Collectively We Care.

White Rock-South Surrey
Primary Care Network

2023 ANNUAL REPORT

DELIVERING OPTIMAL TEAM-BASED CARE

WRSS PCN IS A PARTNERSHIP OF:

White Rock-South Surrey Division of Family Practice
An FPSC initiative

fraserhealth

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Glossary of Terms

CHF	Congestive Heart Failure
CHN	Home Health Nurse
CHSA	Community Health Service Area
ED	Emergency Department
FHA	Fraser Health Authority
FFS	Fee-for-Service
FNHA	First Nations Health Authority
FNPCI	First Nations Primary Care Initiative
FP	Family Physician
MHSU	Mental Health and Substance Use
MOA	Medical Office Assistant
NiP	Nurse-in-Practice
NN	Neighbourhood Nurse
NP	Nurse Practitioner
NSW	Neighbourhood Social Worker
NTP	New-to-Practice
PAH	Peace Arch Hospital
PAMC	Peace Arch Maternity Clinic
PCAC	Primary Care Access Clinic
PCCP	Primary Care Clinical Pharmacist
PE	Patient Educator
PMH	Patient Medical Home
PSDA	Plan-Do-Study-Act
PSP	Practice Support Program
RN	Registered Nurse
SCSP	Specialized Community Services Program
SFN	Semiahmoo First Nation
TBC	Team-Based Care
TR	Transformative Reconciliation
UBC	University of British Columbia
WRSS	White Rock-South Surrey
WRSS DoFP	WRSS Division of Family Practice

1. The WRSS PCN
1.1 Overview

The community of White Rock-South Surrey (WRSS) is situated in the southwest corner of the Lower Mainland, 45 kilometers from Vancouver. It is bounded by the Pacific Ocean to the west, the United States to the south, Langley to the east, and the City of Surrey to the north. The community is comprised of two Community Health Service Areas (CHSAs) 2,341 (South Surrey) and 2,342 (White Rock) with a combined population currently estimated at 119,672 (2021)[1], a 16% increase between 2016 and 2021. Approximately 25.4% are aged 65 or older[2] and 2.0% identify as Indigenous[3]. Across all ages, over 47% of the population are either frail or live with a chronic condition[4]

Our community is collectively addressing our attachment gap and working to improve access through enhanced team-based care, while also recruiting additional Family Physicians and Nurse Practitioners to attach patients. Through a team-based approach, our PCN is able to ensure better access to comprehensive care and improved care coordination that is patient-centred and culturally safe. Research has shown that the provision of primary care through a team-based approach improves inter-provider connection and collaboration for team members, reduces practice silos, and improves satisfaction among patients and providers.[5]

The WRSS PCN comprises three service areas:

1. **Enhanced team-based care to ensure seamless access to services and increased support for providers and patients.**

   Care will be provided proactively for patients of all ages with mild-to-moderate health issues by developing a three-pronged approach to care. With enhanced clinical care through the addition of Neighbourhood Nurses (NNs), access to social supports through the addition of Neighbourhood Social Workers (NSWs), and robust patient education and health promotion through the addition of Patient Educators (PEs)[6], Family Physicians (FPs) will be supported in community clinics, and the number of patients who use acute care services and/or eventually require specialized community services will be reduced.[7]

   This service is important for our community because the number of patients with chronic diseases is increasing and those patients are frequenting our local Peace Arch Hospital's Emergency Department, demonstrating the need to be proactive while patient care needs are still mild-to-moderate to avert or delay their decline.[8]

2. **Enhanced services for mild-to-moderate mental health clients**.

   There are two distinct components to fill the gap in services for patients with mental health and substance use concerns in our community. The first is the introduction of two new Primary Care Clinicians (MHSU), which will support the PCN team by connecting FPs and Clinicians with primary and community care services to help patients access the most appropriate services, as well as providing MHSU-related education to FPs and Clinicians. The second is the re-introduction of the successful counselling initiative with Sources Community Resource Centres (Sources). This program assists patients who need professional counselling services but having to pay is a barrier. The goal is to assist patients in recognizing and resolving their personal difficulties using a short-term therapy model. The initiative will confirm and strengthen the FP-patient continuous relationship by providing better supports for the mental health needs of patients and increase capacity in the primary care system.[9]

This service is important because mood disorders are the third most prevalent chronic condition in our community.[10] Annually in WRSS, approximately 12% of patients visit an FP for a mental health concern[11] and, in 2021/22, there were 2,255 visits to Peace Arch Hospital's ED related to mental health and substance use, which represents a 36% increase from 2020/21.[12] A community-level research project undertaken in 2021 by the WRSS DoFP examined transitions in care for patients with mental health concerns and found that mental health services are often fragmented and difficult to navigate for FPs and patients, and eligibility criteria is often restrictive. These PCN mental health services will help to ensure FPs have the support they need to help patients navigate the system and connect with community services and programs, thus freeing up FP time to see other patients and attach new patients.

3. **Enhanced access to primary care services for vulnerable and homebound patients**.

   These patients are served by two programs in our community. Firstly, the Primary Care Access Clinic (PCAC) provides primary care to vulnerable and complex patients that have challenges attaching to a traditional FP practice or are being discharged from the hospital and require follow-up care but do not have an FP. Secondly, the HomePACE program provides primary care for senior patients who are clinically frail and homebound (living at home and cannot get to a primary care clinic). This service is important in our community because as these patient populations face complex health challenges, access to primary care is critical. Demand for this service is anticipated to grow due to an increase in the populations they serve.[13] In 2023, these two programs merged into one and are called the Primary Care Access Clinic.

In 2023/24, we reached the milestone of our four-year implementation process. The focus of the WRSS PCN continues to be on having a robust, timely, and relevant PCN to serve our patient population and members, while integrating supports, structures, and partnerships with Fraser Health Authority (FHA) and other partners for program growth and sustainability.

This Annual Report provides a detailed update on the progress made during the 2023-2024 fiscal year, including advancements toward the eight PCN attributes, key milestones achieved, highlights of findings of physician experiences in the PCN, financial reporting, partnerships with FHA, and an update on the PCN moving forward.

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[1] Census Profile, 2021 Census of Population. Retrieved from: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=white%20rock&DGUIDlist=2013A000459030&GENDERlist=1&STATISTIClist=1&HEADERlist=0. Note: Census Canada pulls the population all the way to 56th Avenue (Highway 10) but the boundary for the WRSS DoFP ends at 40th Avenue.
[2] Ibid
[3] Ibid
[4] Primary and Community Care Profile: Your Community - South Surrey/White Rock (202), Ministry of Health: Health Sector Information, Analysis and Reporting Division, March 2017. Note: updated data was not available by the time this report was finalized.
[5] Schottenfeld, L., Petersen, D., Peikes, D., Ricciardi, R., Burak, H., McNellis, R., & Genevro, J. (2016). Creating patient-centered team-based primary care. Rockville: Agency for Healthcare Research and Quality, 1-27.
[6] As of March 31, 2023, nine Neighbourhood Nurses, five Neighbourhood Social Workers, and two Patient Educators are in the WRSS PCN. The full complement of team members will be phased in by the end of 2023.
[7] WRSS PCN Revised Service Delivery Plan, 2019, pg. 5.
[8] This service was revised from the original plan, which comprised of two service areas. The first is to capitalize on the current willingness to redesign how Home Health services are delivered in the community and adopt a team-based care model more closely aligned with FP practices, with less restrictive criteria and better continuity of care. The second is to create a team of allied health professionals (speech-language pathologists, occupational therapists) to provide more proactive support and enhance FPs' ability to support patients with the management of chronic conditions. The Ministry of Health did not recommend these services for approval as they overlapped with the Specialized Community Services Program (SCSP). The Service Plan was therefore amended to the service described in number 1 above and was approved.
[9] WRSS PCN Service Delivery Plan, 2019, pg. 34.
[10] Local Health Area Profile FHA-South Surrey/White Rock (202), Ministry of Health-Health Sector Information, Analysis and Reporting Division, October 2016. Note: updated data was not available by the time this report was finalized.
[11] Local Health Authority FHA South Surrey/White Rock, Ministry of Health, Health Sector Information Analysis and Reporting Division, October 2016. Note: updated data was not available by the time this report was finalized.
[12] 2022 PAH Emergency Department Visits; Data Source: Fraser Health.
[13] WRSS PCN Service Delivery Plan, 2019, pgs. 47-48.

1.2 Descriptive Statistics of the WRSS PCN

Description	2023/24	2022/23	2021/22	2020/21
Number of Family Physicians (FPs)[14] in the community	89	92	100	91
Number of FPs in the community participating[15] in PCN	89	92	100	91
Number of FPs on FFS ALL ON	86	92	98	89
Number of FPs on group sessional contract	1	1	1	2
Number of FPs on New to Practice contract	2	2	1	0
Number of sessional FPs (locums)	11	14	4	3
Number of FPs in the enhanced team-based care model[16]	89	66	43	18
Number of Neighbourhood Nurses (NNs)	14[17]	9[18]	5	3
Number of Neighbourhood Social Workers (NSWs)	5	5	3	1
Number of Patient Educators (PEs) in the PCN	2	2	2	1
Number of Primary Care Clinical Pharmacists (PCCP)	1	1	1	0
Number of Mental Health Clinicians	1			
Number of Registered Nurses (RNs) in the PCN[19]	1	1	1	1

1.3 Qualitative Reflections

a. What are some stories of where the WRSS PCN is working well?

The key mechanism to realizing the WRSS PCN is the continued transition to an integrated team-based approach to primary care delivery. The following examples illustrate where our PCN is working well in terms of implementing team-based care and some of the benefits this transition is having for patients and FPs in our community.

Strategies to address capacity challenges with team-based care

The following examples demonstrate how our PCN has worked collaboratively to create innovative solutions to some of those challenges.

[14] Family Physician is defined here as a physician working in a WRSS clinic with a panel of attached patients providing longitudinal primary care.
[15] Currently, there are two levels of participation in the PCN by Family Physicians. In level one, FPs have had access counselling services as of June 15, 2020, access to the PCCP as of July 26, 2021, are contributing to the collective community attachment goals, and have agreed to progress towards implementing a team-based model of care over the next two years. Level two participation includes all the components of level one as well as an active transitioning to a team-based model of care with the addition of NNs and NSWs.
[16] Level two of participation – see footnote 15.
[17] There are now 14 Neighbourhood Nurses attached to FPs, along with 2.5 relief NNs to cover leaves.
[18] A total of 11 NNs were hired, three of which were hired for maternity relief, and two of those were subsequently hired to permanent positions as the team grows.
[19] This total is for the RN with the HomePACE and PCAC programs. It does not include NNs, who are also RNs.

As more FPs were joining the PCN and working in a team, it started to become apparent that the need for social work services in the community exceeded the number of NSWs in our PCN. We were not able to add new NSWs to the PCN given the current funding structure yet wanted to ensure that every FP in the community had access to an NSW to help support their patients. To solve this challenge, we analyzed referral data, such as the number and types of referrals NSWs were receiving, as well as their caseloads, to better understand where and how changes could be made to increase capacity. A system of lateral referrals was implemented whereby NSWs could send certain referrals to NNs and NNs were upskilled in topics such as mild mental health, advanced care planning, and system navigation. Using this innovative and collaborative approach, **additional capacity was created among the NSWs** so that now, all 89 FPs in the PCN have access to an NSW so that their patients can receive the support when they need it.

> *Through collaboratively working alongside our NNs the lateral referral process has benefited our NSW team profoundly. Our NSWs are able to have the capacity to address higher priority referrals in a timelier manner which has allowed for more engagement with clients that require direct SW support.*
> - Neighbourhood Social Worker

A second example of how innovative and collaborative approaches were employed to address healthcare challenges this year has been the creation of a group medical visit model through the **PCN Chronic Pain Management Education Series**. The aim of this initiative is to provide patients with information on pain management and increase their confidence in their abilities to self-manage their pain and enable patients to achieve improved health and well-being. It was created in response to the Primary Care Community Pharmacist's (PCCP) capacity challenges, specifically because the data showed there was a high volume of referrals for pain management. The team of PCCP, NNs, and PEs came together to develop and facilitate the group education sessions.[20]

This series takes place in an online group format, with referrals from PCN FPs or Clinicians. During each session, participants implement newly gained knowledge by setting goals and determining ways to address barriers that may arise as they make changes. Resources and connections to community services are also provided. An evaluation is involved to assess the effectiveness of the sessions[21].

> *Without education and guidance, self-management can be a frustrating process. Through shared care, we can empower patients to take charge of managing their pain by learning more about their condition, self-management tools and skills to enhance their wellbeing. There is incredible value in people with similar experiences coming together and learning from each other.*
> - Primary Care Community Pharmacist

[20] See promotion poster in Appendix A
[21] The results from this evaluation will be shared once the data collection and analysis are complete.

Additionally, the PEs also provide the referral-based group online Lifestyle Management Series for patients needing support in this area. This Series has 4 topics: (1) Managing Lifestyle Changes, (2) Physical Activity, (3) Nutrition, and (4) Sleep.[22]

b. If you had to list two major learnings that have emerged from PCN implementation in the last year, what would they be?

The WRSS PCN continues to build timely and relevant primary care through our PCN to serve our patient population. Two key learnings that have emerged this year are:

Firstly, the importance of a multi-pronged approach to change management

We use a diversity of change management strategies, recognizing that the **transition to a team-based care model of care** is a different way of practicing for most FPs. One of the goals is to evolve to a place where an FP in a patient appointment habitually asks themselves 'who else can help with this patient?' and then refers to the appropriate clinician. We use the Prosci ADKAR® Model[23] of change management, which is comprised of phases: Awareness, Desire, Knowledge, Ability, and Reinforcement. Our approach is to integrate communications, training, coaching, and mentoring (including peer-to-peer with FPs), and evaluation throughout the transition to team-based care.

Secondly, the importance of learning as we go

We are continually learning about the **amount of time required from the FPs to lead** this type of program. We have a five-person PCN FP Lead team that meets regularly to discuss 'what's working and what's not working/where are the areas for improvement' in the program, where adjustments are required, as well as discussing strategic next steps. Each FP Lead is also responsible for a 'stream' of work such as training and development and working directly with the PCN Clinicians. We do hear from the FPs that they find working on these initiatives fulfilling and they get a lot of value out of being an instrumental part of the process of making positive change for primary care in our community, however, they also note that it is time-consuming, and can become overwhelming at times as they are also juggling their family practice, families, and other commitments. To help address this and prevent FPs from burning out, we have learned the importance of recruiting a larger group of FP Leads to distribute the work. Strategies are currently underway to bring more FPs into these roles. It will have the additional benefit of bringing more diverse voices to the table, which always adds value.

c. What are the top two successes that have emerged from PCN implementation during the last year?

Firstly, the benefits for patients and healthcare providers that have resulted from collaborative partnership development

In several areas across the PCN, FPs have led the work of developing partnerships within the local medical community and finding innovative ways to collaborate for the purpose of delivering more coordinated and comprehensive care, which is leading to better patient outcomes. A key example is the launch of the PCN **Congestive Heart Failure (CHF) pilot project**. Working collaboratively with the Hospitalists at Peace Arch Hospital (PAH), and PAH Facilities Engagement, this project involves PCN

[22] See promotion poster in Appendix B
[23] https://www.prosci.com/methodology/adkar

NNs proactively reaching out to patients who have been discharged from PAH for CHF, scheduling a home visit (or virtual, if that is not possible), to provide patients with education on how to weigh themselves daily and track their weight. The goal is for patients to be able to quickly detect any weight gain, which is an early sign of CHF exacerbation, so they can contact their FP and adjust their medication in order to avoid hospital readmission, which is both stressful for the patient and their family, and difficult for an over-capacity acute care system. Additionally, for weight monitoring, NNs, provide CHF education for signs and symptoms of fluid retention, medication reviews, and make nursing assessments on their status post discharge.

Early data shows that patients who have a visit to receive CHF education by an NN within three days of a hospital discharge have a 2.7% re-admission rate, compared to patients who decline the education (8.3% re-admission rate) or are not eligible to receive the education because their FP is not part of the WRSS PCN (9.8% re-admission rate). While still early, this data suggests that an early visit by a PCN NN can reduce the hospital re-admission rate by more than two-thirds. While no formal plans are in place yet, the intention is to take the learnings from this pilot and expand this project to other chronic diseases, such as COPD, which will lead to better patient outcomes, as well as further reduce emergency department visits and hospital admissions.

Another pilot project was initiated this year to **better connect the PCN NN with Home Health Community Health Nurses** (CHN) and thereby provide more seamless care to patients. In this pilot, the NN and CHN who are working with an FP in the PCN, are now having regular conversations, and reviewing patients' transition to CHN from PCN or integrated care cases.

In another example, **the partnership between the PCN and Primary care Access Clinic (PCAC) has been strengthened** through increased communication, the sharing of resources, and new supports provided to the PCN-funded RN at the PCAC, including education. The PCN team is also working with the PCAC to improve processes for attaching PCAC patients who have become stable and ready to attach to an FP in a community clinic. This has created some additional capacity for the PCAC to attach new patients, such as those being discharged from hospital who require follow-up care but are not attached, to help keep them from being re-admitted to hospital. We are also planning to support the PCAC patients with our NSWs, as this population has a high need. This would likely be in the form of group education sessions as our NSWS capacity is being fully utilized. The PCAC RN is more supported with this strengthened partnership:

> *For me personally, I feel better supported in my role. I have access to educators, colleagues, pathways, education materials etc. that I can turn to if needed. I am invited to all staff education sessions which has helped me develop in my role here at PCAC. I regularly receive emails from staff and educators with resources which may be useful to myself or to provide to patients. I have been trying to connect our patients to the patient education courses that have been organized by the PCN group (e.g. Chronic Pain Education, Lifestyle Management Program, Hypertension Education Sessions, and Fit for life). The PCN NSW team have also offered to help support our panel which will greatly benefit our patients as we have limited SW support.*
>
> - Primary Care Access Clinic RN

This was the second year that the PCN FP and NN provided **health care at the White Rock Daytime Warming Centre**, operated by Engaged Communities Canada Society (Engaged Communities)[24]. They were onsite one morning a week to provide healthcare assessments, prescriptions, wound care, and referrals. Through this collaborative partnership between the PCN, Engaged Communities, FHA's Integrated Homelessness Action Response Teams (IHART) Nurses, and Mental Health Substance Use (MHSU) Clinicians, the PCN FP and NN cared for over 61 clients (some multiple times) between November 2023 and early March 2024.

Photo 1: PCN FP and NN (far right on the bottom) at the White Rock Daytime Warming Centre

Secondly, the integration of maternity care and the PCN

The majority of local FPs refer their patients in early pregnancy to the Peace Arch Maternity Clinic (PAMC). The PAMC is a local FP-owned clinic with expertise in maternity and newborn care; the FPs working at the PAMC also have their own separate general family practices. The PAMC sees patients up until approximately six weeks postpartum and provides newborn care up until the first month of an infant's life.

During the year, the PAMC started **referring patients to three of the NNs** who have a background in maternity care. The NNs provide care through home visits, telehealth visits, and clinic visits. They help patients with a variety of topics from lactation support to blood pressure management. The NNs also make lateral referrals to NSWs where needed.

- The integration of the PAMC with the PCN has meant that patients can access care when and where they need it, and in some cases, it has led to the prevention of potential risks to health, as the following story illustrates: A NN saw a new mom and her baby in the Maternity Clinic for a baby check, but upon further discussion with the mom, it was revealed she had gestational hypertension and was still taking anti-hypertensives. The patient informed the NN of her recent BP readings which seemed sub-optimal, so the NN called the FP in the Maternity Clinic for further assessment and as a result, her medications were increased. The NN saw the patient the following day in her home, mostly to check on the baby's weight and feeding but ended up checking mom's BP, and found she was extremely hypertensive despite the recent increase in her medication. While still in the patient's home, the NN contacted the FP on call at the

[24] https://www.eccsociety.org/

Maternity Clinic and the FP called to notify the ER of her arrival and the mom went to ER immediately. The mom was seen relatively quickly and was given additional medication and sent home stable. Reflecting on this case, the NN said "*I think had I not seen the patient in her home and checked her BP myself, she may not have recognized the severity and potential risks to her health that such high BP can cause.*"

Photo 2: FP with baby at the Maternity Clinic

d. What are the top two challenges that remain regarding the PCN implementation? How will they be addressed in the coming year?

Firstly, the lack of a planned PCN Wellness Hub

A key challenge for the realization of the full implementation of the WRSS PCN is the delayed development of the PCN Wellness Hub (Hub). Originally conceptualized during the PCN planning phase, the Hub strategy was selected as the most effective solution to meet our community's healthcare needs because it:

(1) Aligns with the Ministry of Health's strategic direction to improve access to care and increase capacity.
(2) Increases patient wellness by creating a collaborative and coordinated system of care where patients have access to the right services in the right place.
(3) Provides a space for PCN, PCAC, WRSS DoFP, and other health care community partners to come together to share ideas and resources to improve the delivery of health care in our community.

Despite concerted efforts over the last several years, the Hub remained in the Functional Program phase as the fourth year of PCN implementation came to an end. Delays in its implementation have resulted in inadequate space for delivering PCN, PCAC, and WRSS DoFP services, hindering patient access to healthcare. The delays were primarily due to assessing the suitability of the Centre for Active Living as the Hub location. Nonetheless, significant progress has been achieved over the past year, including:

- Productive meetings held to discuss and promote the hub concept and affirm the Centre for Active Living as the preferred site
- Substantial completion of the Functional Program, providing a solid foundation for the project

With stakeholders eager to move the Hub forward at the Centre for Active Living, we anticipate significant progress in the near future to enhance healthcare delivery in the community.

Secondly, the change in the PCN Pharmacy program with the transition out of UBC

While we did have advance notice of the transition of UBC, it involved a significant amount of change as to how the PCCP worked. Without UBC, there was not an MOA for PCCP support. This affected her referrals significantly as it is taking some time for FPs to understand the updated referral process without the UBC MOA. The PCN Pharmacy FP Lead spent a lot of time with the PCCP supporting her with this change. Additionally, there are plans to implement a future strategy to pilot clinical support coordination not only for the PCCP but also for other PCN Clinicians.

2. Attachment

a. How many Family Physicians have been accepting new patients in this fiscal year?

During the 2023/24 fiscal year, the $0 WRSS PCN attachment code used by clinics in the community to identify newly attached patients was changed to a new $0 provincial attachment code. However, this new code was applied to all patients on FP panels, not only newly attached patients. As a result, there is no mechanism to track the number of new patients attached to FPs in WRSS in 2023/24.

b. How many new attachments have been made in this fiscal year in relation to the attachment targets set out in the Service Plan?

Between 2020/21 and 2023/24, WRSS community clinics attached more than 13,377 new patients. We know that between 2020/21 and 2022/23, there was an average of 4,459 patients attached each fiscal year. Based on this, an estimation could be made that a similar number was attached in 2023/24, bringing the estimated total to 17,829 patients for 2020/21 to 2023/24, far surpassing our 4-year attachment target of 8,900, as illustrated in the chart below.

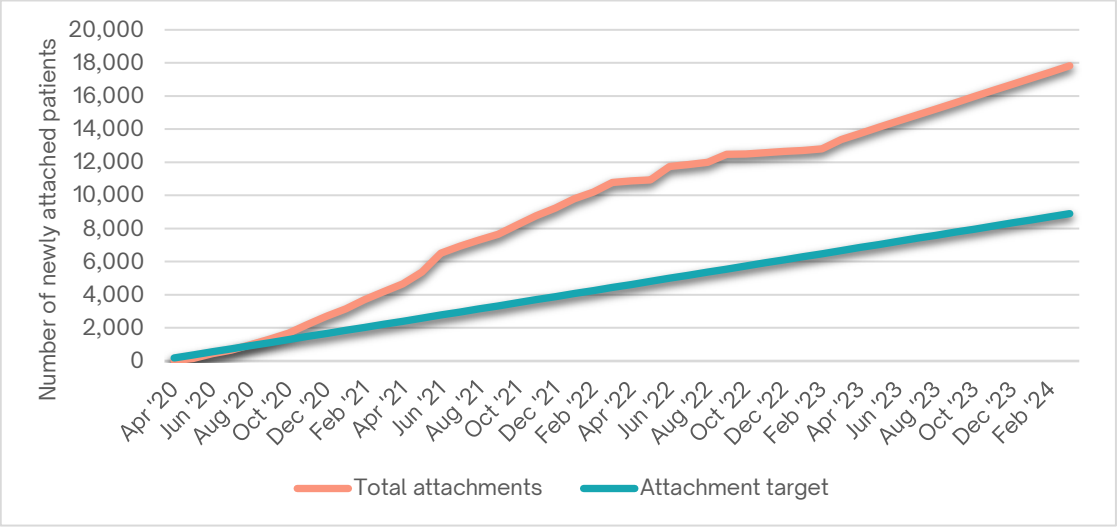

Figure 1: WRSS new patient attachments each month fiscal 2020/21 to 2023/24

c. What processes are available to support new attachments?

The WRSS DoFP employs a multi-pronged approach to support new patient attachments. Patients call or email the WRSS DoFP looking for an FP for themselves or family members[25] and staff will provide information about clinics with FPs accepting new patients or direct patients to the Medimap website.

Medimap[26] is a site available to the public that provides up-to-date information on clinics accepting new patients. The WRSS DoFP Recruitment Manager connects clinic staff to the Medimap team, which works with the clinic to get them set up and trained on how to use the platform. Clinics then receive weekly prompts asking if there are any FPs accepting new patients and the website is updated accordingly.

Several clinics in WRSS also maintain their own waitlists of patients needing attachment, keeping the WRSS DoFP informed when FPs are accepting. When a new FP joins the clinic, patients are contacted to book a 'meet and greet' with the new FP.

To provide additional attachment supports, two new FPs have joined the community under the new two-year New-to-Practice (NTP) contracts which contain new patient attachment targets.[27] Our PCN has also secured two Nurse Practitioner (NP) contracts, one of which has been filled, and the filling of the second one is in progress.

The PCAC also fulfills an important attachment role in our community, acting as a flow-through attachment mechanism. It accepts complex and vulnerable patients who have challenges attaching to a traditional FP community practice, as well as patients who are being discharged from the hospital and require follow-up care but do not have an FP. Once patients are stabilized, the PCAC connects them to FPs in the community who have agreed to attach them.

This year, we have started planning to have the provincial Health Connect Registry (HCR) integrated into attachment for our community and will continue a strategic approach to the integration.

d. What are some challenges that remain around facilitating patient attachment?

In 2023/24, the WRSS DoFP recruited 15 FPs and 1 NP, which is a success for patients in our community. However, a few FPs left the community unexpectedly, resulting in a net loss of three FPs (see Section 1.2 above). Additionally, as noted in Section 1.1 above, the population of WRSS has grown significantly, increasing by 16% between 2016 and 2021. This rapid population growth is expected to continue, as BC Stats estimates the population to increase by an additional 13% to 136,380 between 2021 and 2026.[28] Taken together, the demand for FPs has surpassed the supply, resulting in an attachment gap in our community.[29]

[25] The WRSS DoFP office receives, on average, 2-3 calls and emails per week from members of the public looking for an FP.
[26] www.medimap.ca/wrss
[27] The intent of NTP contracts is to provide new FPs with the time needed to gain experience and become comfortable in a busy family medicine clinic setting, thereby facilitating a smoother transition to a full panel practice.
[28] https://bcstats.shinyapps.io/popApp/
[29] There is no mechanism in place currently to measure the number of patients in WRSS who are unattached.

The WRSS DoFP's Recruitment Manager works with physicians from around the world to support them in coming to WRSS to practice family medicine. However, the process that FPs go through to be able to practice is complicated and fraught with delays. And, as in many other communities across the province and country, the demand for FPs outpaces the number available due to several systemic reasons, including a lack of medical school capacity. While BC is working on increasing the number of physicians trained in family medicine,[30] it will take several years to begin to see the impact of this strategy and in the meantime, it is affecting us in terms of facilitating patient attachment. A strategy is currently underway to work more collaboratively with other Recruiters from Fraser Valley Divisions of Family Practice potentially leveraging recruitment and retention efforts and additional funding that may be available from FPSC.

This year, a Welcome Guide[31] and Onboarding Guide[32] were created. The first guide is being used to introduce WRSS and the medical community to FPs in the recruitment process, to highlight for them all the benefits of living and working in the community. The second guide is for recruits who have decided to practice in WRSS and provides information about how to set up and start working in the clinic, to help make the transition smoother and more seamless.

3. Access

a. Provide examples where PCN resources have helped improve patient access to care and services

Through this team-based model of care, FPs are working collaboratively with NNs, NSWs, and the PCCP to provide primary care services to patients, leading to better health outcomes for patients.

Here are a few examples of how PCN resources have helped improve patient access to care:

- **NNs helping mom and baby care in clinic or at home**: NNs are helping improve follow-up care for families in our community. Especially in the first couple of weeks postpartum when breastfeeding is being established, the NNs support families by visiting them at home to provide breastfeeding education and support, newborn weight checks, and follow-up visits to repeat newborn weight checks when we could not accommodate follow-up visits in the Maternity Clinic.

- **FP and NSW support for counselling and housing resources:** NSW received a referral from an FP to support a patient in the community who was struggling to maintain employment due to their medical condition, which was then affecting the patient's ability to pay their bills and rent. The NSW supported the patient to make sure they had applied for financial support through the provincial and federal governments as the patient was unable to rely on steady employment income. The patient was falling behind on their rent payments, and ultimately decided they would need to move from the Lower Mainland in order to make ends meet. The NSW provided the patient with supportive counselling and housing resources. The patient was able to find housing and is now living much closer to their family and friends. The patient shared with their NSW that they had called the Suicide Hotline on two separate occasions, as they found themselves to be struggling emotionally with where their life was at, and that the NSW was able to help them during those "dark times". The patient was incredibly appreciative of the support and assistance they had received from the NSW.

[30] https://news.gov.bc.ca/releases/2022PREM0067-001809
[31] See https://divisionsbc.ca/sites/default/files/inline-files/dofp-welcome-guide-2024.pdf
[32] See https://divisionsbc.ca/sites/default/files/inline-files/dofp-onboarding-guide-2024.pdf

- **Medication management support from the PCCP:** An FP made a referral to the PCCP for a medication review and hypertension management for their patient. During the initial assessment, the PCCP completed a comprehensive medication review and identified poor patient adherence with blood pressure medications. The patient reported stopping his medications shortly after they were prescribed due to not fully understanding the rationale for use and concerns about possible side effects. The PCCP provided extensive medication counselling and reviewed the risks and benefits of each medication with the patient. The PCCP discussed lifestyle modifications for blood pressure management and encouraged additional support from allied health clinicians. Through shared decision-making, the patient agreed to restart some of his medications and to work with the NN for support with lifestyle changes. The PCCN created a comprehensive care plan with clearly defined treatment goals and recommendations which were discussed with the FP.

- **Access to counselling to address lingering mental health issues for patients who may not otherwise be able to access the service:** A client who was presenting with pervasive feelings of abandonment and the lingering symptoms of traumatic brain injury was referred by their FP to the PCN-funded Sources counselling program for support. This client began their counselling sessions to process their life, career, and place within their adoptive family. They used the session time to explore themself with the hope of both creating a better life and aiming that life at something that will fill their life with meaning instead of alienation. Through the process of counselling, the client began to experience self-acceptance and steer their life towards fulfilling their need to belong. This client is also highly sensitive and is prone to bouts of social withdrawal in the wake of episodes of over-stimulation. The counselling has also assisted them in creating coping mechanisms for such episodes.

- The following is a quote from another client who accessed counselling, explaining the impact it has had for them:

> *I was referred by my doctor for counselling services through Sources and was introduced to a Counsellor. In my lifetime I have had counselling, also my professional life is in the same field, so therefore I have an opinion on who is 'good' at it, and are they appropriate, demonstrate knowledge and have the skill of listening. I had such a remarkable experience with the Counsellor; he is an excellent listener, and he understood the goals I had, and we reviewed them at each session. Each session gave me new information that encouraged me to seek and search myself and my life, to get clearer, and learn a new skill set. I come away with peace, and knowledge I did not have before. It was an experience by which I looked forward to, and had plenty of time between visits, that allowed me to focus on the new ideas, suggestions. Success!! Thank you so much to making this possible.*
> - Sources Counselling Client

The PCAC provides access to care for complex and vulnerable patients, as well as those discharged from the hospital who require follow-up care but do not have an FP. The HomePACE program provides care for frail and homebound elderly patients. This year, PCAC

and HomePACE programs were amalgamated and the PCN-funded HomePACE RN now provides care to patients in both programs.

- **PCAC RN care and support for a patient waiting for surgery:** A patient had been waiting for back surgery for over three years. His FP was semi-retired and was unable to manage his care due to limited office time, so the patient was referred to PCAC. At the time of referral, the patient was depressed, not getting out of bed at all, refusing to eat and drink for several days at a time, and not showering or changing his clothing. The initial home visit was completed by the PCAC RN to obtain a health history and build rapport. Over several weeks, the PCAC RN spoke with the patient and spouse to build trust and rapport. MHSU referral was also completed, and the patient spoke and met with MHSU nurses as well. The patient became receptive to meeting with the NP and the NP was able to advocate for the patient and streamline referral to a surgeon. The patient became more hopeful and began to get out of bed and participate in care. The patient received surgery the following month.

b. What are the top factors that have helped enable virtual care?

The groundwork started by the Patient Medical Home (PMH) initiative, in collaboration with PSP and the Practice Support Coach, facilitated the integration of virtual care into practices. Through personalized coaching, FPs have been guided in adopting virtual care. Clinics benefit from support mechanisms like the WRSS DoFP monthly Clinic Managers' meetings, where staff exchange insights, successes, and hurdles, particularly concerning virtual care implementation. The surge in virtual care adoption during the COVID-19 pandemic has led many FPs to maintain a hybrid approach, balancing in-person and virtual consultations.

c. What are the top challenges to implementing virtual care that remain?

Virtual appointments may pose challenges for patients accustomed to in-person visits with their FPs, as it requires clinics to educate patients for adaptation. Certain groups, particularly seniors and marginalized individuals, may feel uneasy or lack access to the necessary technology for virtual care, like a camera-equipped computer or smartphone, or reliable internet connection.

4. Comprehensive Care

a. Provide examples of where PCN resources have helped to increase the comprehensive range of services to patients

Comprehensive care is defined[33] as:

> A range of longitudinal health care services over a patient's lifetime through an integrated team-based care model involving health care providers from different professional backgrounds working together with patients, families, caregivers, and communities.

[33] https://bcpsqc.ca/improve-care/team-based-primary-and-community-care.

The PCN has helped to increase comprehensive care for patients in the following ways:

- This year we have all eligible FPs integrated into our PCN. The full team is 89 FPs, 1 NP, 15 NNs, 5 NSWs, 1 Pharmacist, 3 relief NNs, 2 Patient Educators, 1 Mental Health Educator, and Sources counselling. Together, they are working with a team-based approach and many more patients are having their primary care needs met.

Photo 3: 2024 WRSS PCN Clinician Team

- NNs have enabled FPs to provide patients with a **breadth of primary care services, including the ability to see patients quickly**, in patients' homes when needed, and provide patient education to support self-management of their health conditions. To date, 2,387 referrals have been made to NNs.

- NSWs have enabled FPs to provide patients with **much-needed social support**, such as assistance with housing concerns and financial hardships, suspected abuse, caregiver burnout, and social isolation. Many FPs had not previously worked with Social Workers and were unfamiliar with the breadth of services they offer. They now see NSWs as an invaluable part of the team. To date, 1,419 referrals have been made to NSWs.

- The PCCP has provided support to FPs and their teams to provide better care for patients **through medication assessments and recommendations**, chronic disease management, patient education, medication adherence issues, as well as medication costs and coverage concerns. Between August 3, 2021 (when the PCCP began seeing patients) and March 31, 2024, the PCCP provided 861 patient visits, and between August 3, 2021 and September 30, 2023, the PCCP provided care to 352 unique patients.[34]

- FPs and PCN Clinicians can refer **mild-to-moderate mental health patients to free short-term therapy** delivered through a local community organization and funded by the PCN. In 2022/23,

[34] Unique patient data was tracked by UBC for this period. As of October 1, 2023 this data was no longer collected due to changeover challenges and associated administrated challenges. .

the PCN-funded counselling program (with Sources Community Resources) provided 2,152 counselling sessions to patients who would not have been able to afford counselling services. Between June 15, 2020 (when the program was launched) and March 31, 2024, the program has provided 7,9920 counselling sessions.

- Patients who are discharged from the hospital without an FP or who find it challenging to attach to a traditional family practice **receive primary care through the PCAC** from a team of an FP, NPs, and an RN. In 2023/24, the PCN-funded RN provided 898 PCAC patient visits, including in-person visits at the clinic or home visits, and virtual visits.

- The PEs continue to create **Service Maps for various health conditions and Patient Journeys for navigating community services**; these resources are located on Pathways (28 in total to date). Service Maps and Patient Journeys are communication tools between FPs and NNs/NSWs to support patients in managing health conditions. This tool allows the FP to know exactly which path the NN/NSW will go along with the patient. It also provides information about services and programs that are available locally, which the NNs/NSWs use to support patients' navigation of community services and self-management.[35] Adoption of these maps into Clinician work processes has been high.

5. Care Coordination

a. Provide examples of where the PCN has helped to increase care coordination

Care coordination is defined[36] as:

> A critical component of team-based care that involves the planning and organizing of patient care activities between two or more providers involved in a patient's care to facilitate the appropriate delivery of healthcare services. When care is coordinated, all team members share important clinical information about patients, and they have clear shared expectations about their roles. Additionally, they work together to keep patients and their families informed and to ensure that effective referrals and transitions take place to help ensure continuity of care.

These examples demonstrate the progress made over the past year towards care coordination and show the benefits for patients and providers:

- **NN referral to NSW for interim counselling support:** A NN was supporting a patient with injections and made a referral to an NSW to provide counselling support until the White Rock Mental Health team was able to take over. A family meeting was arranged involving the NN, FP, patient, and her father to ensure there was a support plan in place during this interim time. A plan was developed with the team to have the NSW visit the patient weekly for support and then was discharged once the Mental Health team was able to start working with the patient.

[35] See Appendix D for an example of a WRSS PCN Service Map
36 McDonald KM, Sundaram V, Bravata DM, et al. (2007). Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7 Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

- **NN interim wound care and referral to Home Health:** A NN received a referral from an FP to assess a wound on a patient who has a difficult time getting to the clinic due to age and mobility issues. After assessing the wound and determining that it was chronic, the NN sent a referral to Home Health, as the patient would benefit from wound care management. The NN saw the patient for three visits before Home Health took over. The referral and transition process went very smoothly for the patient and clinicians from both teams.

- **NNs and NSWs lateral referrals to ensure timely patient-centred care:** The ability to send and receive lateral referrals between PCN Clinicians has allowed for true team-based care. Whether it be collaborative visits or simply allowing each Clinician to work in their scope of expertise, patients have expressed their gratitude for the multi-disciplinary approach to addressing the individual as a whole, embodying what it means to deliver patient-centered care.

- **PCCP referral to NSW to help patient pay for medication and connect socially in her language:** An NSW received a referral from the PCCP, who had reviewed an elderly patient's medications and noted that the patient was having trouble paying for her medications consistently. The NSW met with the patient and conducted a financial assessment and found that the patient's income fell far below her monthly expenses. The NSW was able to liaise with the PCCP, help the patient complete paperwork to eliminate her Pharmacare deductible so that her monthly medication expenses were reduced to a more manageable amount. The NSW also conducted a psycho-social assessment and multiple home visits, revealing that the patient was socially isolated and in housing far from appropriate amenities. The NSW assisted the patient in connecting with a Senior's Community Connector to connect her to social programs in her native language (Arabic) and helped her complete several applications for subsidized housing programs to bring the patient one step closer to securing affordable housing to increase her quality of life.

- **PCAC RN supported a patient with gender-affirming care:** A patient was referred to the PCAC from the Vine Youth Clinic by a FP who was aware that the PCAC provides gender-affirming care. Upon admission, the patient was withdrawn, depressed, and minimally verbal/not engaging. The patient reported not feeling gender affirmed. The patient was referred to a psychiatrist but did not follow-up and did not attend the PCAC for one year. The patient was contacted by the PCAC and asked to come back for a re-assessment. At the appointment, the patient again stated that they were not feeling gender-affirmed, was depressed, and struggling to come out and facilitate conversation with their family. The patient's mother was present but also withdrawn. The patient was started on anti-depressants and referred to a gender clinic. Upon recent assessment, their mood has improved, and the patient is engaged and involved in care. They are smiling and dressing according to their gender identity. The patient's mother also appeared more comfortable and involved in the patient's care.

A FP, NSW, and PCCP worked together to help a patient with **income assistance for housing and medication**:

I had the opportunity to work with both the NSW and PCN Pharmacist together with my patient. Usually, it is one or the other clinicians.
This patient was referred to us for medication coverage assistance due to financial issues. I was able to do my physical assessment and do a medication review with him in person (for the Pharmacist to determine which medication he was trying to "conserve" due to lack of financial funds). I then connected with the Pharmacist to let her know my findings and assessment. This patient has a few chronic conditions. I was able to connect him to the Pulmonary Rehabilitation and do some COPD education as well. In the meantime, the NSW was working with him to apply for MSDPR income assistance (which he is now receiving). This patient was facing eviction amongst all the other stressors. He had income assistance and crisis supplemental approved. The PCN Pharmacist was able to connect with this patient's pharmacist to determine if there are alternatives for his medication as some of his medications are quite specific and not covered. I am also doing a shout out to my awesome PCN team!
- Family Physician

6. Clear Communication

a. What communication types have been implemented within the network of providers and to the public?

A multi-pronged approach to communication has been implemented within the network, including a variety of learning sessions, 1:1 coaching, and meetings, as well as documents, newsletters, and website resources for FPs, clinic staff, and Clinicians:

- When new FPs join the PCN, they attend an **onboarding and integration session** facilitated by FP Leads that have experience in the PCN. These foundational sessions help FPs to better understand the PCN and what it entails, learn about the roles of everyone on the team and how to work together, referral types, referral processes, and best practices for team communication. As the sessions are facilitated by FPs who are in the PCN, they educate and communicate with other FPs from experience, which FPs have found very valuable in supporting the process of change, as indicated by post-event surveys.

- A **series of check-ins with FPs** that was launched in 2022/23 and continued in 2023/24 to learn about their experience with the PCN as well as answer questions and provide additional resources (e.g., one page posters that outline the types of referrals FPs can make to PCN Clinicians and the Referral and Communication Flowchart).

- During the WRSS DoFP's **Member Engagement sessions**, a PCN Physician Lead discusses the PCN with FPs who are not yet in the PCN, explaining what the program entails, what it has been like as an FP to gain PCN resources, and answering questions. This strategy has been very effective in increasing FP interest in joining the PCN.

- The Doctors of BC Practice Support Coach works 1:1 with FPs to develop and implement **action plans** to integrate PCN Clinicians into their practices and proactively see what patients, through panel management, could benefit from team-based care with NNs, NSWs, or PCCP.

- Information and updates are shared at **bi-monthly PCN Lead Physicians' meetings**, who then communicate the information back to the other physicians and staff in their respective clinics.

- **Learning Circles** (previously called In-Service Presentations) are webinars held with health-related organizations in the community. The intent of these Learning Circles is for PCN Clinicians to learn about available services for their patients, for the organizations to learn about our PCN, and for the Clinicians and organizations to build relationships. The Circles are recorded and available for Clinicians to review at any time.[37]

- A series of **"when to refer" 1-page documents** have been created for FPs and clinics which outline the types of referrals that FPs can make to their NNs, NSWs, and PCCP.[38]

- A **Referral and Communication Flowchart**, developed collaboratively with FP and Clinician input, provides guidance on the referral and communication processes within the PCN team.[39] Use of the flowchart has been supported by action planning with the Practice Support Coach and a Plan-Do-Study-Act (PDSA) cycle has been initiated to test the change.

- At the **March 2024 WRSS DoFP's All Members' Meeting**, a PCN update on the program's implementation was provided to attendees in a panel and also with booths at a Mini Expo showcasing resources and having PCN FP Leads and Clinicians available to talk to members.

- PCN-related information is shared in the WRSS DoFP's **monthly newsletter**, '*Did You Know*', which is distributed to all members. The newsletter has an average 64% open rate.

- The WRSS DoFP **website** contains information about the PCN, both for health care providers and the public.[40]

- **Pathways**[41] continues to be updated with PCN-related information and is where all the Service Maps and Patient Journeys can be accessed.

[37] See https://www.youtube.com/watch?v=osmfos7hjkA for the Comfort Keepers and READ Surrey White Rock from March 2023.
[38] See Appendices C, D & E
[39] See Appendix F for the WRSS PCN Referral and Communication Flowchart
[40] https://divisionsbc.ca/white-rock-south-surrey/initiatives/primary-care-network
[41] Pathways (https://pathwaysbc.ca) is an online resource that provides physicians with information about health resources and community services.

Photo 4: WRSS FPs and some PCN Clinicians gathered at the WRSS DoFP All Members Meeting in March 2024, sharing their experiences of working as a team in the PCN with FPs

7. Culturally Safe Care

a. What methods are in place in your PCN to address cultural safety for patients receiving primary care?

"Relationships create knowledge." This quote from Dr Dustin Louie, Nee Tahi Buhn Nation and UBC Indigenous scholar, guides us as we continue to move in our organization-wide strategy to embed Indigenous cultural humility and safety into the work we do at all levels. Our phased approach to learning and unlearning allows us to engage, embrace change, and act in a transformational way to increase culturally safe primary care for all patients, especially Indigenous patients.

Here is our current working definition of transformative reconciliation (TR) for the WRSS PCN and DoFP:

To capture the spirit of transformative reconciliation, consider a journey of incremental action-oriented change moving toward reconciliation. Reconciliation can be imagined as being a good neighbour. Through this emergent work, we aim to enhance cultural change in our organization and community, with the goal of creating cultural safety at the program and practice level. We are affected personally, professionally, and organizationally.

Through a handful of education and dialogue sessions this year, the WRSS DoFP engaged in diverse settings to experience and embrace Indigenous knowledge. Our team culture is to be curious and challenge our biases as we learn and unlearn.

As we are growing the design of a responsive approach toward truth and reconciliation, we chose to gather ourselves around two important Indigenous recognizing dates: May 5, Missing and Murdered Indigenous Women, Girls and Two Spirit (MMIWG2S) Day and September 30, National Day for Truth and Reconciliation.

In May 2023, **Riley Mackenzie, of Mohawk and Scottish descent**, led us on a team-based learning journey 'Where Did The Women Go?', spotlighting missing and murdered indigenous women, girls and two spirit (MMIWG2S). Riley taught us through story and interactive conversation about the truth in the current day, helping us to be aware and make changes in our lives and in our health care practices.

To recognize National Day for Truth and Reconciliation, **Harley Eagle, Dakota and Ojibway ancestry** led us in a Learning Circle on September 13, 2023. Taking team-based care to the next level, Harley welcomed us to participate in a team-based learning outdoor experience: PCN Clinicians, Family Physicians, and Division staff gathered as one. Harley shared the truth of colonization and its impact on his family and patients and left us with hope for the future.

Photo 5: Learning Circle with Harley Eagle

After years of respectful reaching out, our initial meeting with **Chief Harley Chappell from Semiahmoo First Nation** happened through a mutual relationship. We extended our support to Semiahmoo First Nation as Chief Harley Chappel described the steps for their community to achieve a healthy and sustainable future.

On February 14, 2024, we learned about **Cultural Safety with Cultural Tools when Riley Mackenzie** gathered the PCN Clinicians, Family Physicians, and Division staff in-person. Riley showed us how to bring

the medicine wheel, an ancient Indigenous practice, into our daily practice and support Indigenous and non-Indigenous patients.

Photo 5: Cultural Safety with Cultural Tools Session with Riley Mackenzie

The Division's **All Members Meeting in March 2024 included a teaching visit from Harley Eagle**, supported by our Board Chair and Transformative Reconciliation Family Physician Lead. PCN clinicians co-presented at the Mini Expo where we offered information for the upcoming learning sessions and the Indigenous Learning Library.

We look forward to strengthening our relationships with Semiahmoo First Nation and Métis Nation BC as well as integrating our learnings to increase culturally safe primary care for the patients in our community.

8. PCN Milestones Achieved in Year Four

The WRSS DoFP has established a stable, thriving, and member driven PCN that serves various populations in the community. Now completing the fourth year of implementation in March 2024, the WRSS PCN has met its hiring targets of 29 Clinicians: 14 NNs with 3 relief NNs, 5 NSWs, 2 PEs, 1 PCCP, 1 MHC, 1 RN, and 1 FP at PCAC as well as Counselling with Sources (the equivalent of 2 MHC). The PCN original implementation timeline aimed to enroll 100% of eligible FPs into the PCN between 2020 and 2024. We met that target ahead of time, with all 89 FPs and 1 NP in our PCN.

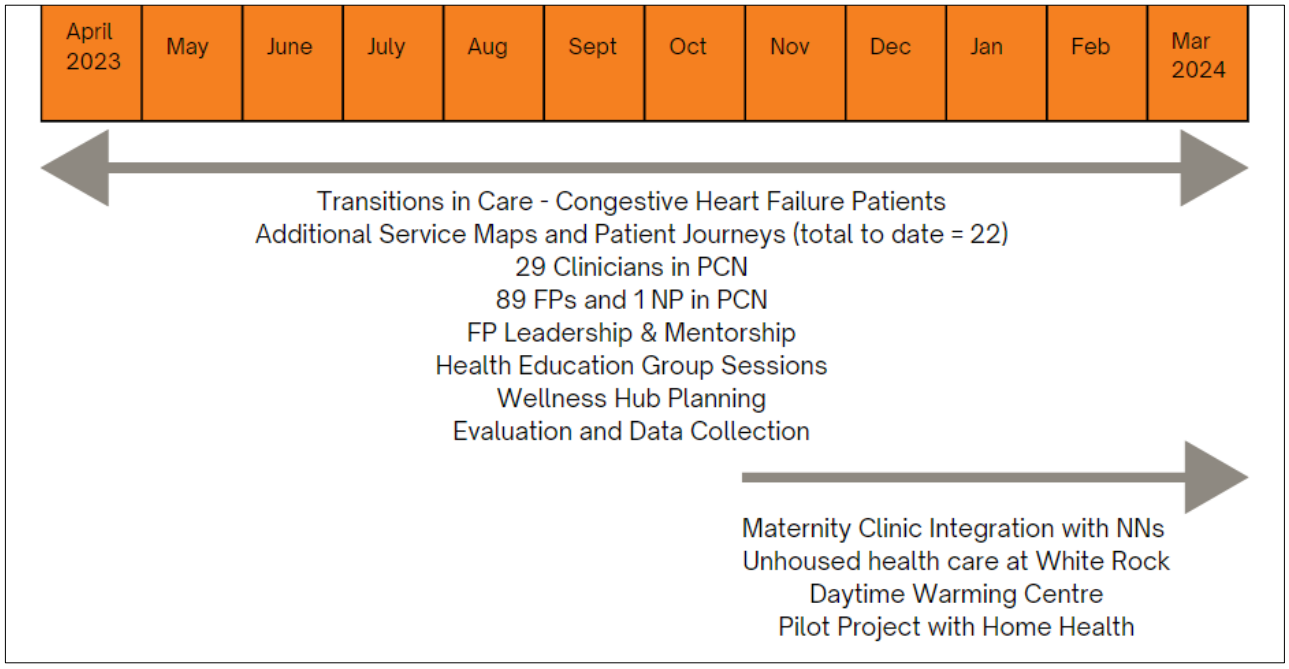

Figure 2: Timeline of Milestones for our PCN 2023-2024

9. Family Physician Experiences in the WRSS PCN

Each year of the PCN, we chose a group on which to focus and conduct in-depth analysis to learn about their experiences in the PCN, what was working well, and what the issues and challenges were. In 2020/21, we conducted a series of interviews with PCN patients, in 2021/22 with Clinicians, and in 2022/23 to 2023/24 with FPs.

Between January 2023 and February 2024, **25 check-ins were conducted** by the WRSS DoFP Evaluator with FPs who have been in the PCN for varying lengths of time and have a range of referral patterns. The findings from these check-ins are being used to better understand FP experiences in the PCN and their referral practices, as part of our continuous improvement process. FPs were asked questions to better understand:

- PCN referral decision-making processes
- factors that might affect FPs' referral rates (e.g., panel size and composition)
- FP experience with the referral process
- impacts of the PCN that FPs have observed for themselves and for their patients

During the check-ins, FPs **described a number of considerations they make when deciding whether to make a referral to a PCN Clinician**, which include time constraints of a 10-minute FP visit and whether it is an issue that requires more time to address; if an FP needs 'eyes and ears' in the patient's home to get a more fulsome sense of the situation or there are safety concerns; if connections to resources are required but they are not known to the FP or there are barriers to the patient accessing them; if an FP wants clinical support and expertise, particularly for patients with complex health and social issues; and if a patient is in crisis or requires hospital discharge follow-up care. These FP considerations are all in line with the intended use of the PCN when it was being developed.

FP-to-Clinician referral data, which has been tracked since the beginning of the PCN, shows that there is **a broad range of PCN referral frequencies among FPs**. One purpose of the FP check-in series was to explore the reasons for this range. We learned that FPs tend to refer more if their panel consists of a high proportion of patients who are seniors, have MHSU challenges, complex care needs, chronic diseases, are new moms and babies, and/or vulnerable patients with socio-economic issues. FPs tend to refer less when their panel is mostly comprised of young, healthy patients, or if they have a small panel. There did not appear to be any correlation between referral rates and times of the year, seasons, etc.

When asked about the process of making referrals to clinicians, the majority of FPs indicated there was a small learning curve when making their first referral but once they had made one or two, **there were no challenges making referrals to their PCN Clinicians**, with one FP commenting "*it is an amazing referral process, there are no barriers,*" and another stating "*the referral process is straightforward*." Several FPs commented that they appreciated that the process was the same as other referrals they made through their EMRs.

A small number of FPs did note challenges with the referral process, however all of these FPs had made very few PCN referrals. Their challenges were related to the process of changing how they work, not the referral process itself. Many FPs have been working alone for the entirety of their practice and through the PCN are now transitioning to working with a team. Many noted they are aware of the benefits of team-based care both for themselves and their patients, but change is difficult and takes time, as one FP stated, "*I am a creature of habit, so it just doesn't pop into my mind to refer".*

The **second challenge identified by this group was a lack of knowledge about the 'right reasons' to refer**. This was particularly true for referrals to NSWs. Many FPs have worked with nurses before so understand their scope but working with social workers is entirely new, as one FP said:

> *If I had a good idea of who would be a good patient to refer, it would help. What is an appropriate referral & and what they can do, what is their scope? I have a big gap in knowledge.*
> - Family Physician

The check-ins were initially intended as a way to collect information from FPs. However, it quickly evolved to also be an opportunity to provide information, particularly to low-referring FPs, about clinicians' scope and referral reasons, and to encourage FPs to reach out to their clinicians if they have questions. As a result of what was learned, the PCN Manager arranged for the Clinicians to reach out and set up meetings with FPs to talk about these issues. This had the additional benefit of building relationships and helping low-referring FPs to more easily remember they have a PCN team in place to help support them. In many cases, referrals to clinicians began to increase after the check-ins took place.

Physicians were asked about their initial observations regarding the impacts of the PCN for them and for their patients. They noted that **key benefits for them included working in a team where they felt more supported and less alone**, as they now had access to an expanded skillset for the delivery of patient care via the Clinicians to better problem solving as they worked together on complex problems for patients. Many FPs indicated they were feeling less stressed and overwhelmed, noting

the PCN did not lead to decreased workloads but it did take work ‘off their plates’ so they could spend more time with their patients. They also reported that visits to patients’ homes by Clinicians was a significant benefit, as it enabled them to gain valuable information about the entire picture of a patients’ condition, and it provided an additional layer of security, for example, by checking to ensure there was food in the fridge and medications were being taken as prescribed. It was also helpful for both the FP and patient that Clinicians were able to spend more time with a patient during a home visit, as one FP said:

> *CHF and chronic diseases have so many aspects that you have to manage that you'd need 5 or 6 visits in the office to do what one visit with a NN can do in a 1-to-2-hour visit. It frees up my time to do other things and gives the patient that much more support. It's been a huge help to my practice.*
> - Family Physician

Lastly, FPs have **noted significant benefits of the PCN for their patients, including improved patient care as there is immediate support available** for patients when they need it. For example, if an FP is concerned about a patient, a NN can quickly schedule a home visit to assess the patient and determine whether a patient needs to go to hospital. They also noted that patients feel well cared for, as one FP stated “patients have the profound sense that somebody cares. We can do our best to show we care in 10 minutes in our office but it's not the same as somebody coming to your house, learning your story, and looking at the whole situation." Patients are also having have more of their needs met through a coordinated team-based approach to care.

While more research is needed, **some FPs linked the PCN to improved patient health outcomes**, including reduced hospital admissions, in particular through the CHF project (see section 1.3b), and increased patient accountability through lifestyle management education (see Section 1.3a), as patients making lifestyle changes are supported through regular check-ins by NNs, which FPs noted that both they and their patients say are making a difference.

Further evaluation is needed to more profoundly understand the impacts of the PCN on FPs and their practices, however, initial indicators are demonstrating substantial positive impacts.

Photo 7: A few of the PCN FPs in our community

10. Financial Reporting

a. Surplus/Deficit:

Category	Budget	Actuals	Surplus/(Deficit)
Administration	$307,576	$331,273	($23,697)
Governance	$40,000.00	$34,247	$5,753
Change Management	$293,199	$213,381	$79,809 (to be carried over)

b. Variance Explanation:

Category	Explanation
Administration	Program design and implementation activities were far more significant than in previous years, which resulted in more program management hours required to complete the work and keep on target for implementation timelines.
Governance	No in-person meetings therefore no venue rentals and other related costs. The Steering Committee only needs to meet every two to three months and this is lower than we had budgeted for at the beginning of year one.

Change Management	Change management efforts will need to continue in the years to come, given the transformational nature of the change for FPs. The surplus will allow for continued efforts to increase knowledge and ability in referring to PCN clinicians as well as reinforcing the changes that FPs are already beginning to make. Therefore communications, training and evaluation will play a significant role in the coming year.
Health Authority Clinical Resources	The total Health Authority expenditure for fiscal 2023/24 was $4,982,689.66. Of this, $3,293,677 related to FHA WRSS PCN funding and $998,179.64 related to FP NTP expenditure. Of the FHA WRSS PCN funding ($), $1,266179 related to FP contracts, the remaining ($2,883,207) related to clinical resources and overhead expenditure. At the fiscal year-end, there was a forecasted surplus of $694,580 on the FHA clinical resources and associated overhead which was primarily due to hiring lag during the year (some invoices still in process). Out of the 27.25 FTE clinical resources, 25.25 FTE were hired by year end. The two remaining positions were posted.

11. The Partnership of WRSS DoFP and FHA

Our partnership with FHA has strengthened over this last year, both locally and regionally. We have come together with the PCN Governance Refresh and have a collective vision of the PCN overall and specifically with the updated PCN Steering Committee members and the new Community Advisory Group. The continued work on the development of a Wellness Hub for our community has highlighted the alignment of our vision and values towards providing the best health care for WRSS.

The PCN Clinicians, employed with FHA, are at the heart of our PCN and are very passionate about primary care and health education. The Clinicians work closely with FP Leads as well as the WRSS DoFP staff and their input is valued by all. We continue to work closely on hiring and training Clinicians and they are integral to the onboarding and integration of FPs into PCN.

This year the partnership deepened through the collective efforts of supporting the more vulnerable people in our community with the integration of PCN with the Maternity Clinic, PCAC, and the White Rock Daytime Warming Centre.

The WRSS DoFP and FHA understand the strengths of each organization and are committed to collaborating, addressing challenges, and finding solutions collectively for the health and well-being of WRSS.

12. The WRSS PCN Moving Forward

Going forward, our vision continues to be an integrated PCN that uses team-based care and collaboration to provide optimal 'wrap-around' care for all patients in our community. We will accomplish this with strong FP leadership, strategic partnerships, and innovation.

With the refreshed PCN governance, we now have more FPs involved in our PCN Steering Committee with continued partnership with FHA, and will have more community involvement, including Indigenous partners, with our Community Advisory Group.

We will continue to work on developing a Wellness Hub for our community to provide a space for PCN, PCAC, WRSS DoFP, and other health care community partners to come together to share ideas and resources to improve the delivery of health care in our community.

As we broaden out our PCN into the community, we are working with more vulnerable populations including the Congestive Heart Failure proactive education by NNs, Maternity Clinic integrating NNs for care, and the Warming Centre care with FPs and NNs. The following year will also focus on mental health solutions and managing chronic diseases with more upstream care. We will continue with our group format of health education sessions with the Patient Educators and begin a few maternity education sessions.

Internally, we are restructuring the PCN FP Lead areas to bring more integration to all of the PCN and ensure it is connected with all of our initiatives.

Appendices

Appendix A: Chronic Pain Management Poster

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FREE
AGES 19+

CHRONIC PAIN GROUP SESSIONS

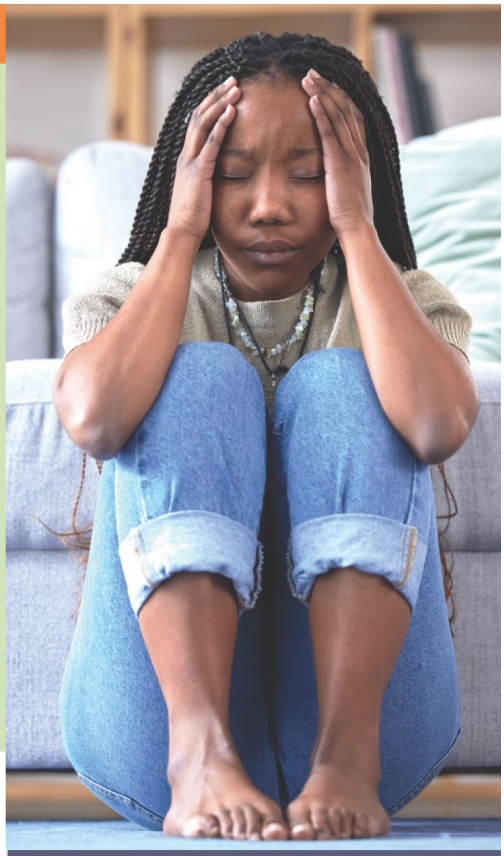
The Group Sessions for Chronic Pain provide patients with the opportunity to learn not only from our Patient Educators, Neighbourhood Nurses, and Pharmacist, but most importantly, **from patients in the group.** Participants also have the chance to practice the knowledge and skills learned between each session.

ONLINE SESSIONS

The series has 3 online sessions; each session runs 90-minutes from 10:30am to 12:00pm:

1. **Introduction to Chronic Non-Cancer Pain**
2. **Non-Opioid Medications**
3. **Opioid Medications**

In all 3 sessions, emphasis is placed on the importance of non-medication treatments to manage chronic pain whether taking medications or not. During the medication sessions, a Neighbourhood Nurse and Pharmacist will review medication options, potential side effects, and how to manage those side effects, along with opioid safety.



MORE INFORMATION

Kelli or Simren | Patient Educators
WRSS PCN | Fraser Health
wrsspcneducation@fraserhealth.ca
Cell: 236.632.7457 or 236.332.7600

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REFERRALS

Referrals are through Neighbourhood Nurses. They will complete an initial assessment before the patient is referred to the group education sessions and potentially the PCN Pharmacist.

Session details will be provided to patients upon confirmation of referral.

Appendix B: Lifestyle Management Education Series Poster

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LIFESTYLE MANAGEMENT EDUCATION SERIES

FREE ONLINE SERIES

The Lifestyle Management Education Series will provide participants with the knowledge and skills to implement lifestyle changes that can have an impact on their health.

The series has 4 topics: (1) Managing Lifestyle Changes, (2) Physical Activity, (3) Nutrition, and (4) Sleep. In all sessions, the participants will implement the knowledge gained by setting goals and determining ways to address barriers that may arise. Resources will also be provided. The 90-minute sessions run on Mondays once a week for 4 weeks.

MANAGING LIFESTYLE CHANGE

Review the differences between behaviour change and lifestyle change, along with exploring how to create, implement, and achieve small sustainable goals that can impact health.
May 6: 1:00pm-2:30pm

MOVEMENT FOR HEALTH

Participants will learn the importance of being physically active, how it differs from exercise, and ways to incorporate physical activity into daily life. SMART goals related to physical activity will also be set.
May 13: 1:00pm-2:30pm

FOOD & NUTRITION

Participants will review the different aspects of healthy eating, the foundations of nutrition, making healthier choices, and understanding nutrition labels. SMART goals related to healthy eating will also be set.
May 27: 1:00pm-2:30pm

SLEEP

Participants learn about the importance of sleep, how sleep affects health, the stages of sleep, and tips for getting a good night's sleep.
June 3: 1:00pm-2:30pm

MORE INFORMATION

Kelli or Simren | Patient Educators
WRSS PCN | Fraser Health
wrsspcneducation@fraserhealth.ca
Cell: 236.632.7457 or 236.332.7600

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REFERRALS

A referral is required (sent via Pathways) to attend these sessions.

Session details will be provided to patients upon confirmation of sessions.

SCAN

Appendix C: NN Referral One-Pager

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SUPPORTIVE CARE FOR YOUR PATIENTS

NEIGHBOURHOOD NURSE

A Primary Care Network (PCN) Physician can refer their client to the PCN Neighbourhood Nurse (NN) for assistance with the following issues.

SCREENING
- Fall risk
- Swallowing/nutrition/oral health
- Anxiety/depression
- MMSE/MOCA

ASSESSMENTS
- Physical assessments
- Skin breakdown
- Cognition
- Medical response
- Mobility/functional abilities

INTERVENTIONS
- Short-term wound care
- Fall prevention strategies
- Hospital discharge follow-up
- Medication compliance
- Well-baby checks
- Referrals to community respiratory services

Team-Based Care at your Fingertips
WRSS PCN

SUPPORT FOR HOME-BOUND CLIENTS
- Specimen collection
- Ear flushing
- Injections/immunizations
- Liaison with Home Health

CHRONIC DISEASE MANAGEMENT
- CHF, COPD, Diabetes, weight/wellbeing, anxiety depression, chronic pain
- Medication education and management
- Assessment, education, monitoring

*These are suggestions; not a complete list. For clarification, contact your NN directly.

PCN TEAM CONNECTIONS
- Other PCN team members (NSW, PTED, NPH)
- Group education classes
- Sources counselling
- Mental health/substance use connections

WHERE TO GET HELP
- Indigenous cultural connections
- Public Health resources
- Non-profit organizations
- Transportation
- Accessing resources

EMOTIONAL SUPPORT
- Depression, isolation, anxiety, grief/loss

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Appendix D: NSW Referral One-Pager

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SUPPORTIVE CARE FOR YOUR PATIENTS

NEIGHBOURHOOD SOCIAL WORKER

A Primary Care Network (PCN) Physician can refer their client to the PCN Neighbourhood Social Worker (NSW) for assistance with the following issues.

WHERE TO GET HELP

- Advocacy
- Vulnerability (due to life stage, social situation, cognition, physical deficits)
- Social Determinants to Health

Team-Based Care at your Fingertips

WRSS PCN

FINANCIAL HARDSHIP

- Eligibility to service/benefits/grants
- Income supports
- Medical coverage
- Help managing financial matters

MANAGING HEALTH PROBLEMS

- Quality of life decision
- Treatment decisions
- Advance care planning
- Diagnostic specific resource

CRISIS SITUATIONS

- Child protection/welfare
- Abuse/neglect
- Family system challenges
- Caregiver responsibility challenges (example guardianship)

*These are suggestions; not a complete list. For clarification, contact your NSW directly.

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Appendix E: PCCP Referral One-Pager

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SUPPORTIVE CARE FOR YOUR PATIENTS

NEIGHBOURHOOD PHARMACIST

A Primary Care Network (PCN) Physician can refer their client to the PCN Neighbourhood Pharmacist (NPH) for assistance with the following issues.

MEDICATION REVIEWS

- Polypharmacy
- Recent discharge from hospital
- Sub-optimal medication response
- Adverse events
- Medication sensitivities

PATIENT COMPLEXITY

- Medical questions
- Complex schedules
- Patient self-treatment
- Multiple co-morbodities

EDUCATION

- Chronic pain
- Blood pressure

Team-Based Care at your Fingertips
WRSS PCN

REFERRALS

- Refer via Pathways Referral Tracker or eFax/Fax to 604.538.1296.
- Login required and available from your Clinic Manager, MOA, or email the WRSS Division at info@wrssdivision.ca.

*These are suggestions; not a complete list. For clarification, contact your NPH directly.

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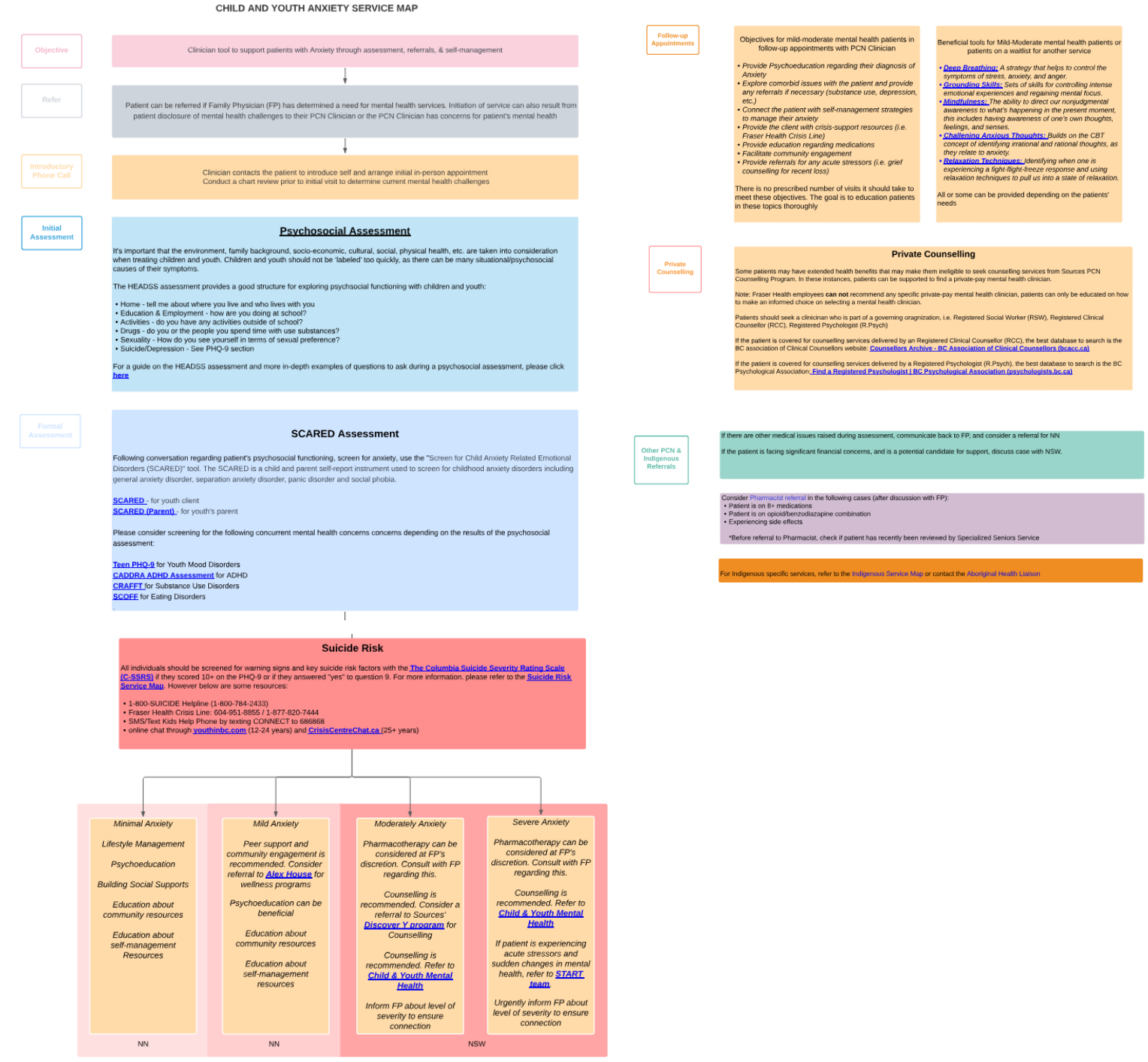
Appendix F: Example of WRSS PCN Service Map



Appendix G: WRSS PCN Referral and Communication Flowchart

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SUPPORTIVE CARE FOR YOUR PATIENTS

REFERRAL WORKFLOW

FP IDENTIFIES REFERRAL NEED

- Identify during:
  - Patient appointment/visit
  - Complex care visit
  - Lab/results review
  - Panel or other QI work with PSP

**Let the patient know the Clinician's phone shows Fraser Health*

FP CREATES REFERRAL VIA EMR

- Inform patient of referral to PCN Clinician
- Include relevant information in the referral, i.e.:
  - Need for a home visit? Y or N
  - Type of referral
  - Include specific goals and end-point
  - Urgent or non-urgent
  - Medical history/collateral chart information

CLINICIAN RECEIVES REFERRAL

- Review referral/chart information
- Text or contact FP as needed to discuss:
  - Appropriateness
  - Sensitivity
  - Psychosocial issues

CLINICIAN SCHEDULES APPOINTMENT WITH PATIENT

- Acknowledge referral received
- Enter the appointment in the schedule

CLINICIAN SEES PATIENT

- Confirm goals of care
- Assessments and interventions (if more than 6 visits, will confirm with FP)
- Ongoing communication with FP via task, note, and/or case conference
- Documentation in clinic EMR
- Referral to other PCN Clinicians as indicated (discuss with FP)

CLINICIAN CLOSES REFERRAL

- Final EMR note
- Clinician check-in with FP
- Close referral

FP FOLLOWS UP WITH PATIENT

QUICK TIPS

- FPs and Clinicians may want to set times for regular or episodic case conferencing and address post-visit concerns.
- Visit bcfamilydocs.ca or doctorsofbc.ca for information on billing codes related to PCN case conferences and collaboration.

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