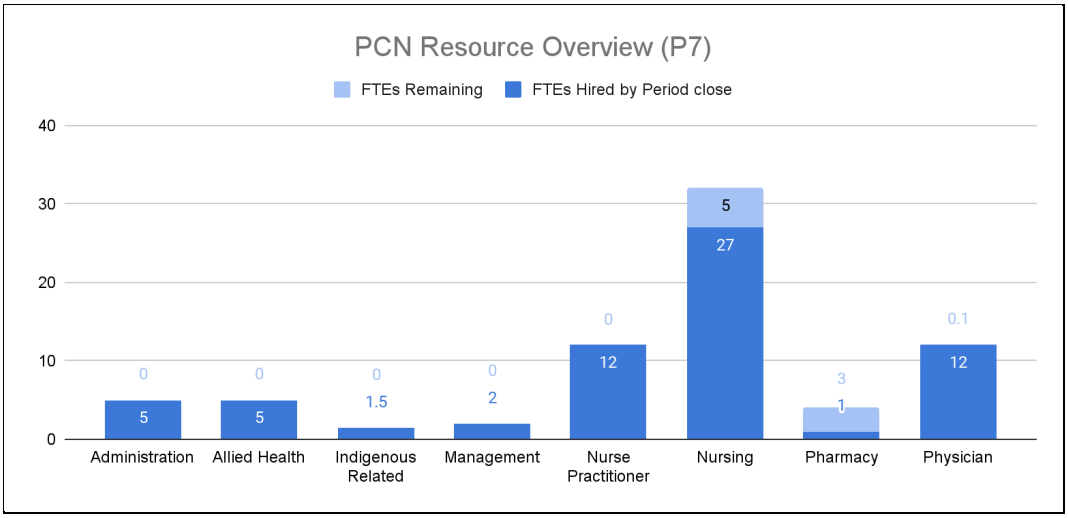
Fraser Northwest Primary Care Network

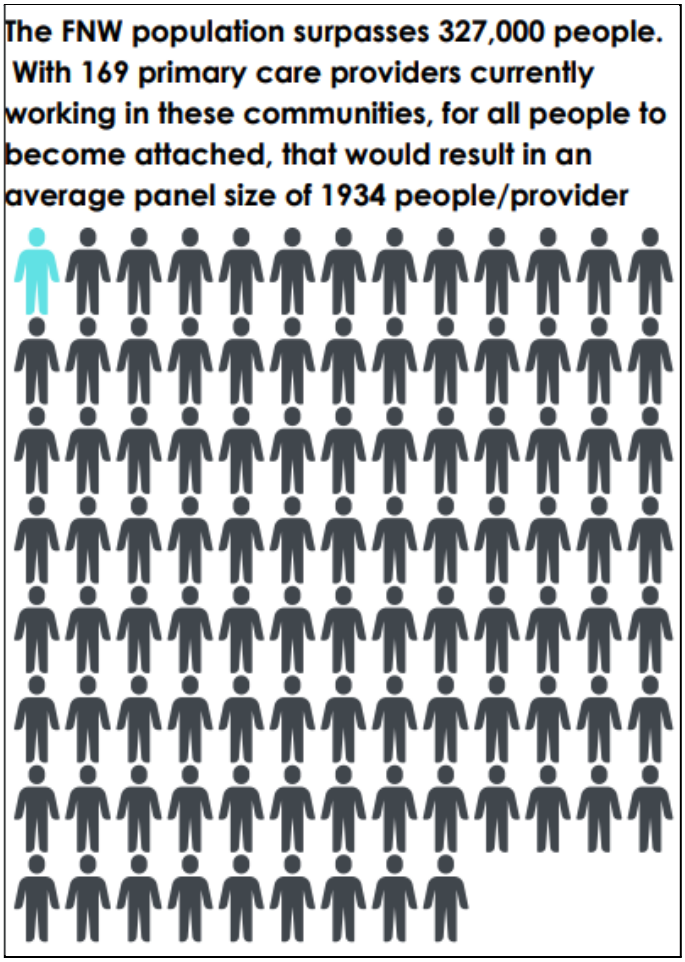
Period 7 Addendum Report



Patient Medical Home Snapshot

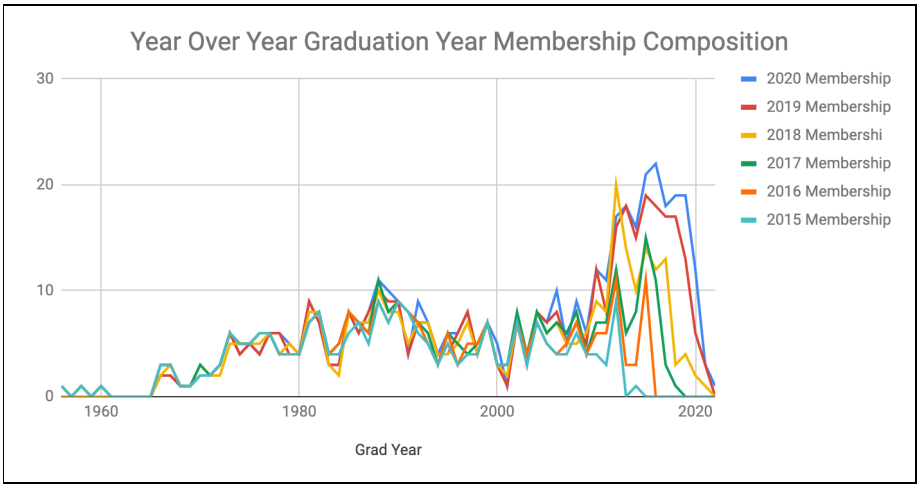
Provider Types	# in FNW
FFS Longitudinal Family Physician	137
PCN funded FP	12
PCN funded NP	12
Community NP	8

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

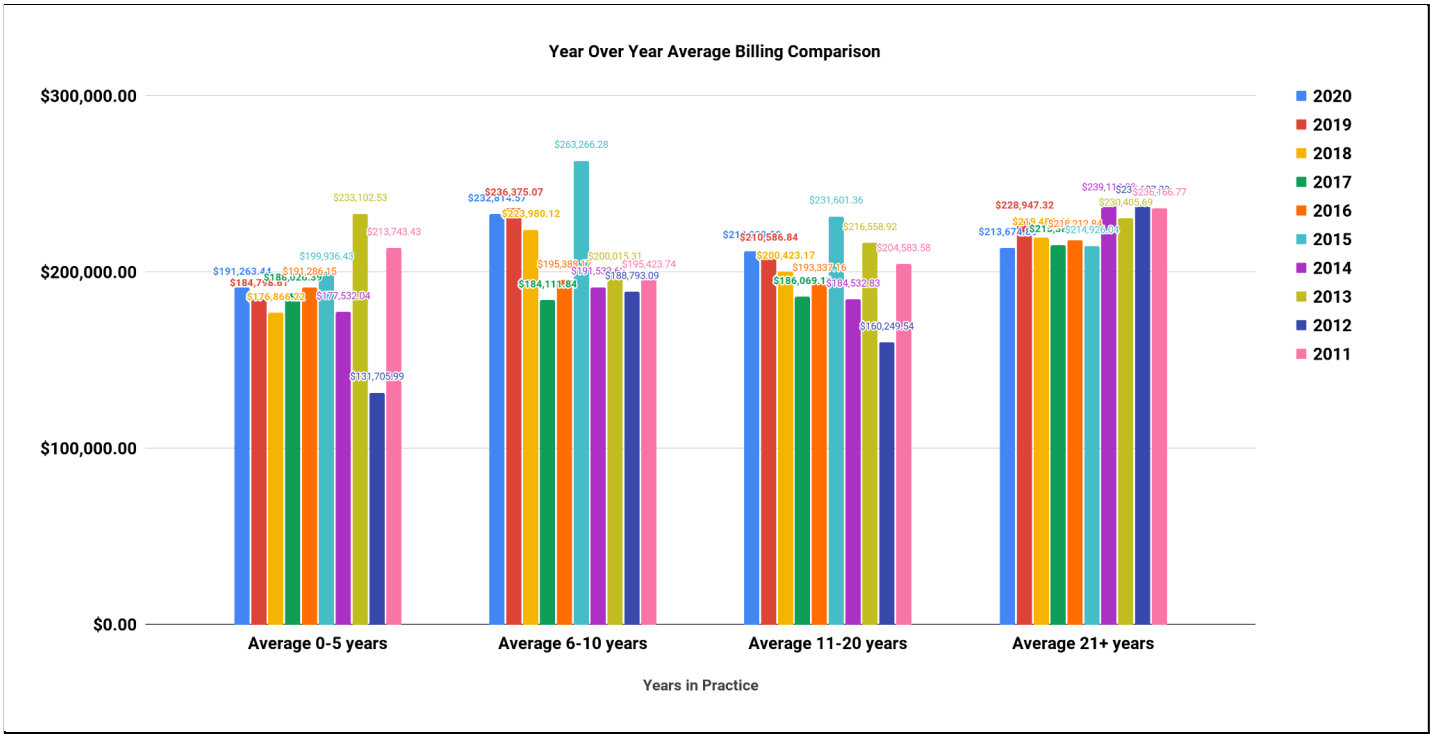


FNW Community Overview

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



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



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

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

Overview: Primary Care Provider Community Adds & Losses

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

	2019	2020	2021
Provider Adds	12	18	14
Provider Losses	27	13	17
Net Loss/Gain	-15	+5	-3
FNW Attachment Hub #	856	2792	5644
MoH $0 Fee Code Attachment	NA*	73,742	4104

**MoH Data not available for 2019*

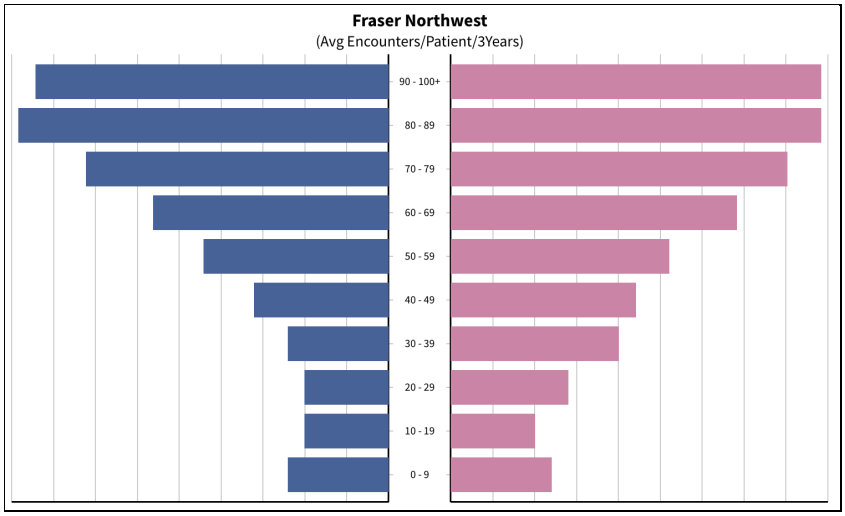
Data was updated to reflect currently known retirements, moves and leaves for the table above. Previous data did not account for a clinic relocation in 2019 and upcoming retirements for 2021. Although 2021 reflects the highest attachment numbers to date, it's important to note that the patients whose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

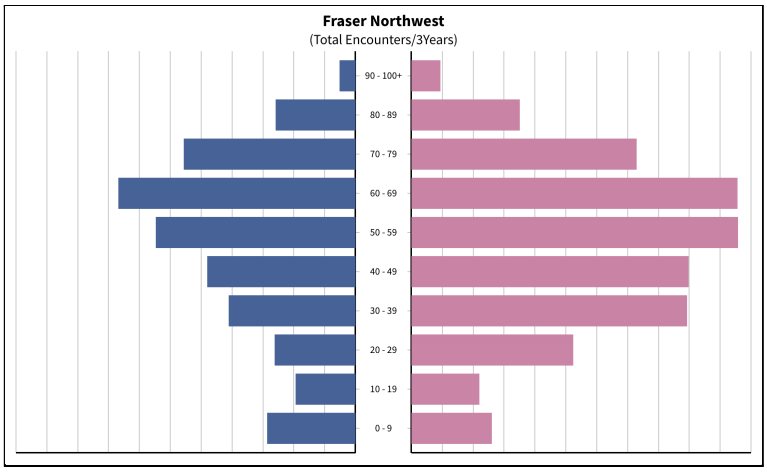
Projected retirements in the next year are set at 7 with a five year forecast of 25 family physicians retiring out of the FNW communities. This projection is an estimate and is based on an estimate that approximately 10% of our members that are 21+ years in practice will retire between 2020-2024 as we have 173 members that are 21+ yrs.

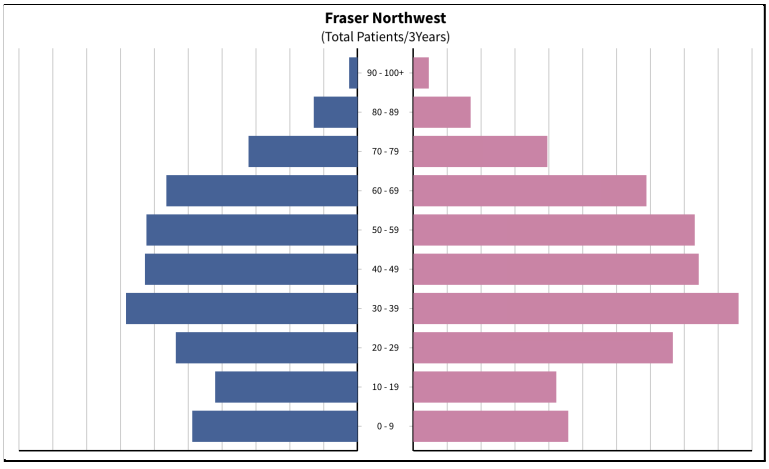
Supportive resources such as RNs in Practice, access to rapid clinical counselling resources and practice improvement support are paramount to retaining the current physicians in the FNW, and recruiting future physicians to practice in these communities.

Overview: FNW Population Summary

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







Attachment

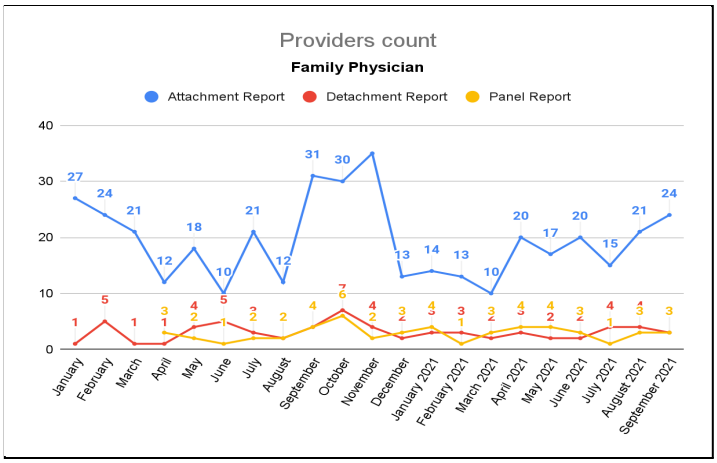
Measuring true attachment continues to be a conversation at all stakeholder and partner organization levels. Attachment level data through the use of the 0$ fee code provides a distinction between types of providers and patient counts. A challenge with implementing support for all PMHs to incorporate the use of these codes has been consistency in education across a variety of PMHs who utilize differing EMRs. An overestimation of attachment in the FNW is reflected in the data from 2020 whereas the 2021 data may reflect a more accurate

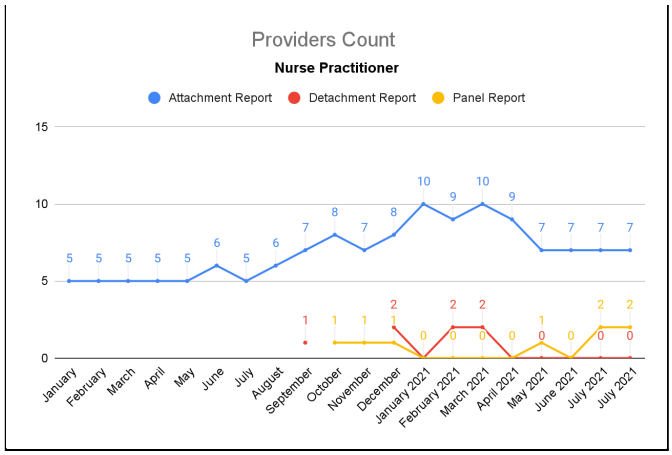
representation of attachment in the community. This data is shared by the MoH out to FNW PCN partner organizations.

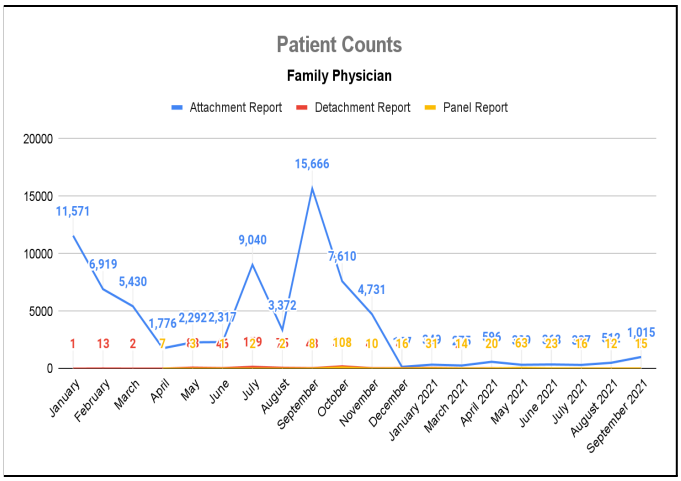
In tandem with the 0$ fee code, the FNW Division has an internal Attachment Hub mechanism which supports patients in the FNW seeking a primary care provider to be attached to primary care providers accepting new patients in the FNW communities.

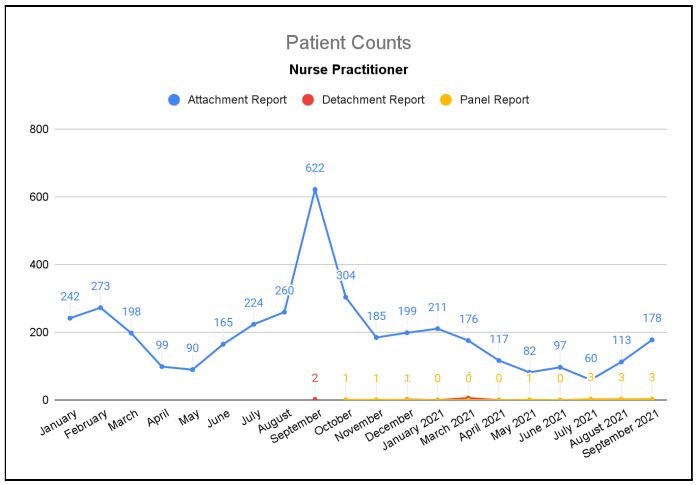
Attachment Coding (MoH)

Attachment data from the MoH is available and provides an analysis of the breakdown of attachments and detachments based on provider type and the associated patient counts. Data was shared starting from January 2020 reflecting the trends of provider counts and patient counts - broken down by type of provider and # of times that the specific encounter code was used. The visuals below reflect the month over month trends for both distinct providers (Family Physicians and Nurse Practitioners) and distinct patients (that are attached/unattached to a Family Physician or a Nurse Practitioner):









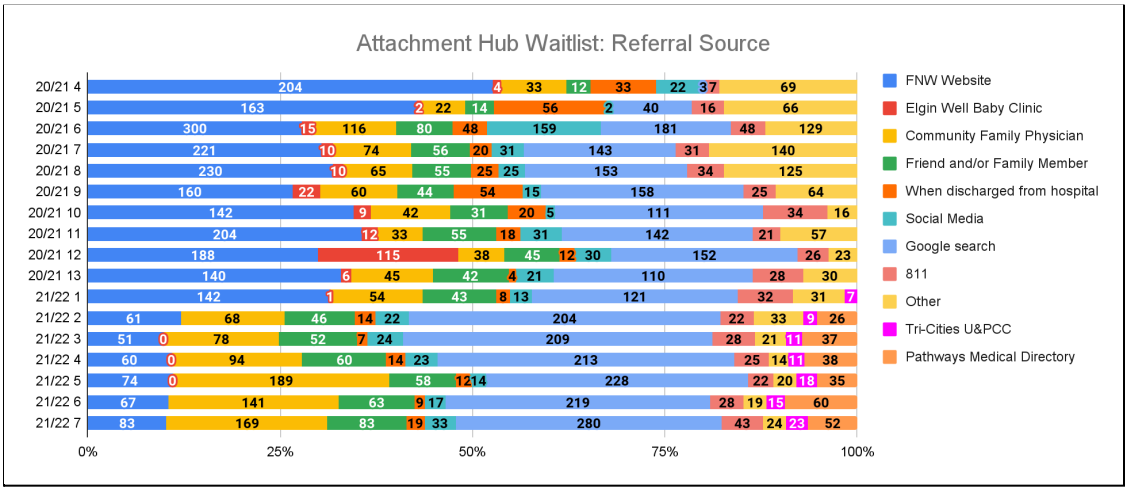
FNW Attachment Hub Waitlist

The FNW Division Attachment Coordinator continues to support the attachment between the public seeking primary care providers accepting new patients. It is important to note that these numbers do not capture the full scope of the community attachment taking place as there are primary care providers attaching patients without connecting with the Attachment Hub. True attachment data may be reflected in the 0$ MSP fee codes; however, work to implement those across the region is an ongoing process between partners. Since the inception of this

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

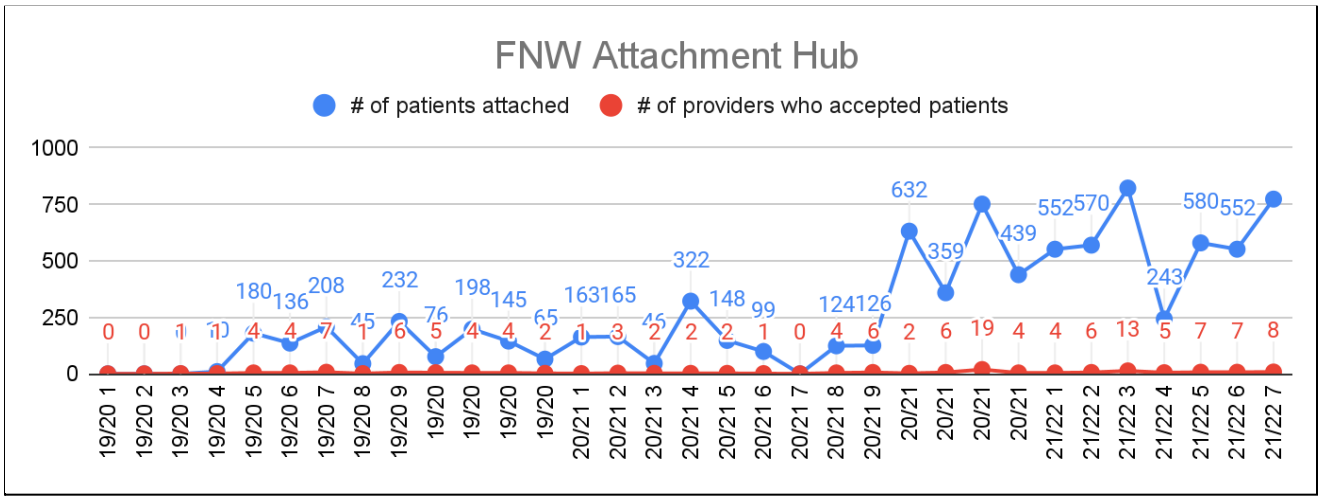
Community	**Average Wait Time (*days)***
New Westminster	199
Port Moody	226
Coquitlam	167
Port Coquitlam	118

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 7 as a data is currently available for these periods:



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	3	2	1
# of patients attached	210	318	243	3
# of people waitlisted	1166 ***6.3% ↑ from P6***	1740 ***2.1% ↓ from P5***	150 ***56.5% ↓ from P5***	1429 ***5.8% ↑ from P5***
Total Attachments to date	**8527**			



Period 7 reflects the largest drop in number of people waiting to be attached in Port Coquitlam since this data tracking began with a 56.5% decrease from the previous period alone. Comparatively to this same period in the previous reporting year (FY20/21), there has been a 71% decrease in the number of people waiting to be attached in this community.

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

Program Impacts: RN In Practice Attachment

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

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

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

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

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

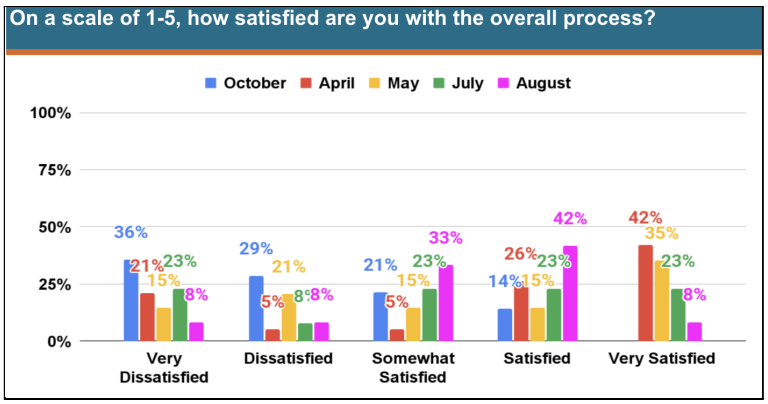
Patient Impacts: Impact of Unattachment

Knowing the depth of the unattachment rates in the communities is one thing; however, understanding the impacts of this for those people and their families truly reflect the importance and huge need of attachment and access to a primary care provider. Through mechanisms such as the Division's Attachment Hub, stories are shared from community members reflecting the impacts of not having access to a longitudinal primary care provider. Wait time data such as the table shared in an earlier section reflect the length of time - on average - it take for attachment to occur after signing up for the waitlist. One recent story shared reflected the severity of a patient's need in finding a provider to support longitudinal care - and the implications of not finding one

> *"I do not think this doctor is a match for me, or anyone suffering from chronic pain. It seems that most GPs do not have tolerance for someone who has trouble navigating the medical system. I do not have the ability to take care of myself anymore, and [the Dr.] seems to be frustrated. I think I am done seeking help-I have tried numerous times in my years of suffering, and will seek medically assisted suicide from now on. Thanks for your help"*

Another patient shared the necessity of having a longitudinal primary care provider, especially when in later stages of life. Patients face challenges in understanding the scope of the healthcare system and how complex and interwoven the systems and services have become, thus making it difficult to navigate.

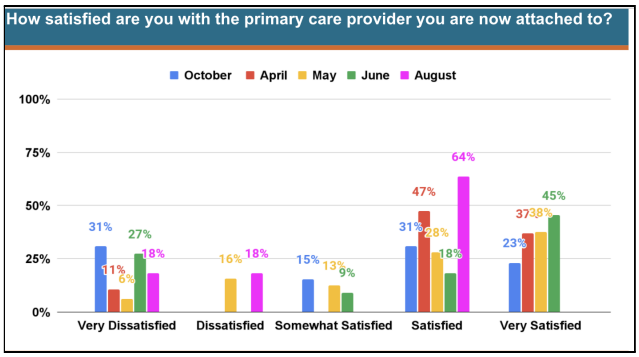
> *"I have never been a burden on the BC healthcare system, I have worked hard all my life, never collected welfare or EI and this is what we get. I am getting older and I am just looking for a family doctor and after several months of waiting (that's understandable) I was kicked to the curb on Friday afternoon. Now I have to start all over."*



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.



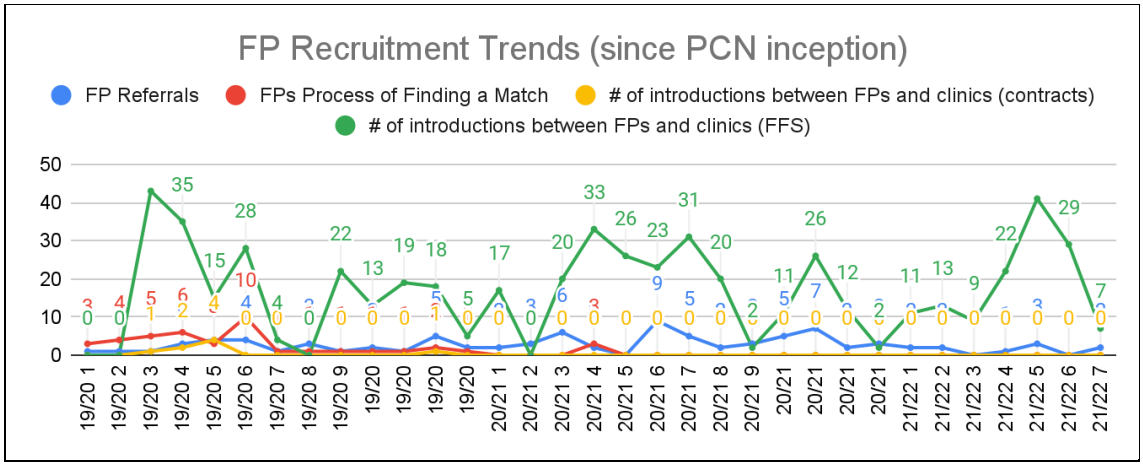
Once attachment was completed, satisfaction levels with the longitudinal provider certainly is weighted towards a higher and more positive satisfaction level; however, there continues to be diversity in patients satisfaction.

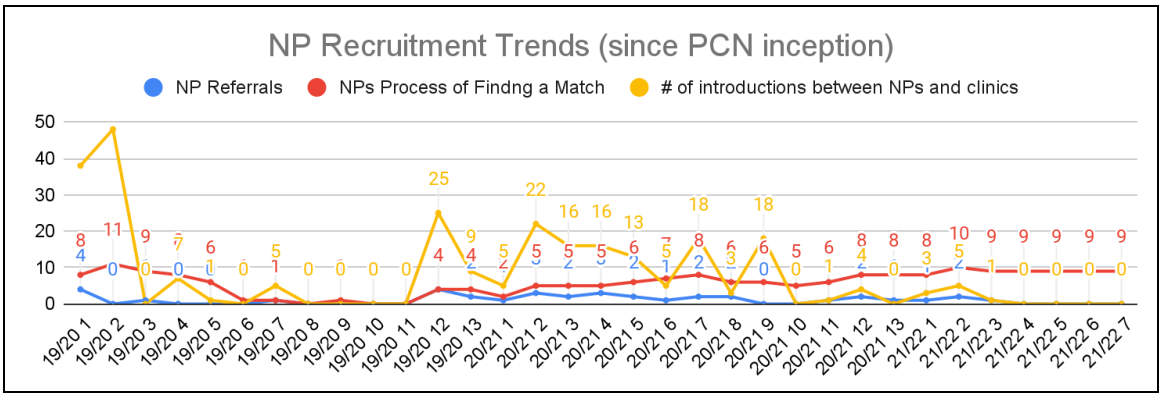
Patient feedback stories such as the one shared above will continue to be collected and shared through this report as well as work is underway to establish a reporting metric on the number of patients who return for re-attachment.

Family Physician and Nurse Practitioner Contracts

Collaborative work between the FNW, FHA, HealthMatch and the Ministry of Health is vital in order to support increased FP and NP resources in the FNW communities. In Period 7, clinic openings grew slightly to 25 FTE. Table 1 below provides a status overview and update on the breakdown of the NP and FP contracts by PCN within the FNW:

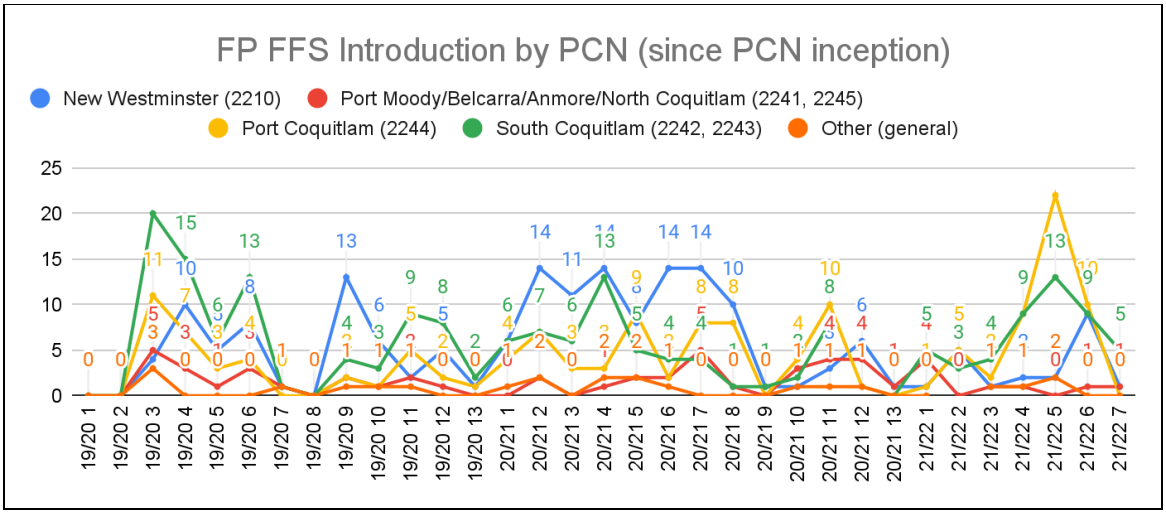
	Referrals		# in the process of finding a match	# of introductions between provider and clinics	# of contracts signed
	# of New Referrals	Running Total of Referrals since PCN Launch			
Family Physician	2	95	0	7	0 PCN Launch Total: 12
Nurse Practitioners	0	46	9	0	0 PCN Launch Total: 12





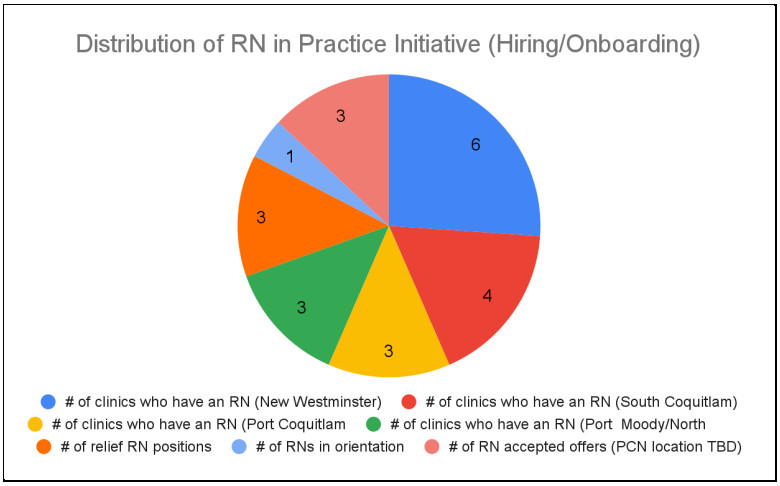
The number of active postings on HealthMatch BC for FPs for both FFS or contract positions decreased slightly to 46 active postings by period close. Opportunities for these postings include: locum and permanent part-time and permanent full-time in the FNW.

Fee For Service (FFS) opportunities and engagement efforts are underway on an ongoing basis and in this period, there were 29 new introductions between FPs and practices for FFS opportunities such as locum, permanent part-time and permanent full-time.

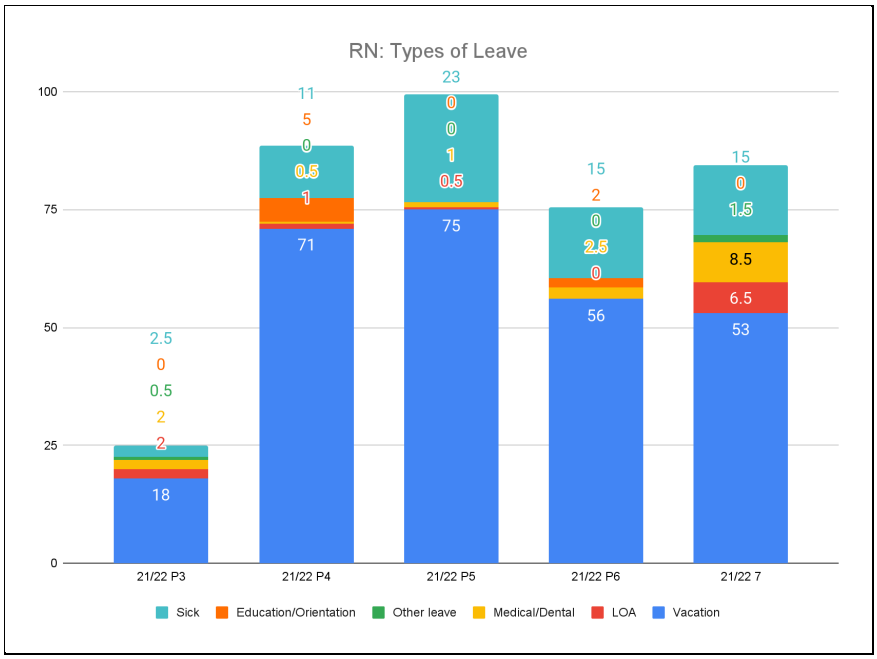


Registered Nurse in Family Practices

This initiative has seen some fluctuations in the number of family practices who have RNs, at the end of this period, there are 15 clinics in this program with permanent RN in practices, 4 additional clinics with temporary coverage, 5 clinics who are actively recruiting and additional relief positions. The period distribution across the PCN's are:



Recently, reporting on the number of days that RNs are out of practice has began and the Period over period distribution for the number of days away include:



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

Discussions are occurring at the local, regional and provincial level around the process for incorporating practice agreements into this initiative (and similar initiatives in other communities). Currently, these agreements are not signed at the local level and currently there are implications to signing and not signing that directly impacts

patient access to care. FHA is not able to place new RNs into clinics without a clinic practice agreement being signed; however, anecdotal feedback from clinics indicates a level of risk to the private business if these agreements are signed. Work is underway between partner organizations and funders to develop a provincial agreement to support seamless placement and continued access to primary care resources within the PMH setting.

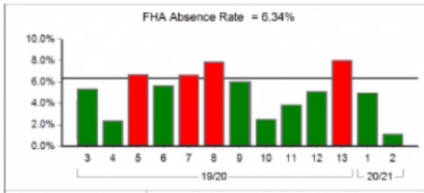
RN In Practice Impact Stories

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

Program Impacts: Absence Rate Analysis

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

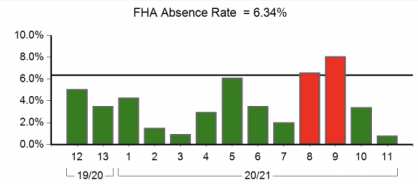
Absence Rate (rolling payperiods in the last 365 days)



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

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

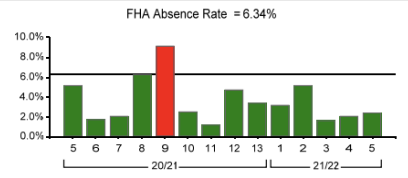
Absence Rate (rolling payperiods in the last 365 days)



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

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

Absence Rate (rolling payperiods in the last 365 days)



Absence Rate	20/21									21/22				
	5	6	7	8	9	10	11	12	13	1	2	3	4	5
3.70%	5.18%	1.76%	2.17%	6.25%	9.20%	2.58%	1.28%	4.72%	3.47%	3.22%	5.23%	1.67%	2.11%	2.50%

Only includes N_DC1 and N_CH1

Absence Rate calculation: Paid Sick + Unpaid Sick Hours / Productive + Vacation Hours
Note this differs from the Finance Sick Time Rate: Paid Sick Hours / Productive Hours

This report is NOT based on Hrs costed to the departments but based on the home department of an employee and all hours coded regardless of where they physically worked.

Employees are grouped (with all hours worked to their home department not the dept they worked). The reason is so managers have a full absence rate of the employee not just when they worked in their department.

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	04/21	05/21	06/21	07/21	08/21	09/21
38010-38045 IMMUNIZATIONS			71%	59%	22%	2%	2%	3%		14%	15%	10%	10%	17%	8%	9%	9%	25%	15%
38060-38062 AND 38064-38065 MEDICATION INTERVENTIONS,										1%	1%		1%		1%	2%	3%		1%

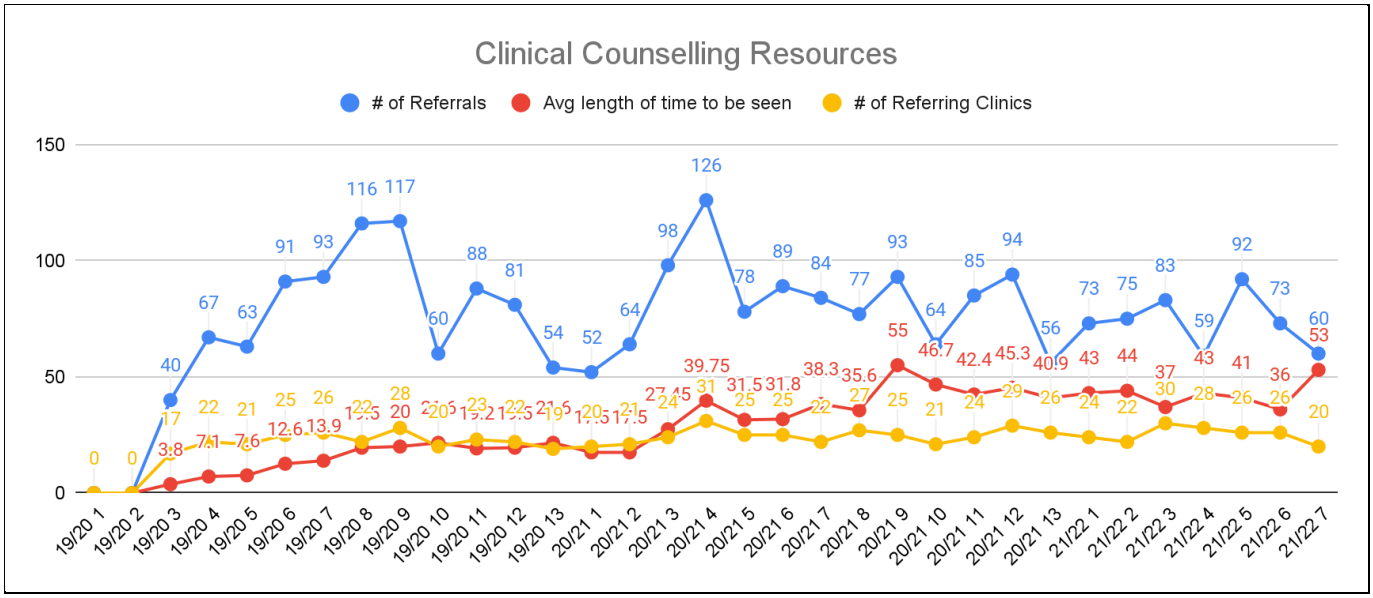
MONITORING AND INFORMATION																				
38063 MEDICATION THERAPY COORDINATION			1%							1%	1%				2%	2%	1%			
38070 NIPCP REQUESTING ADVICE FROM AN NP/GP										1%	1%						1%			
38117-38119 NIPCP PATIENT AND/OR BODY COMPOSITION ASSESSMENT		9%	6%	17%	11%		13%	8%		3%	2%	1%	4%	6%	4%	6%	2%	8%	9%	
38125 NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT								3%		1%	1%	1%	1%	1%	5%	6%	4%	1%	1%	
38130-38135 NIPCP CASE CONFERENCE/CASE MANAGEMENT/FAMILY CONFERENCE							1%	3%		1%	1%	1%	1%	1%	2%	2%	1%			
38141-38155 NIPCP EDUCATION		5%	1%	2%	4%	2%	1%	4%		2%	2%	1%	2%	1%	5%	6%	3%	1%	1%	
38160-38162 NIPCP INJECTIONS	3%		1%	2%	4%	8%	6%	5%		18%	11%	11%	9%	14%	9%	10%	11%	15%	16%	
38168 NIPCP SYRINGING - EAR			1%	2%	4%	3%	3%	4%		3%	3%	4%	3%	2%	8%	7%	8%	3%	3%	
38169-39170 NIPCP SUTURE/STAPLE REMOVAL/DRESSING CHANGE	3%	5%	1%	2%	4%	2%	1%	3%		3%	1%	2%	1%	1%	7%	5%	7%	2%	2%	
38171 NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS							1%	3%		1%	1%	1%	1%	1%	2%	3%	4%	1%	1%	
38172 NIPCP FOOT CARE										1%	1%				1%	1%	2%			
38174 NIPCP ASSISTING WITH PROCEDURES										1%	1%			1%	3%	2%	3%			
38175 NIPCP WOUND CARE		5%		2%		2%	1%	3%		1%	1%		1%	1%	2%	3%	4%	1%	1%	
38180 NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER	3%	5%	1%					3%		3%	1%	1%	1%	1%	3%	5%	4%			
38184 NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND	12%	11%	1%	2%	5%	2%	1%	3%		2%	1%	3%	4%	2%	6%	6%	5%	1%	2%	
38185-38186 NIPCP TELEPHONE CONSULTATION/FOLLOW UP	47%	18%	4%	6%	12%	19%	5%	9%		8%	9%	13%	11%	8%	8%	6%	7%	7%	6%	
38191-38192 NIPCP COUNSELING		5%				2%	1%	3%		1%	2%	1%			1%	1%	2%	1%		
38195 NIPCP VISIT - CHRONIC DISEASE MANAGEMENT						2%	4%	8%		3%	4%	5%	5%	4%	6%	6%	5%	2%	3%	
38073 NIPCP GP REFERRAL TO NURSE										1%			5%						1%	
38188 NIPCP TELEPHONE CALL (PHARMACY)	3%							3%		1%					1%					
39080-38085 NIPCP VISIT - IN OFFICE VISIT	27%	36%	11%	7%	35%	42%	50%	33%		30%	43%	42%	41%	35%	9%	9%	11%	27%	34%	
38116 NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT						10%	7%	3%				2%	2%	2%	2%	2%	2%	2%	2%	
38165-38167 NIPCP GLUCOSE, PREGNANCY, URINE SCREENING						2%	1%			1%				2%	4%	2%	1%	1%	3%	
38173 NIPCP SUTURING MINOR LACERATIONS						2%														
38123 NIPCP COMMUNICABLE DISEASE FOLLOW UP										1%										
38176 NIPCP INR MANAGEMENT										1%					1%					

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

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

	Previous Period (P6)	**Current Period (P7)**	**Difference**
# of Referrals	73	60	↓
# of Referring Clinics	26	20	↓
Average length of time for patients to be seen (*days)*	36	53	↑
# of clients seen	144	149	↑
# of appointments scheduled	253	241	↓
# of cases open	366	387	↑

The chart below details the period over period trends for the # of referrals, # of referring clinics and the average length of time for patients to be seen after first contact since PCN inception.



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

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

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

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

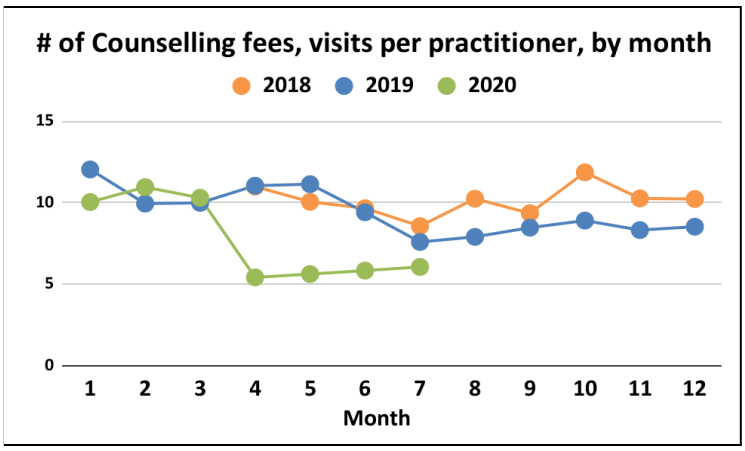
A FHA resource developed to support access to mental health and substance use supports for FNW community physicians launched where 4 FTE Mental Health Clinical Counsellors are available to FNW physicians to support providers and patients as part of the Primary Community Care team. Details on the number of referrals can be found in the table below:

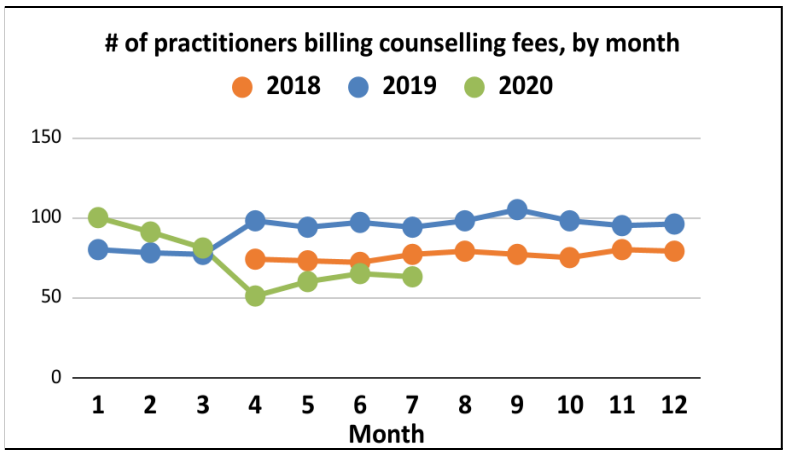
	Previous Period (P6)	**Current Period (P5)**	**Difference**
# of Referrals	61	61	**=**
# of Referring Clinics	26	25	↓
Avg. caseload/Clinician	28	26	↓
# of appointments scheduled	212	241	↑

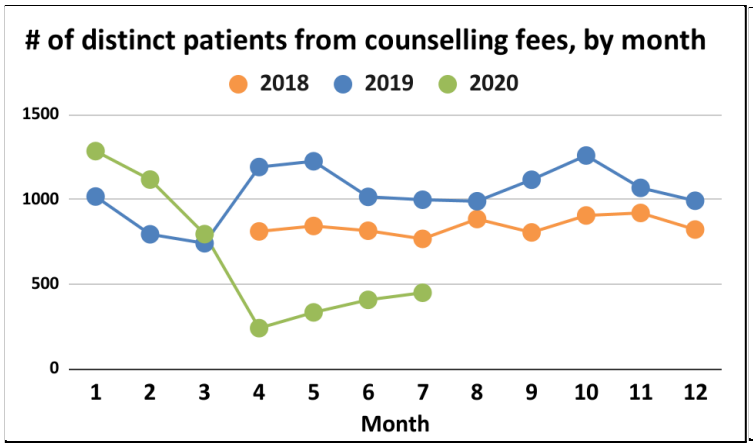
Mental Health Program Impact

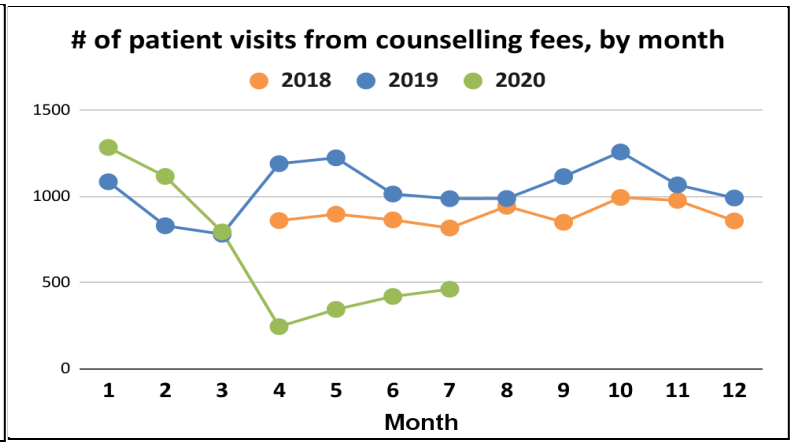
Through the co-development of these programs, the intention was to increase patient and physician access to rapid counselling supports given the high waitlist for existing community supports. This intent in turn decreases the burden in caring for these patients that is placed on family physicians which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



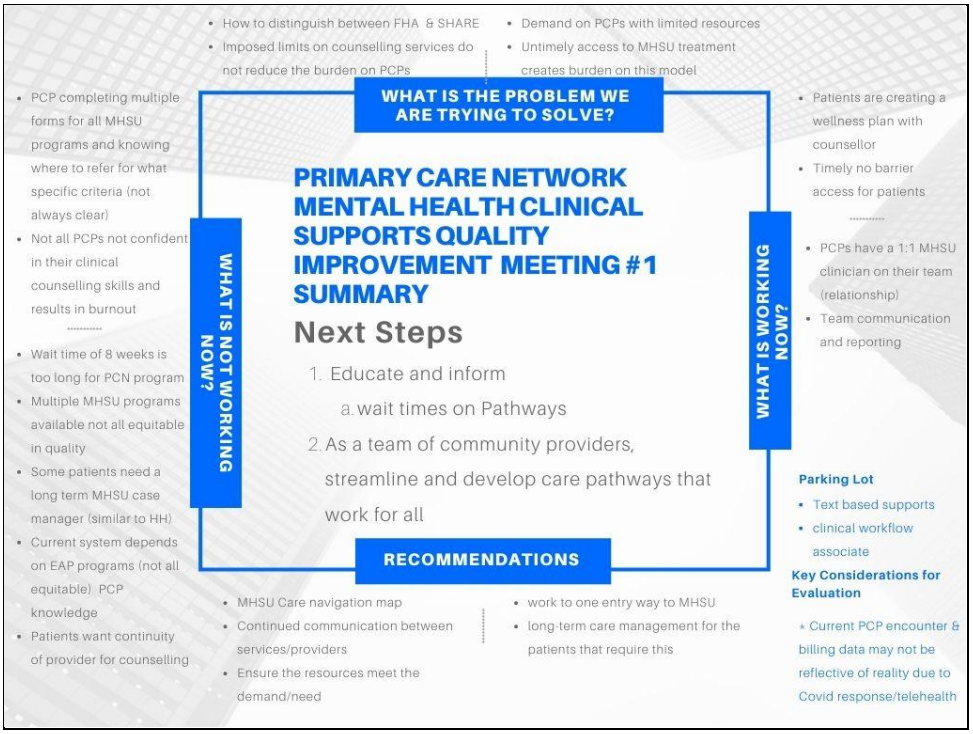




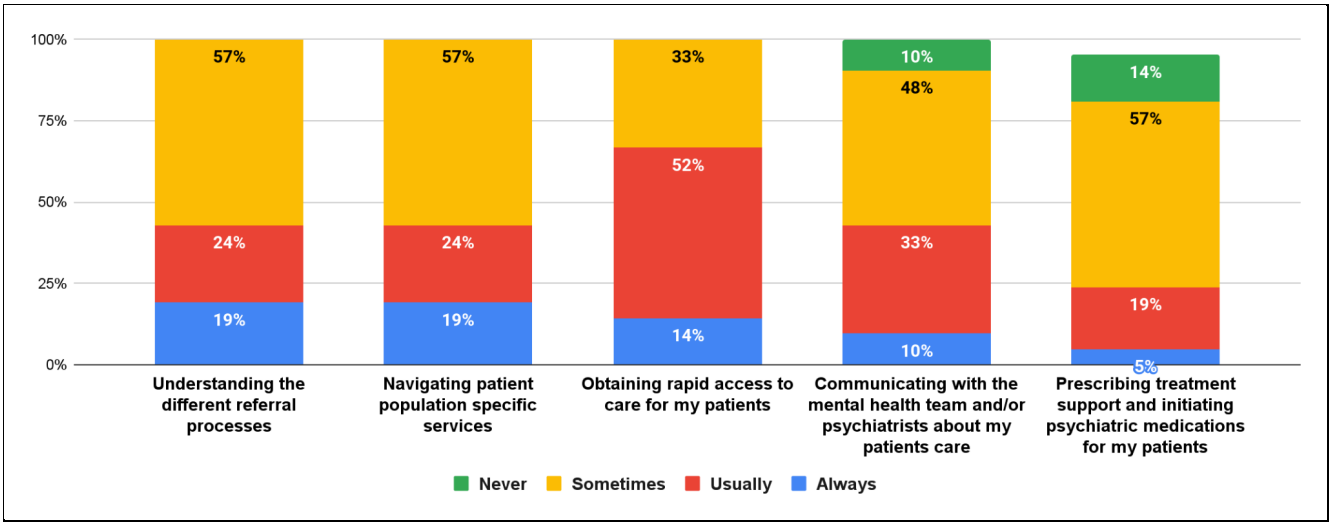


Mental Health Community Physician Engagement

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:



FNW Primary Care Providers were recently asked to provide feedback on opportunities for improvement and what's working well with the current mental health care system. When asked about challenges when accessing Fraser Health mental health services, members noted experiencing challenges with the following:



Members also shared roadblocks and successes with accessing mental health services:

What roadblocks do you experience when referring patients to Fraser Health?

Raw Responses:

- Long wait no follow up care.
- I have not always received a consult note
- YEs all the time
- There are so many options in different locations and they seem to want to pass the buck. This annoys me and patients as they need to talk to various people.
- Would be nice to have an Access and Assessment Service like VCH
- Wait times to be seen by a psychiatrist
- LONG WAITING TIME
- Sometimes months of waiting
- I've noticed many referrals being declined recently because MHSU couldn't reach the patient after 2 tries. Many of my mental health patients are poor at keeping appointments or are low SES so don't have a reliable phone, so greater effort should be made to contact the patient. Doesn't really help me to just discharge them back to my care without achieving anything.
- Yes - Tried to refer an actively psychotic patient for the psychosis clinic and was reprimanded on a phone call by the mental health nurse that I started the patient on an antipsychotic before they were seen at their clinic. I did this after consulting a Psychiatrist via the RaceApp because I could not speak to any Psychiatrist at the mental health team on an urgent basis. I couldn't wait until the pt's appointment.
- Would be helpful to have the ability to call the Psychiatrist directly at the mental health team. I've tried calling the tricities mental health team during clinic hours and no one picks up. There's also no voice messaging system. Not sure how patients can contact them either.
- Sometimes, stated patients not suitable or patients do not reside in the area.
- long wait times, limited long term follow up, titrating doses of medications as pts still symptomatic while returned to primary care provider, tapering off benzodiazepines started by psychiatrist

What is working well when referring patients to Fraser Health mental health services?

Raw Responses:

- counseling services for pts. detailed consultation with pharmacological recommendations in case of relapse
- Greatly appreciate the psych consults for diagnostic clarification and med adjustments for schizophrenia and bipolar disorder. Some of my patients benefit from group CBT.
- Mental health nurse reaches out to patients early
- Multi-disciplinary care.
- NA
- Nothing
- Sometimes they get seen without significant delays. Most of the time there's a wait and there doesn't seem to be a way for me to contact the Psychiatrist directly for patients I'm concerned about.
- When they start seeing a pt, usually there is appropriate/regular follow up

Indigenous Related Supports

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

The Kwikwetlem Primary Care clinic opened mid-October for community members. The clinic is staffed with two doctors (52 FP Sessional), an MOA, a Nurse Practitioner, a Registered Nurse, elder home support worker (0.5 FTE) and an Aboriginal wellness advisor (1.0 FTE).

The members of the Kwikwetlem First Nation are accessing the services from the clinic. The soft opening has been a great success according to the team and the community members accessing services. The Physicians are in on Tuesdays. There is also a Nurse Practitioner in the clinic on alternate Fridays. The Community Health Nurse is in 2 days/week to do drop-in for Kwikwetlem First nations members for injections, medical assessments, referrals, wellness checks, blood pressure, blood glucose checks, wound care and assisting with the Physician of the day's phone calls.

The elder home support worker is serving three elders and has two elders waiting to be seen. Now, they are in 3 days/week and help the elders with meals, housework, shopping, medical appointment transport for specialist appointments, referral for specialists, and when it can be done safely planning activities for the elders in the community hall.

The Aboriginal wellness advisor has assisted the Director of health to assess the wellness needs of the community. They are currently working on meeting the needs of the community by seeking community partnerships with local organizations. In addition, the wellness team is actively seeking grants for wellness programs. Lastly, the Aboriginal wellness advisor worked with the Nurse to hand out food to the community members and provide lunch for the children, youth, and elders.
Feedback from the community identified "love[ing] the two new doctors and the elders are incredibly happy with the elder support person. They are seeking an increase in elder support due to increasing needs in the community." The doctors and community leaders have identified interest in having the doctors move towards doing outreach in the community. The health clinic continues to work on relationships with other partners in the Tri-Cities communities.

Primary Care Clinical Pharmacists (PCCP)

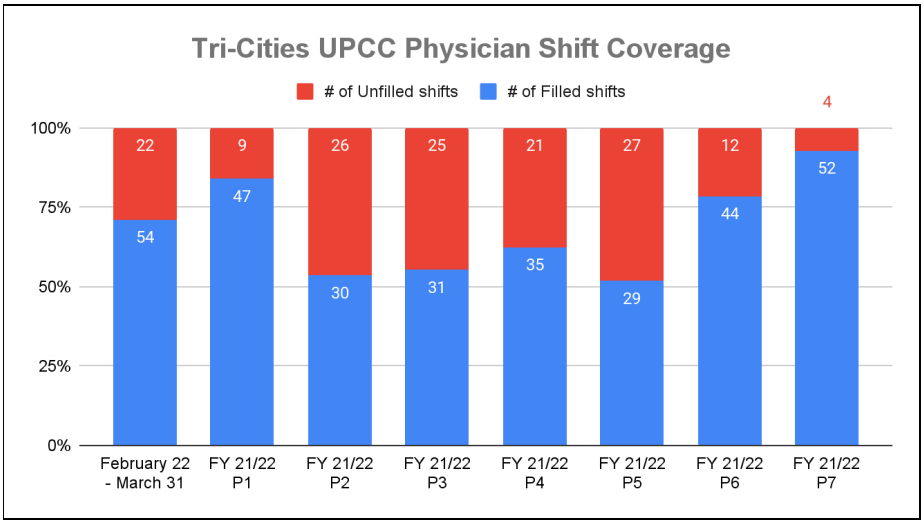
As part of the funding for the FNW PCN, the New Westminster and Tri-Cities communities were allocated resources for 4 Clinical Pharmacists across the Frasernorthwest region. Work has been underway since the PCN inception around identifying strategies for incorporating these positions to support longitudinal primary care services. The first Pharmacist was hired in Period 5 with an anticipated start date in this period.

Urgent & Primary Care Centre: Tri-Cities

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

	Period 6	Period 7	Difference
# of In-person patient visits	298	450	↑
# of virtual patient visits	202	206	↑
# of new attachments	22	13	↓
Total # of attachments	171	184	↑

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



Program Impact: Accessible Primary Care

A Physician recently shared an experience whereby having access to the Tri-Cities UPCC enabled follow-up for a patient who was considered high risk and had received routine testing in the ER; however, was not attached to a primary care provider in the community. The UPCC was able to contact this patient for ongoing treatment regarding the test results and ensure follow-up is supported at this site.

FNW Practice Support Program

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

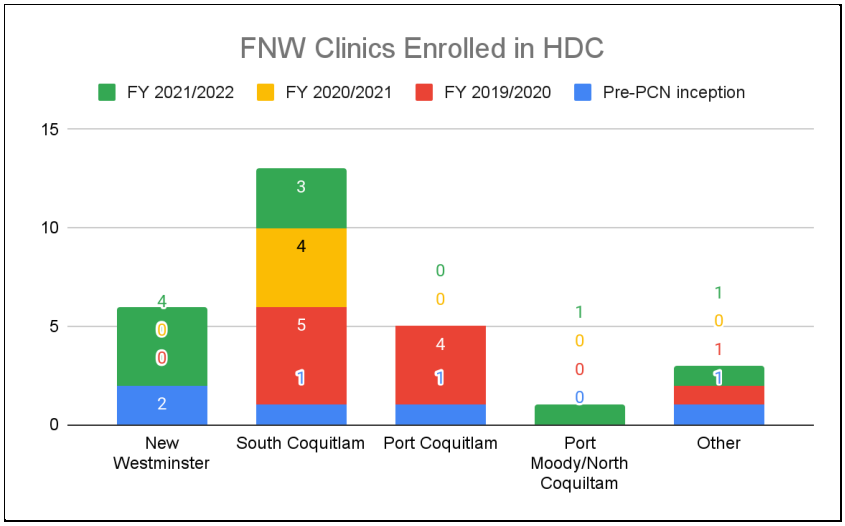
- Panel Management
- Panel Maintenance
- Patient Experience Tools
- EMR Skills Assessments

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

	# of MSOC Physician	# of PMH Assessments completed	% started Panel (MSOC)	% Completed Panel (MSOC)	Started Panel	Working on Phase 1	Working on Phase 2	Working on Phase 3	Workbook Complete
Previous month (August)	176	116	63%	52%	110	12	1	5	92
Current month (September)	179	116	63%	53%	112	12	1	5	94
Change	↑	=	=	↓	↑	=	=	=	↑

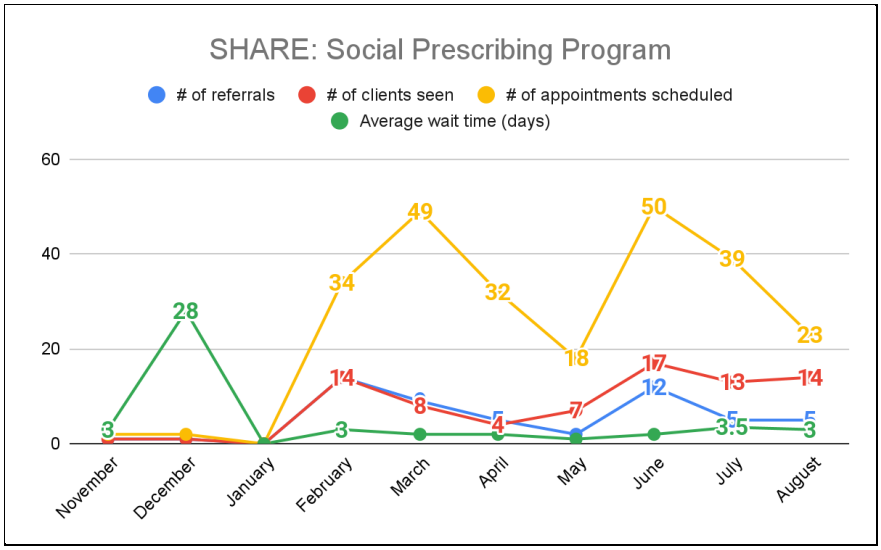
Health Data Coalition (HDC)

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. Due to staff transition, referral data for September and October is currently unavailable.



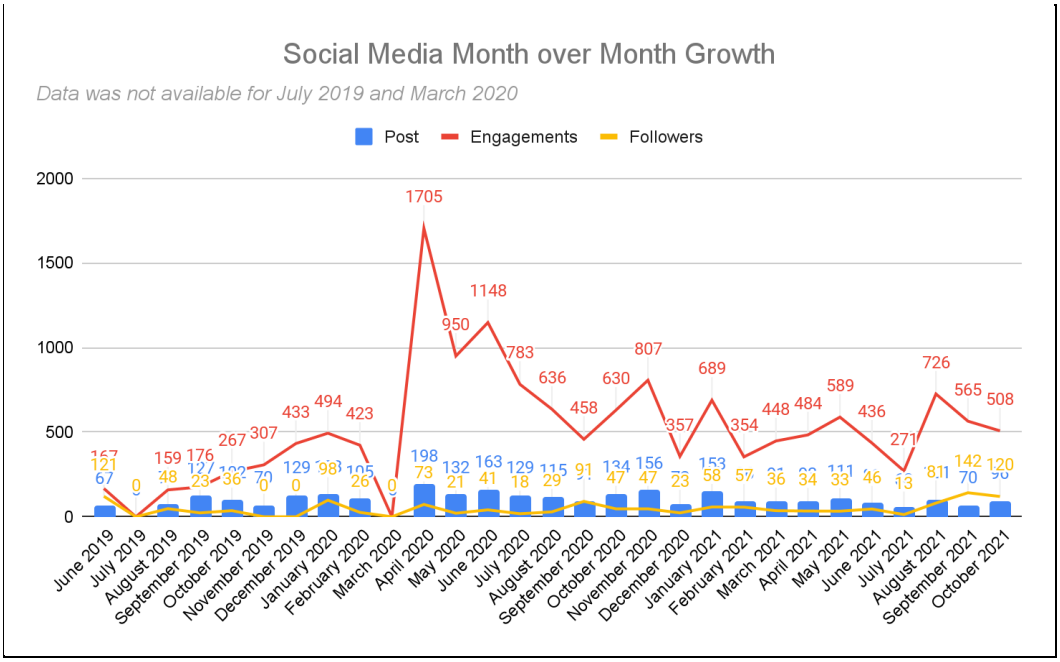
The program shared a testimonial regarding one of the referred patients who was able to successfully update their identification and care card information. These identification pieces had been expired for over 10 years and

through cross-agency collaboration, the patient now has valid picture identification.

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 September they've recorded the following changes in public engagement through the social media platforms:

Channel	# of Posts	Engagements	Followers (+/-)
All Channels (Facebook, Instagram, Twitter, LinkedIn)	+96	508	+120



Each quarter, a newsletter is distributed to patients in the communities who have signed up or agreed to receive newsletters from the Division. When this resource launched in May 2020, there were a total of 170 subscribers, whereas in May 2021 the overall year end growth was 2103%. A breakdown of the # of subscribers, opens and % of opens is below:

	# Subscribers	# Opens	% Opened
May 2020	170	63	38.20%
August 2020	573	279	49.60%
November 2020	1982	1447	73.60%
February 2021	3288	1364	41.70%
May 2021	3745	2203	59.10%
August 2021	3830	1012	28.3%

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

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

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

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

Community Engagement Series: "Whats Up Doc" Mini-Med School

In June 2021, "*What's Up Doc?*", a community engagement series aimed at providing a space for dialogue and conversation between community members and Primary Care practitioners and experts to support a growth in public education and capacity building for creating a common understanding of health related needs in an accessible format. The following have been topics focused on:

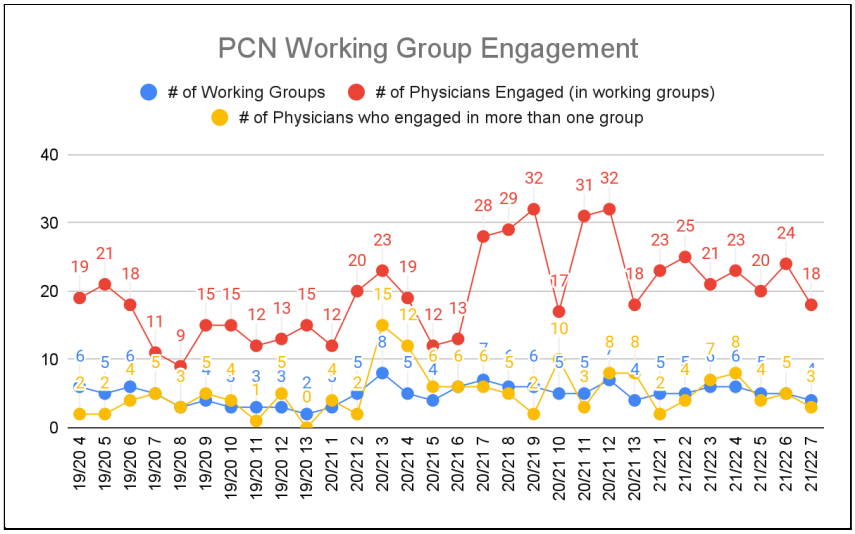
- June 2021 - Infant Development in the first 12 months
- July 2021 - General Primary Care
- August 2021 - Palliative Care
- October 2021 - Long Term Care

Public Engagement: Feedback Collection

Members of the public are encouraged to provide ongoing feedback on the public facing division website. This method of feedback collection was introduced in 2019 and has been ongoing. Themes from this data collection largely focus on the need for attachment to FPs in the community with additional feedback inquiring about finding either a FP or an NP in the community. These themes continue to be consistent with what was heard

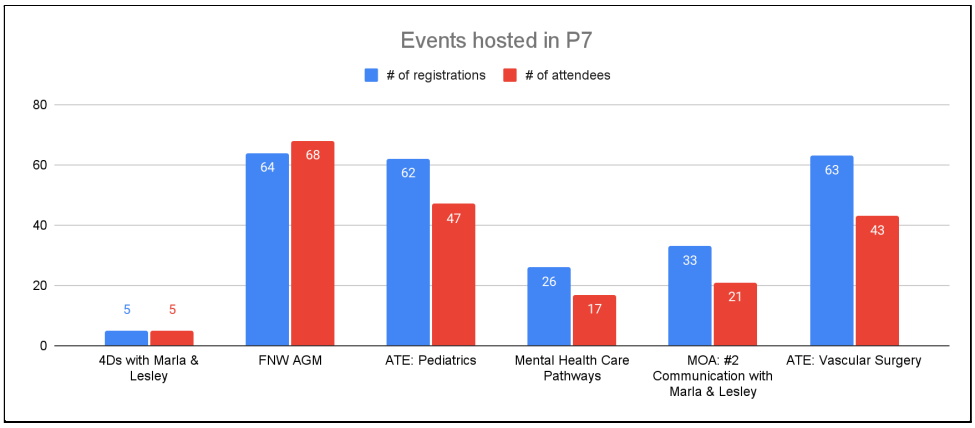
when this mechanism was initially launched and is a reflection of the ongoing need for access to primary care despite the addition of the PCN Primary Care Provider resources.

Physician Feedback and Engagement



Physician engagement for this reporting period includes a breakdown of both the PCN Working group engagement as well as the PMH team engagement events. As part of the FNW PCN, Primary Care Provider engagement and leadership is integral to the successful development and delivery of community services and resources. This engagement is reflected through a number or provider working groups and advisory committees which include:

- PCN Steering Committee
    - *The purpose of the FNW PCN Steering Committee is to provider governance and leadership to te activities, working groups and strategic planning for the FNW PCNs.*
    - *Membership is comprised of PCN partner organizations, community family physicians, hospitalists, administrative program staff and non-profit and stakeholder groups*
- PCN/PMH Provider Advisory Committee
    - *The purpose of this committee is to advise the Division and FHA Leadership regarding the direction of the primary care improvement work underway in the FNW communities*
    - *Membership is comprised of FNW Family Physicians, Hospitalists, Nurse Practitioners, Maternity providers and Division program staff*
- RN in Practice Physician Leads group
    - *The purpose of this group is to provide a space for Physician leads at clinics where RNs are placed to come together, share learning, ask questions and support the ongoing development of the initiative within PMHs and the FNW PCN.*
    - *Membership is comprised of Physician Leads for clinics who have RNs in practice and Division program staff.*
- Community Health Focus Groups
    - Initially launched to support discussion and conversation between FHA Home Health and Family Physicians, these recurring monthly focus groups have evolved to encompass additional aspects of community care including medication management, and mental health supports.



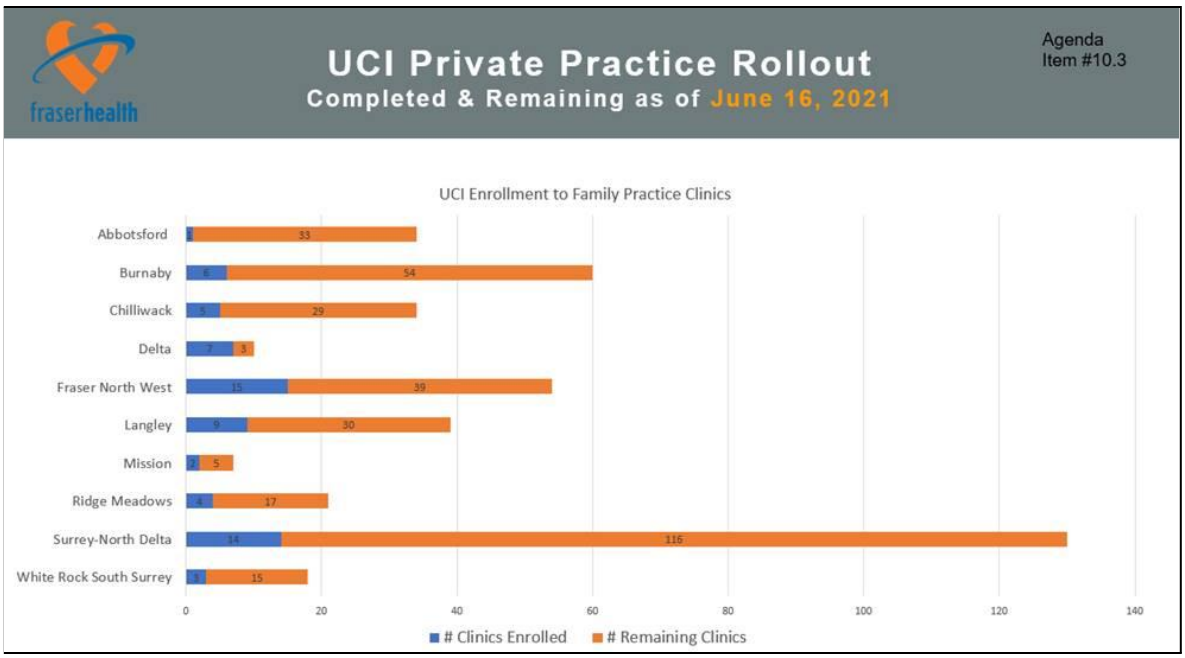
Additional engagement support provided to FNW physicians is the website development. The move to providing primary care services in a virtual setting continues to grow and expand. A full list of the clinics in the FNW and their associated websites can be found by clicking here.

Physician Engagement: Virtual Care

The influx of virtual care over the last 18 months has been significant, largely due to the impacts of the Covid-19 pandemic; however, it's opened up opportunities for access in a quick and convenient manner for patients for certain concerns. Physicians on the FNW Board sat down and shared their reflections on the impacts and benefits of virtual care in a short video (*click the picture below*).

Physician Engagement: UCI and/or CareConnect Access

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



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

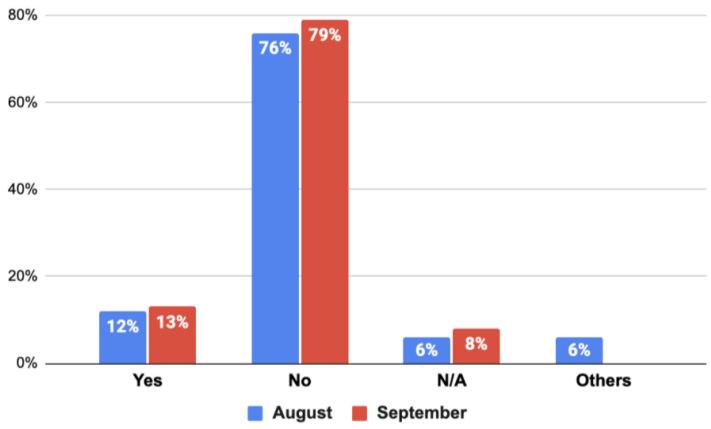
Community Gaps in Obtaining PCN Core Attribute 5/6

Attribute #5: Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.	***Attribute #6***: Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in the community.

Opioid Agonist Treatment

Coordination and access to services for vulnerable and high-risk populations is a priority for the FNW, and as such, recognizing the current state and gaps in access to care has been identified by community physicians through feedback collected from surveys as well as interviews. Physicians have identified barriers to providing Opioid Agonist Treatment inductions and maintenance:

Do you provide Opioid Agonist Treatment inductions?



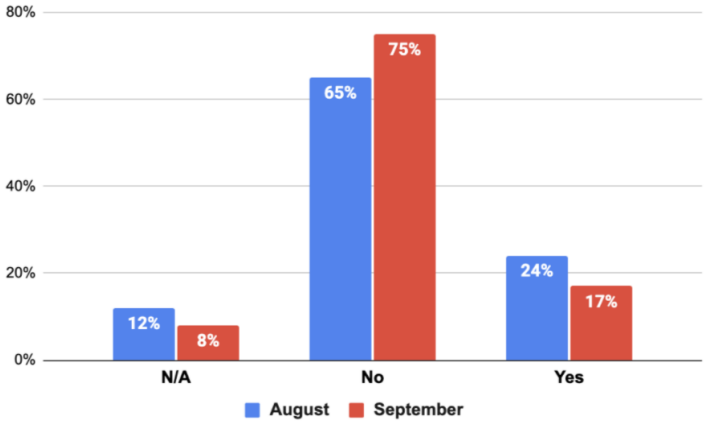
If yes, what are some of the challenges?
Raw Responses :-

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

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

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

Do you provide Opioid Agonist Treatment maintenance?



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

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

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

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

Car 67

Additionally, community resources such as a Car 67 has been identified as a need in the community from FNW community physicians through recent interviews. The benefits and impacts of a resource like this is shared in a short video (*click the picture below*).

Aggregate data shared from the RCMP Mental Health Unit identified that officer's average time on scene in a mental health related call identified 189 minutes in the case of an apprehension and 74 minutes without apprehension. The average time that officers wait with patients upon arriving at the hospital is approximately 100 minutes. The mental health and substance use calls for Coquitlam and Port Coquitlam note the year over year changes below:

Coquitlam - Mental Health Statistics						
	2016	2017	2018	2019	2020	2021 (Jan 1 - Sep 30)
Mental Health Related Files	1289	1267	1187	1156	1288	960
Population Estimate	146019	148055	149309	150636	152800	154207
Mental Health Files per 1,000 residents	9	9	8	8	8	6

Port Coquitlam - Mental Health Statistics						
	2016	2017	2018	2019	2020	2021 (Jan 1 - Sep 30)
Mental Health Related Files	590	584	606	574	611	545
Population Estimate	61441	61943	62932	63654	63503	64445
Mental Health Files per 1,000 residents	10	9	10	9	10	8

Maternity Care

Maternity care in the community is a significant concern in terms of sustainability as many of the providers currently providing this care are later in their careers and the desire for new providers is limited. Members provided feedback on the following barriers to providing maternity care:

What prevents Family Doctors in our community from doing maternity care? What are the barriers?

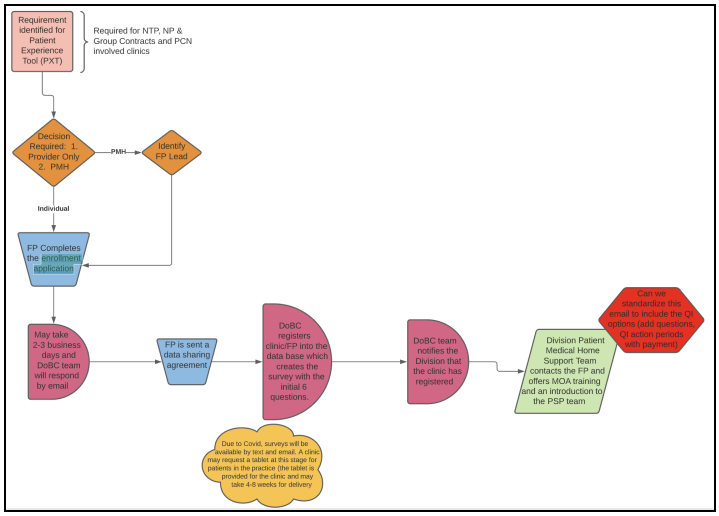
Raw Responses:

- Being on call, I gave up maternity because it was draining on me and my family to be called out to the hospital all the time.
- Also when I last did maternity there was underlying tension with nurses and family physicians, and between the family practice groups like they were competing for money.
- confidence in it
- For me, it's a lack of comfort with the field. I did not have a good experience in residency.
- I personally have a lack of interest in this area of medicine, and don't keep up with the guidelines so it becomes harder and harder to practice it.
- I provide maternity care up until 20 something weeks. I don't do deliveries. Do you mean barriers to providing e.g. any care vs. care up to 10 weeks vs. deliveries?
- Lack of confidence
- Lack of training
- Lack of interest
- Liability
- Comfort
- Accessibility to timely support if things get complicated or urgent care required
- Not sure
- On-call and hours. Training and loss of experience from not practicing it.
- Schedule and I lack skills
- Time limitations. Usually take longer to care for them and answer all their questions, which is often not well compensated. Some doctors continue to do early prenatal visits due to their interest, but aware that they are compensated less compared to other visits that doesn't take as long.
- Everything feel very rushed when we want to do a good job. It does make some people want to seek midwife care because they feel there is more time.
- Feeling overworked already. Unable to take on more to do night and evening shifts due to being on the brink of burnout, already burned out, or recovering from burnout.
- TIME MANAGEMENT
- DIFFICULT TO LEAVE PTS IN THE OFFICE AND ATTEND A DELIVERY AT HOSPITAL

Patient Engagement

Work is underway to implement the GPSC created Patient Experience Tool (PET) within all practices who have RNs

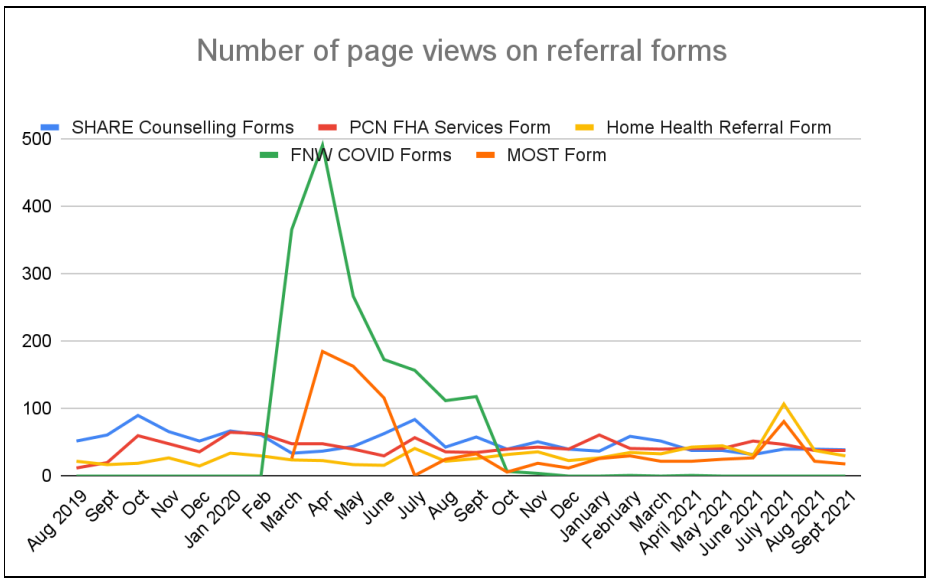
in Practice, or providers on contract. A workflow was developed to share out to PMHs to visually represent the process for implementing the PET into practice. The visual is a draft representation of the workflow process for this tool's implementation.



So far, 1 PMH within the FNW have signed up for the Patient Experience Tool.

Pathways

Pathways is a virtual directory that allows local Family Physicians and providers to identify and access resources, supports and services for their patients on a variety of healthcare related concerns. It is a tool used by Physicians and Specialists for referral resources, wait times, and has been proven to play an important role in the coordination of care between providers. Data pulled from the FNW Pathways site from August 2019 shows the page views of PCN
related referral supports as well as details the rapid increase in Covid-19 supports since March 2020.



PCN Lessons Learned

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