Victoria
Division of Family Practice
An FPSC initiative

MONTHLY PROJECT REPORTS TO THE VICTORIA DIVISION BOARD OF DIRECTORS

Ending
December 31, 2022

MISSION
Happy Doctors; Healthy Communities.
VISION
We strive to make Family Practice in Victoria fulfilling, sustainable, and attractive to family physicians, to support the provision of excellent longitudinal primary care.
VALUES
• Our work is member-driven in response to local concerns. • We engage with stakeholders to effect needed change at a community and systems level. • We execute innovative solutions grounded in practice- and research-based evidence. • We are committed to being respectful, equitable, and inclusive.

Project managers for the Victoria Division of Family Practice (VDFP) submit detailed monthly reports to the Executive Director. The detailed reports are summarized and provided to the Board of Directors in their monthly agenda package.

To increase transparency and maximize opportunities for collaboration, the Victoria Division circulates a version of the Board report to members and partners. The report provides high-level information on how the VDFP is achieving the strategic goals in our current Strategic Plan. Further information about each project is available upon request.

We welcome your questions and input. Please contact the Executive Director, Catriona Park, at cpark@victoriadivision.ca

Project / Program Status Legend:

Color Coding	Progress
	Good - Excellent Progress
	Limited - Moderate Progress
	At Risk/Significant Problems

Project / Program Name: Physician Engagement, PMH / PCN Development

Summary

***Physician Lead**: Katharine McKeen (PCN SC, Indigenous Advisory)*
***Board Liaison:** Anna Mason (PCN SC)*
***Project Manager:** Helen Welch*
***Project Coordinator**: Alyssa Beurling*

The Victoria Collaborative Services Committee (CSC) is currently implementing Primary Care Networks (PCN) in Victoria through the PCN Steering Committee and its associated structures (operations table, working groups, etc.). VDFP is a key partner in this work and is the employer for the PCN administrative team. Other VDFP staff are implementing the physician engagement strategy as part of overall PMH/PCN development.

Note: The CSC is the table where community based physicians, represented by the VDFP, collaborate with Island Health. The CSC identifies priorities common to both organizations and enables shared (lead/lead) work to make improvements in the local primary care system.

Key Project / Program Areas and Progress in Last 30 Days

Area	Details	Progress
Physician Change management / Engagement	**Physician Leads** - Physician Leads continue to meet bi-weekly. The focus is largely on PCN activities and strategies. - The Leads will meet again with the UPCC Leads in January to further discuss collaboration and an MHSU/SW Working Group. - Physician leads continue to provide leadership and advise to the all the PCN implementation activities. **Monthly Neighbourhood Meetings** - No meetings in December. **PCN in Practice (formerly Learning Labs)** - No meetings in December. **Quarterly Webinars for PCN Updates** - No meetings in December. **One-on-one Team Based Care (TBC) Development Fund** - Despite several reminders sent to members and staff offering this program to members directly the uptake is low. PCN and Division staff are preparing an updated budget forecast to potentially reallocate some of this funding to other initiatives. **General PCN Physician Engagement** - There are many family physicians involved in PCN Implementation – e.g. developing strategies for the Longitudinal Case Managers, MHSU consults, Social Workers, High Complexity Care team and the Health	

Area	Details	Progress
	Connect Registry. - As a result of PCN engagement with clinics we have also had several new members over the last few months.	
PMH -PCN Resource Updates	**Allied Health Professionals (Strategy 2)** **Social Workers (SWs) and MHSU Consultants** • To better reflect the spirit and intention of team-based care, the PCN team and Steering Committee approved a transition away from the current MHSU referral service model towards a new model of care where MHSU Consultants and SWs work together to support a group of PMHs. • Karolina is the first HC to transition to the new model, starting February 1, 2023. • Due to onboarding times, the earliest SWs can start is early February, with postings going up in early January. **Clinical Pharmacists** • The latest Clinical Pharmacist hired has started taking referrals from providers. • New patient referrals and appointments are up this quarter. **RNs** • A RN has been successfully hired at Sitka Health and initially the process seems to be going well. • The PCN team is continuing to meet with interested PMHs in person to better understand their clinical needs as well as provide overview of other available PCN services – an information session is being planned to communicate with the broader membership. **Longitudinal Case Management Team (Strategy 3)** • The program continues to grow with the next phase seeing the two existing LCMs each taking on three more PCPs (~30 more patients per LCM). • The current focus is around the referral process and whether or not LCMs can work through Community Access Intake.	
Recruitment & Retention	Follow-up on leads from attendance at Family Medicine Forum (Toronto) and St Paul's CME (Vancouver). Both conferences gave us the opportunity to speak directly to family physicians interested in practicing in BC. 60 leads were generated at FMF, and 61 leads were generated at St Paul's. Continuing social media marketing strategy to drive traffic to the islanddocs.com website. Ads are running on Facebook and Instagram. The Resident Engagement working group continues to meet. We have a robust schedule of presentations and supports for residents planned for 2023. Activities include a session on billing, ULP, joy in being a family doctor, welcome events, annual resident retreat and the annual R2 survey.	

Area	Details	Progress
Urban Locum Pilot (ULP)	**Highlights** • We have roughly 4.39 FTE across the duration of the program. • 76 host applications have been received and 201 shifts covered. **Mentorship** • A virtual meeting is scheduled with locum mentors on January 9th, where they will review and discuss the newly developed Mentor guidelines. • We hope to schedule an in-person meet and greet with mentors/locums in February.	

Next Steps

Continued recruitment to ULP.

Project / Program Name: Vic-SI Long Term Care Initiative

Summary

LTCI Co-Chair: *Dr. Margaret Manville (Island Health)* ***LTCI Co-Chair:*** *Dr. Mike Miles (VDFP)*
Board Liaison: *Dr. Dave Harrison*
LTCI Steering Committee members: *Dr. Ian Bekker, Dr. David Brook, Dr. Nikki Del Bel, Dr. Dave Harrison, Dr. Ben How, Dr. Margaret Manville, Dr. Katharine McKeen, Dr. Mike Miles, Dr. Peter Neweduk, Catriona Park, Catherine Ryan (NP), Dr. Robin Saunders*
Program Manager: *Jessica Swinburnson*

The Vic-SI LTCI launched in 2015, with an emphasis on improving medical care for all residents in care homes, through ***engaging and supporting physicians*** to meet the provincial LTCI Best Practice Expectations (BPEs), and ***facilitating collaborative system change*** with physicians, long-term care site teams, and Island Health. Our mission is to consistently meet the LTCI BPEs and make impacts in the system-level outcomes by 2020 through three key focus areas (see in Key Program Areas).

As of December 2022, the Vic-SI LTCI is active at all 37 local long-term care sites, with **72 LTCI physicians** acting as MRP for 98% of all 3,441 local residents. These 72 physicians represent approximately 68% of all MRPs practicing in LTC. 100% of residents are covered by LTCI after-hours call groups in Victoria, Sooke, and the Saanich Peninsula.

Key Project / Program Areas and Progress in Last 30 Days

Area	Details	Progress
Practice Support	Learning Series: -Events continue to be virtual, 75% of survey respondents prefer virtual -January, Pain with Romayne Gallagher -February, Hip Fractures with Trevor Janz After-Hours Call Groups: -LTCI after-hours call groups in Sooke, Saanich Peninsula, and Victoria provide coverage for ALL long-term care residents in Victoria-South Island -LTCI team have written and recorded 20 resource videos, 14 of which are directly related to after-hours call QI. The final edits of these videos has taken longer than expected and required time consuming detailed feedback. Should be live on the website soon. -Island Health has requested an extension of coverage of the Bridgeview Unit at Gorge Rd Hospital, the group agreed to extend coverage until February 2023 Resources and supports: -QI Resource Pathway Tool on LTCI website, here -LTCI resource search function available here Mentoring Program -The Advanced Long-term Care Training Program, developed and trialed with physician leads, is available for physicians interested in expanding their long-term care knowledge -LTCI physicians have been undertaking sessionally remunerated shadowing sessions to facilitate resident handover in the event of retirement or panel size reduction	
Practice Model Innovation	Summary: -Coordinated practice models are functioning at 24 of 37 local sites -Facilities continue to experience reduced capacity due to significant staffing shortages -A practice model rubric has been developed and will be trailed to help identify sites who are on the cusp of a formalized model	
Excellent Care and Quality Improvement	-The LTCI has formed a Community of Practice Working group led by Dr. Ian Bekker -The meetings are open to any interested LTC provider -The goal of the group is to create a community of practice and centre of excellence -Meeting topics have included Supportive Care Visits, Dementia Behaviours (BPSD), and Goals of Care -LTCI team working on finalizing draft guidelines that are a result of this collaborative meeting process -The Supportive Care Visit Guideline can be found here, further documents will be available soon	
Program Admin	Evaluation: -LTCI SC members have decided to recommence participation in the provincial FPSC quarterly evaluation/satisfaction survey, have been meeting with the new evaluation team regarding data issues with QI reports	

Area	Details	Progress
	-Preliminary investigations have revealed that figures and data are not accurate in these reports. Power Chart queries, and a physical chart review at a facility could not duplicate the values presented in the FPSC reports -FPSC has since suspended the data component of evaluation reports due to inconsistencies, it is expected there will be further news on this in the New Year	
	Governance & networking: - FPSC has released updated BPE matrices and released them for feedback. The LTCI SC reviewed and provided written feedback, view feedback here -The intent is for the FPSC to include the updated BPE guide in amended TOR and FTA -As of end of December, no update has been forthcoming. Most recent advice from FPSC was that the feedback is being incorporated and the matrices will be re-distributed once this is finalized	
	Project Management: -HR: -Team huddles every week -Jessica Swinburnson is now the LTCI Program Manager -Communications: -LTCI Winter Newsletter distributed, read it here	
System Coordination and Sustainability	-A Victoria LTCI Physician Workforce and Practice Planning Committee has been formed -The group aims to focus on recruitment, retention, and retirement. Read their publication here -The LTCI have been informally made aware of a significant retirement in the New Year, this with the current vacancies constitutes a significant recruitment challenge **-7 physicians have left, or have indicated they intend to leave LTC sites, to date they do not have replacements. This represents coverage for 365 residents across 18 LTC homes. Approximately 11% of the Vic-SI LTC system.** -A LTC provider Town Hall is planned for the early New Year and a recruitment event in February -LTCI Team actions to support recruitment: • meeting with Josie Terlesky re: connecting more explicitly with UBC & Island wide recruitment group • in talks with FPSC re: raising GPSC $45,000 cap • outreach to physicians who don't care for many LTC residents – How is it going, how can we help, do you have capacity to take on more? • adding contingency planning to practice model meeting agendas, how can existing MRPs stretch to accommodate? • working on a re-branded LTCI pamphlet to drop at clinics addressing how LTC has changed & how barriers to practice have been addressed • linking with the PCN, how does the PCN address/incorporate/support LTC?	

Next Steps

January 10, 2023 – LTCI Recruitment Crisis Town Hall
January 19, 2023 – PWPP WG meeting
January 31, 2023 – LTCI Learning Series – Pain
February 7, 2023 – LTCI SC Social Dinner
February 9, 2023 – LTCI PWPP Recruitment Event
February 22, 2023- LTCI Learning Series Event - Management of Hip Fractures in Late Frailty & Dementia
February 28, 2023 – LTCI Victoria After-Hours Call Group Review

Project / Program Name: Transitions in Care

Summary

Project / Program Name: Transitions in Care
Physician Lead: Drs. Laura Phillips and Lisa Veres
Board Liaison: Dr. Ami Brosseau
Project Manager: Kristin Atwood

The Transitions in Care Committee (TiC) identifies key challenges to patient transitions in order to implement and evaluate solutions aimed at improving care coordination and continuity. We have emphasized communication improvements and defined short-term goals related to effective, efficient information transfer; the creation of many possible methods of communicating to allow flexibility for different physicians' needs; and positive provider relationships through building trust and awareness. TiC operates on a quality improvement, project-based model.

Key Project / Program Areas and Progress in Last 30 Days

Area	Details	Progress
Communication Systems	A secondary provider field, which will enable auto-distribution to additional providers has been developed and will be rolled out soon. Connected Health Information Management (HIM) to LTCI to discuss (a) use of one field for facilities and (b) how to ensure up-to-date connection of LTC physicians to their patients in Cerner. HIM is tackling new provider fields in phases. LTC facilities will be included in the first phase, expected to go live at the end of November, along with new fields for oncology, pediatrics, maternity, and nephrology. I have connected HIM with the LTCI to discuss how to gather information on the LTC facility EMRs to ensure that reports distribution is working and that patients are attached to the correct facility. Medical Affairs has indicated that, contrary to their previous communication, they are not able to enable collection of back-office or direct lines for FPs to store in Cerner (so that hospital clinicians can call a physician directly instead of calling their main office line). HIM has asked for but not yet received a formal communication from Medical Affairs so that they can report back to the Chief Medical Information Officer, Dr. Mary Lyn Fyfe. I will be preparing a briefing note on this issue.	

Area	Details	Progress
	HIM has developed a Left Without Being Seen alert for patients who leave the ED after triage but before seeing a physician. TiC provided input into wording and the alert launched on December 15th. A communication went out to members in the Newsflash in December.	
Familiar Faces	2022 data for RJH and VGH was received on June 21, 2022, Cool Aid patients were identified, and patient identifiers were added to the database in preparation for sending letters to the FPs. However, Shared Care advises that there is no possibility of further funding and no possibility of a timeline extension. The FTA expired on Sep. 30. A project close-out meeting was held, and both the final evaluation and final report are in progress. We are working with Island Health to determine the best way to sustain remuneration for ED physicians involved in care conferences after the project's conclusion. Patient Flow was unable to find a solution and agreed that this should be brought to the CSC. We presented and Leah MacDonald has offered to assist with business case planning for operational funding. We have met twice, and she is working with someone in Contracts to ensure all funding possibilities with the Ministry of Health have been explored.	
OAT (Suboxone) Starts in the ED	We received $15,000 for early engagement regarding suboxone follow-up and have reached out to core stakeholders to engage for initial problem description. We have completed a literature scan of success factors for initiating suboxone in the ED and our patient journey map. At our follow-up event in June 2022, we identified possible quality improvements to further develop into a full-scale proposal. We have further developed our literature review as requested by stakeholders at the June meeting and received additional patient input. A UBC FLEX student is currently completing the literature review and will also be reaching out to three potentially similar projects at St. Paul's Hospital, Kelowna General, and Cranbrook. Work on the full project proposal has commenced. The workplan has been reviewed by MHSU, Substance Use Rapid Follow-up (SURF) team, ED, and one addictions medicine physician. We are meeting with the medical director for the Rapid Access Addictions Clinics (RAAC) in January.	
Tips and Tricks	Last Spring, we placed a description of Tips and Tricks in the UBC FLEX project catalogue and three students have been in contact requesting to work on the project. The students created three new tips and updated the existing ones. There are a few remaining edits before we can re-issue the documents.	
Patient Summaries – Sustainability and Spread	Continuing to meet with the Digital Health Strategy (DHS) and Canada Health Infoway about the best approach to supporting this work in BC. Lisa and Laura's time is being covered by the Digital Health Strategy at this time. We met with the DHS, PHSA, and Shared Care for an update on Dec. 2.	

Area	Details	Progress
	Work on patient summaries at the provincial level is on pause until the provincial health IT/interoperability RFP identifies a lead proponent (goal is Feb. 2023). At that time, they will be reaching out looking for pilot communities to test data distribution and repositories. Patient summaries is not one of the initial pilots, but they expect it to be part of the pilot phase at some point (they have adapted a pilot project that St. Paul's was already developing as their first initiative, followed by a pilot focused on MRI requisitions). The timeline for deploying the entire solution is 3 years. Lisa and Laura will continue to be part of the DHS clinical advisory group for both the DHS and the work on the national patient summary standard being undertaken via Infoway. Regarding the latter, Infoway has encountered difficulties with EMR readiness to deploy the standards and there is a "projectathon" scheduled for March 2023 to help them develop the technical infrastructure required. We are working on collating the results of our past projects into a manuscript for publication, with co-authors from Reichert and Associates who produced the case study for the GPSC. All authors have reviewed the manuscript and provided edits.	
Patient Summaries – Collaboration with VIHA	EMR Connect provides a monthly data feed to update on the number of patient summaries being sent, so that we can continue to track long-term sustainability. Alyssa is reviewing the monthly data provided to compile an ongoing monitoring report.	
Long Term Care Transitions	There is one piece of outstanding work from the original LTC Transitions project: Facilities Database – reformatting into SharePoint site (Island Health will provide technical support). Island Health has created the database and is ready to go live. LTCI has reviewed the database and the accompanying online text and provided input. We are now waiting for Island Health to actually implement the database (no progress in December).	
Coordinating Complex Care – Heart Failure	We have provided substantial input into the Heart Failure Unit nursing discharge tool. The HFU is trialing the tool with patients and tracking FP names for follow-up. We have distributed patient surveys to the ward. We are building toward a collaborative approach to training hospital-based MRPs to ensure that they provide medication rationale information routinely when completing summaries - we have not yet received a response. The Heart Failure Unit has created an admission notice that invites FPs to fax back a form with a patient's scheduled follow-up appointment (if possible) so that HFU staff can remind patients of when they are to see their FP upon discharge. The nursing staff have approved the form, but they have not had a chance to deploy it because the admissions to the HFU have been low.	

Area	Details	Progress
	We are saddened to report the passing of our patient partner, Jim Lyster, who died of heart failure in September 2022. Our second patient partner also needs to step away from the project due to caregiving responsibilities and her own poor health, and in late December our caregiver representative also indicated that she is unable to continue. As this project is set to close in March 2023, we will not be attempting to recruit new patient or caregiver partners to the group. The working group has decided to end the project with a culminating education event for FPs at which the many services available for heart failure patients can be showcased. The event has been confirmed for April 3, 2023, at the Hotel Grand Pacific. We are planning an in-person, Dine and Learn style event. The Dine and Learn Committee declined to include this event in their annual CME application so we will be applying for CME on our own. To date, Home Health Monitoring; Hospice's Serious Illness Conversations Tool team; BC Family Caregivers, Better at Home, Pathways, Palliative Care, Hospital at Home, and PSP Panel Management have confirmed their interest and availability. The Heart Function Clinic has confirmed interest, but they are in the process of hiring a new Director so cannot confirm availability. We have also contacted the Heart and Stroke Foundation and are awaiting a response.	
Specialist Referrals	TiC decided in June to pursue a new project related to building strong relationships with specialists, in response to the loss of connection between colleagues that has grown over the last few years and to the issue of re-referrals in particular. Shared Care approved a $25,000 EOI and funds have been received. We have received input from both SI and VDFP Boards. We have found a specialist co-lead, Dr. Gaylene Hargrove (nephrology). The co-leads requested that an additional SP and FP be added to the planning group, and we successfully recruited Drs. Patrizia Moccia (dermatology) and Chris Dowler (FP at Shoreline). We were not able to find a date to meet in December and we are struggling with scheduling in January as well, so the launch of the work will likely be delayed until February.	
Other	We are providing project support to Dr. Anna Mason for her FEI-funded specialist engagement project. Dr. Mason's FLEX student, Frieda Hodgins, completed 37 interviews and an additional 22 specialists provided brief comments on an online forum. Analysis of specialist, patient, and system impacts is completed, and write-up is in progress. Dr. Mason received additional funding from the FEI and has engaged with a videographer to create an animated video to summarize findings. The script is in development. A draft manuscript summarizing key findings has been shared with Dr. Mason and Frieda and we are awaiting feedback. We continue to discuss the idea of an Island Health co-chair and are approaching Dr. Leah MacDonald about the role on January 5th.	

Next Steps

Familiar Faces: Final report (in progress) and continued discussion with Island Health re: sustainability.
Suboxone: Engagement meeting with RAAC, work on full proposal
Patient Summaries: Continue to participate in Infoway and DHS meetings as they arise
Long Term Care Transitions: Confirm all aspects of database maintenance have been transferred to Island Health/LTCI and close project
Coordinating Complex Care: Collaborative training for medication rationale in discharge summary, event planning for April 2023
Specialist Referrals: Planning for engagement activities