Collectively We Care.

White Rock-South Surrey
Primary Care Network

2023 ANNUAL REPORT

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

fraserhealth

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Glossary of Terms

CHF	Congestive Heart Failure
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
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 Area (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 supports 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 that 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 2022/23, as we are approaching the end of the implementation process, the focus of the WRSS PCN continues to be on continuing to build a robust, timely, and relevant PCN to serve our patient population and members, while integrating supports, structures, and partnerships with FHA for program sustainability. This Annual Report provides a detailed update on the progress made during this 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.

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

Thinking outside-the-box to respond to community needs

Creative outside-the-box thinking is required to solve some of our most complex healthcare challenges and meet the needs of patients in our community. The following examples demonstrate how our PCN has worked collaboratively to create innovative solutions to some of those complex challenges.

Firstly, congestive heart failure (CHF) is a growing epidemic in our healthcare system. It is the third leading cause of hospitalization in Canada.[19] At the WRSS' Peace Arch Hospital between January 2017 and June 2018, 1 in 4 patients was readmitted to the hospital within 60 days of an admission for CHF decompensation[20], resulting in stress and suffering for patients and their families as well as a strain

[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] 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.
[18] This total is for the RN with the HomePACE and PCAC programs. It does not include NNs, who are also RNs.
[19] Canadian Institute for Health Information. (2017). Hospital stays in Canada.
[20] 2018 PAH PQI; Data Source: Fraser Health.

on our over-burdened hospital. To address this issue, a QI project was undertaken at Peace Arch Hospital with the aim of decreasing the hospital readmission rate due to decompensated heart failure through patient education and follow-up.

The PCN was ideally positioned to support this QI project as the NNs could follow up with patients in the community and provide education on how to weigh themselves daily, keep a weight diary, and understand when they need to contact their FP regarding weight changes. The PCN was already doing work on chronic disease management, thus the CHF project was well suited to support these improvements in transitions-in-care. An evaluation is currently underway to assess the effectiveness of the project. Anecdotally, FPs have reported successes with their patients. In one instance, a man in his 90s visited his FP after working with a NN on self-management skills and brought in his weight diary, proud to show his FP how he has been tracking his weight and that he now knows what to do as soon as he notices changes. He also noted he felt so relieved to have stayed out of the hospital after a series of prior readmissions. Notably, this project will serve as a model for further collaboration between the hospital and primary care delivery in the community through the WRSS PCN.

Another example of outside-the-box thinking to address healthcare challenges is the creation of the PCN Lifestyle Management Education Series. This series was created in response to an emergent priority identified by PCN FPs and Clinicians and is tailored to meet the specific needs of patients in our community. It was also intended to relieve some of the patient education load off the NNs so they can spend more time providing direct patient care.

This PCN Lifestyle Management Education Series, developed by our PCN Patient Educators, is in line with the PCN's upstream approach to care by providing participants who have a diagnosed chronic condition with the knowledge and skills necessary to implement lifestyle changes, thereby reducing the risk of a deterioration of their condition(s). The sessions are designed to be interactive rather than didactic to encourage patients to feel empowered and take an active role in their health. Topics include Managing Lifestyle Change, Physical Activity, and Nutrition. During each session, participants will 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 currently underway to assess the effectiveness of the initiative.

Creating and maintaining a supportive space for FPs who previously felt alone

When asked about the impact of being in the PCN and working with a team of Clinicians, one FP summarized this sentiment aptly by stating:

"I feel like I have a partner to share some of the difficult things I experience. It used to be that I would know the patient's story but nobody else would know that I was trying to help them and running into problems. It felt very lonely and isolated. Even in the few cases where the Clinician puts in their best effort and we are still at the place where we were at in the beginning of the referral, I feel like I am in a different place because I can say 'well, you also tried, this really is as difficult of a problem that it seems it was'. It has been profound for me as a physician. We talk a lot about FP burnout, but that usually is in reference to workloads and demands but not about the working in a silo part. It looks like we are surrounded by lots of people in a clinic but none of them are working on the same problem I am, and at the intimate level I am, except the NN and NSW now are. That has been the biggest impact for me, and I think it helps to prevent burnout for FPs, actually I'm sure it does."

These examples illustrate that by moving to a team-based model of primary care delivery tailored to meet the specific needs of our community through the PCN, FPs are able to expand their reach to better support the physical and mental health care needs of patients more rapidly through a collaborative and coordinated approach to care, and it is leading to better care for patients. FPs have noted that these PCN resources are making a difference by enabling improved quality of attachments and better patient care, which is leading to decreased FP burden and increased job satisfaction, with another FP stating:

"Before I joined the PCN, I was drowning and felt lost. I was unable to meet all patient needs, especially my complex patients and those with mental health concerns. The PCN has helped a lot. I am so happy to have the support, it has really eased my stress levels."

Increasing uptake of NSWs into FP practices

Including NSWs in the WRSS PCN was intended to address the evolving care needs of our community. However, prior to joining the PCN, most FPs did not have experience working with social workers. As a result, it has taken additional time for FPs to learn about social workers' scopes of practice and incorporate them into their daily practices, as one FP new to the PCN noted "I totally get the NN's role, but I am still figuring out the NSW."

To help support this change in practice, a series of posters were created outlining the types of referrals FPs can make to their Clinicians, including the NSW. The posters are each one page, with limited text so FPs can hang them in their offices and quickly refer to them as needed. FPs are also encouraged to schedule regular check-ins with their NSWs to support the learning and change process.

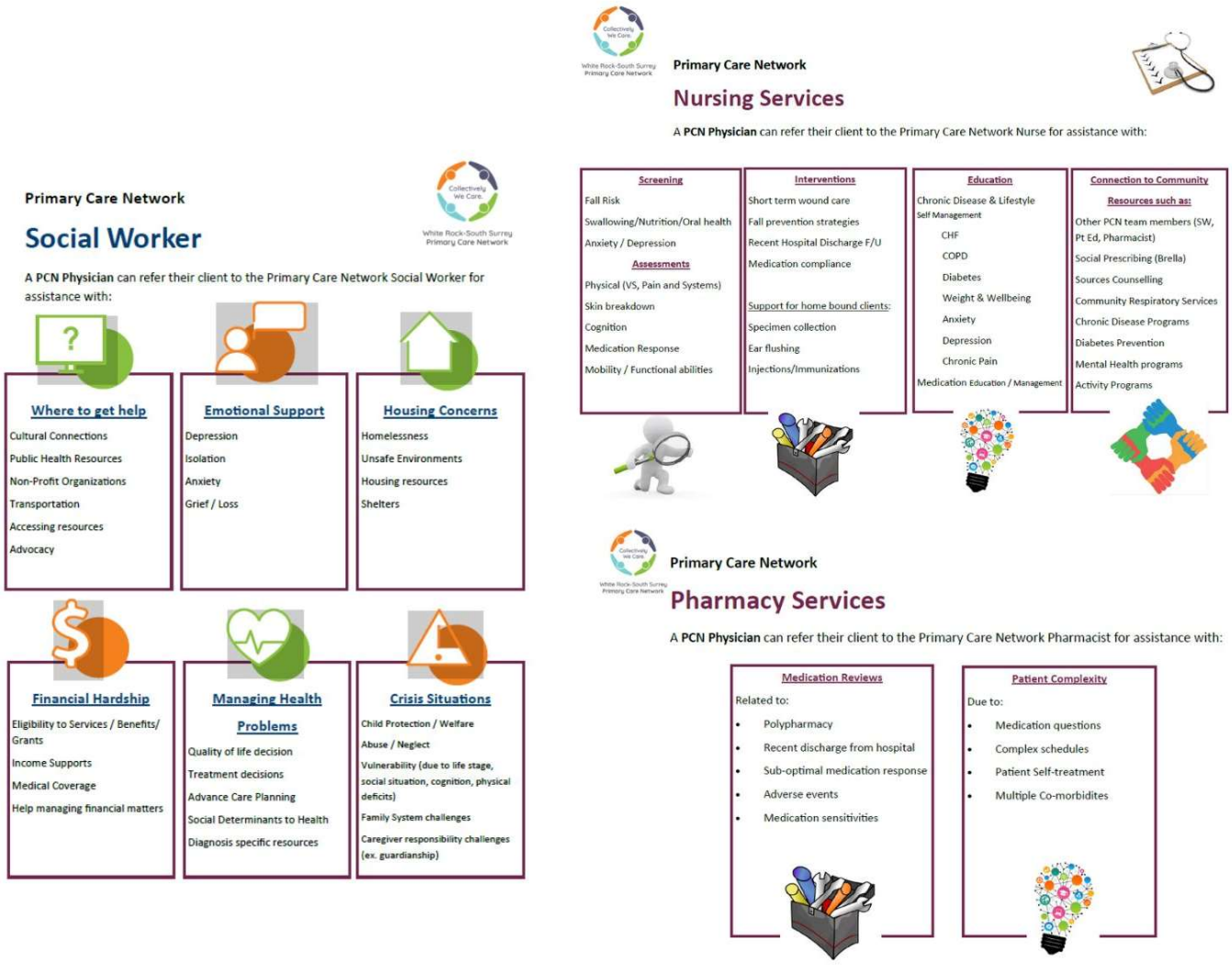


Figure 1. PCN Referral posters for NSW, NN, and PCCP[21]

FPs have come to value the services NSWs can provide and appreciate the breadth of experience and skills the NSWs bring to the team, as one FP noted, "it's been a great help. I don't even know how

[21] See Appendices A, B & C for full-sized version of the posters.

I was able to function before without the Clinicians, especially the NSW." FPs are sending an increasing amount of referrals to NSWs for a range of reasons, many of them complex including abuse, financial strain and housing insecurity, mental health, family issues (e.g. a couple where the wife is developing dementia and the husband is overwhelmed), and for system navigation (e.g. when an FP feels "stuck" because a patient needs support, but they do not know where to start). The inclusion of NSWs into PCN teams has helped relieve FP stress they had been feeling prior to the PCN when trying to support their patients through such challenges, with one FP explaining:

> *It's made a huge difference for me. NSWs are able to address my patients' needs in a way that I am unable to in a 10-minute appointment. For example, I will refer the NSW to visit patients in their home to make sure they are safe, see if they need resources in the community, ensure the patient fully understood what I was telling them during the in-clinic appointment. Are they overwhelmed? Are they able to take away all the info they need? If I feel the patient did not quite get everything they needed during the visit and needs follow-up with more time, and maybe in their own home, I will refer them to the NSW.*

Several FPs noted that their patients are very appreciative of the care provided by the NSWs, with one FP stating, "The NSW is so useful, and my patients love it."

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

If the WRSS PCN had a theme this year, it would be continuing to build a robust, timely, and relevant PCN to serve our patient population and FPs, while integrating supports, structures, and partnerships with FHA for program sustainability. Two key learnings that have emerged this year are:

Firstly, the importance of a strong and nimble change management strategy

Prior to the PCN, FPs providing primary care have been working in a siloed manner, many for all of their careers. The transition to a team-based model of care delivery means a different way of practicing and change, even positive change, is difficult. To ensure success, designing a program that can be easily embedded into the ways FPs are already used to working has been critical. For example, using a referral-based system for Clinician referrals was easily adopted by FPs, as they use this method in many other parts of the healthcare system.

However, we have learned that it is not just program design that will ensure a program's successful implementation. It is equally important to ensure there are robust change management strategies in place to assist FPs along their journey of understanding that team-based care is a different way of practicing care delivery, allowing the time and providing supports needed to get FPs accustomed to working differently. It has been important to acknowledge that FPs need different levels and types of supports, which has led us to develop a multi-pronged approach to supporting change management, including an evolving orientation and onboarding process (see point two below), a series of one-pagers about referrals to NNs, NSWs and PCCPs (see Section 1.3a above), conducting check-ins with FPs to learn about their experience integrating into the PCN, answering questions they have, and providing additional supports and resources as needed (see Section 9 below).

This change management strategy extends beyond the FPs in the PCN. Clinicians also require support as they learn to work in the PCN. For example, a key pillar of the PCN is the focus on upstream preventative care, not just intervening once the problem presents itself. To help support this change, we developed a series of Service Maps (see Section 4a). Service Maps are a communication tool between FPs and NNs/NSWs to support patients in managing chronic conditions. But they are also a means to help Clinicians look at chronic diseases differently, and approach them through a preventative care lens.[22]

Secondly, the importance of adapting creatively through the implementation process

As we approach the final stage of PCN implementation, thoughtful adaptations to meet the needs of FPs and clinics in our community have been imperative. This has been particularly evident in the process of bringing in the latest cohorts of FPs, and is supported by E.M. Rogers' Diffusion of Innovation theory which categorizes adopters of change from innovators and early adopters to laggards along an S curve.[23] During the first phases of implementation, the FPs joining the PCN were the most keen and eager to participate, excited by this new and innovative program. The orientation and onboarding sessions for this group was comprised of many participants from several clinics. Team-based care sessions were offered to further support integration and uptake into the PCN for these FPs.

However, as we progressed through this group and moved into late adopters and laggards, it became evident that these FPs were more wary and required more change management support. We learned we had to adjust our orientation and onboarding strategy to meet the needs of this group of FPs. As a result, we adopted a new strategy by creating a customized, consolidated in-clinic team session for each clinic led by our PCN FP champions and PSP partner. Based on what we learned from previous sessions, Clinic Managers were also included in these sessions to foster whole-clinic adoption of the PCN from the beginning.

This “clinic delivery” approach was welcomed and not only offered sessions at the convenience of the FPs and their clinics, but also provided a forum for FP leads to mentor and coach the late adopters and encourage uptake. In a recent welcome and onboarding session, halfway through the session, one FP commented 'Oh, this will be perfect! I am really looking forward to having the support."

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

Firstly, the progressive integration of the Primary Care Community Pharmacist into the PCN. When the PCCP was initially brought into the PCN, the process was not without challenges. It took time for the PCCP to get set up in each clinic and build relationships with FPs and clinic staff in order to feel like a team; gaining access to and learning to use each clinic's EMR was not always straightforward or fast; and working with three partners - the University of British Columbia's Pharmacy program, FHA, and the WRSS DoFP - each with their own set of systems, structures, and cultures which can, at times, diverge and differ.

Despite these challenges, the PCCP and Physician Lead for Pharmacy have continued to make progress addressing challenges and transforming the role into what it is now. Some key activities that

[22] See Appendix D for an example of a WRSS PCN Service Map
[23] Rogers, Everett (16 August 2003). Diffusion of Innovations, 5th Edition. Simon and Schuster. ISBN 978-0-7432-5823-4.

were organized to foster relationships and increase referrals included a WRSS DoFP All Members Meeting in April 2022, where FPs met Clinicians, including the PCCP, face-to-face and learned about their respective roles in the PCN, as well as a series of clinic visits was carried out by the PCCP to educate FPs about the Pharmacist's scope of practice.

The PCCP is now well-integrated into WRSS clinics, and FPs refer to her regularly for support, resulting in a growing number of referrals quarter over quarter. The latest available data shows that between October and December 2022, the PCCP received 72 referrals, which is more than double the number received during the same period in 2021. Currently, wait times for non-urgent referrals are between three and four weeks, with capacity for urgent referrals to be responded to quickly.

The PCCP also works with each new clinic that is onboarded into the PCN, including attending Welcome Sessions and Team-Based Care sessions. During the PCN FP Check-Ins (see Section 9), several FPs commented on how invaluable the PCCP's services are, in particular, because she can answer more difficult medication-related questions for medically complex patients.

As part of her role, the PCCP has provided several pharmacy education sessions for FPs. Topics include safe medication use in older adults, cannabis, QTc prolongation, and palliative care. The sessions have all been well-attended, with between 13 and 25 FPs participating. The sessions were also recorded and available for FPs to watch at a later date.

Secondly, significant indicators have emerged that demonstrate the strength and value of the program. As we come to the end of year three of PCN implementation, there has been an excellent uptake from FPs in the community, with over 70% of all FPs in WRSS clinics having joined the PCN, which is ahead of target. FPs in the PCN are using the program well, having made over 2,500 referrals to NNs, NSWs, and PCCP to date. The PCN Clinicians have very high job satisfaction rates, with an average 8/10 satisfaction rating[24] and very little staff turnover, a sign of the strength of the program. Feedback from patients has also been very encouraging, with many FPs reporting their patients have come back to them recounting very positive experiences in receiving care from Clinicians. Taken together, these indicators speak to the strength of not only the program's implementation but also its design as it is meeting the needs of patients and FPs in our community.

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. During the PCN planning phase, the options of embedding Clinicians in community clinics or establishing a central hub were considered, and the hub was selected as the best choice to meet our community's needs. The objectives of the Wellness Hub are to:

(1) align with the Ministry of Health's strategic direction to improve access to care and increase capacity;

(2) increase patient wellness by creating a collaborative and coordinated system of care where patients have access to the right services in the right place; and

(3) 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.

[24] Data is from a round of comprehensive interviews conducted with all PCN Clinicians. Please refer to the 2021/22 PCN Annual Report for further details.

However, as year three of implementation comes to a close, the Wellness Hub plan is currently in the Functional Program phase. The Functional Program provides an overview of the Hub's service levels and an assessment and description of the Hub's activities, together with an estimate of the space and staff resources required to support them. The completed Functional Program will be used as a communication tool for all involved parties, including user groups, health care administrators, architects, engineers, etc. going forward. Meetings are currently underway with FHA and the City of White Rock to fine-tune the Hub's Functional Program to ensure that the building can physically accommodate all the Hub's planned activities and resources. The next steps will be completing a Fit-Test, sourcing vendors (architect, construction firm, designer, etc.), creating building drawings, and construction.

Due to these significant delays, the PCN has been hindered in fulfilling the three stated objectives above. Additionally, Clinicians have expressed frustration working out of the temporary space, which does not have the necessary requirements (such as quiet spaces where they can take private, confidential calls with their patients and families). As patient rooms availability in community clinics is quite limited, Clinicians are spending more time driving to patients' homes for visits that could be held at the Hub.

Secondly, the PCAC is not functioning optimally. As discussed in Section 2c below, the PCAC is intended to fulfill an important attachment role in our PCN by providing primary care to patients who are more complex and vulnerable as well as patients who are discharged from the hospital and require follow-up care but do not have an FP. However, due to several issues outside the scope of this report, the PCAC is not functioning optimally. Wait times for urgent referrals are approximately 1-2 weeks, and for non-urgent referrals, the wait is 3-4 weeks. This is resulting in challenges, particularly for patients requiring more urgent post-hospital discharge care and leaving our community's most complex and vulnerable patients unattached, likely relying on our already strained PAH ED for their care. While work is underway to address attachment challenges, the sub-optimal functioning of the PCAC is having a negative impact on our community's overall attachment strategy.

2. Attachment

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

Based on available attachment data, an overwhelming majority, 94%, of FPs in WRSS have been accepting patients in 2022/23.[25]

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

During the 2022/23 fiscal year, WRSS community clinics attached 2,594 new patients[26], bringing the total number of new patient attachments since April 2020 to 13,3377, surpassing our 4-year attachment target of 8,900, as illustrated in the chart below.

[25] During this fiscal, individual FPs have accepted between 1 and 324 new patients.
[26] Based on data from clinics that have reported attachments at the time of this report.

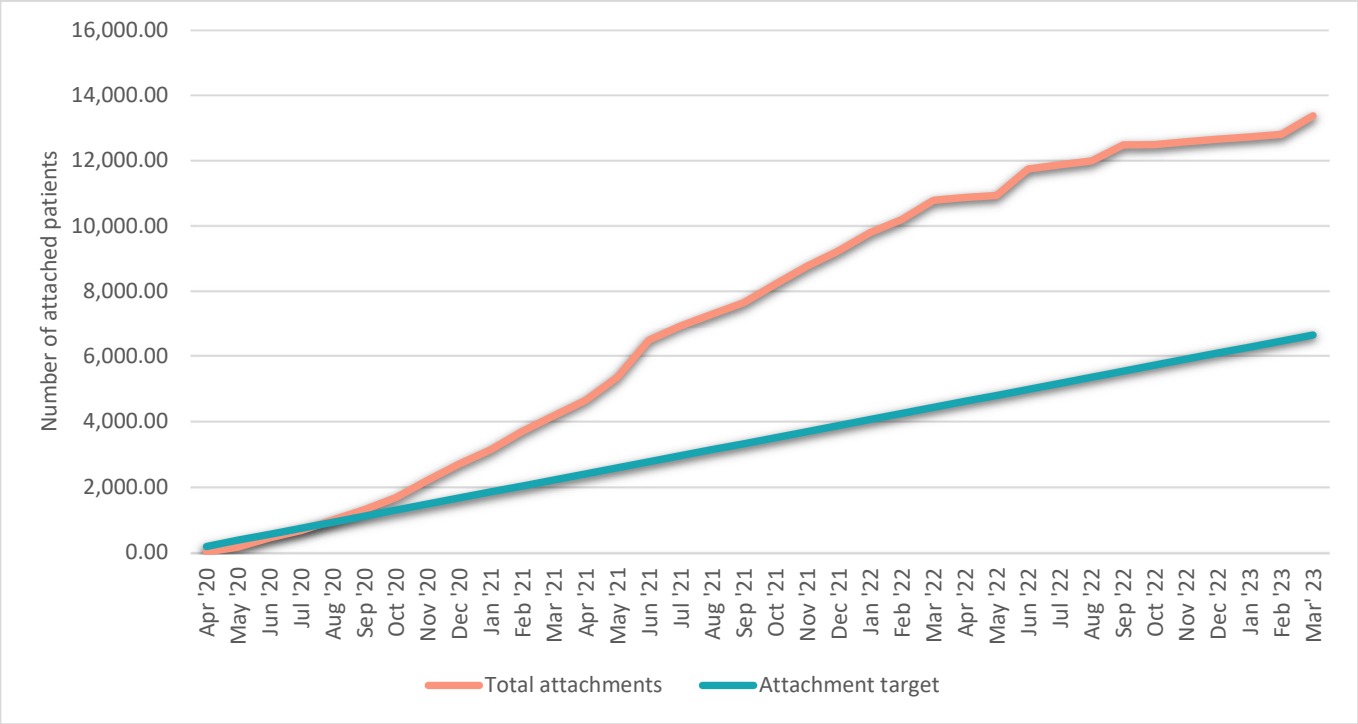


Figure 2. WRSS new patient attachments each month fiscal 2020-2023

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 seeking an FP for themselves or family members[27] and staff will provide information about clinics with FPs accepting new patients or direct patients to the Medimap website.

Medimap[28] is a website available to the public that provides up-to-date information on clinics accepting new patients. The WRSS DoFP Recruitment Specialist connects clinic staff to the Medimap team, who 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.[29] Our PCN has also secured two Nurse Practitioner (NP) contracts and work is underway to connect NPs with community clinics to facilitate additional patient attachment.

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

[27] The WRSS DoFP office receives, on average, 1-4 calls and emails per day from members of the public looking for an FP.
[28] www.medimap.ca/wrss
[29] 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.

a traditional FP practice in a fee-for-service model, as well as patients who are being discharged from 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 are accepting new patients.

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

In 2022/23, the WRSS DoFP recruited 7 FPs, which is a success for patients in our community. However, several FPs left the community unexpectedly, resulting in a net loss of 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 an additional 13% between 2021 and 2026.[30] Taken together, the demand for FPs has surpassed the supply, resulting in an attachment gap in our community.[31]

The WRSS DoFP's Recruitment Specialist 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,[32] 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.

3. Access

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

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:

- A NN visited a patient for a post-abdominal surgery dressing change with packing due to dehiscence, as the community wound care clinic was not able to see the patient for several days and the patient needed to be seen immediately. During the visit, the NN observed that the patient did not look well and was still bringing up coffee ground emesis. The NN updated the FP immediately about the patient's condition and they decided to contact the surgeon's office about the next steps. The surgeon saw the patient right away at the hospital for further investigation. The patient ended up requiring a gastroscopy and was admitted to the hospital. After the patient was discharged, the NN visited the patient at their home to monitor the recovery.

- A NSW received a referral from an FP for an 11-year-old patient with speech delays who required therapy. Through the CKNW Kid's Fund, the family received $2,500 for speech

[30] https://bcstats.shinyapps.io/popApp/
[31] There is no mechanism in place currently to measure the number of patients in WRSS who are unattached.
[32] https://news.gov.bc.ca/releases/2022PREM0067-001809

therapy with a local clinic. Unfortunately, therapy could not begin until the patient had an initial assessment – a $300 process that could not be covered by the Fund. The family, consisting of eight children ranging in age from 2 to 19, could not cover the assessment costs; the family is low-income and new to Canada, having arrived as refugees a few years ago. The NSW connected with a local club, the White Rock (431) branch of the Elks of Canada and through their Royal Purple Fund for Children (which specializes in helping children with communication, speech, and hearing) provided the $300 grant needed for the patient's speech therapy assessment. The patient was then able to undergo the assessment and begin the therapy he needed.

Photo 1. WRSS NSW receiving the grant for a patient's speech therapy assessment from a member of the White Rock Elks

- A patient was referred to the PCCP for support with migraine management, as she was taking multiple medications but was still experiencing severe breakthrough headaches that were affecting her quality of life. The patient expressed feeling overwhelmed with a significant medication burden and was motivated to gradually reduce some of her medications but did not know where to start. During the initial appointment, the PCCP and patient reviewed previous medication trials for migraines, discussed their benefits and side effects, reviewed

non-pharmacological strategies for migraines (reinforcing the identification and addressing of triggers), and discussed therapy options for acute treatment vs preventative treatment. During subsequent appointments, the PCCP worked together with the patient to identify which of her current prescribed medications were effective to treat her symptoms and a plan was created to treat mild-moderate headaches vs severe headaches. Through shared decision-making, the patient opted to try a medication for migraine prophylaxis. The PCCP made suggestions to the patient's FP to initiate such medication while gradually tapering others. The PCCP subsequently followed up with the patient who reported significant improvements in migraine frequency and intensity with the new regimen. She has more migraine-free days with less use of medications for acute treatment. The patient stated she is now more engaged at work and at home with her family.

Patient access to care has also been improved through other PCN resources, including the addition of counselling services for mild-to-moderate mental health clients by skilled counsellors. Through the PCN-sponsored counselling program, many patients who were previously unable to access the mental health care they needed due to financial barriers are now able to.

- A patient with Multiple Sclerosis who was experiencing high levels of social isolation accessed the counselling program to help resolve their grief, process complex trauma, and learn how to maintain personal autonomy, despite severe physical disabilities. At the end of the sessions, the client expressed profound appreciation for the program, noting that without the PCN-funded counselling, they would have never been able to afford counselling and would have had to resolve their presenting concerns on their own, potentially through suicide.

- Another patient, who was struggling to cope with depression, panic disorder, and post-traumatic stress disorder, was referred to the program by her FP. In describing her experience, the patient said the counsellor provided her with many useful tools and strategies to help and she noted:

> *My first few sessions would be me crying through most of the session, but my counsellor took the time to calm me down and listen. Now my sessions don't begin like that. I see progression in myself. The tools that I am beginning to learn are so very helpful and I can't thank my counsellor and the program enough…Thank you from the bottom of my heart.*

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.

- A patient with complex medical needs came to the PCAC for an appointment for his Hepatitis B vaccine. Because the appointment was not rushed like a conventional 10-minute doctor's visit, the RN had the opportunity to talk with the patient in an impromptu manner about his current circumstance and the patient opened up about his life stresses. Concerned with what she heard, the nurse referred the patient to a mental health counsellor, where he is now

getting the care he needs and is starting to learn tools to deal with his stress and is feeling better.

- An elderly patient who is homebound and isolated was complaining of shortness of breath, so the RN did a same-day visit to listen to her chest and check her vitals. It was determined that the shortness of breath was related to the stresses of feeling alone and isolated. The patient thanked the nurse for seeing her that same day, stating “I felt so much better after the visit.” The nurse connected the patient with a program provided by a local community service provider, Sources, that provides homebound and isolated patients with a visit from a volunteer once a week to help ease stress through social contact. The nurse also calls the patient every Friday to check on them to reduce the risk of the patient going to the ED over the weekends.

Without PCN resources, the patients in these examples would require many more visits to their FPs or hospital emergency departments, as one FP noted:

> *"CHF and other chronic diseases have so many aspects that you have to manage that you'd need 5-6 visits in the office to do what one visit with a NN can do in a 1–2-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."*

Through the PCN, patients are able to access the care and support they need more easily from a team of providers in the community. In discussing the impact of having PCN resources for her patients, one FP commented:

> *"For my patients, the most significant impact of the PCN has been a 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."*

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

Virtual care has been enabled by the foundational work accomplished through Patient Medical Home (PMH), in partnership with PSP and the Practice Support Coach, which has been providing tailored one-on-one coaching to FPs to support the adoption of virtual care into their practices.

Virtual care has also been enabled through FP access to free Zoom accounts from Doctors of BC. Additionally, clinics have received support such as the WRSS DoFP-supported monthly Clinic Managers’ meetings where clinic staff discuss successes and challenges, including sharing best practices related to virtual care implementation.

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

Challenges to implementing virtual care are experienced by both care providers and patients. FPs, who have for the most part returned to clinics with the lifting of COVID-19 pandemic restrictions, are resuming their in-person visits with many of their patients.

Virtual care also presents a challenge for patients who often prefer to see their FPs in-person, because that is what they have been used to for most of their lives and requires patient education by clinics to help patients adapt. Some patients, specifically seniors and marginalized groups, may be uncomfortable or lack access to the technology required for virtual care, such as a computer or phone with a camera, or access to the Internet.

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 and with patients, families, caregivers, and communities.

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

- This year, an additional 23 FPs have been onboarded into the PCN, bringing the total to 66 FPs. Additionally, five new NNs and two new NSWs were hired into the PCN, resulting in many more patients having their primary care needs met through a team-based approach.

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

Photo 2. The WRSS PCN Clinician team in March 2023

- NNs have enabled FPs to provide patients with a breadth of primary care services, including the ability to see patients on an urgent basis, the provision of medical care in patients' homes when needed, and patient education to support self-management. To-date, 1,474 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, with one FP stating, "The NSW is so useful and my patients love it, especially for issues such as housing, financial issues, and Pharmacare coverage." To-date, 846 referrals have been made to NSWs.

- The PCCP has provided support to FPs and their teams to provide better care for patients through the provision of comprehensive medication assessments and recommendations. Between August 3, 2021 (when the PCCP began seeing patients) and December 31, 2022, the PCCP has made 435 patient visits to 203 unique patients.

- This year, a new primary care Clinician for MHSU, a Mental Health Educator, was hired to support the PCN team by connecting FPs and Clinicians with primary and community care services to help patients access the most appropriate services. This Mental Health Educator role was developed collaboratively to address the unique needs of the community. Work is currently underway to enable the MH Educator to provide MHSU education to NNs and NSWs to increase their skills and confidence to care for patients with MHSU concerns. Additionally, the MH Educator is planning visits to WRSS clinics to understand FP needs regarding MHSU education.

- 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, the PCN-funded counselling program provided 2,581 counselling sessions to 456 unique patients who would not have been able to afford counselling services. Between June 15, 2020 (when the program was launched) and March 31, 2023, the program has provided 5,942 counselling sessions to 1,028 unique patients.

- 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 2022/23, the PCN-funded RN provided 257 PCAC patient visits, including in-person and virtual visits.

- FPs can refer homebound and frail seniors to the HomePACE program where they receive primary care in their homes from a team of NPs and an RN. In 2022/23, the PCN-funded RN provided 310 HomePACE patient visits, including in-person and virtual visits.

- The PEs have created 12 Service Maps[34] and work continues on developing more.[35] Service Maps are a communication tool between FPs and NNs/NSWs to support patients in managing chronic conditions. This tool allows the FP to know exactly which path the NN will go along with the patient. It also provides information about services and programs that are available locally, which the NNs use to support patients' navigation of community services and self-management.[36] 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[37] 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.

[34] The 12 Service Map topic areas are: Weight & Well-Being, COPD, Heart Failure, Intermediate Risk Factors of Chronic Disease, Paediatric ADHD & Behaviour, Depression, Anxiety, Social Isolation & Loneliness, Frailty, Type 2 Diabetes, Indigenous Services, Pediatric Asthma and Housing.
[35] Service Map topic areas currently under development are: Chronic Pain and First Year of Life.
[36] See Appendix D for an example of a WRSS PCN Service Map
37 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.

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

- A NSW received a referral for an elderly patient, as it had been a while since the FP had seen her and was concerned about her well-being. This patient has a history of opioid dependency and had recently displayed severe behaviour changes including paranoia, alcohol use, and a confrontational attitude towards health care providers. After several failed attempts at reaching the patient, the NSW consulted with a NN who knew the patient and had developed a trusting relationship with her. The ability to do a joint interdisciplinary home visit with the patient greatly increased the trust between the patient and the NSW, and as a result, the NSW was then able to bridge the patient to FHA's Older Adult Mental Health team and a Substance Use Clinician. With the patient's consent, the NSW, NN, and other members of her care team have all worked together and shared information to address the patient's pain management, substance use, home conditions, and adherence to medical appointments. This has resulted in a profound positive impact. In discussion with the patient, she recently stated: "I feel like I'm starting to get my life back."

- A NSW received a referral from an FP for a patient who was experiencing chronic pain, significant financial stressors and was in a long-time verbally abusive relationship. The NSW conducted a psychosocial assessment and referred the patient to counselling to address historical trauma and current stressors. During intervention, the patient brought up a longstanding history of emotional eating and the relationship between her poor eating habits, weight gain, chronic pain, and emotional well-being. To enhance the NSW's support, a lateral referral was made to a NN colleague to work with the patient on weight and well-being education from a nursing perspective to facilitate a holistic and interdisciplinary approach to the patient's care. The patient appreciated the complimentary roles of the NSW and NN and is making great introspection about how her eating behaviours can trigger or result in emotional responses, and vice versa.

- FPs and PCN Clinicians can access the Pharmacist to support patient care. In one case, the PCCP received a referral initiated by a NSW to help a patient with the high cost of medications. The disabled patient has a complex mental health and neurological history. After multiple consultations with specialists, the patient, and his family felt that the current regimen was effective, and the patient's conditions were very stable. As a result, they were nervous to make changes in the patient's current medications although the cost was a significant burden. During the initial appointment with the PCCP, it was identified that the patient was not registered with Fair Pharmacare so the PCCP provided guidance to the patient and family about registering and assisted with special authority for some medications, highlighting the patient's long history of medication trials, side effects, and intolerances. The PCCP also suggested therapeutic equivalents to the patient's FP for other medications which were more cost-effective. The patient is now registered with Fair Pharmacare and the special authorities were approved, significantly decreasing the cost of the patient's prescription medications and easing financial burdens. The patient and his family are very grateful to receive this level of support directly from his FP's care team.

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 a welcome (onboarding) 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 can teach 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 in-person Team-Based Care sessions led by the Doctors of BC Practice Support Coach (PSP) facilitates communication among PCN providers by bringing FPs, Clinicians, and clinic staff together to work through case examples, plan how they will work together, and practice problem-solving and conflict resolution. The sessions have also provided valuable opportunities for informal communication and cross-connections (e.g., FPs talking with other FPs in the PCN, exchanging ideas, and learning from each other's experiences). The formal and informal learning that takes place during these sessions has helped to improve communication and strengthen relationships among providers in the PCN.[38][39]
- A series of check-ins with FPs was launched to learn about their experience with the PCN as well as answer questions and provide additional resources (e.g., 1-page posters that outline the types of referrals FPs can make to PCN Clinicians and the Referral and Communication Flowchart – see bullets below).
- 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 Clinicians into their practices.
- 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 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.[40]
- A series of posters have been created for FPs and clinics in the PCN which outline the types of referrals that FPs can make to their NNs, NSWs, and PCCP.[41]

- A Referral and Communication Flowchart, developed collaboratively with FP and Clinician input, provides guidance on the referral and communication processes within the PCN team.[42] 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.
- In a segment of the March 2023 WRSS DoFP's All Members' Meeting, a PCN update on the program's implementation was provided to attendees, including new Mental Health Educator supports, Service Map updates, and sharing of stories from PCN FPs and Clinicians, as well as an opportunity for FPs and Clinicians to gather in small groups and share examples of how they are working together as PCN teams.[43]

[38] The PCN leadership team continues to collaborate with Catherine, local PSP Coach/Facilitator as she supports our physicians with this change in her role including helping them to integrate an expanded TBC approach for their patients. Since PCN launched in 2020, Catherine and Dr. Phillips have facilitated 3 cohorts of the "TBC learning series", with session themes focusing on aspects such as "patient centred care", "team functioning" "interprofessional communications" and "conflict mgmt." Over 50 physicians /14 clinics, and the majority of our PCN clinicians have attended these sessions and have worked with Catherine to develop meaningful action plans to support this integration and significant change in practice.
[39] Each Team-Based Care session is evaluated by participants. See Appendix E for examples of infographics summarizing the session findings.
[40] See https://www.youtube.com/watch?v=osmfos7hjkA for the Comfort Keepers and READ Surrey White Rock from March 2023.
[41] See Appendices A, B & C
[42] See Appendix F for the WRSS PCN Referral and Communication Flowchart
[43] There were 73 attendees at the event, including FPs, Clinic Managers, and Clinicians.

Photo 3. WRSS FPs, clinic staff, and PCN Clinicians gathered at the WRSS DoFP All Members Meeting in March 2023, sharing their experiences of working as a team in the PCN with FPs

- 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 59% open rate.
- The WRSS DoFP website contains information about the PCN, both for health care providers and the public.[44]
- Pathways[45] continues to be updated with PCN-related information and is where all the Service Maps can be accessed.

[44] https://divisionsbc.ca/white-rock-south-surrey/initiatives/primary-care-network
[45] Pathways (https://pathwaysbc.ca) is an online resource that provides physicians with information about health resources and community services.

7. Culturally Safe Care

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

To address cultural safety for patients receiving primary care, we have adopted an organization-wide strategy to embed cultural humility and safety into all the work we do at both the program and practice levels. We are employing a phased approach to learning and unlearning to create meaningful change on our journey to transformative reconciliation. Here is our current working definition of Transformative Reconciliation (TR) for the WRSS PCN and DoFP:

Our initial focus for TR is on the WRSS DoFP staff team and Board, PCN FP leads, and Clinicians. Once a solid foundation has been established with this group, we will begin to expand to FPs, clinics, patients, and the community.

The intent of our TR journey is to recognize biases, unlearn colonial ways of thinking and doing that have caused historical and contemporary harms, and learn about Indigenous ways of being and knowing - to create change and relationships. As Dr. Dustin Louie (Indigenous scholar with UBC's Faculty of Education who we have consulted with to help guide our transformative reconciliation journey) aptly stated, "It is through relationships that we learn." As we progress along our journey, we are adopting a team-based learning process, which comes intentionally out of the PCN's team-based care work through a variety of initiatives.

> *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.*

For example, we held a team-based learning event with the WRSS DoFP staff and PCN Clinicians on September 29, 2022, commemorating the National Day for Truth and Reconciliation and Orange Shirt Day by visiting the White Rock Museum's 'I am Semiahmoo, I am Survivor of the Floods' exhibit[46] to learn about the history of the Semiahmoo peoples, on whose unceded territory we live and work on. The team then engaged in an Indigenous sharing circle, a practice taught to us by Dr. Dustin Louie to reflect on what team members learned, how they felt about it, and what changes they would make as a result of these new learnings.

Photo 4. PCN Clinicians and WRSS DoFP staff at the September 29, 2022, team event at the White Rock Museum's "I am Semiahmoo, I am Survivor of the Flood" exhibit commemorating the National Day for Truth and Reconciliation and Orange Shirt Day

On March 29, 2023, several PCN FPs, clinic staff, and WRSS DoFP staff participated in an urban cultural safety tour, visiting Kilala Lelum Health Centre, Luma Health Centre, and Westcoast Family Centre to learn from their teams about how to provide culturally-safe primary care to patients in a clinic setting.

[46] https://www.whiterockmuseum.ca/exhibits/che-semiahmah-sen/

Photo 5. From the March 2023 Cultural Safety Tour. From top left to bottom right: Smudging materials in an exam room at Kilala Lelum Health Centre, exterior of Luma Health Centre, a patient room inside Luma Health Centre, an exam room at Luma Health Centre, a staff member of Westcoast Family Centre demonstrating a smudging ceremony.

This year, a PCN Service Map on the topic of Indigenous Services was developed to better support PCN FPs and Clinicians work with Indigenous patients in the community.

Other TR-related activities we have engaged in this year include taking the self-guided '21 Things You May Not Know About the Indian Act' training by Bob Joseph[47] and participating in the KAIROS Blanket Exercise, an experiential workshop that explores the nation-to-nation relationship between Indigenous and non-Indigenous peoples in Canada. In the exercise, blankets are arranged on the floor representing land and participants are invited to step into the roles of First Nations, Inuit, and later, Métis peoples. The workshop helps people to understand how the colonization of this land impacts those who were here long before settlers arrived.[48]

[47] https://www.indigenousrelationsacademy.com/products/21-things-for-groups-bundle-with-ebook
[48] https://www.kairosblanketexercise.org/

We have established a Learning Library comprised of books and other learning materials by Indigenous authors for FPs, clinic staff, Clinicians, and WRSS DoFP staff. In addition, we have distributed sɬə́məxʷ Rain Pierre's 'Light of Irene' poster to every WRSS clinic to help create a welcoming space for Indigenous patients, inspire conversations, show support, and signify the importance of culturally safe care.[49]

Photo 6. WRSS DoFP staff member dropping off Rain Pierre's 'Light of Irene' poster to a WRSS clinic for display in their waiting room

We appreciate the reality of capacity challenges experienced by our Indigenous community partners and recognize the impact this can have on relationship building. As we move forward, we are

[49] https://www.doctorsofbc.ca/news/truth-and-reconciliation-advancing-cultural-safety-health-care

continuing to learn and to focus on the work that is ours to do, as we look for opportunities to build relationships and support local Indigenous partners, including the Semiahmoo First Nation (SFN).

8. PCN Milestones Achieved in Year Three

The WRSS DoFP has established a stable, thriving, and member-driven Primary Care Network (PCN) that serves various populations in the community. Now entering the third year of implementation, the WRSS PCN has exceeded staffing and recruitment targets while continuing to serve some of the most vulnerable populations through the team-based care (TBC) model. The WRSS DoFP's original implementation timeline aimed to enroll 100% of eligible Family Physicians (FPs) into the PCN between 2020 and 2024. However, membership enrollment and clinic uptake into the PCN has progressed rapidly. The WRSS DoFP anticipates that 100% of our eligible FP members will be part of the PCN by the summer of 2023. Moreover, our community's PCN has surpassed original Service Plan attachment targets by 6,660 patients. To-date, 13,377 patients have been attached, which is well above the 4-year (2020/21-2023/24) target of 8,900 patients.

While a great deal has been accomplished this year, this figure shows some of the key milestones:

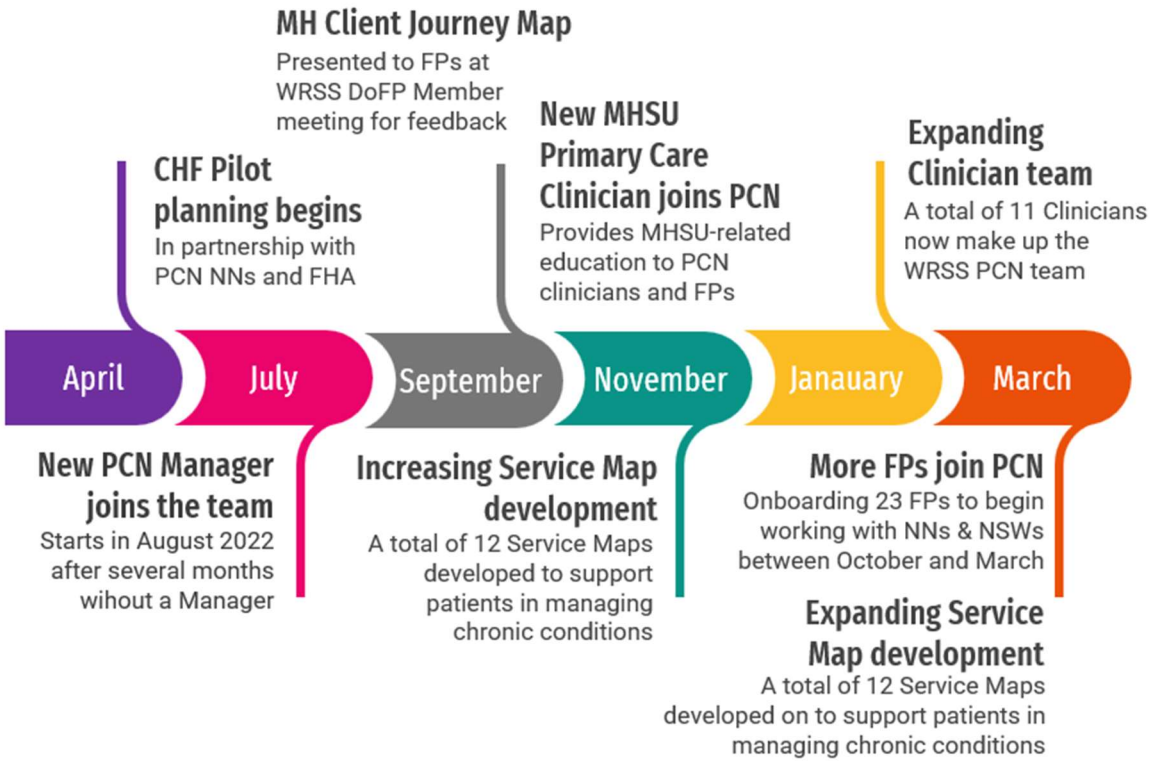


Figure 3. WRSS PCN Milestones for 2022/23

9. Family Physician Experiences in the WRSS PCN

Having conducted a series of interviews with PCN patients in 2020/21, and Clinicians in 2021/22, we focused this year on FPs in the PCN through a series of one-on-one check-ins. Between January and

March 2023, 13 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.[50] The findings from these check-ins are being used to better understand FP experiences in the PCN and their referral practices. This information is being used as part of our continuous improvement process to help inform decision-making as we transition from program implementation to sustainability.

The PCN is being well-used by FPs. While some are still adapting to practicing in a team-based environment, overall, there has been a steady increase in the number of referrals sent by FPs to their clinician teams. There has also been a broadening of the range of referral types, such as post-hospital discharge care, cognitive assessments, polypharmacy, chronic disease management and patient education, community service navigation, addressing complicated family issues, financial and housing insecurities, mental health supports and counselling, and for other complicated cases that cannot be addressed in a 10-minute doctor's visit, such as a couple where the wife was developing dementia and the husband was overwhelmed. Clinicians are also able to be FPs 'eyes and ears' by visiting patients in their homes as needed, ensuring they are taking their medications as prescribed, and checking for safety concerns, which is a significant benefit, as one explained,

> *"I really appreciate having the NSW visit my patients in their home because she can assess their living space and get a hands-on sense of their environment. The whole situation can be looked at in depth in a way that can't be accessed in a short visit at the clinic".*

FPs indicated that the Clinician referral process is straightforward, and that Clinician-to-FP communication occurs quicky and is thorough. Many FPs have regular check-ins with their Clinician team to follow up about patients, which they note has helped to improve communication and strengthen the team relationship.

Physicians reported many benefits to transitioning to a team-based model of care. In a multi-disciplinary team, each provider brings unique skills and experiences to draw from, leading to better patient care. When asked about their experience working as part of a team, one FP stated, "one provider can't do it all so this way, the patient can get all their needs met. It's an excellent way forward." Several FPs who have come from other jurisdictions in Canada and globally that have already implemented team-based primary care delivery noted they are happy that it has come here and they can now practice medicine in this way.

FPs indicated they have a high degree of confidence in the skills and experience of the Clinicians, as an FP commented, "the Clinicians are absolutely invaluable. I don't have the skills of a social worker so it's invaluable to have her skills and her assessment." Clinicians' knowledge of community resources has also been beneficial as it alleviates the need for FPs to search themselves, which can be time-consuming and FPs may not be up to date on all the services, eligibility requirements, etc. Many FPs indicated that as a result of the services provided by Clinicians, work is being 'taken off their plates' and they now have more time to see more patients.

The feedback FPs are receiving from patients about the care they are receiving through the PCN has also been overwhelmingly positive. One FP stated, "I have only heard good feedback from my patients about their experiences with Clinicians…they love them, they tell me they provide good care,

[50] This is an ongoing project and check-ins will continue in 2023/24.

and they have the time for patients to get what they need from a visit," and another noting "I have not heard any negative feedback from my patients, and I do hear a lot of negative feedback from my patients about a lot in our healthcare system."

Beyond patient satisfaction, the PCN has helped to ensure patients are getting the care and supports they need and are entitled to, which is facilitated by the advocacy role Clinicians can play. When asked about this, one FP commented,

> *"To me, the most profound impact on patients is having systems that should be working for them actually work for them, like the benefits you were supposed to get 3 years ago, and I've filled out the forms 6 times, but now you get your benefits as a result of the work the Clinician did. Or the organization that everybody agrees is who should be helping you but they keep coming up with loopholes why they can't, suddenly now they are helping you – so a huge advocacy role."*

Importantly, these factors are leading to a reduction in stress levels for many FPs, as one FP commented,

> *" I am so happy to have the support [of the PCN]. Before we were drowning and felt lost, unable to meet patient needs, especially for our complex patients and those with mental health challenges but we are doing better now...it eases my stress level. Even if it takes two cases off my list, the overwhelming ones that I don't know where to go, it helps a lot. Sincerely, it is fabulous."*

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.

10. Financial Reporting

a. Surplus/Deficit:

Category	Budget	Actuals	Surplus/(Deficit)
Administration	$246,150.00	$313,229.90	($67,079.90)
Governance	$40,000.00	$5,341.00	$34,659
Change Management	$202 821.00	$124,395.60	$78,425.40 (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 significantly lower than we had budgeted for at the beginning of year one.
Change Management	We anticipate more change management efforts will be required for late and laggard adopters; therefore, we planned activities to ensure we have some surplus carried over into year four so that we could successfully support future activities. In addition, we expect that training, communication, and evaluation activities will continue to ramp up in year four as well.
Health Authority Clinical Resources	The total Health Authority funding expenditure was $2,716,145 during the 2022/23 fiscal year. Of this, $2,355,414.00 related to FHA WRSS PCN funding and $360,731.00 related to FP NTP expenditure, which was funded separately. Of the FHA WRSS PCN funding ($2,355,414.00), $447,627.00 related to FP contracts, the remaining ($1,907,787.00) related to clinical resources and overhead expenditure. At fiscal year-end, there was a surplus of $824,686.00 on the FHA clinical resources and associated overhead which was primarily due to hiring lag during the year. Out of the 27.25 FTE clinical resources, 19.00 FTE were hired by year end.

11. Partnership of WRSS DoFP and FHA

Healthy and prolific partnerships are at the crux of our work within the PCN. Our FHA counterpart has been integral to the successful design and development of the PCN. This vital partnership is where strengths are complimented, and limitations are navigated through collaboratively. At the heart of our program are our PCN Clinicians, a unique team of carefully chosen allied health care professionals that feel passionate about primary care and prevention. Recognizing that much of the program's success depended on having a good fit for these positions, FHA and the WRSS DoFP worked closely together throughout the hiring and training process. Once the Clinicians were hired, the WRSS DoFP and FHA thoughtfully match Clinicians with the appropriate FP clinics to create a solid team. In the

year ahead, our partnership with FHA will serve as the basis for our sustainability plan and will involve months of discussion and visioning together. Ultimately, both the WRSS DoFP and FHA are integral members of the community who work to serve our members for the betterment of their health and well-being.

12. The WRSS PCN Moving Forward

Over the past year, the WRSS DoFP has made strides in stabilizing and refining an already prominent and impactful PCN program for our members and community. Concerted efforts focused on bringing in the final group of FPs into the PCN, parallel to building out and hiring our highly skilled and passionate Clinician team. Furthermore, physician leadership development and engagement were a core focus for continued program development; we have seen several FP champions rise to the occasion in helping us further create PCN supports and resources for the program.

The year ahead is a promising and exciting one, as it brings the opportunity for the WRSS DoFP to solidify the past three years of collective dedication and planning with our FP members and partners. For our community, this means ensuring and implementing a well-thought-out sustainability plan that honours and considers all the significant elements of the program, including change management, physician leadership development, resource development, program administrative support, and ongoing partnerships with FHA. The WRSS DoFP recognizes the importance of maintaining what has been built and understands that this will require ongoing staff and partnership support for the longevity of the program. Equally important will be the ongoing involvement of our FP members to further augment PCN program deployment so that it remains responsive to evolving community needs. Ultimately, it is our vision that the will PCN continue to do what it does best, and that is provide the right care, at the right place, at the right time.

Appendices

White Rock-South Surrey Primary Care Network

Primary Care Network

Nursing Services

A **PCN Physician** can refer their client to the Primary Care Network Nurse for assistance with:

Screening	Interventions	Education	Connection to Community
Fall Risk	Short term wound care	Chronic Disease & Lifestyle Self Management	**Resources such as:**
Swallowing/Nutrition/Oral health	Fall prevention strategies	CHF	Other PCN team members (SW, Pt Ed, Pharmacist)
Anxiety / Depression	Recent Hospital Discharge F/U	COPD	Social Prescribing (Brella)
Assessments	Medication compliance	Diabetes	Sources Counselling
Physical (VS, Pain and Systems)	Support for home bound clients:	Weight & Wellbeing	Community Respiratory Services
Skin breakdown	Specimen collection	Anxiety	Chronic Disease Programs
Cognition	Ear flushing	Depression	Diabetes Prevention
Medication Response	Injections/Immunizations	Chronic Pain	Mental Health programs
Mobility / Functional abilities		Medication Education / Management	Activity Programs

Appendix B: NSW Referral One-Pager

Primary Care Network

Social Worker

Collectively We Care.

White Rock-South Surrey Primary Care Network

A **PCN Physician** can refer their client to the Primary Care Network Social Worker for assistance with:

Where to get help

- Cultural Connections
- Public Health Resources
- Non-Profit Organizations
- Transportation
- Accessing resources
- Advocacy

Emotional Support

- Depression
- Isolation
- Anxiety
- Grief / Loss

Housing Concerns

- Homelessness
- Unsafe Environments
- Housing resources
- Shelters

Financial Hardship

- Eligibility to Services / Benefits/ Grants
- Income Supports
- Medical Coverage
- Help managing financial matters

Managing Health Problems

- Quality of life decision
- Treatment decisions
- Advance Care Planning
- Social Determinants to Health
- Diagnosis specific resources

Crisis Situations

- Child Protection / Welfare
- Abuse / Neglect
- Vulnerability (due to life stage, social situation, cognition, physical deficits)
- Family System challenges
- Caregiver responsibility challenges (ex. guardianship)

Appendix C: PCCP Referral One-Pager

White Rock-South Surrey Primary Care Network

Primary Care Network

Pharmacy Services

A **PCN Physician** can refer their client to the Primary Care Network Pharmacist for assistance with:

Medication Reviews

Related to:

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

Patient Complexity

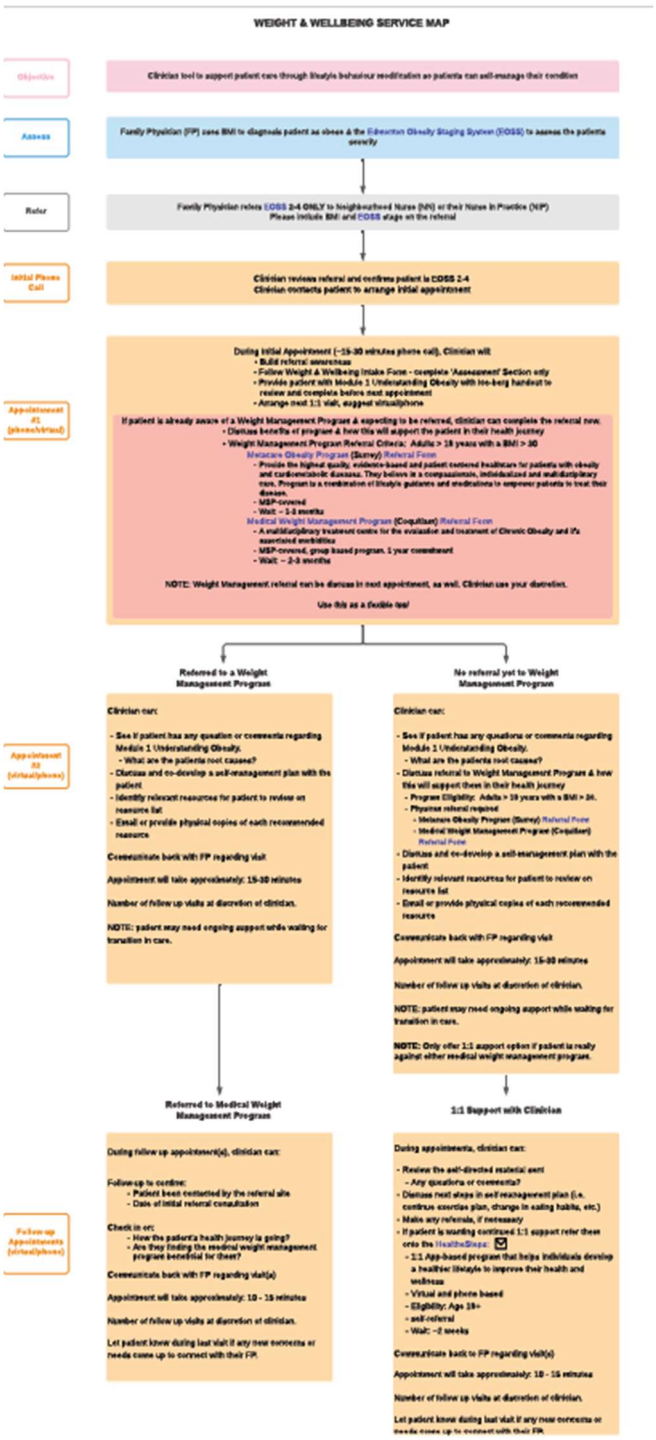
Due to:

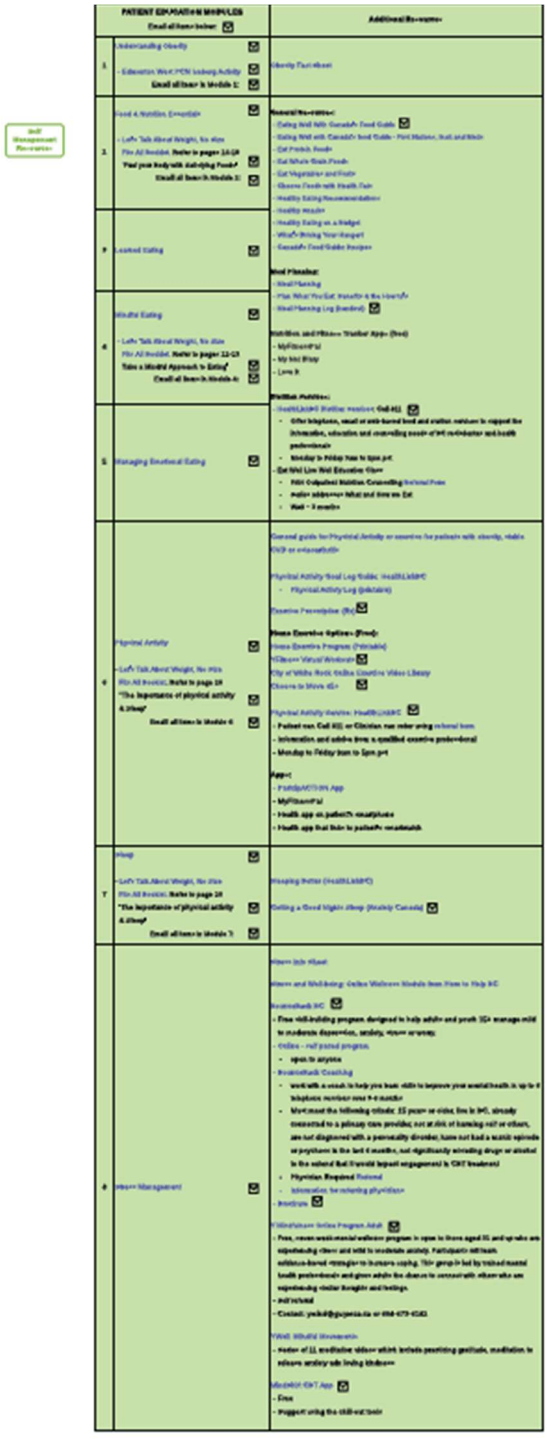
- Medication questions
- Complex schedules
- Patient Self-treatment
- Multiple Co-morbidites

Refer via Pathways Referral Tracker or eFax/Fax to (844) 691-1237

(Login required and available from your Clinic Manager, MOA or email the WRSS Division at wrssdfp@divisionsbc.ca)

Appendix D: Example of WRSS PCN Service Map for Weight & Wellbeing





Appendix E: Example of PSP Team-Based Care Learning Series Evaluation Infographics

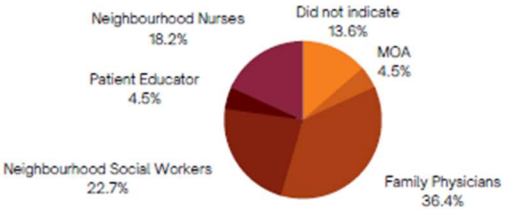
PCN Team-Based Care Learning Series for Cohort 3

Post-Series Survey Findings

Between November 2022 and January 2023, the newest cohort of FPs, clinicians and clinic staff entering the WRSS PCN were provided this team-based care learning series, which consisted of three in-person sessions: team-based care foundations, patient-centred care, and conflict management and team function. This learning series was delivered by PSP in partnership with the WRSS DoFP and the PCN team. The findings presented here are from a survey delivered at the end of the last session to evaluate the entire learning series.

Session Participants

A total of 22 participants completed the post-series survey. Here is a breakdown of participant roles:



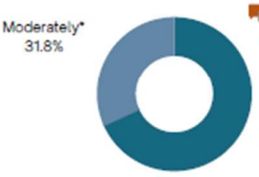
Q1. Through participating in the learning series, I have gained a better understanding of the scope and role of my new team members and how this benefits and supports team-based approach to care for my patients:

Comments from Participants:

- *"Case studies and scenarios were helpful to decipher roles." - NSW*
- *"Keep learning more as we meet and form how to move forward as a team." - FP*

*The two participants who responded 'moderately' also noted that they had missed one or more of the sessions.

Q2. Through participating in the learning series, I have gained a better understanding of team work group/ team processes to enable effective interprofessional collaboration:



Comment from Participant:

- *"In addition to the material covered, it allowed time together to discuss ways to collaborate in an in-person setting." - NN*

*Two of the participants who responded 'moderately' also noted that they had missed one or more of the sessions.

Q3. In participating in the learning series our team has had an opportunity to discuss, share strategies, evidence based tips and approaches to enable a patient-centred approach during care:

Comment from Participant:

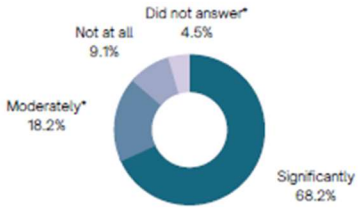
- *"Yes, reviewing material, learning more about scopes, spontaneous team meetings during break." - FP*

*One participant who responded 'moderately' noted that they had missed the first session.

Q4.Through the learning series, our team has developed strategies to actively listen to other team members and communicate to ensure common understanding of care decisions, functioning as an expanded team:

*One of the participants who responded 'moderately' and one who did not provide a response to this question noted that they had missed one or more sessions.

Q5. Through participating in the learning series, our team has or is developing strategies and protocols to manage conflicts. We are also identifying common situations that are likely to lead to disagreements or conflicts including, but not limited to, role ambiguity, power gradients, and differences in goals in order to take constructive steps to address them:

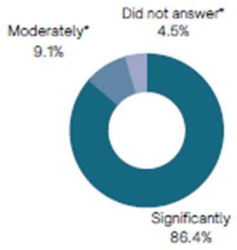


Comments from Participants:

- *"No real examples of conflict, thankfully."* - FP
- *"We have so much mutual respect and good communication that at this time, it's not needed."* - NN
- *"Section was quick."* - NSW
- *"Liked the assertive/cooperative graph!"* - FP

*One participant who did not respond to this question noted that they had missed two of the sessions.

Q6. Through participating in the learning series our team has established a safe environment in which to express diverse opinions:



Comments from Participants:

- *"Great sequence of sessions to aid seamless integration of new clinicians."* - FP
- *"Thank you for your time and thoughtful facilitation."* - NSW

*One participant who responded moderately and one who did not respond to this question noted that they had missed one or more of the sessions.

OTHER COMMENTS FROM PARTICIPANTS

- *"Sitting with my team was very helpful to get to know the team."* - FP
- *"Excellent education sessions."* - FP
- *"Great series! Learned a lot and it is all working well so far in our clinic."* - MOA
- *"Excited!"* - FP
- *"Some of the videos were a little basic in regards to the materials, however they did set up good discussion."* - NSW
- *"Thank you!"* - NN
- *"Thank you for everything!"* - PE
- *"The learning/education sessions brought a lot of new and great information to help me in my new role. Series was great/informative."* - Role not indicated

PSP Practice Support Program

White Rock-South Surrey Division of Family Practice

Appendix F: WRSS PCN Referral and Communication Flowchart