Nanaimo
Division of Family Practice
A GPSC initiative

Annual Report 2020–21

FOR THE PERIOD ENDING MARCH 31, 2021

Snuneymuxw Totem structured by Joel Good. Formerly the site of St'litlup, the original village of Snuneymuxw First Nation Departure Bay, Nanaimo, BC.

We acknowledge with gratitude that we work on the unceded and traditional territories of the Snuneymuxw First Nation, and Coast Salish Peoples – Stz'uminus and Snaw-Naw-As Nations.

Table of Contents

Introduction

Way back in the mists of time Divisions operated by holding in-person meetings, often after hours, with dinner, and opportunities to connect with familiar faces over a coffee and a chat.

Education events were held where we could learn from the wise and experts from within our community and beyond. Virtual care was a gift one received in the mail, and Zoom was a little used verb. Projects were planned and executed within reasonable timelines, and collaboration was the name of our game.

Flash forward 12 months, and the landscape looks very different. Shared Care projects are sputtering back to life following a stall of in person engagement and project activities. Some, unfortunately, may never regain the impetus lost to the pandemic response. Our meetings are on Zoom, creating fatigued 'Zoombies' in offices and kitchens (and basements and bedrooms). Virtual primary care became a necessity and has kicked open the door to corporate pretenders to the Primary Care crown. Relationships, collaborations, and engagement have been compromised as we all adjusted to life at a distance.

2020-2021 as they might say in Wales was a 'bit of a year'. However, as is often the case in times of adversity, we can marvel at the innovation, persistence, resilience, and collaboration it creates. Within the change we can focus on the positive results of a distressing year.

As the Covid-19 pandemic took a throttle grip on our lives, over and again our staff and members rose to the challenge, creating new ways of delivering care; protecting our workforce; and lifting each other up.

86% UBC Family Practice Residents retained

94% of Long Term Care patients in Nanaimo have access to Physician care

BeST team concept in collaboration with Island Health & Fraser Health to spread into new communities

PCN Service Plan received approval and funding from the Ministry of Health on March 30, 2021

Working with our partners in Island Health, a Covid Assessment Centre was established led by Dr. Otte, and later Dr. Wallis. To support members who were unable to obtain basic Personal Protective Equipment (PPE) for their staff and patients, a Nanaimo wide donation drive and distribution service was established by the Division. New relationships were formed over a common desire to help one another. The engineering department at Vancouver Island University worked with the Division to develop 3D printed face shields which were made available to Long Term Care (LTC) centres via the LTCI. LTC Physicians pivoted to provide safe in person care for LTC patients, reducing

footfall into facilities and pioneering virtual visits in Nanaimo.

Divisions collaborated with each other. Partners both new and old shared knowledge and resources in a spirit of true altruism.

And whilst this was all happening, work still got done. Once the initial challenges were responded to, and supply chains and daily life began to resume, our members and staff pivoted once more to return to what they do best, deliver care and support those who deliver care. Remarkably, the Primary Care Network team managed to complete our service plan submission to the Ministry, just a few weeks later than originally anticipated. We are delighted that we have received funding for a raft of team based services and supports for members and clinics which will address attachment, and improve primary care for patients in Nanaimo.

"…the Division Board has committed to review all work within the lens of cultural safety and has adopted the Snuneymuwx First Nation 'One Canoe' model to improve healthcare in Nanaimo."

As Healthcare in BC responds to the ugly reality of racism in the Healthcare sector, the Division continues to walk the road of reconciliation with our community partners, Snuneymuxw First Nation, Snaw-Naw-As First Nation, Tillicum Lelum Aboriginal Friendship Society, and, recently, the Mid Island Metis Nation. Our Truth and Reconciliation in Healthcare committee was established by Leslie Keenan in 2018 to bring forward the voices of Indigenous partners. This work is not easy, nor always comfortable, but the Collaborative Services Committee and the Division Board has committed to review all work within the lens of cultural safety and has adopted the Snuneymuwx First Nation 'One Canoe' model to improve healthcare in Nanaimo. We recognize that these are small steps to start the ongoing journey of reconciliation and improve healthcare for the next seven generations.

Our Long Term Care Initiative turned 5 years old in 2020, with Myla Yeomans-Routledge taking over the reins of this successful initiative that provides Physician care to approximately 94% of LTC patients in Nanaimo. The strength of the improvements and commitment to Best Practice developed over time was tested as Covid-19 threatened the lives of our most vulnerable seniors. Again and again the LTC Physicians created new processes and came together as a team to care for frightened and lonely LTC residents. As we enter 2021, the LTCI continues to innovate and adapt to continue its legacy.

Our Recruitment team also had to battle with adversity, as staff members adapted to new ways of working, and recruiting in a virtual world. The Nanaimo Division, always a standard bearer for recruitment success, was in danger of being overwhelmed by interest from Physicians from other countries and provinces. During 2020-2021 we have attracted new Physicians and retained 86% of our UBC Family Practice Residents. At the time of writing, we have an additional Recruitment team member to help us respond to numerous potential new Physician members.

The Nexus Nurse Practitioner clinic continued recruiting clinicians and

Beccy Robson
Executive Director

attaching patients. Now at its planned staffing capacity it has NPs and 1 part-time Physician, and their leadership is working with the PCN to determine resource sharing with other Patient Medical Homes in Nanaimo.

Several of our Shared Care projects were forced to stall as staff capacity was pushed to its limit. As the pandemic starts to become more manageable, we are returning to complete the Behavioural Support Team project by collaborating with Island Health and Fraser Health to spread the BeST team concept into new communities.

The OAT network project 'Evolving Doors' nears completion after a hiatus of almost 1 year. Partnering with the Provincial PATHWAYS platform to increase useability and providing a unique visual network for strategic planning has been the outcome of the latter stages of this work.

Our new Adult Mental Health and Substance Use Shared Care Spread project was initiated during the early days of the pandemic, requiring the team to pivot to virtual meetings. Remarkably this project was completed on time, and the working groups never met in person during the duration of the project!

As those mists start to clear and we can see the beginning of the end of the pandemic, where are we now, one year later in March 2021? Our CME events that were on hold will return in the Fall, and perhaps the knowledge gained over the last year will enrich opportunities for in person events, as well as provide space for convenient online content to be developed to complement our program and facilitate access to expertise. Our programs revive, and a new Shared Care project is in the pipeline for Pediatric referrals.

We continue our PCN adventure building services for the patients we know are going to come, and the many who have been underserved in the past.

The relationships cultivated by the Nanaimo Division of Family Practice with partners have become more meaningful throughout the last year and we look forward to working hard together – with the Health Authority, our community partners, our members, our work colleagues, our universities, and our patients — to improve patient and provider care for Nanaimo for the future.

Beccy Robson — Executive Director

Roger Walmsley
Board Chair

"ONE CANOE"

(Musings of your outgoing Chair)

Once upon a time there was a Family Physician for almost every citizen in our community. And when I first came to Nanaimo there was mostly one model of primary care—there were only a couple of ERPs and no hospitalists; Palliative care and walk-in clinics were new concepts; Long Term Care was one of the stops between home, office and hospital; there were very few Nurse Practitioners north of the 49th; and the majority of Family Physicians were an integral part of all hospital departments, administration, surgical rotas, and so on.

So how do we connect the dots between then and now, between all our various members …and a spiralling need for increased patient attachment? How do we better connect a hospitalist or ERP with community Family Physicians? How do we support early career FPs, and those whose interests don't include joining a full-service practice? How do we better serve Physicians providing longitudinal family medicine, or walk-in services? How do we counsel a FP Resident who envisages a very different future for primary care? How do we connect with an Nurse Practitioner providing outreach for the unsheltered? …and in the process provide quality care to a growing community.

The reality is that the care we all provide, in our various capacities, interweaves in creative ways to significantly strengthen the fabric of Nanaimo's Primary Care Community. Accepting our various roles and developing connections between ourselves, our Specialist colleagues, and Allied Health Providers builds a strong community of care and benefits our patients. We can no longer hope to attach everyone to one professional, but perhaps we can attach each patient to our community of care professionals, to our "One Canoe."

All of you collectively form our "Division community." Your Divisional Board of Directors strives to represent your various interests by finding common ground with our many healthcare partners, Indigenous, and community members. When you find that we have veered off course please help us to redirect. In turn, when our various healthcare and community partners are less than collaborative, we will help them to redirect on your behalf. Our dominant current focus is to collaboratively build a Patient Care Network (PCN) that has the potential to create a "One Canoe" model of care for our community.

Division Board work is a privilege that requires your input to be successful. Thank you for your support in this important work. Please welcome Taylor Swanson as your incoming Chair. May the next year of our joint efforts bear visible fruit — to make each day a little sweeter or to ferment over time into a fine wine…pass the paddle!

Roger Walmsley — Board Chair

Covid-19 Initiatives

In response to the Covid-19 pandemic strategies were swiftly developed to support Division members and other healthcare and patient stakeholders.

ACCOMPLISHMENTS

- When the pandemic began, community members and colleagues in non-essential professions inquired about how and where they could donate PPE to frontline workers. The Nanaimo Division rapidly established a donation system for items. In total, 127 people donated over 58,000 PPE items: masks (N95, reusable masks with filters, Pro-tech), gloves, hand sanitizer, disinfection wipes, gowns, and face shields.
- The Division also created a partnership with Vancouver Island University Engineering Campus to design and supply hundreds of 3D printed visors. These were distributed free of charge to clinics and Long Term Care centres. In the summer, the Division partnered with Island Health and the Victoria Division to receive more robust visors from University of Victoria which were distributed to Patient Medical Homes across Nanaimo.

Operation Uplift Lunches

- To help address the increased need for mental health services resulting from Covid-19, the GP Psychiatry service was accelerated to address the extensive waitlist to see a psychiatrist in Nanaimo. The Division hosted virtual Cognitive Behavioural Therapy (CBT) classes for community members
- A variety of strategies to spread positivity to the public and front-line workers were executed. A very active social media campaign included numerous posts across social media channels. Emotional support services were made available to Physicians; and using Division and donor funding, coffee cards, gifts, nearly 800 lunches were sent to front-line workers. While this involved a great deal of logistics, their impact was received very positively by recipients.
- The Division also worked to support Long Term Care (LTC) facilities and their associated Physicians during the pandemic. LTC facilities are particularly vulnerable to Covid-19, given the age of residents and the potential for spread within and across facilities. The central project goal was to reduce the potential for Covid-19 exposure in LTC facilities. To achieve this, five strategies were implemented:

  1. Create a LTC WhatsApp group, to focus on LTC-specific Covid-19 issues

2. Change protocol for primary care visits
3. Provide iPads to facilities to enable remote visits from Physicians, NPs, and residents
4. Provide suture kits for LTCs to reduce the number of hospital visits
5. Provide facilities with PPE.

The protocol for in-person primary care visits changed to reduce the potential spread of the virus across facilities. Rather than have the MRP come to the facility for an essential in-person visit, one of two Physicians assigned to a facility would make the visit instead. Eight Physicians participated in this initiative.

Following a pilot in the early days of Covid, ten LTC centres received iPads from the Division. LTC managers indicated that the iPads provided greatly assisted residents' ability to safely access Family Physicians or Nurse Practitioners. The iPads also facilitated social contacts between patients and loved ones.

Transfer from LTC facility to acute care and back not only increased the risk of spreading the virus, but also required a 14-day isolation upon return. To reduce the need for hospital visits, the Division partnered with Victoria Division of Family Practice to assemble and distribute 10 disposable suture kits to the LTC Physicians for use in the facilities.

Our LTCI, Physicians' efforts, the support of the Division, and guidance from other organizations contributed to a successful response in LTC facilities, allowing them to maintain high standards of care.

Be Calm

Be Kind

Be Safe

Dr. Bonnie Henry

Family Practice Clinic

Operation Project Uplift

Covid-19 Ministry Health Funding

The Ministry of Health provided additional funds to Health Authorities and Divisions to allow rapid implementation of services to help the most vulnerable in our community. In Nanaimo we partnered to provide the following services.

LOW BARRIER PRIMARY CARE OUTREACH SERVICE

OBJECTIVES:

- Pilot a Low Barrier Primary Care Outreach Service through temporary funding to determine effective ways to reduce barriers to access to team-based primary care to community members who are unsheltered.
- Conduct an evaluation of the pilot service to inform a future Low Barrier Service under the Primary Care Network.

ACCOMPLISHMENTS:

- Identified the need for Low Barrier Primary Care through PCN Service Planning
- Received short term COVID funding to Pilot a low barrier outreach service
- **Engaged Peers (those with Living experience) in the planning of the Low Barrier Service:** Early in the planning process, the local Community Action Team for the overdose response was consulted about the potential to have Peers as part of the planning and service delivery. A peer led organization, **Open Heart Collaborative**, became an active planning partner and was contracted to provide the Peer support as part of the Low Barrier Team. Peer involvement in the planning and operation of the service was instrumental in creating a service that truly meets people where they are and build trust between clinicians and service users.
- **Service implementation in August 2020:** After the initial planning period, the Service was rolled out gradually starting in August 2020. The team included 4 Family Physicians; 2 Full Time RNs from Island Health Mental Health and Substance Use Services; and 2 Peers sharing a full-time role. Clinical Coordination support was also provided in-kind from MHSU Services. The Physicians were oriented to the work through the help of the Peers and Nurses, who had established relationships in the community. The team works in direct patient care 4 mornings per week during the Physicians Sessional tie (3.5 hours per day) at various sites in the community including at encampments, on the street, and temporary housing sites. The Team utilizes an outreach van initially provided in-kind from the NRGH Hospital Foundation.
- **COVID Funding extended beyond the initial 9-week pilot:** While COVID funding was only intended for 9 weeks, the project was extended twice. This has allowed the service time to learn about providing care to this population and determine how to transition the service to a PCN Service (in progress).
- **Monthly Education/Training Sessions:** Monthly sessions were held on topics such as Trauma-Informed Practice, Dermatology/Wound Care and Street smarts to support training for the entire Low Barrier Team.

""One of the more transformative aspects of the Low-Barrier Outreach Service has been the opportunity to work alongside Peers in a meaningful and authentic way, enabling the team to build trust and truly meet people where they're at"- Laura Loudon

- **Evaluation results shared with PCN Leadership and team:** The evaluation results showed that the service has been very effective in addressing barriers to care and highlights the success of the team-based care approach. The team typically provides care to well over 300 patients in a 4-week period. These results are informing the future PCN service.
- **Low Barrier Primary Care Clinic/Outreach Service Approved through the PCN Service Plan:** The Low Barrier Service was included in the PCN Service Plan and approved in March 2021. The PCN resources will increase the Physician hours to full time and enables the team to establish a home base, or clinic, as a hub for the outreach team

PHYSICIAN LEAD

Dr. David Sims

PROJECT MANAGER

Laura Loudon
Tanis Dagert, Coordinator

PRIMARY CARE CHILD, YOUTH, AND FAMILY SERVICE

OBJECTIVES

- A partnership between Physicians and Specialists, School District #68, Nanaimo Division of Family Practice, and Island Health, to provide access to Primary Care services to marginalized children, youth, and their families.
- This pilot project was designed to provide access to Primary Care to those children, youth, and their families who live in marginalized circumstances (identified through the school system), who are not attached to a Family Physician/Primary Care Provider, who have been further isolated by the Covid-19 pandemic, and who need healthcare and wellness.
- Short-term consultations are provided to:
    - Create a care plan to stabilise medical, social, and psychological challenges while families search for a permanent primary care provider
    - Help children, youth, and families with identified support needs navigate the Nanaimo region health-system; and
    - Create an electronic medical record for children, youth, and/or their families, which will then be accessible at a growing list of Island Health locations.

ACCOMPLISHMENTS

- Created a team-based approach to care involving a Family Physician, Pediatrician, Social Worker, and Manager of Mental Health and Addictions for School District #68.
- **12 clinic days** will have been held since January 22, 2021.
- **23 high-complexity individuals** (16 children/youth and 7 parents) will have been referred to and seen by the service.
- Through this pilot project, a strong program delivery model was developed. With the approval of additional funding and services through the Nanaimo Primary Care Network (PCN) Service Plan, this project baseline will greatly aid in the transition to a PCN service.
- Project evaluation is currently in progress, and the final project report is anticipated for July 2021.

PHYSICIAN LEADS

Dr. Kevin Martin — FP
Dr. Wilma Arruda — Specialist

PROJECT MANAGER

Laura Loudon

SNUNEYMUWX FIRST NATION HOME VISIT PROGRAM

OBJECTIVES

- Provide Physician home visits, integrated with Snuneymuxw First Nation's community care nurse, to Snuneymuxw community members on and off reserve who have chronic and/or complex conditions and are not receiving the medical care needed, either due to Covid-19 or due to a lack of access to technology (phone/internet/computer) needed to receive virtual care.

ACCOMPLISHMENTS

- Physicians in the home visit program provided outreach at Snuneymuxw at a rate of approximately one half-day per week between August 2020 and June 2021.
- Between November 2020 and April 2021, the Home Visit service was operational over 21 half-days and provided a total of 69 patient visits, 42 of which were in-person and 27 of which were conducted virtually with the help of the community care nurse.
- The home visit program has been successful at bridging the gaps in medical care experienced by many Snuneymuxw community members. With the approval of additional funding and services through the Nanaimo Primary Care Network (PCN) Service Plan, the services made available by the home visit program will be able to continue in some form.

PHYSICIAN LEAD

Dr. Derek Poteryko

"I have been isolated for months now. I am weepy with tiredness. My adult children and their choices is weighing heavy on me. I feel very alone. I only see a doctor in the emergency department or in the scanning department. Doctors need to come to the home of old people; we should not be around all the young people who may not be doing all they can to protect us. So please come to my home, protect me." – Snuneymuwx First Nation Elder

INTERIM PRIMARY CARE COVID RESPONSE FUNDING, MINISTRY OF HEALTH GP-PSYCHIATRY PILOT

OBJECTIVES

- In response to the Covid19 pandemic, the Adult MHSU Spread Network accelerated launching a GP-Psychiatry pilot position in Nanaimo to address the increased need and demand on MHSU services arising from the pandemic.

ACCOMPLISHMENTS

- With approximately 800 patients on the Psychiatry waitlist at the beginning of the project and a shortage of less than 2.0 FTE Psychiatrists supporting primary care, the Interim Primary Care funding was utilized to support the severe MHSU patients currently waiting extended periods for outpatient care.
- Over a 9-month period, the funding supported 5 GP-Psychiatrists an alternate payment model than fee-for-service for providing consults to 348 patients as of March 31, 2021. This reduced the above waitlist numbers by more than 40%, while increasing access to Psychiatry services for the amplified MHSU impacts of the pandemic.
- The Interim Primary Care Covid Response funding has been extended to September 30, 2021, to continue providing the GP-Psychiatry consults until the PCN Implementation plan is confirmed.
- The planning and coordination of care was funded by Shared Care, and GPSC; and implemented by the Adult MHSU Spread Network Advisory Committee.

"After returning from a leave, I was amazed by the new GP-Psychiatry project and how much it increased access to psychiatry!"

Initiatives

EVOLVING DOORS: INCREASING ACCESS TO OPIOID AGONIST THERAPY FOR PATIENTS IN THE CENTRAL/NORTH VANCOUVER ISLAND REGION.

OBJECTIVES

- Create a community of practice by increasing and enhancing the connections between Opioid Agonist Therapy (OAT) prescribers in the Central and North Vancouver Island region
- Improve patient access to OAT and provide a continuum of care for patients across the region.
- Provide a sustainable mechanism to facilitate communication and connections between all OAT prescribing Physicians in the region.

ACCOMPLISHMENTS

- Unique collaboration between five Divisions of Family Practice and the Rural and Remote Division to explore transitions for patients receiving OAT treatment on Vancouver Island.
- In late 2019 a subproject emerged to collect information to reveal barriers, gaps, and successes in urban Indigenous Peoples' access to substance use and related services to improve primary care resources. A series of engagement events were designed and planned to be held in overdose 'hotspot' communities in 2020. However, due to Covid-19, all scheduled events were postponed indefinitely.
- Covid-19 response prioritization reduced staffing capacity for project coordination, and the Evolving Doors project activities were paused between March and December 2020. The project slowly started to regain momentum in 2021.
- Mapping of the OAT prescribers and resources network has continued, and the results will be shared with leaders in system planning and in participating communities. It is hoped that the data will be able to be disseminated further, both at the local and provincial levels.
- In conjunction with the Doctors of BC PATHWAYS team, the OAT prescriber's data compiled through the mapping process will be optimized for searchability in the PATHWAYS database during 2021. This initiative will be communicated through the OAT prescriber's network.

PHYSICIAN LEADS

Dr. Sandy Barlow

Dr Patricia Mark

PROJECT MANAGER

Beccy Robson

"When we talk about networks of care, addictions is one of those that you cannot work effectively in isolation as a prescriber. It's very much a team-based network."
– OAT Physician

PRIMARY CARE NETWORK

OBJECTIVES

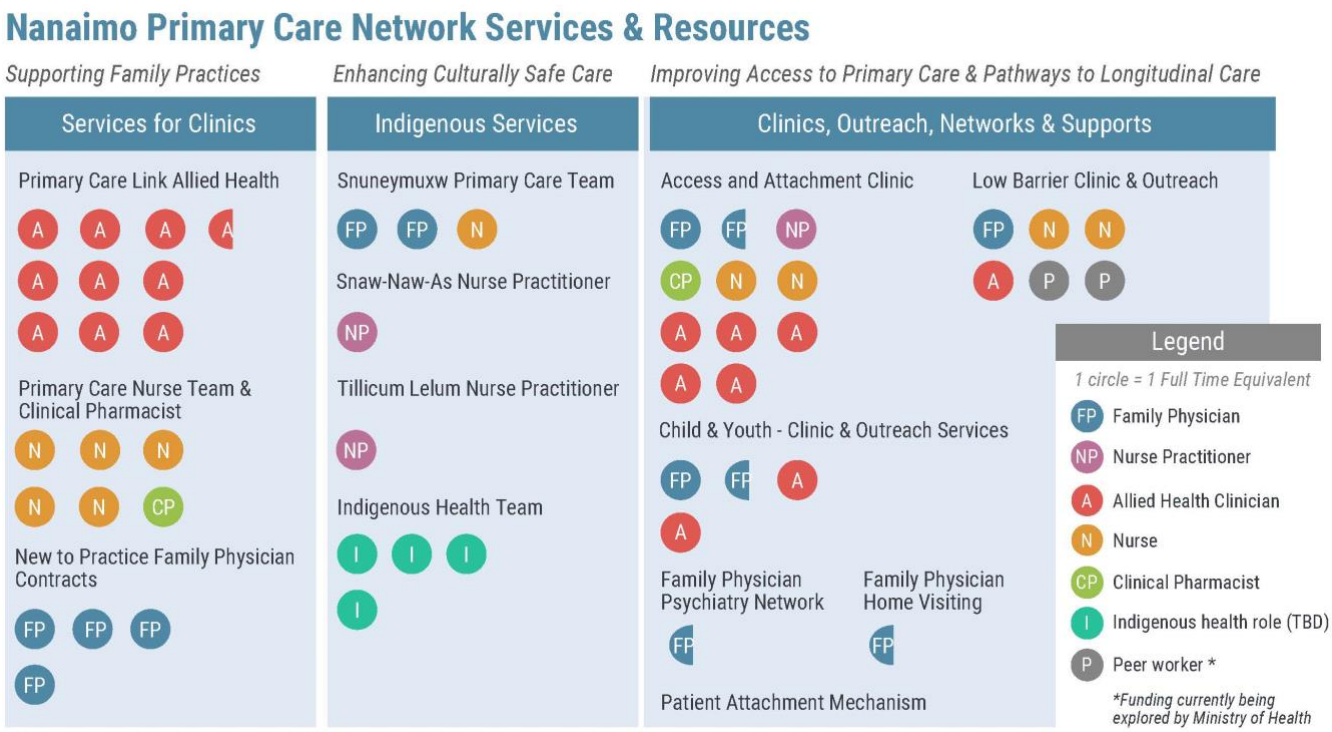
- Engage and involve Family Physicians/clinics in foundational Patient Medical Home (PMH) development and engagement in Primary Care Network – as the foundation of the PCN service.
- Develop a collaborative partnership with Vancouver Island Health Authority and Indigenous partners to guide the work.
- Engage community, providers, and Indigenous communities to better understand current gaps in care, needs, opportunities, and health disparities to inform future PCN Service Planning.
- Undertake PCN Service Planning by engaging providers and patients around potential service opportunities to address the identified service gaps and opportunities.
- Finalize and submit the Nanaimo PCN Service Plan to the Ministry of Health.

ACCOMPLISHMENTS

- **Completion of a comprehensive summary report and map of themes from engagement and identified opportunities to address Service Gaps:** During the start of the COVID-19 Pandemic in March 2020, the Collaborative Services Committee (CSC) approved a limited PCN Planning Strategy, recognizing that we could not undertake meaningful engagement of partners during this uncertain time. The focus became comprehensive analysis of input and data from the many and various pre-covid engagement activities. A summary report and map was shared with Physicians and PCN Partners in June 2020. This marked the re-initiation of full PCN Service Planning and, along with an analysis of local health and demographic data, informed the service opportunities included in the PCN Service Plan.

"An important goal of our Primary Care Network is to better support Family Practice Clinics by connecting their patients to new team-based care resources. The integration of social workers, mental health clinicians, nurses, and pharmacists in primary care not only improves care for patients, it creates a supportive community that physicians want to come work in."

- **Continued Engagement of Family Physicians and Patient Medical Homes:** While engagement of Family Practice clinics was delayed at the start of the COVID-19 pandemic, after re-initiation of service planning in June 2020, we resumed efforts to connect with clinics to finalize the services to be put forward in the PCN Service Plan. Together we identified a Clinic Representative(s) who met with the Physician Leads and Project Manager through the Summer and early fall. These meetings, and subsequent communication, provided a sense of the support's clinics felt would be most helpful connected to their practice, as well as data on clinic patient populations. We continue to communicate regularly with Clinic Representatives as a primary point of contact for PCN Planning.
- **Primary & Community Care Mapping Sessions (2) with University of British Columbia Innovation Support Unit (UBC ISU) Team and local Physicians and community partners – Complex Adults and Children (September 28, 2020) & Youth Session (October 5, 2020):** With some service opportunities already identified, we worked with the UBS ISU team to bring together stakeholders for two mapping sessions. These sessions were designed as an opportunity to assess potential service options through various patient case examples.



- **Collaboration with Indigenous partners to determine opportunities for attachment, team-based care, and culturally informed care**: Through the Truth & Reconciliation Task Group; individual meetings with Snuneymuxw and Snaw-Naw-As First Nations; and Tillicum Lelum Aboriginal Friendship Centre, we identified service opportunities to stabilize and enhance care at the respective health centres and gain all Indigenous partners' approvals on the final proposed service plan. Mid Island Metis were also engaged in the process as a full PCN Partner but did not actively engage in planning until after the Service Plan was submitted. They are now an active participant on the PCN Steering Committee and TRHC Task Group.
- **Develop Nanaimo PCN Service Plan and confirm approval with all PCN Partners through the Nanaimo Collaborative Services Committee (CSC):** From August to October 2020, the PCN Project Management team undertook extensive work to confirm, write, and finalize the service proposals for inclusion in the Nanaimo PCN Service Plan. The final Service Plan was approved by the Collaborative Services Committee in October 2020 and officially submitted to the Ministry of Health on November 4, 2020.
- **Development of a Governance Structure for PCN Implementation:** The CSC and PCN Project Management Team built the foundational pieces needed to enable successful PCN implementation. This included establishing a new, nimbler, governance and operational structure. A PCN Steering Committee was established as the main decision-making committee, with the CSC maintaining high level strategic oversight. A management and administrative structure were established with PCN Managers within the Division and Island Health co-leading an implementation team to

facilitate and manage the day-to-day planning and working groups. The entire Collaborative Governance Model is designed as a non-hierarchical structure inspired by the values of our Indigenous partners.

- **Development and implementation of New to Practice Contracts process approved through the PCN Service Plan:** In early 2021 the Ministry of Health and Doctors of BC released updated New to Practice (NTP) Physician Contracts. We moved quickly to understand the contract process for clinics and interested Physicians and developed a local process to provide clinics a way to access the contracts for a NTP Physician to join their practice. Several NTP contracts are now in process.
- **Received Final Approval of the PCN Service Plan:** We received notional approval of our PCN Service Plan on March 17, 2021, followed by official approval and funding package from the Ministry of Health on March 30, 2021.

PHYSICIAN LEADS

Dr. David Sims — Patient Medical Home (PMH)
Dr. John Trepess — Primary Care Network (PCN)

PROGRAM MANAGERS

Laura Loudon
Brenda Adams — Supporting Manager

SHARED CARE: OBSTETRICS COLLABORATIVE

OBJECTIVES

- The Obstetrics Collaborative is a community of Family Physicians who provide maternity care. The group is made up of Obstetrician/Gynecologists, Midwives, and Labour & Delivery Nurses. The professionals work together to enhance the understanding of roles across professions, improve relationships, streamline common work, and ultimately enhance the childbearing experience for women and families in Nanaimo.

ACCOMPLISHMENTS

- The Advisory Group met in February 2020 and reaffirmed their interest in pursuing a prenatal education program, with COVID-19 this work was put on hold.

PHYSICIAN LEADS

Dr Sheila Findlay — GP Maternity
Dr. Evelyn Eng — OB/GYN

PROGRAM MANAGER

Brenda Adams

"The Improvement of understanding is for two ends: first, our own increase of knowledge; secondly, to enable us to deliver that knowledge to others" – John Locke

BEHAVIOURAL SUPPORT TEAM (BEST) CARE FOR DEMENTIA PATIENTS IN LONG TERM CARE (LTC)

OBJECTIVES

- Working in partnership with Family Physicians, Specialists, Island Health MHSU, and Long-Term Care Facilities in Nanaimo, this project aims to improve the quality of long-term care for residents living with dementia through:
- Implementation of P.I.E.C.E.S. methodology and practice and creation of in-house behavioral teams.
- Improvement in resident outcomes by better supporting behavioral and psychological symptoms of dementia (BPSD) and improving processes.
- Development of standardized documentation and referral process and post referral feedback
- Improvement in collaboration and communication across Family Physicians (FP), Specialists, MHSU, and Facilities

ACCOMPLISHMENTS

- **Best in a Box**. To help facilitate the spread of BeST Care to other facilities, BeST in a Box was created. This physical resource includes a how to guide to support facilities in adopting BeST Care as well as electronic copies of all of the standardized forms that were developed.
- **Medication Education Workshop**. This online workshop was designed to fill the gap identified by physicians and staff around the appropriate use of medications to support residents living with dementia. The workshop is designed for both staff and families to create a better understanding of common conditions residents may experience and the various treatment options that might be considered and why. The workshop can be accessed for free at bestcare.thinkific.com/
- **Project Spread.** BeST Care was presented at the 2021 BC Patient Safety and Quality Council Forum. This has led to a number of connections throughout the province with other Health Authorities who would like to incorporate BeST Care into their communities. Conversations to support their implementation are on-going.

PHYSICIAN LEAD

Dr Erfan Javaheri

PROJECT MANAGER

Brenda Adams

BeST in a Box How to Guide and resources.

"Best Care is like a safety net to help make sure no resident falls through the cracks."
– Anna Martin, Social Worker, Long Term Care

LONG TERM CARE INITIATIVE (LTCI)

OBJECTIVES

- Improve patient outcomes and reduce unnecessary hospital admissions by removing barriers and improving processes to allow Physicians to achieve the GPSC Best Practice Expectations of:
    1. Proactive Visiting (at least 1 visit/3 months)
    2. Provision of 24/7 care
    3. Participation in care conferences
    4. Undertake meaningful medication reviews
    5. Complete documentation

ACCOMPLISHMENTS

- **LTCI Communications:** Created an LTCI WhatsApp forum for all LTCI Physicians in Geo 2.
- **Change Protocol for Primary Care Visits:** Implemented Primary Physician visits reducing the number of physicians physically entering facilities.
- **Piloted Remote Visiting:** iPads given to facilities to enable remote access for LTCI Physicians to reduce risk of cross infection.
- **Suture Kits & PPE:** LTCI Physicians received personal suture kits and additional PPE to reduce admissions to the ER.
- **PEAK on-Call pilot** successfully being extended for additional year.
    - Pilot being expanded to take on call requests outside of PEAK holidays.
- **LTCI Quality Improvement Initiatives** in collaboration with Seniors Care, MOST, Informatics, and LTC. Island Health focusing on streamlining communications between Divisions and Island Health:
    - Ability to update MRP for Affiliated and Private sites.
    - Ability to reflect changes to MOST status *before* admission into ER Department.
    - LTC Transfers into Acute Care and ER Department by enhancing the Pink Band Initiative.

PHYSICIAN LEADS

Dr Erfan Javaheri (March – October 2020)
Dr. Diane Wallis (November 2020 – Present)

PROJECT MANAGER

Myla Yeomans-Routledge

ADVISORY:

Representation includes Family Physicians from various community clinics; Directors of Care from various LTC facilities; ER Department; Pharmacy; Practice Support Program for Community Health & Care; Geri-Psychiatry; Vancouver Island Association of Family Councils; and Nurse Practitioners from an Island Health Owned and Operated

"I think the LTCI might be the most successful program the Division has facilitated to date. Providers are happy and well supported, the care of patients I think has improved simply because of access/availability/specific interest in geriatric care, and I think the nurses, care aids, patients, and families appreciate the program too (even if they aren't aware of all of the work put in behind the scenes)."
– Myla Yeomans-Routledge.

ADULT MENTAL HEALTH AND SUBSTANCE USE (AMHSU)

OBJECTIVES

- Increase awareness of AMHSU services
- Improve the referral process to AMHSU resources
- Enhance the coordination of communication and care between providers
- Reduce the burden on Family Physicians, Psychiatry, and MHSU

ACCOMPLISHMENTS

- Full Project Funding Received: $70,000
- April 2, 2020, pilot launched with 2 Family Physicians mentored to offer GP-Psych consults
- Early learnings demonstrated FFS payment model was inequitable for time required with GP-Psych consults
    - Secured alternate funding through Ministry of Health's Primary Care Interim Covid Proposal
    - Changed to sessional payments for consults by shadow billing MSP, in partnership with Island Health
- 5 Family Physicians recruited to pilot (total); waitlist started for others who indicated interest
- Created new, or updated the following for distribution to community clinics and hosted live on Pathways:
    - NEW MHSU Referral & Locus Form
    - MHSU & Psychiatry Triage Sheet (for Referring Providers)
    - MHSU Patient Handout (for Self-Referrals)
- With 5 sessions/week, GP-Psych Pilot offers a total of 10 New Patient Consults/week (equivalent to more "new" patients/week than a FT Psychiatrist)
- As of March 1, 2021, 312 GP-Psych consults booked, and those patients removed from the Psychiatry waitlist
- Pilot gained recognition from various regions and DoFPs: Vancouver, Victoria, Thompson Region: Kamloops & Kelowna, Surrey North-Delta, South Island, and more
    - Entire project was planned and implemented virtually during Covid! No Advisory Committee or working group meetings were able to be held in person due to Public Health restrictions

PHYSICIAN LEADS

Dr. Joris Wiggers — Psychiatry
Dr. Jenny Bell — GP-Psych Lead
Dr. Derek Poteryko — GP

PROJECT MANAGER

Myla Yeomans-Routledge

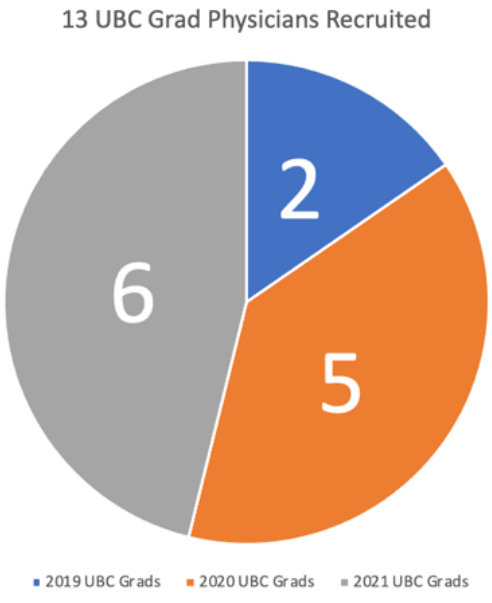
"It [GP-Psych Consult Report] is fantastic—Thank you! Such a tangle to walk into that med regime as a newbie. The plan is very clear, and I really appreciate that. I didn't know we had GP-Psych consults—how lucky we are!"

PHYSICIAN RECRUITMENT AND RETENTION (R&R)

Working in partnership with the Nanaimo UBC Residency Program, all Vancouver Island Divisions, Island Health Physician and Recruitment, Health Match BC, and Nanaimo's community clinics, this program cultivates successful recruitment of new Family Family Practice Physicians and the retention of UBC Family Medicine Residents to Nanaimo.

OBJECTIVES

- Attend previously successful recruitment conferences and source new conferences/strategies for generating new candidate leads.
- Advertise local opportunities provincially, nationally, and internationally.
- Provide red carpet welcome and site visits for Physician candidates and newly relocated Physicians.
- Liaise with recruitment partners to ensure effective collaboration and recruitment success for the Island as a whole.



ACCOMPLISHMENTS

- Two 2019 UBC Family Medicine grads have returned to practice in Nanaimo following 3rd year specialty training:
  - One joined Nexus Primary Care Clinic.
  - One joined the ER Physician group and is providing FP Locum coverage.
- One 2020 UBC Family Medicine Graduate is returning to Nanaimo in July 2021 to practice post 3rd year specialty training. Will Locum at first to determine interest in clinics.
- Five 2020 UBC Family Medicine grads have remained in Nanaimo:
  - Three are providing Locum coverage
  - One joined Medical Arts Clinic
  - One joined Lexitor Clinic
- Six of the 2021 UBC Family Medicine grads are planning to stay in Nanaimo post-graduation.
- Eight Physicians recruited to Nanaimo:
  - Four providing Locum coverage
  - Four joined Clinics (Wallace St, Caledonian Clinic, and Pacific Station)
- Six more Family Practice Physicians are considering relocating to Nanaimo in 2021

"Physicians are Nanaimo's heartbeat."
– Leslie Keenan, E.D.

PHYSICIAN LEAD

Dr. Taylor Swanson

COORDINATORS

Regan Grill (leave of absence May 1- October 19, 2020)
Myla Yeomans-Routledge (covering for Regan's absence)

Board of Directors and Staff 2020-21

BOARD MEMBERS

Dr. Roger Walmsley
Board Chair

Dr. Danielle Downe
Director at Large

Dr. Diane Wallis
Director at Large

Dr. John Trepess
Director at Large

Dr. Duncan MacGillivray
Resident, Director at Large

Dr. Taylor Swanson
Director at Large

Courtney Defriend
Director at Large

Doug Torrie
Director at Large

Dr. Michelle Workun-Hill
Resident, Director at Large

Thank you to our previous Directors at Large Board Members until November 2020:

Dr. Melissa Gilis
Dr. Matt Toom

STAFF

Beccy Robson — Executive Director

Myla Yeomans-Routledge — Operations & Program Manager

Laura Loudon — Project Manager

Teresa Graham — Operations Coordinator & Executive Assistant

Regan Grill — Coordinator

Meghan Bajzath — Coordinator

Karita Sedun — Coordinator

Katrina Love — Executive & Administrative Assistant

Ari Rivas — Administrative Assistant

Sandra Weymouth — Administrative Assistant

Michaela Daniel — Office Assistant

Meet the Team

Teresa Graham, Katrina Love, Brenda Adams, Ari Rivas, Regan Grill, Myla Yeomans-Routledge, Meghan Bajzath

CONTRACTORS

Brenda Adams — Project Manager

Janice Schmidt — Nanaimo Pathways Administrator

Kelsey Chandler — Coordinator

Leila Scanell — Evaluator

Financial Statements

STATEMENT OF FINANCIAL POSITION

NANAIMO DIVISION OF FAMILY PRACTICE SOCIETY

Statement of Financial Position
March 31, 2021

	2021	2020
	$	$
ASSETS		
Current Assets		
Cash	992,585	861,825
Short Term Investment	207,378	207,378
Accounts Receivable	55,169	31,712
GST Recoverable	3,793	5,118
Deposit on Lease	1,648	1,648
	1,260,573	1,107,681
LIABILITIES		
Current Liabilities		
Accounts Payable **(Note 3)**	133,944	86,863
Wages Payable	38,880	14,794
Government Remittances Payable	15,633	15,264
Deferred Revenues **(Note 4)**	1,040,159	961,540
	1,228,616	1,078,461
NET ASSETS	31,957	29,220
	1,260,573	1,107,681

Approved by the Directors:

Director
TAYLOR SWANSON

Director
Roger Wahmley

CHAN NOWOSAD BOATES
CHARTERED PROFESSIONAL ACCOUNTANTS

STATEMENT OF OPERATIONS

NANAIMO DIVISION OF FAMILY PRACTICE SOCIETY

Statement of Operations and Changes in Net Assets

Year Ended March 31, 2021

	2021	2020
	$	$
Revenues		
Government Funding	1,426,526	1,437,151
Interest	2,737	3,467
	1,429,263	1,440,618
Expenditures		
Administrative **(Schedule 1)**	1,277,265	1,280,558
Conferences	5,687	13,448
Events	17,356	34,076
Office	69,453	49,938
Professional Fees	12,443	15,346
Promotion and Member Engagement	5,133	6,357
Rent	36,454	34,792
Telephone	2,735	2,636
	1,426,526	1,437,151
Excess of Revenues Over Expenditures	2,737	3,467
Net Assets - Beginning of Year	29,220	25,753
Net Assets - End of Year	31,957	29,220

CHAN NOWOSAD BOATES
CHARTERED PROFESSIONAL ACCOUNTANTS

STATEMENT OF CASH FLOWS

NANAIMO DIVISION OF FAMILY PRACTICE SOCIETY

Statement of Cash Flows

Year Ended March 31, 2021

	2021	2020
	$	$
Cash Flows From Operating Activities:		
Cash Received from Funding	1,483,013	1,446,169
Cash Paid to Suppliers and Employees	(1,354,990)	(1,470,983)
Interest Received	2,737	3,467
	130,760	(21,347)
Cash Flows From Investing Activities:		
Proceeds from Redemption of GIC	207,378	203,912
Purchase of GIC	(207,378)	(207,378)
	-	(3,466)
Net Increase (Decrease) in Cash	130,760	(24,813)
Cash and Cash Equivalents - Beginning of Year	861,825	886,638
Cash and Cash Equivalents - End of Year	992,585	861,825

CHAN NOWOSAD BOATES
CHARTERED PROFESSIONAL ACCOUNTANTS

Contact Us

CONTACT INFORMATION

Nanaimo Division of Family Practice
2137A Bowen Rd.
Nanaimo, BC, V9S 1H8

Email: nanaimo@divisionsbc.ca
Phone: 250-591-1200
Fax: 250-591-1205

Nanaimo Division of Family Practice
A GPSC initiative

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