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 August 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 | 433 | +24 |



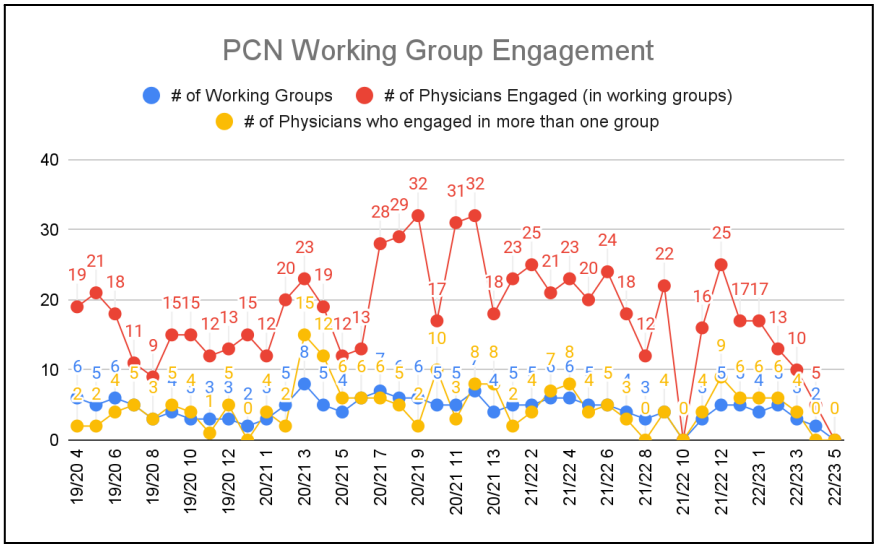

Each quarter, a newsletter is distributed to patients in the communities who have signed up or agreed to receive newsletters from the Division. When this resource launched in May 2020, there were a total of 170 subscribers, whereas in May 2022 the overall year end growth was 4143%. A breakdown of the # 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% |
| May 2022 | 7,213 | 4,135 | 57% |
| August 2022 | 7166 | 3853 | 54% |

## Physician Feedback and Engagement

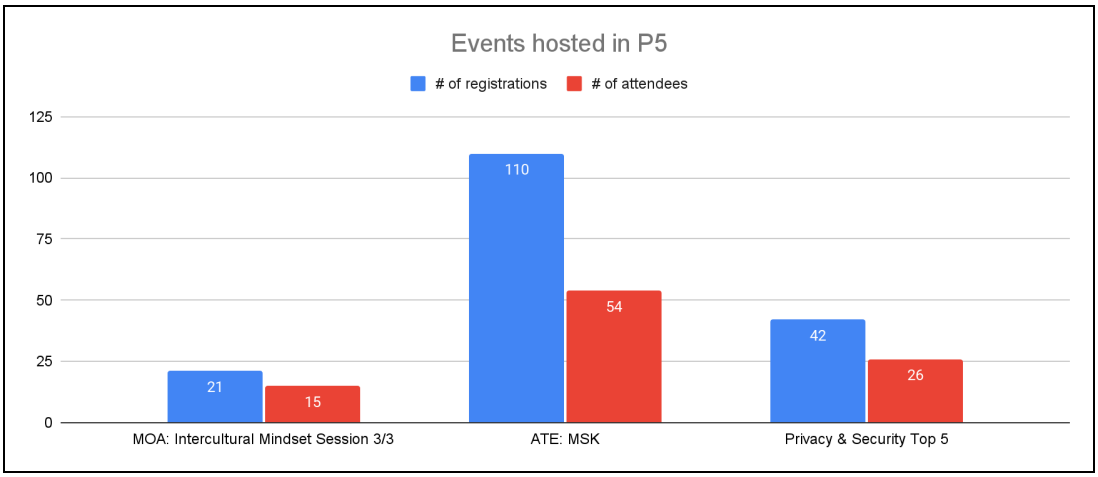
Physician engagement for this reporting period includes a breakdown of both the PCN Working group engagement as well as the PMH team engagement events. As part of the FNW PCN, Primary Care Provider engagement and leadership is integral to the successful development and delivery of community services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

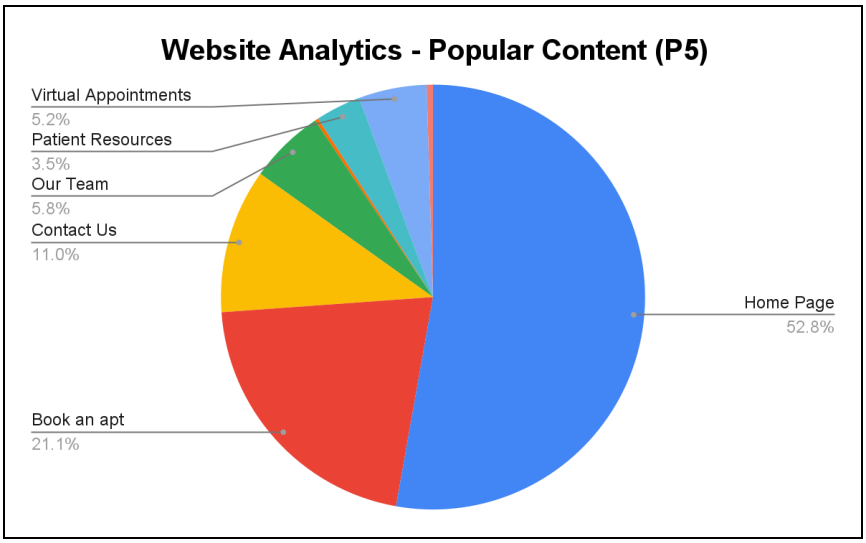



- PCN/PMH Provider Advisory Committee
  - *The purpose of this committee is to advise the Division and FHA Leadership regarding the direction of the primary care improvement work underway in the FNW communities*
  - *Membership is comprised of FNW Family Physicians, Hospitalists, Nurse Practitioners, 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:

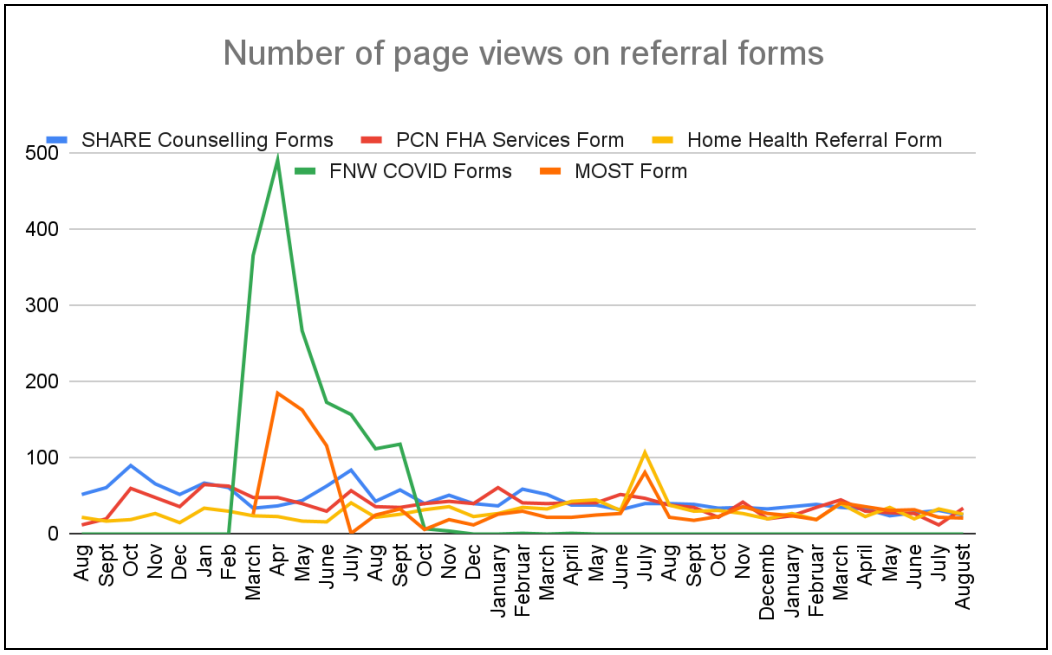



Additional engagement support provided to FNW physicians is the website development. The move to providing primary care services in a virtual setting continues to grow and expand. A full list of the clinics in the FNW and their associated websites can be found by clicking here. Analytic data provided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




## 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 be a struggle.
    a. 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.