Victoria
Division of Family Practice
An FPSC initiative

MONTHLY PROJECT REPORTS TO THE VICTORIA DIVISION BOARD OF DIRECTORS

Ending
February 28, 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

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. **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** - The PCN hosted a virtual update webinar on February 21st. There were 36 FPs in attendance. The session was informative and well received. **PMH/PCN Development -One on One TBC Fund** - The PCN staff team is spending time in clinics helping to implement the MHSU/SW Team based care strategy. Physicians involved in these meetings can be compensated under this fund. **Locum Compensation Discussion** - A locum compensation discussion was hosted on January 31st, and had 17 FPs in attendance, representing both locums and FSFPs. Agenda included anonymous polls, and space for group discussions on locum compensation, current and upcoming pay structures, and how hosts and locums can navigate challenges together. The meeting ended with an action to send a survey to the larger membership. Alyssa met with two physicians who attended the session to get feedback on	

Area	Details	Progress
	structuring the survey questions. The survey is drafted and in final review stages before sending out. **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** • Ongoing engagement with cohort 1 about team/service integration/implementation. • Engagement with upcoming cohort 2 and 3 clinics **Clinical Pharmacists** • There is a small increase in uptake in CPs service from last quarter • The PCN is exploring option for CPs to go into clinics/service providers to look for eligible patients **RNs** • RNs in practice have been approved for: o Richmond Medical Clinic o Saanich Plaza Medical o Ross Bay Medical **Longitudinal Case Management Team (Strategy 3)** • The program has been expanded to include two new PMHs and more FPs within PMHs • An increase from 11 FPs to 26 FPs/NPs over the past month • Types of services include advocacy, navigation, referrals, RAI assessments, and emotional support	
Recruitment & Retention	Funding for the Regional R&R strategy has been approved. Highlights of the work include funding for staff support (R&R coordinator), conference attendance, red carpet welcome and increase social marketing. We will attend 5 recruitment conferences in Canada this year. Our regional Social Media marketing campaign will resume on March 1. 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. The event has moved to the Parksville area and currently we have 19 residents registered to attend. The funding received for WIC stabilization ends March 31, 2023. It is our understanding the Dr Sari Cooper is reaching out all the clinics directly with details around continuing with the funding or pivoting to a new solution.	

Area	Details	Progress
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/locum in-person meeting was held on February 21 at the office. There were 3 mentors and 5 locums in attendance, and the agenda included 30 minutes for networking amongst attendees. • The monthly locum meetings will transition to a space for mentor-focused meetings/engagement. Most meetings will be virtual, with more informal social-style opportunities every 3-4 months. • The mentor meetings will begin with a series on community resources/supports; with the first meeting being on Pathways on March 27, led by Dr. Kathy Dabrus.	

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 February 2023, the Vic-SI LTCI is active at all 37 local long-term care sites, with **71 LTCI physicians** acting as MRP for 98% of all 3,441 local residents. These 71 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: -January, Dementia with Romayne Gallagher- 185 registered -February, Hip Fractures with Trevor Janz – 164 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 -The annual Victoria AHCG review event occurred in February 28. See the PPT here. Group reviewed stats (volume, reason for call etc.) collated from the dispatch centre. No major changes to reasons for call or volume, anecdotal shifts in quality of call due to LTC home staffing issues. LTCI is exploring current dispatch scripts to see if opportunity to prompt callers to be more organized. Exploring making sections of the SBAR mandatory. Drafting a note to all call group members to remind them to be extra diligent in communicating with callers. 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 -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 goal of the group is to create a community of practice and centre of excellence -Topics have included Supportive Care Visits, Dementia Behaviours (BPSD), and	

Area	Details	Progress
	Goals of Care -LTCI team working on finalizing draft guidelines that are a result of these collaborative meetings -The Supportive Care Visit Guideline can be found here, further documents will be available soon -Next meeting in March, topic is deprescribing	
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 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 February, 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 -Next LTCI SC meeting April 4 with a budget focus	
	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 -LTCI team has been meeting with the PCN team about Luther Court CHC providing medical care to the LTC residents where they are co-located. Read the SBAR here -The goal of meeting is to better understand barriers to Luther court CHC providers being MRPs, and then how to remove these barriers -Coming up against push back from individuals within the PCN team and Island	

Area	Details	Progress
	Health who do not agree that LTC is primary care	
System Coordination and Sustainability	-The LTCI Physician Workforce and Practice Planning Committee aims to focus on recruitment, retention, and retirement. Read their publication here **-The LTCI is seeking MRP coverage for 365 residents across 18 LTC homes. Approximately 11% of the Vic-SI LTC system.** -A LTC provider Town Hall occurred Jan 10th to brainstorm solutions and raise awareness -A LTC Information (recruitment) event was held Jan 9th. Attended by 27 physicians not currently affiliated with LTC -LTCI team are following-up one-on-one with new recruits to determine next steps ○ seven meetings have occurred/scheduled ○ two have agreed to sign up to the LTCI and take panels ○ two are interested later on in the year when off parental leave ○ one will start LTC locuming while awaiting confirmation of partner's employment ○ two meetings yet to occur -LTCI Team actions to support recruitment: • met with Josie Terlesky re: connecting more explicitly with UBC & Island wide recruitment group. LTCI invited to speak at May resident retreat • facilitating a resident day in September at the Summit LTC home for R1s and R2s (50ish attendees) • facilitating work on a new LTC resident elective • 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 addressing how LTC has changed & how barriers to practice have been addressed • linking with the PCN, how does the PCN address/incorporate/support LTC? • looking at Luther Court CHC and Health Point as opportunities to collaborate and coordinate medical care <u>Saanich Peninsula</u> -SPWG met in January to reconfirm purpose and mission of the group -Group is planning clinic lunches in the Spring to gauge interest in LTC	

Next Steps

March 9 – Community of Practice WG

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 which Jessica has distributed. 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 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 and expects an update in April.	
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 discussing the implications of adding this work to the existing EDP contract – waiting for a response from the ED physicians.	
Transitions for Opioid Users ("Suboxone/OA	Work on the full project proposal is complete and the proposal has been submitted to the Boards for approval.	

Area	Details	Progress
T project")	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. 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 have been republished and advertised via the Newsflash.	
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. 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 met with Telus to discuss use case scenarios on Feb. 23. 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. Edits from co-authors have been completed and we are moving on to finalizing the tables and figures.	
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 February).	
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 continue to receive tracking data from 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. The CPOE team is not yet ready to create this training but has asked us to keep in touch every few weeks so	

Area	Details	Progress
	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 3, 2023, at the Hotel Grand Pacific. We are planning an in-person, Dine and Learn style event. We were successful in our CME application and planning continues for the event. The invitation went out on Monday Feb. 27 and at the time of writing 35 people were registered (we are hoping for ~50). We were successful in getting a timeline extension for this work which will allow us to extend into the summer to wrap the project.	
Specialist Referrals	The working group requested that the project be launched with anonymous opportunities to engage due to the ongoing tensions and concerns about negative consequences for existing FP-specialist relationship. An engagement tool has been created and we will review it with the working group in March. MOA engagement was identified as a key part of this work. We have met with MOAs from Rebalance and have a meeting scheduled in early March with MOAs from Shoreline. We continued to support the FEI project initiated by Anna Mason. Currently the findings from that research are being translated into an animated video, and being written up for conference presentations and other forms of knowledge translation.	
Other	At our Feb. 6 Steering Committee meeting we welcomed Dr. Ami Brosseau as our new VDFP Board Liaison, Dr. Ali Tafti as a new representative for the ED, and Dr. Leah MacDonald as our new Island Health co-chair. We revised the existing Terms of Reference. 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. After multiple inquiries into whether the work began as planned we have been informed that the work is waiting on a meeting between Caitlin Davies and Marg Manville in Island Health.	

Next Steps

Familiar Faces: Continued discussion with Island Health re: sustainability.
Opioid Users: Assuming Board approval, send proposal to Shared Care
Patient Summaries: Complete manuscript
Long Term Care Transitions: Confirm all aspects of database maintenance have been transferred to Island Health/LTCI and close project; continue to push for improvements to LTC placement form.
Coordinating Complex Care: PDSA monitoring of admission fax and discharge checklist, heart failure event on April 3
Specialist Referrals: Online/anonymous engagement launch, second MOA meeting, scheduling of initial focus groups, reach out to PCN staff re: including engagement about this issue in their one-on-one visits