Victoria Division of Family Practice
An FPSC initiative

MONTHLY PROJECT REPORTS TO THE VICTORIA DIVISION BOARD OF DIRECTORS

Ending
January 31, 2023

Mission
Happy Doctors, Healthy Communities
Vision
Family medicine in Victoria is fulfilling, sustainable, and attractive to family physicians.
Approach
• Affirming the value of family doctors by amplifying their voice and experience. • Committing to being respectful, equitable, and inclusive. • Ensuring our work is member-driven in response to local concerns. • Engaging with stakeholders to effect needed change at a community *and* systems level. • Executing innovative solutions grounded in practice – *and* research-based evidence.

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

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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. - Dr. Chris Fraser is stepping back from his role, but has found a replacement in Dr. Chris Stuart, a fellow colleague at Cool Aid. Helen and the PCN team have met with Dr. Stuart for onboarding. - Physician leads continue to provide leadership and advise to the all the PCN implementation activities. - A draft TOR is currently under development to give further structure to the PCN Lead roles (e.g., eligibility, length of term, and succession planning) **PCN in Practice (formerly Learning Labs)** - PCN staff are busy doing one on one office visits to update members on all things related to the PCN. There is conversation ongoing about how to integrate other Division information in these meetings. **Quarterly Webinars for PCN Updates** - Update Event will be held in February with Dr Anna Mason leading the meeting. Other physician leads will sit on an informative panel. **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 exploring how to get funds to physicians more easily via a survey to	

Area	Details	Progress
	PCN members that asks a few simple questions to confirm that: physicians are working towards the PCN attributes, staying on top of PCN information and resources, and that they have/or plan to spend 6+ hours of time on eligible activities. **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 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** • The first cohort of 4 PMHs has been identified, and they will work with one MHSU Health Consultant and one Social Worker (i.e., the dyad). • Next steps are to onboard first cohort and dyad, develop and engage cohorts 2-7, and recruit and onboard the remaining 2-7 dyad teams. **Clinical Pharmacists** • In implementation phase with active evaluation occurring • ~20 PCPs made referrals between April-September 2022 **RNs** • Six additional RNs have been approved for Y2. • The PCN team continues to engage with interested PMHs that have expressed interest in an RN in Practice • The PCN staff team will continue to support the hiring of 3 RN in 2023. The clinic identified are: Richmond Medical, Ross Bay Health and Saanich Plaza Medical **Longitudinal Case Management Team (Strategy 3)** • 11 FPs are now making referrals to two case managers (soon to be three) • Types of services include advocacy, navigation, referrals, RAI assessments, and emotional support	
Recruitment & Retention	We have submitted our funding report and 2022-23 funding application for the Regional R&R collaboration. Highlights of the application include funding for staff support (R&R coordinator), conference attendance, red carpet welcome and increase social marketing. Plans are underway for the Resident Engagement Session (retreat). The first annual event was held in Victoria in 2022 and will be expanded this year to include all Residents on Vancouver Island. Assuming our funding request is approved we will host the event at Crown Isle in May. Details TBC The funding received for WIC stabilization ends March 31, 2023. Staff are	

Area	Details	Progress
	actively working with the MoH to ensure we continue to have stable WICs in our region. Currently the messaging from the MoH is that a plan is coming before March 31, 2023 and it will be provincial solution. We will continue to push for more details asap.	
Urban Locum Pilot (ULP)	**Highlights** • We have roughly 3.33 FTE across the duration of the program. • 77 host applications have been received and 201 shifts covered. **Mentorship** • The first mentor meeting was held on January 9th where mentor guidelines were reviewed • An in-person meeting for mentors/locums is scheduled for February 21 at the office. There have been challenges with locum attendance/RSVPs, so staff will check in on numbers next week and do targeted follow-up if needed. • Plans are underway for a March 27 mentorship meeting for locums on Community Supports: what's available, how to access, and when to use (e.g., RACE, MOAs, Pathways, Pharmacists/Pharmanet, etc.). • Mentors have been invited to speak to examples of when and how they utilized these supports.	

Next Steps

Continued recruitment to ULP.

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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 January 2023, 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, Dementia with Romayne Gallagher- 185 registered -February, Hip Fractures with Trevor Janz – 100 registered 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 have 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 (ALC beds) at Gorge Rd Hospital again, the group agreed to extend coverage until January 2024 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	

Area	Details	Progress
	-LTCI physicians have been undertaking sessionally remunerated shadowing sessions to facilitate resident handover in the event of retirement or panel size reduction -Planning for a significant number of shadowing sessions with physicians new to LTC to support the retirement of a FP with a significant panel size	
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 to help identify sites who are on the cusp of a formalized model to help inform coordinator actions	
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 -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 -Vic-SI LTCI has opted in to help FPSC check data accuracy	
	Governance: - 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 January, 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 -The LTCI held a leadership dinner October 27th attended by LTC physician and facility leadership. Read the one-pager here -A LTC Town Hall was held Jan 10th attended by 25 FPs to raise awareness and brainstorm solutions to upcoming recruitment challenges	

	Project Management: -HR: -Team huddles every week -Jessica Swinburnson is now the LTCI Program Manager -Team is also supported by Gillian (contractor 28 hrs/week), Sunita (admin 19 hrs/week), Fiona (consultant 10 hrs/week) -Communications: -LTCI Winter Newsletter distributed, read it here -LTCI website with resources and learning series recordings here: https://vicsi-ltci.ca/	
	LTCI &PCN: -Had a preliminary meeting with Nancy to discuss integration of LTCI & PCN. We will discuss having an LTCI rep at some of the PCN meeting tables to bring a focus to LTC as a component of primary care -Had a meeting with Stan and Gemma re: how LTC fits into the priority referral process. Have asked Gemma to link with LTCI if any unattached patients are destined for LTC as most LTC sites have a practice model in place with an existing MRP attachment rota	
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 -Current vacancies at the Priory, the Heights, and the Gorge LTC homes are the current focus of the group -The LTCI have been informally made aware of a significant retirement forthcoming, 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 occurred Jan 10th and a recruitment event in February 9th -LTCI Team actions to support recruitment: • meeting with Josie Terlesky re: connecting more explicitly with UBC & Island wide recruitment group • 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?	

	Saanich Peninsula -SPWG met in January to reconfirm purpose and mission of the group -Group is planning clinic lunches in February to gauge interest in LTC	

Next Steps

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. LTC facilities were included in the first phase, expected to go live at the end of November, along with new fields for oncology, pediatrics, maternity, and nephrology. HIM would like to proactively link LTC patients to their facilities so that this information is already in Cerner when the patient is admitted, and has requested a patient census from all LTC facilities in order to create this link. I created a memo to LTC directors explaining the value of providing this information and how it will be used and handed it off to Jessica to distribute via LTCI. 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 received	

Area	Details	Progress
	a formal communication from Medical Affairs that implied that the data elements do, in fact, exist and that there is a mechanism for consent – contrary to what we have been told for years. HIM is continuing to investigate.	
Familiar Faces	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 confirmed that MoH will not provide sessional funding for this work and Leah is now reaching out to the ED clinicians to discuss implications for adding this to their Island Health contract.	
OAT (Suboxone) Starts in the ED	Work on the full project proposal has commenced. The workplan has been reviewed by MHSU, Substance Use Rapid Follow-up (SURF) team, ED, the Rapid Access Addictions Clinics (RAAC), and Addictions Medicine. The workplan proposes two streams: QI that can be implemented regardless of whether a program to initiate suboxone microdosing in the ED is feasible, and a trial of ED initiation that would only move forward if an assessment (built into the project) showed that it would be feasible. The work plan and budget for the former is complete and in progress for the latter, with an aim to present both to the TiC Steering Committee Meeting on Feb. 6. We have a UBC FLEX student who has been conducting key stakeholder interviews with existing ED initiation projects in Interior Health and Vancouver Coastal and is writing a brief trial development plan that will support assessing feasibility.	
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. Alyssa has completed the outstanding work and the Tips are ready to re-issue as soon as we have the capacity to do a final review and prepare a communication.	
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. 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	

Area	Details	Progress
	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, and Laura will be meeting with Telus to discuss use case scenarios sometime in the next month. 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 monitoring monthly.	
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 January).	
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 and have begun to receive tracking data from the ward (finally!). We are building toward a collaborative approach to training hospital-based MRPs to ensure that they provide medication rationale information routinely when completing summaries. The CPOE team is not yet ready to create this training has asked us to keep in touch every few weeks so that it doesn't fall off the radar. 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 and it is in use. 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 32023, at the Hotel Grand Pacific. We are planning an in-person, Dine and Learn style event, including CME. Home Health Monitoring; Hospice's Serious Illness Conversations Tool team; BC Family Caregivers, the Heart and Stroke Foundation, Better at Home, Pathways, Palliative Care, Hospital at	

Area	Details	Progress
	Home, the Heart Function Clinic (with Pharmacy representation) and PSP Panel Management have confirmed their availability. Held a separate meeting with PSP regarding how their action plan/panel management opportunities could give FP attendees a practical next step for putting what they learn at the session into practice. Our specialist co-lead, Dr. Elizabeth Swiggum, sits on the new Sharee Care Chronic Disease Community of Practice (CoP), and she has encouraged us to explore whether there are any funding opportunities through the CoP that would allow us to address a number of potential future directions that have emerged from the project.	
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. Our EOI working group (2 specialists and 2 family physicians) met in January and a preliminary workplan has been developed. The working group requested that the project launch with anonymous opportunities to engage due to the ongoing tensions and concerns about negative consequences for existing FP-specialist relationships, and Mel and I are working on engagement materials. MOA engagement was identified as a key part of this work. A clinic manager from Pulse Cardiology and two MOAs from Shoreline have expressed interest in participating in working group meetings.	
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 video is in development and Anna has engaged with Doctors of BC regarding consistency of messaging. At our Feb. 6 Steering Committee meeting we will welcome Dr. Ami Brosseau as our new VDFP Board Liaison and acknowledge Dr. Leah MacDonald as our new Island Health co-chair. This necessitates revising the existing Terms of Reference and new Tor are up for approval at the Feb. 6 meeting. We will also sadly be saying goodbye to long-standing member Dr. Jason Wale, who has been with TiC since 2015. Jason is starting a new position as a medical director within the Ministry of Health in March. Thankfully he is already recruiting his replacement!	

Area	Details	Progress
	We continue to monitor and push for progress on Island Health's work to revise the LTC placement form. In December we were informed that due to a lack of manager capacity, Island Health would not begin the work until January. Inquiries into whether the work began as planned have not been responded to.	

Next Steps

Familiar Faces: Continued discussion with Island Health re: sustainability.
Suboxone: Review full proposal at TiC SC and pending approval submit to VDFP and SIDFP Boards
Patient Summaries: Meeting with Telus re: use cases in preparation for the next Infoway meeting in March
Long Term Care Transitions: Confirm all aspects of database maintenance have been transferred to Island Health/LTCI and close project
Coordinating Complex Care: Event planning for April 2023, PDSA monitoring of admission fax and discharge checklist, exploring whether there are opportunities for further work through the CoP
Specialist Referrals: Online/anonymous engagement launch, MOA meeting, scheduling of initial focus groups