Divisions of Family Practice
An FPSC initiative

Annual Report
2022-2023

Northern Interior Rural Division of Family Practice

Northern Interior Rural Division of Family Practice
An FPSC Initiative

TABLE OF CONTENTS

OUR VISION

Purpose

We are a group of rural practitioners who value rural patients, rural medicine, and rural communities.

Mission

Rural practitioners supporting rural practitioners helping to build healthier communities together.

Vision

To create healthy communities connected by a solid collaborative practitioner community within a stable network of healthcare.

Values

Collaborative, authentic (acting with integrity & accountability), respectful and proactive relationships.

EXECUTIVE DIRECTOR'S REPORT

Executive Director – Errol Winter

Perspective

2022 was a year that can be best described by the opposing forces at work in the successes and the challenges our recruitment and retention program. Last fiscal we recruited 25 practitioners into our region. This astounding feat was countered by the 27 family care providers that left our region.

As with all things it is about perspective. In this year of yin and yang NIRD had many opportunities for celebration. Amazing partnerships built on a decade of trust, retention of a fabulous supportive staff, dedicated caring health care providers steadfastly holding us true to our vision during the toughest of times. All of which was ensconced in solid yet flexible funding from our new friends at the Ministry.

On the yin front our practitioners faced incredible periods of stress, ER closures, diversions, long hours, staffing shortfalls, and a disconcerted public wondering what was happening to their health care system.

As we look toward the future, we continue to see the carryover of most of these challenges, with the added public burden of a flagging economy, rising prices, housing scarcity, and the ever-burgeoning environmental crisis, is it any wondering we are seeing a virtual doubling of mental health patients in our system.

However, when I spend time with our membership I see a determination, a grit, that at times defies logic. This is the Northern way. An indomitable and independent spirit that always seems to find a way. I believe innovation was born in this same type of environment, and when coupled with supportive partnerships there is little that cannot be overcome.

Like an orchestra we all have our own instruments, but it is only when we play together in harmony that music is made.

RA AND PHYSICIAN LEADERSHIP REPORT

Representative Assembly Chair – Dr. Ian Dobson

Friendly greetings and well wishes for the next year! Although much of our work is only measurable in medium- and long-term outcomes, we need to recognize the short-term accomplishments, initiatives, and challenges of our membership.

I would like to begin by acknowledging that some of our colleagues have been gripped with tragedy this past year, our sincerest condolences and support to those affected. Whether it be related to mental health crises and the loss of a colleague, or natural disasters, I appreciate your strength and resilience as you continue to provide care for patients during difficult times. It is adversity such as this that makes me grateful for our supportive community, strong relationships, and our avenues to advocate for physician wellness.

Our PCN work forges ahead as we provide wrap around care to patients in some of the provinces most isolated communities. With our strong physician leads, we advocate for rural interests and support as the primary care landscape changes with the PCN and LFP rollouts. With change comes apprehension and uncertainty, which is why we strive to position our division at the forefront of this wave of change to allow our practitioners to surface in the strongest position to serve our communities.

I am grateful to continue working with a strong group of physician leads, representatives, and directors as we serve an incredibly passionate and resilient membership.

Physician Tri-Leads

Written by Dr. Nav Sidhu on behalf of our Physician Lead team: ***Dr. Ray Markham, Dr. Lindsey Dobson, Dr. Nav Sidhu***

Dr. Nav Sidhu

Dr. Lindsey Dobson

Dr. Ray Markham

It has been my pleasure to join Dr. Lindsey Dobson and Dr. Ray Markham as a physician co-lead during the last three months.

During the last year, I've seen first-hand the perseverance and indomitable spirit of our rural Family Physicians when facing multiple adversities and challenges. We not only advocate for equitable health care for our patients, but also stand strong to sustain our shared values of collaboration, authenticity, and maintaining respectful relationships all around. That said, rural and remote settings across the north are facing surmountable challenges that need to be timely addressed. Of utmost importance is the recruitment and retention of physicians to maintain a healthy provider workforce. NIRD has increased recruitment efforts such as targeting various echelons of learners including medical students and residents to good success. We remain to advocate at various levels for equitable pay for our rural colleagues, as the small portion of "incentives" barely address the challenges of living and raising families in the north. We continue to maintain successful relationships with NH, FNHA, various divisions, community leadership, and Doctors of BC. We are excited about the changing landscape of technology and the opportunity to integrate it in innovative ways. NIRD launched more virtual care services including mental health and addiction services.

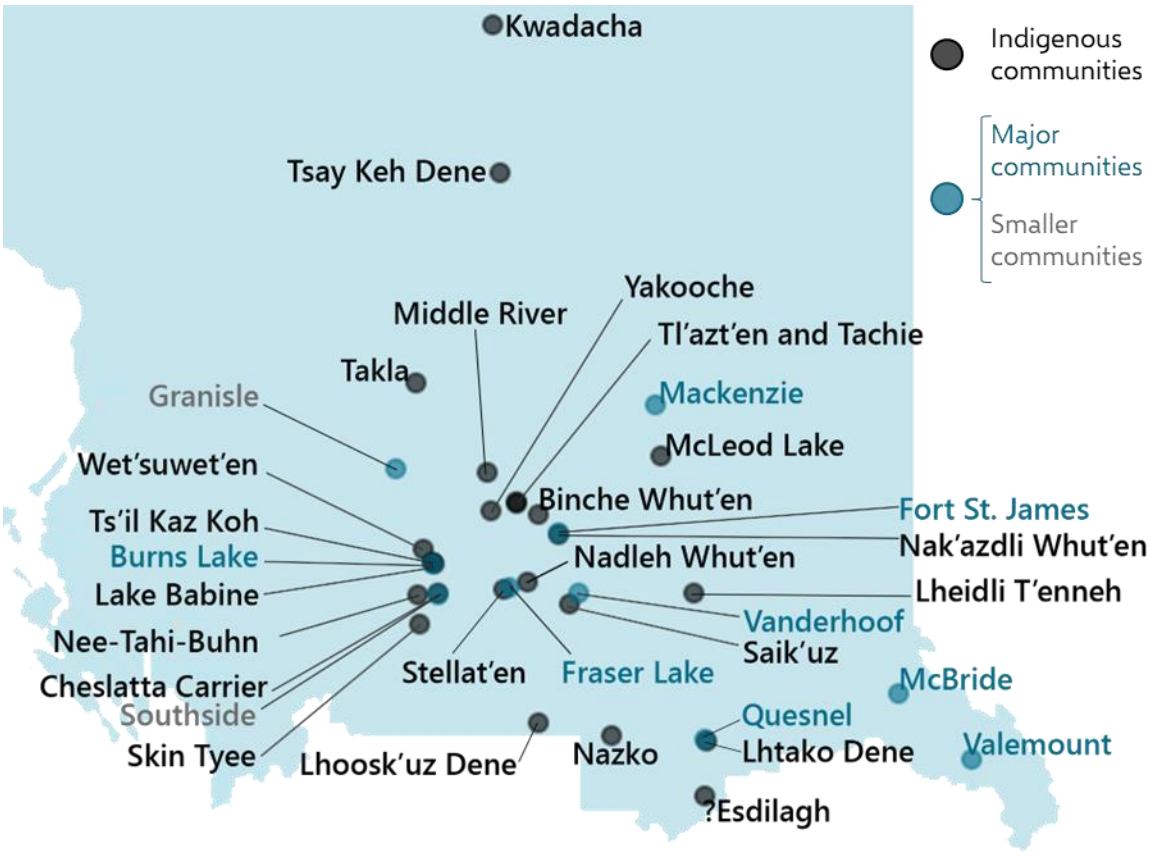
We trust that our NIRD physicians will identify and prioritize the necessities and requirements they need to be able to provide the best care possible to their patients. We are privileged in being able to advocate and bring your concerns to the right people and help in the process of implementing policies and supports important to you. By maintaining good relationships with various leadership levels, patients, communities, and other divisions, we can be helpful in creating and spreading policies that provide sustainable change and not just band-aid solutions. We want to not just prevent burnout, but help us obtain professional fulfillment and enjoyment in caring for patients that we aspired to have as young learners.

I was pleased to see so many fellow providers at the BC Rural Health Conference in June. We believe it is important to continue our collegiality and support for one another in a difficult time. We should recognize our strength when faced with many challenges including, overcoming the aftermath of a global pandemic, dealing with the devastating consequences of forest fires/climate change, and supporting distressed colleagues suffering in silence due to the stigma of mental health. In our attempts to help save the world, though, we should also remember that it is important to save ourselves.

We should be proud of how far we have come as a collective since the beginning of this year. That being said, it is a long road ahead and we need to stand strong against ongoing adversities and hardships. As Shakespeare said, "Once more unto the breach, dear friends, once more".

MEMBERSHIP

The Northern Interior Rural Division has a membership of 108 physicians and nurse practitioners (NPs) in a region with a large and complex healthcare system, comprised of eight rural communities and 22 First Nations communities. The Division serves approximately 61,454 patients across a geographic area of 130,302.57 sq. km.



We appreciate with gratitude living and working on the traditional territories of our 22 Indigenous partners listed above.

YEAR IN REVIEW

Inpatient Care Bridge Funding (ongoing)

The aim of this funding is to **help communities maintain the current provision of inpatient care** while a long-term and sustainable model is developed, through increased Doctor of the Day stipends and compensation top-ups per hospital admission for physicians who attach unassigned patients.

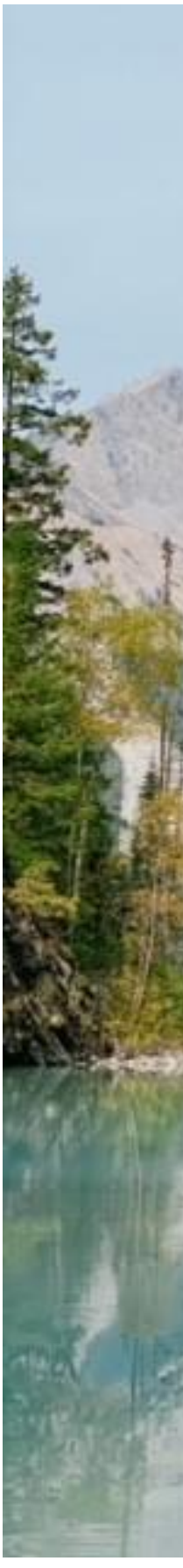
The funding is for hospitals where inpatient care is primarily provided by community-based family physicians on fee-for-service and there is no health authority-funded hospitalist program.

Pills of Knowledge

The 6th Annual Pills of Knowledge for Best Evidence Rural Practice virtual conference was held on October 1, 2022 with 39 participants (19 physicians, 17 residents/students, and 3 in other roles). The **7th annual Pills of Knowledge** for Best Evidence Rural Practice took place on **September 16, 2023.**

Health Emergency Management (completed)

- NIRD staff met with Northern Health staff in each community to review emergency plans
- NIRD staff met with Northern Health Director of Health Emergency Management to ensure the Division was on the right track and avoided duplicating work
- Talked to staff at clinics and hospitals in the region about their processes in case of emergency: some have them, some rely on Northern Health policies, and some do not have a formal process
- Developed an **Emergency Preparedness Clinic Toolkit** and an **Emergency Planning Guidebook** (based on the Thompson Region Division's guidebook, with permission) to help clinics plan for emergencies: both available at https://divisionsbc.ca/northern-interior-rural/initiatives/emergency-preparedness



Long-Term Care Initiative (ongoing)

	Quesnel	Vanderhoof
Quality improvement meetings are held…	Multiple times a year (with practice support coaches, physicians, administration staff, etc.)	
Physicians/partners are engaged in LTCI activities through…	Education sessions; meetings with multiple providers; follow-up and review	Twice-weekly team-based discussions (care conferences and chart review)
Educational/ professional development opportunities focus on…	Cultural safety; medication reviews; long-term care coaching and mentoring support	Medical reviews; geriatric medicine; psychiatry
Communities support a team-based approach to long-term care through…	Frequent meetings/teaching sessions; team-based on-call schedule; communication between providers about patient care	Twice-weekly team-based discussions (care conferences and chart review)
LTCI activities support PCN through…	24/7 availability and on-site attendance when required; reduced unnecessary/ inappropriate hospital transfers	24/7 on-call for long-term care

***FPSC**: Family Practice Services Committee; **LTCI**: Long-Term Care Initiative*

Success factors for the LTCI have been the new insights and knowledge gained relating to specific geriatric care, medications, and indications for transfer to a secondary/tertiary care facility.

Microprojects

COMPLETED

Community	***Microproject***	***Details***
McBride	Handheld Ultrasound	Having a portable ultrasound: • Helped providers with clinical assessments • Let providers offer a qualitative initial screen for patients • *"helped with making the decision of whether to transfer the patient to UHNBC urgently for official U/S or it can be postponed. But eventually, we require an official U/S in PG"* (Dr. Melek) • Increased provider satisfaction

		Dr. Burian and Dr. Melek holding the portable ultrasound 
	Team Morale	Giving team jackets to providers: • Increased feelings of team morale, supportive atmosphere, being supported/heard, working as a unit • *"brought a greater sense of belonging and increased interdepartmental relationships for the team in McBride"* (Project team)
Valemount	Team Morale	Giving team jackets to providers: • Increased feelings of team morale, supportive atmosphere, being supported/heard, and working as a unit
ONGOING		
Vanderhoof	Penicillin Allergy Testing	**Activities**: • Patients contacted directly through EMR with information on the study • Initial appointment, then second appointment to provide oral doses and check vitals • Third appointment one week later to confirm no delayed symptoms and advise on next steps **Objective**: Remove penicillin allergy from patients who are not truly allergic
Fort St. James	Nursing Retention Education Tuition Support	**Activities**: • Support tuition costs for two nurses for Emergency Medicine Speciality Training ($10,000 per nurse) • First $10,000 from fundraising in community, and NIRD to provide remaining $10,000 **Objectives**: • Improve nurse job satisfaction and confidence

		• Improve patient outcomes and quality of healthcare • Support recruitment of registered nurses
Quesnel	Physician Orientation	**Activities**: • Include multidisciplinary team in the orientation process (admin, physician leadership, city representatives, etc.) **Objectives**: • Orientation process redesign • Learn about provider before their arrival • Include a social gathering in orientation

HIGHLIGHTS

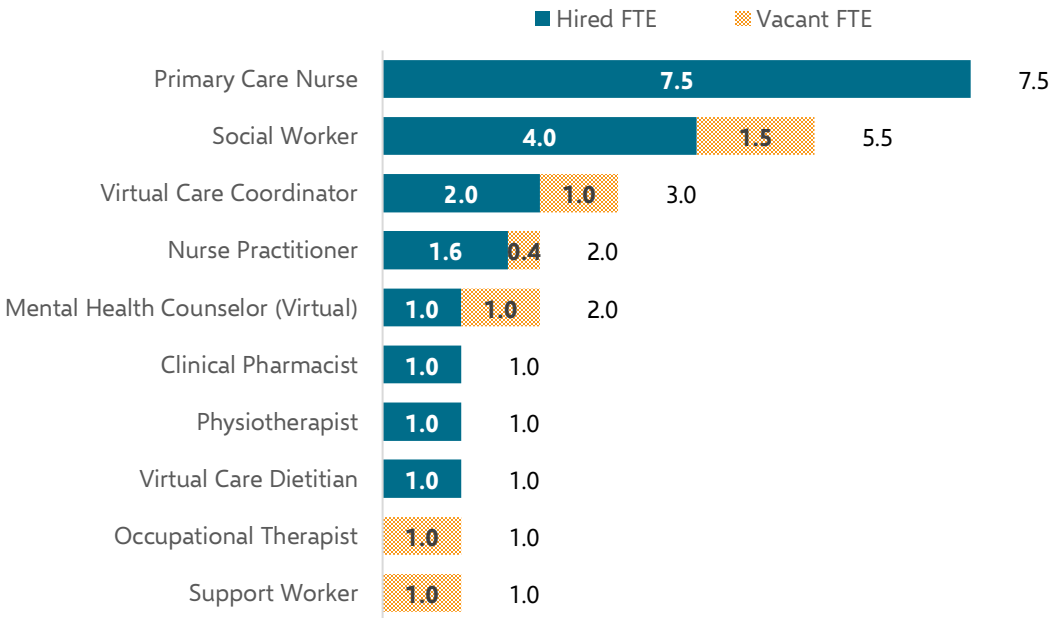
Primary Care Network

The NIRD Primary Care Network (PCN) was approved in January 2021, supporting nurse/NP/allied health hiring as well as patient attachment.

Hiring

Through the PCN, 19.1 FTE (Full Time Equivalent) have been hired, with 5.9 remaining to hire (total: 25 FTE). The largest proportion of FTE have been for primary care nurses with all 7.5 FTE having been hired.

Figure 1. NIRD PCN Positions: hired, vacant, and total FTE



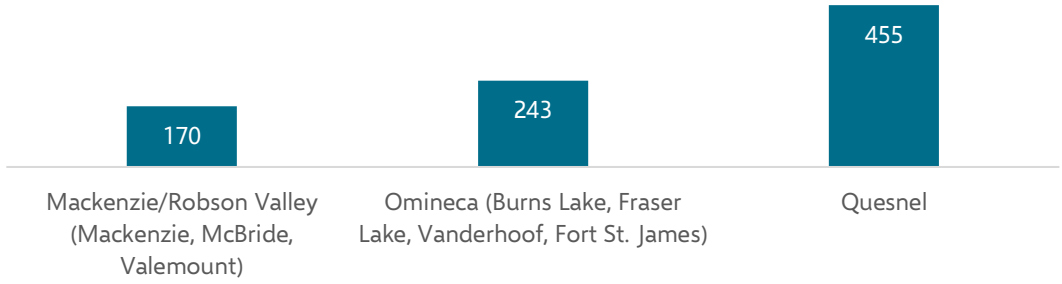
Details on virtual positions:

- **October 2022**: Virtual Care Dietitian hired, working out of the Northern Health Virtual Care Clinic
- **April 2023**: Virtual Mental Health and Addictions Coordinator hired, working out of the Northern Health Virtual Care Clinic
- **May 2023**: Virtual Care Coordinator hired, working out of the Division

Attachment

170 patients have been attached to a primary care provider in the Mackenzie/Robson Valley area, 243 have been attached in the Omineca region, and 455 have been attached in Quesnel.

Figure 2. Attachments to-date



Physician Engagement

Funding for physician engagement in PCN development supported 18 family physicians and 5 family physician leaders. Engagement activities included: coaching and mentoring family physicians for non-clinical work, regional recruitment/retention/retirement strategies, member events, physician leadership, PCN regional tables, and PCN community tables.

Community Tables

Collaborative community tables set priorities for community-based projects depending on local needs.

Community	Priority
Burns Lake and area	Suicide prevention and cyberbullying relating to youth and First Nations communities
Fraser Lake and area	Drug and alcohol use by youth
Fort St. James and area	Child and youth mental health
Mackenzie and area	Accredited childcare and accommodations Drug use and mental health Paramedic shortages
McBride and area	Public transportation for all ages
Valemount and area	My Health Key (where residents can register to access health record and book online appointments)

	Accessibility to health centre
Vanderhoof and area (Nechako Valley Primary Care Collaborative Table)	Men's health Review of high school clinic project (running since 2014)

Evaluation

NIRD worked with program evaluation firm Reichert & Associates to develop evaluation tools (e.g., interview guides) for various roles hired through the PCN and the virtual positions hired. The Reichert & Associates evaluation team have conducted interviews with 9 allied health providers working in the NIRD PCN.

Interviewees shared the hiring process was easy and straightforward

New hires were introduced to other clinics/staff/providers in the community, offered training through the health authority, and received EMR training

Working Well:

Good communication between providers | Supportive staff | Informal information sharing across providers | Interacting with patients | Having administrative support | Having access to patient information | Having other providers able to share caseload

5 of 6 interviewees would recommend working in their clinic / health centre to others

Early Impacts:

- Supporting GPs/NPs/other care providers
- Increased patient access to care
- Having time to spend with patients
- Improvements in health outcomes
- Developing relationships with patients/families

Challenges:

- Lack of time to connect with other providers
- Communication difficulties due to EMR
- Understanding of role
- Initially slow/low referrals
- Caring for complex patients requires more time
- Lack of orientation to/ understanding of PCN

Virtual Care

NIRD's Core Principles of Virtual Care are:

	**Building Partnerships** Collaborate with health authorities, local community partners, and other organizations to increase equitable access to healthcare virtually
	**Consultation to Conversation** Support 2-way visits and other technical support for patients, providers, and clinic staff in preparation for 3-way visits (with patient, provider, and specialist or allied health professional)
	**Hardware/Software** Supply iPads with Zoom for video-enabled appointments, and run pilots with low orbit satellite technology to enable video-enabled care for remote patients with inadequate Internet access
	**Virtualizing Interprofessional Teams** Engage with allied health professionals to provide technology and training, so they can virtually support patients locally and in other communities
	**Patient Support** Support normalization of video-enabled technology to connect patients with providers, allied health professionals, and specialists – including directly support patients to use video-enabled technology for clinical visits

This year, NIRD continued to provide training, workflow assistance, and technical assistance to **clinics for video-enabled appointments**. In Fraser Lake, patients in clinics have been able to see a provider working from home/another community via a video-enabled appointment. A primary care assistant (PCA) attends appointments too, so that the provider does not have to send tasks to the PCA after each appointment, saving time and allowing the provider to see more patients.

NIRD conducted virtual care pilots to provide allied healthcare for patients not directly in community. There was a successful pilot project using **low orbit satellite technology** to bring healthcare to a patient living remotely who did not otherwise have adequate Internet access.

Specialists and allied health professionals have also used virtual care:

- A **mental health and addictions clinician** in McBride provided care to patients in Valemount over Zoom, until Valemount recruited a clinician. According to patient surveys, patients appreciated video-enabled appointments because it was

helpful to see the clinician's face and body language – and it was also helpful for clinicians to see patients' faces and body language.

- NIRD connected with a **cardiologist** in Victoria and facilitated her introduction to Burns Lake, Fraser Lake, and the surrounding Indigenous communities, to begin a heart failure medication project. They enlisted the support of **Practice Support Coaches, the Health Data Coalition, and the primary care pharmacist hired through the PCN.**

Recruitment and Retention

NIRD's recruitment and retention work includes strategies focused on leadership, communities, relationships, and stakeholders.

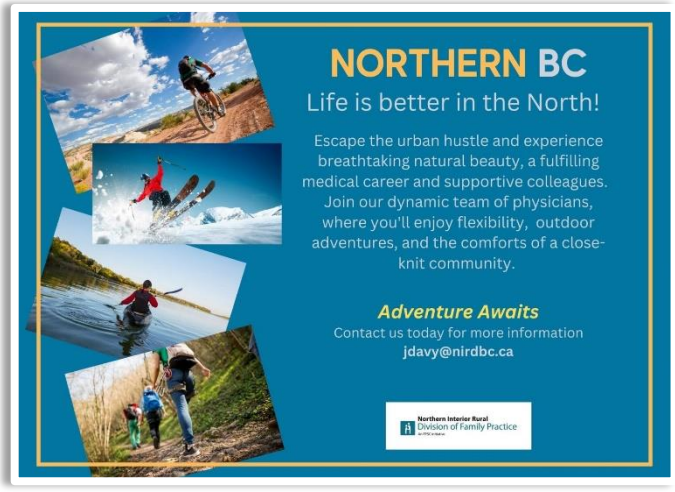
Leadership	Communities	Relationships	Stakeholders
• Engagement • Promote rural working and living • Mentor and teach learners • Practitioners promote the rural advantage at medical events/ tradeshows • Showcase impactful project work • Ongoing face to face talks with medical learners	• Work with learners to create opportunities for a rural experience in NIRD communities • Showcase communities • Work with physicians, NPs, and their families for an optimal experience	• Build relationships with stakeholders, learners, families, and the community to provide the best experience and opportunities possible	• Work with multiple agencies, Divisions, communities, physicians, and NPs to build a solid foundation for recruitment and retention

Activities and successes relating to recruitment and retention include:

Hosting events	• Monthly engagement events with medical learners to hear group talks from physicians • Two social events every year for learners to meet with physicians in the region • Monthly recruitment champion meetings • Social event in Quesnel for spouses of physicians – spouses feeling isolated can be a factor in physicians deciding to move away from rural areas • Visits to communities and meetings with physicians to gather feedback

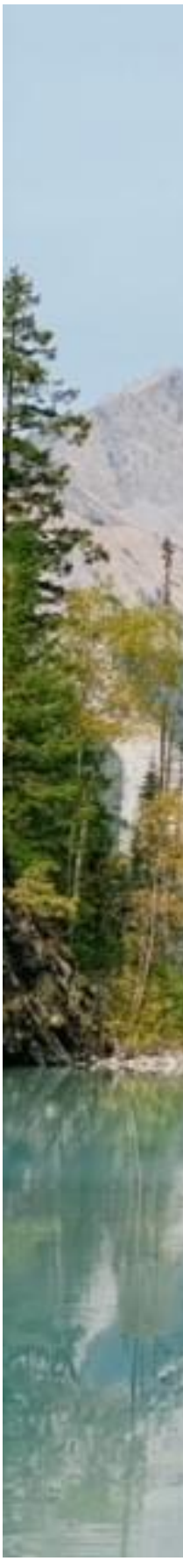
	• Annual learning event (Pills of Knowledge) to support retention • Sponsored resident retreat at Powder King • Hosted a rural practice information session in Vancouver for 20 medical students ○ Organized site visits for medical students that attended this session
Attending events	• A Division staff member and a rural physician attended two rural healthcare conferences • Attended the Rural and Remote Conference in Niagara Falls
Promotion	• Used social media to promote rural medicine and advertise locum opportunities
Partnerships	• Partnered with City of Quesnel to assist with locum costs • Worked with Mackenzie, Vanderhoof, and Fraser Lake regarding housing initiatives
Successes	• Recruited four new grads • Provider vacancy rate is low compared to other regions

Recruitment poster on NIRD website at https://divisionsbc.ca/northern-interior-rural-menu/our-work-0/recruitment



NIRD has two joint Division collaborative recruitment and retention initiatives.

With all Northern Divisions (ongoing)	Phase 1 (completed): Hired research and evaluation firm, Reichert & Associates, to identify barriers to recruiting and retaining physicians in Northern BC
	Phase 2 (ongoing): Bridge the gaps identified in Phase 1



	• A working group with representatives from all Northern Divisions/self-organizing groups and health authority partners meet monthly • Members of the working group have found it useful to hear what other regions are doing to recruit and retain providers
With CIRD (ongoing)	With CIRD, the NIRD Education Committee oversees New Grad recruitment efforts.
	A video will be posted on the NIRD PCN jobs page on Health Match BC, and on the NIRD website.

NIRD's booth at the Rural and Remote Medicine Conference in Niagara Falls (pictured: Joy Davy)

BC Rural Health Conference in Whistler (pictured: Krystal-Lynn Laforest)

NIRD's booth at the BC Rural Health Conference in Whistler

Provider Wellness Initiative

Provider health is a priority for the membership of NIRD. NIRD is working with the Rural Coordination Centre of BC (RCCbc) on a research project which aims to better understand providers' health, wellness, quality of life and job satisfaction, and where there are opportunities for further improvements to supports and services.

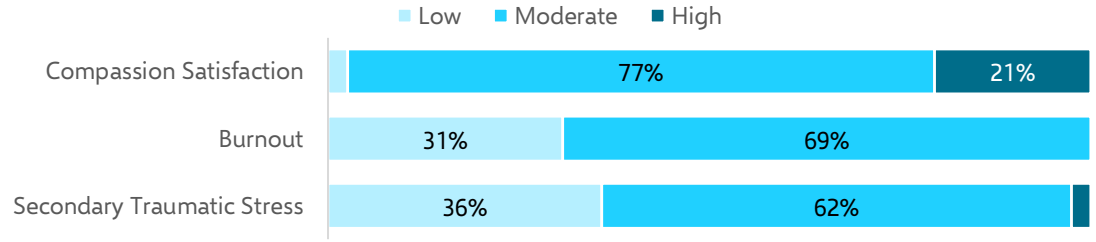
In February and March 2023, 42 providers completed a survey to share their experience.

The survey included the Professional Quality of Life test (ProQOL)[1] to measure scores on the following three scales:

- **Compassion satisfaction** (the pleasure a provider derives from doing their work well)
    - One respondent (3% of 39) had a low compassion satisfaction score. 77% had a moderate compassion satisfaction score (30 of 39), and 21% had a high score on this scale (8 of 39).
- **Burnout** (feelings of hopelessness and difficulties dealing with work)
    - 31% of respondents had a low burnout score (12 of 39), and 69% had a moderate burnout score (27 of 39). No respondents had a high burnout score.
- **Secondary traumatic stress** (work-related, secondary exposure to extremely or traumatically stressful events)
    - 36% of respondents had a low secondary traumatic stress score (14 of 39), while 62% had a moderate score on this scale (24 of 39). One respondent (3% of 39) had a high secondary traumatic stress score.

Survey respondents could opt in to receive their ProQOL score results via email.

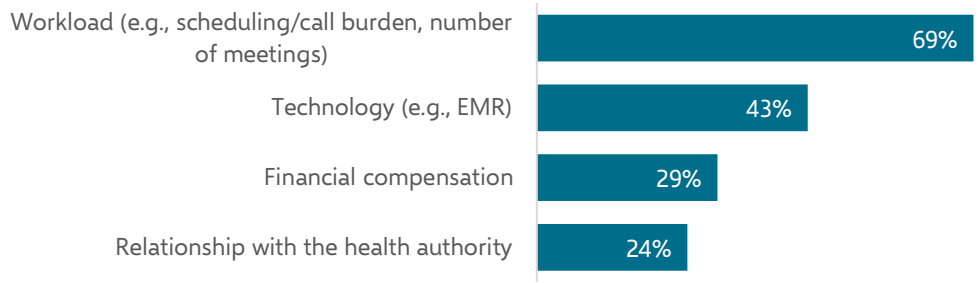
Figure 3. Percentage of Provider Wellness Survey respondents who had low, moderate, or high scores for each scale (out of 39 respondents)



The survey found that 69% of respondents selected workload as one of their top three contributors to frustration in the workplace (29 of 42). 43% selected technology (18 of 42), 29% selected financial compensation (12 of 42), and 24% selected relationship with the health authority (10 of 42) as their top contributors to frustration in the workplace.

[1] B. Hudnall Stamm, 2009-2012. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.proqol.org.

Figure 4. Top answers: "What are your top 3 contributors towards frustration in your workplace?" (out of 42 respondents)

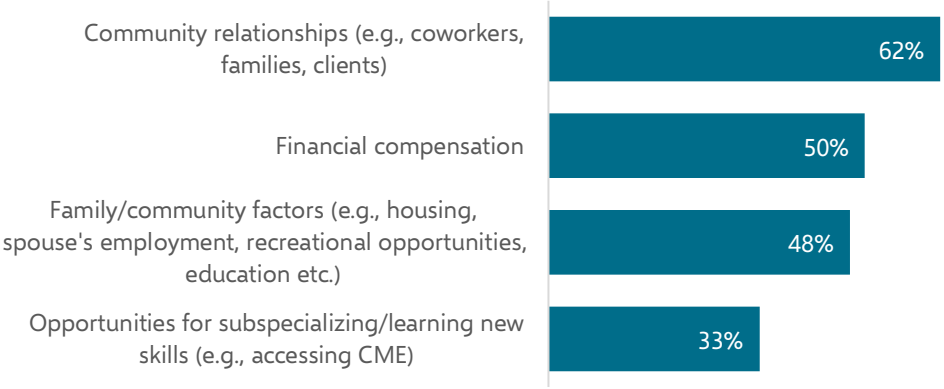


Notes:

- Respondents could select multiple options, so percentages do not add up to 100%.
- This figure shows only the top four answers: other options included *Community relationships* (14%; 6 of 42), *Opportunities to influence management* (14%; 6), *Family/community factors* (14%; 6), *Opportunities for subspecializing/learning new skills* (7%; 3), and *Other* (29%; 12).

62% of respondents indicated that community relationships were a top contributor to satisfaction in their workplace (26 of 42). 50% reported that financial compensation was a top contributor to satisfaction (21 of 42), and 48% (20 of 42) selected family/community factors. 33% of respondents (14 of 42) selected opportunities for subspecializing/learning new skills.

Figure 5. Top answers: "What are your top 3 contributors towards satisfaction in your workplace?" (out of 42 respondents)



Notes:

- Respondents could select multiple options, so percentages do not add up to 100%.
- This figure shows only the top four answers: other options included *Workload* (24%; 10 of 42), *Opportunities to influence management* (12%; 5), *Technology* (10%; 4), *Relationship with the health authority* (7%; 3), and *Other* (21%; 9).

Survey respondents suggested that the following could improve wellness and reduce burnout:

Addressing resourcing

- Access to allied health/primary care/specialists
- Recruitment
- Locums
- Workplace supports
- Remuneration

	Improving work environments and schedules • Work culture and relationships • Flexible schedules • More time for administrative work • Management
	System change • "Doing our part" vs. doing more • Destigmatizing providers' mental health needs/support • Safety • 40-hour work week • Equitable healthcare access • Health authority role in removing barriers
	Alleviating provider workload • Less non-clinical burden • Less call • Improved training for administrative staff • More staff
	Enhancing EMR/administration support • Improved EMR and tech support • Communication from administrators to providers

These survey results were presented to NIRD board members, physicians, NPs and Division staff during the Strategic Planning session in April 2023 (see below). NIRD will use the results of this survey to explore further areas for improvement related to provider wellness.

Strategic Planning

On April 4 and 5, 2023, NIRD hosted a Strategic Planning Session in Prince George. Participants included NIRD board members, physicians, nurse practitioners, and NIRD staff. This section summarizes discussion themes and key potential work from the session.

Participants noted that the results of the Provider Wellness Survey reflected their own thoughts related to workload and what is important to keeping providers in communities.

As well, participants highlighted that recruitment is working well, but retention is challenging. They also discussed the importance of involving learners to speak about rural practice/living and pursuing opportunities to further engage NPs in recruitment.

Participants identified four attributes needed to move the Division forward:

- Certainty
- Stability
- Resources
- Respect

Five themes arose in discussions of potential work that can move the Division forward:

1) Strategy to proactively address loss of physicians in NIRD communities

A comprehensive strategy/toolbox would allow communities and the Division to respond effectively when a physician leaves. Elements could include:

- Communication strategy (to community/partners/physicians)
- Referral paths
- Support for remaining physicians
- Confirmation of external supports including methods of activation (through NH, Rural Locum Network, etc.)
- Community toolbox

2) Value proposition statements

Defining the value that the Division provides and the opportunities in communities would have multiple, ongoing uses within NIRD's activities, such as:

- Value proposition for physicians/NPs working in NIRD communities to support recruitment and retention of physicians/NPs
- Value proposition for physicians/NPs within the Division to support member engagement
- Value proposition for physicians/NPs within the Division to support development of Division leadership
- Value proposition for the Community Network Tables targeting physicians/NPs as well as community members

3) Communications strategy

A more formal communications strategy could outline the current means of communication and identify areas for improvement. Participants also were interested in communications tools or templates that physician leaders could use to collect information and communicate about discussions and actions undertaken at the various tables attended by leaders on behalf of NIRD.

4) Review of mission, vision, and values

Participants expressed support for the current mission, vision, and values in principle – but some participants have different interpretations than others. Reviewing or discussing the mission, vision, and values could present an opportunity to improve member engagement and understand what members want from the Division.

5) Advocacy

Developing a clear strategy for advocacy and identify key messaging would be a useful first step.

BOARD OF DIRECTORS AND STAFF 2023

Board Members

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Dr. Todd Alec

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Debbie Strang

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Kirsten Schmid
Virtual Care Coordinator

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Dr. Nav Sidhu
Fraser Lake

Dr. Ammar Kheder
Fort St. James

Dr. Cody Kaskamin & **Dr. John Pawlovich**
Indigenous Communities

Carmen Schalles
Mackenzie

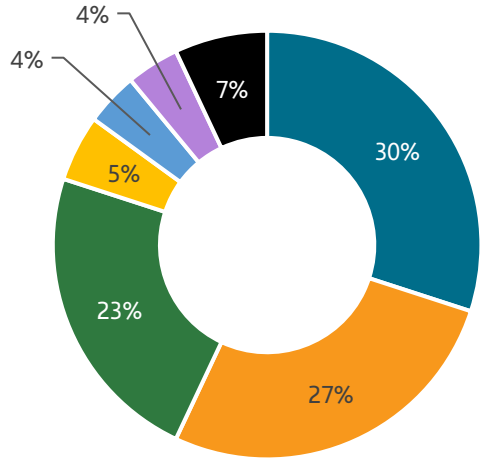
Dr. Jessica Burian
McBride

Barbara Nielsen
Quesnel

Dr. Ray Markham
Valemount

FINANCIAL STATEMENTS

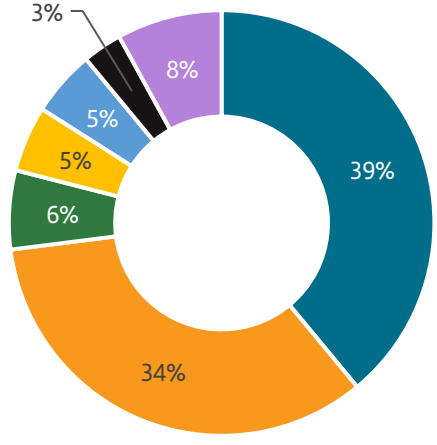
Revenue



- In-Patient Bridge (30%)
- Primary Care Networks (27%)
- Infrastructure (23%)
- Physician Engagement (5%)
- Recruitment and retention (4%)
- Shared Care (4%)
- Other (7%)

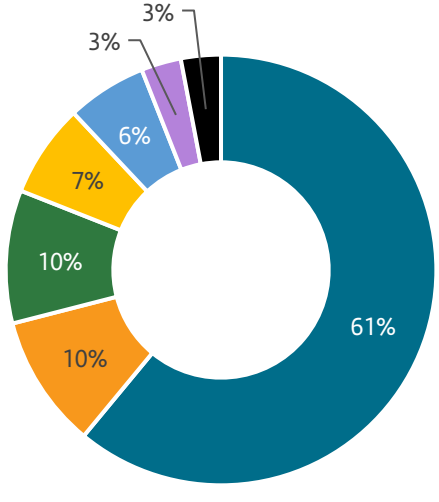
Expenses: Program Services

- In-Patient Bridge (39%)
- Primary Care Networks (34%)
- Physician Engagement (6%)
- Recruitment and retention (5%)
- Shared Care (5%)
- Infrastructure (3%)
- Other (8%)



Expenses: Administrative

- Salaries and Benefits (61%)
- Office and General (10%)
- Sessionals (10%)
- Travel (7%)
- Professional Fees (6%)
- Telephone (3%)
- Meetings and events (3%)



INDEPENDENT AUDITOR'S REPORT

Table 1. Summarized Statement of Financial Position
March 31, 2023, with comparative information for 2022

	2023	2022
Assets		
Cash and restricted cash	$ 1,211,521	$ 847,268
Accounts receivable	5,418	31,915
Property and equipment	48	106
	$ 1,216,987	$ 879,289
Liabilities and Deficit		
Accounts payable and accrued liabilities	$ 325,722	$ 176,234
Deferred revenue	896,289	$ 729,086
Deficit	(5,024)	(26,031)
	$ 1,216,987	$ 879,289

See note to financial summary statements (page 26).

Table 2. Summarized Statement of Operations and Changes in Deficit
Year ended March 31, 2023, with comparative information for 2022

		2023		2022
Revenue:				
Programs	$	1,694,307	$	1,255,750
Interest income		20,943		1,394
		1,715,250		1,257,144
Expenses:				
Administration		352,155		606,790
Program services		1,342,088		671,121
		1,694,243		1,277,911
Excess (deficiency) of revenue over expenses		21,007		(20,767)
Deficit, beginning of year		(26,031)		(5,264)
Deficit, end of year	$	(5,024)	$	(26,031)

Revenues		2023		2022
COVID	$	-	$	10,914
Change Management Infrastructure		-		49,338
Health Emergency Management		1,445		-
In-Patient Bridge		520,000		-
Infrastructure		395,924		633,676
Innovation PMH		11,116		1,110
Interest		20,943		1,394
Maternity Care Quesnel and Vanderhoof		-		33,281
NP Infrastructure		2,713		-
Physician Engagement in PMH/PCN		82,009		-
Physician Integration and Retention		47,864		-
Physician Wellness		3,622		-
Pills of Knowledge		8,000		8,000
Primary Care Networks		461,183		456,445
RCCbc VCC positions		27,420		-
Recruitment and retention		64,585		40,538
Shared Care		68,426		22,448
		1,715,250		1,257,144

Table continued on next page

Table 2 (continued). Summarized Statement of Operations and Changes in Deficit
Year ended March 31, 2023, with comparative information for 2022

Table continued from previous page

Program Services	2023	2022
COVID	$ -	$ 11,520
Change Management Infrastructure	-	52,576
Health Emergency Management	1,445	-
In-Patient Bridge	519,931	-
Infrastructure	43,770	45,203
Innovation PMH	11,116	1,110
Maternity Care Quesnel and Vanderhoof	-	33,281
NP Infrastructure	2,713	-
Physician Engagement in PMH/PCN	82,009	-
Physician Integration and Retention	47,864	-
Physician Wellness	3,622	-
Pills of Knowledge	8,000	8,000
Primary Care Networks	461,183	456,445
RCCbc VCC positions	27,418	-
Recruitment and retention	64,591	40,538
Shared Care	68,426	22,448
	1,342,088	671,121

See note to financial summary statements (page 26).

Table 3. Summarized Statement of Cash Flows
Year ended March 31, 2023, with comparative information for 2022

	2023	2022
Net inflow of cash from:		
Operating activities	$ 364,253	$ 477,393
Cash and cash equivalent resources, beginning of year	847,268	369,875
Cash and cash equivalent resources, end of year	$ 1,211,521	$ 847,268

See note to financial summary statements (below).

Note to the Independent Auditors' Report on Summary Financial Statements:

The summary financial statements are derived from the complete audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations as at and for the year ended March 31, 2023.

The full set of audited financial statements for the Northern Interior Rural Division of Family Practice are available from the Division.

The criteria used to summarize the complete audited financial statements are as follows:

- Assets and liabilities have been summarized according to major captions.
- Gross revenues and expenses have been summarized and presented in the summary statement of operations and changes in deficit.
- Cash flows have been summarized according to operating, financing and investing activities, if any.

CONTACT US

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Divisions of Family Practice
An FPSC initiative

The Divisions of Family Practice Initiative is sponsored by the Family Practice Services Committee, a joint committee of the BC Ministry of Health and Doctors of BC.

Nature photos by Meagan Ryan

Other photos provided by Joy Davy