Victoria
Division of Family Practice
An FPSC initiative

MONTHLY PROJECT REPORTS TO THE VICTORIA DIVISION BOARD OF DIRECTORS

Ending
August 31, 2023

Mission
Happy Doctors, Healthy Communities
Vision
Family medicine in Victoria is fulfilling, sustainable, and attractive to all family medicine-trained physicians in their various roles.
Approach
• Affirming the value of all physicians trained in family medicine 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	Staff are starting work on the new initiatives identified by the Board for 2023-24. **MOA Network** • An EOI for MOA Network Working Group participants was sent to all clinic administrative staff of PCN CLFP clinics, and members have been selected: ○ The WG will consist of two Office Managers, three MOAs, Dr. Lush as FP Lead, and project staff. • Orientation and review of the project outline is scheduled with new clinic staff WG members on September 5. **Supporting non-LFP Family Physicians** • Kristen Atwood will be the lead for this project. **Onboarding new VDFP members** • We will pull a team of staff together to strategize this focused piece of work this summer.	
Recruitment & Retention	The level of interest from new FP continues to be steady. We are currently working with physicians from Canada, US, UK and are supporting one of our new PRA BC physicians from Libya. We are also seeing an increase in the number of people looking for Clinical Observership, we have advertised the opportunities in the Newsflash. The Islanddocs website refresh is complete you can view the new website here: Islanddocs.com The REWG annual survey is complete. Based on the survey results we are	

Area	Details	Progress
	exploring the idea of a Division Sponsored Business of Family Practice learning series that will either facilitate residents to attend a series of sessions presented by either UBC or HIVE. We are planning a retirement planning session for October. FPs from across Vancouver Island who are retiring in the next 5 years will be invited to the virtual event. Based on conversations at the CSC table we will be adding a FP Maternity page to our job posting and will be reaching out to clinics and physicians currently providing maternity care to see if we can recruitment more people this area.	
Urban Locum Pilot (ULP)	**Highlights** • Work is underway to determine if the pilot can continue after the planned end date of June 2024. The hope is that existing underspent physician funds can be used to extend host/locum payments, while additional administrative funding can be requested from FPSC. More detail about the possibility of an extension will be brought to the VDFP Board in October. **Mentorship** • The last monthly locum mentor meeting was hosted on August 28th and had five new locums in attendance, along with three mentors. Pilot feedback • Project staff have received valuable feedback from mentors and locums in the past couple of weeks: o There is a need for more communication to locums regarding inbox management responsibilities and addressing emails that come in after-hours. o The indirect/direct care ratio is causing challenges with timing. Staff is exploring the impacts and requirements around the ratio.	

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. Sarah Chritchley*
LTCI Steering Committee members: *Dr. Ian Bekker, Dr. David Brook, Dr. Sarah Chritchley, Dr. Nikki Del Bel, 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 August 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 70% 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: - September, Osteoporosis with Jennifer Carefoot -October, Common Dermatological Conditions in LTC with Dr. Matthew Galas -November, Ethics in LTC -Sessions are recorded and are viewable on the website here 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 -The Victoria group has agreed to operate as back-up for the Saanich Peninsula Group on a trial basis. In the event the dispatch center can't reach the SP on-call, the call will be directed to the Victoria on-call. This process went live in August with no issues so far. Resources and supports: -QI Resource Pathway Tool on LTCI website, here -LTCI resource search function available here -After-Hours Training Modules available here. These modules provide an overview on how to prepare for a call with the goal of supporting clear communication and informed decision-making Mentoring Program -LTCI physicians have been undertaking sessionally remunerated shadowing sessions to facilitate resident handover. The availability of remunerated shadow sessions and LTC locums has made it much easier to recruit newer to practice physicians to LTC	

Area	Details	Progress
Practice Model Innovation	Summary: -LTCI team have undertaken a comprehensive practice model scan focusing less on the practice model title and more on the structure and functioning of the homes. 34 of 37 sites have structure and organization in line with a practice model -LTCI team will be focusing more on the components of practice models, less on the titles. Focus will be on strengthening the components with the aim to promote LTC physician sustainability. New LTC physicians also practice in other areas, increasing the need for site level organization and practice model components such as regular scheduled visits and cross coverage -Find an example of a communication tool being implemented at sites here -LTCI team works with sites to support regular quality meetings where the interdisciplinary team reviews the best practice expectations -View the BPE commitments here	
Excellent Care and Quality Improvement	-The LTCI has a Community of Practice Working group led by Dr. Ian Bekker. LTC physicians meet to discuss common LTC clinical concerns and aim to reach a common approach -The goal of the group is to create a community of practice and centre of excellence in LTC -Topics have included Supportive Care Visits, Dementia Behaviours (BPSD), Goals of Care, Polypharmacy, and Skin -LTCI team working on finalizing draft guidelines that are a result of these collaborative meetings - In-person events are scheduled for October 4th and November 20th -Published documents are available here. A binder of COP documents will be distributed to each care home as a resource	
Program Admin	Evaluation: -FPSC announced the formation of a provincial group to help guide the refining and re-launching of the provincial LTCI QI process. Jessica Swinburnson & Dr. Ian Bekker joined the group and attended one meeting. This group has now been placed on hold indefinitely pending the launch of the LTC LFP -In recent discussions re: LTC LFP LTCI physicians advocated for inclusion of time categorization mirroring the BPEs (ie, proactive visit, attendance at care conferences) to inform future provincial LTCI evaluation activities. LTC LFP could be a valuable source of data to inform LTCI activities	
	Governance: -FPSC released updated BPE matrices and released them for feedback. The LTCI SC reviewed and provided written feedback, view feedback here. -In April the FPSC announced the Task Group was on hold until further notice -Doctors of BC & Dr. Jaron Easterbrook requested an electronic copy of the new LTCI brochure to use as a template for the brochure in works for the provincial after-hours call group -The LTCI Steering Committee sent a letter to DofBC president Dr. Joshua Greggain & BCFDs ED Dr. Renee Fernandez querying how the LFP Payment Model will support participation in the LTCI and incentivize the LTCI best practice expectations. In response to this letter, Dr. Fernandez responded that	

Area	Details	Progress
	member(s) of the LTCI Steering Committee could expect someone from the Primary Care Compensation Working Group to reach out about organizing a conversation. Dr. Sari Cooper reached out to Dr. Margaret Manville and a meeting was scheduled. In preparation for this meeting, Vic-SI LTCI brought together any interested and available LTCI physicians to provide feedback on the proposed incorporation of LTC into the LFP payment model. From this meeting a one-pager of talking points was created and used to inform Dr. Manville's discussion with Dr. Cooper. Dr. Manville met with Dr. Cooper who was very receptive to the issues raised and iterated very clearly that the intention is to support LTC gains made to date, and they are being very careful to support and not undermine any existing programming. Dr. Cooper was provided with data that speaks to the successes of the Vic-SI LTCI program and a copy of the talking points document. Dr. Cooper indicated these would be brought back to the Steering Committee for discussion -FPSC indicated that the LTC LFP will still be considered fee for service and not a contract, so the LTCI funds can still be used to remunerate physicians on this payment model when the time comes for participation in LTCI QI/attachment to LTC residents	
	Project Management: -HR: -Team huddles every week -Team is also supported by Gillian (coordinator 28 hrs/week), Sunita (admin 19 hrs/week), Fiona (consultant 10 hrs/week) -Cherie Wheeler is returning from parental leave September 14th at 10 hours per week -Communications: -LTCI Newsletters available 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 & Island Health about Luther Court CHC providing medical care to the LTC residents where they are co-located. Read the SBAR here -These meetings were successful, MOH has indicated there are no contractual barriers to CHC providers assuming care of LTC residents. One panel of LTC residents is now cared for by the CHC as of July. The eventual aim is for all resident care to eventually be provided by the co-located CHC -LTCI is working with FPSC to better understand how the stipend ($225/resident/year) interacts with physicians providing medical coverage on a contract instead of fee for service. Conversations with Jillian Wong indicate there is no barrier to providing payments if there is no overlap with what the contract is paying for. Further work needs to be done to better understand this impact	
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 found coverage for 410 residents (12% of system) in LTC after the retirement of a prominent LTC physician	

Area	Details	Progress
	-Vic-SI LTCI has recruited 10 new providers into LTC -A Welcome BBQ was held August 13th as a social opportunity to welcome new LTC physicians and their families into the robust South Island LTC community -Vic-SI expects that recruitment and retention will remain a large focus of our activities going forward - Work will focus on recruiting longitudinal FPs earlier by increasing resident engagement through new LTC electives, resident days at LTC homes to experience LTC, and continued focus on mentoring opportunities -LTCI will also continue to advocate to FPs via clinic lunches and brochure (here) distribution with the message that LTC has changed. Program supports and site organization have helped address barriers to practice making it easier to incorporate LTC into a full-service family practice -The LTCI team will continue efforts to increase organization and improve structures and communication at LTC homes so practicing in LTC is a sustainable component of a longitudinal family practice Saanich Peninsula -Group is planning clinic lunches in the Fall to gauge interest in LTC -Group will be reconvened this Fall to discuss SP AHCG results, specifically looking at opportunities for QI around common reasons for call in the community	

Next Steps

September 19: LTCI Steering Committee Meeting September 20: Resident Academic Half-Day at The Summit September 27: LTCI Learning Series: Osteoporosis

Project / Program Name: Care (Service) Transitions

Summary

Physician Leads: *Laura Phillips, Leah MacDonald, and Lisa Veres*
Board Liaison: *Ami Brosseau*
Project Manager: *Kristin Atwood*

Program summary in development.

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. LTC facilities were included in the first phase. There are still numerous technical issues to work out. Concerns about results distribution for those working in multiple locations have been referred to CT. We coordinated with HIM to create a strategy for informing these physicians of the only currently viable solution (to use "cc clinic" to ensure results go where the patient is if different from the physician's primary location). We have revised the Primary Location Form and created web content to increase awareness and sent out a communication to our members. Back office numbers will be included in the first release of a new provider database. This release is currently in testing and go-live is expected late October.	
Transitions for Opioid Using-Patients (OUP)	Shared Care approved the proposal for full funding ($350,000 over two years). Sara Healing was hired as a part-time project manager and attended the Aug 30 working group meeting. The WG settled on three areas following the patient journey: 1) Improvements to patient care in the ED: up-triage, better SURF referral, better use of addictions medicine SW, feasibility assessment of OAT-in-ED 2) Navigation and support during transitions: working with community agencies (Moms Stop the Harm, Umbrella) to develop peer support/ buddy program ('rent a mom') to be with patients during ED encounter and help them bridge the gap to community follow-up 3) Identifying champions in the community and supporting them to take on long-term follow-up of OUP who lack primary care supports We are in the process of developing workplans for each of these areas.	
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. 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. Tables, figures, and final edits have been completed and the manuscript is being reformatted for submission to the journal.	

	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 and has surveyed FPs and hospitalists about their creation and use of patient summaries under new funding models. Based on survey results Alyssa has created a communication for members which is being revised based on feedback from Lisa/Laura/Leah.	
Long Term Care Transitions	Island Health has implemented the database and Mel has completed a communication for ED physicians. Allied Health have asked for additional information (e.g., OT) about the facilities. Jess confirms that LTCI has capacity to gather this information over the summer and Mel and Jess are collaborating. LTC Placement Form: We continue to monitor and push for progress on Island Health's work to revise the LTC placement form. Island Health's solution is to have nursing staff complete the form rather than a FP. This has been approved and will launch sometime this fall. Jess and I have a meeting with the Island Health team in September to discuss additional changes to the language of the form.	
Coordinating Complex Care – Heart Failure	We are supporting the Supportive Cardiology Project (via project manager Terry O'Brien) to complete an EOI for the next phase of their work. This EOI will be presented at the September Steering Committee. The EOI work will involve: • Recruiting a small number of FP offices to trial a PSP action plan implementing the cardiology tools • Engaging with Cardiac Services BC as a place through which provincial spread might occur (the goal being that the full spread and translation project will be held by CSBC) • Engaging with UBC to start the conversation about how to translate the tools not just in terms of adding additional languages, but also in terms of reviewing the concepts for cultural appropriateness during translation We are completing our final report and the evaluator is completing the final evaluation report.	
Specialist Referrals	Our Health Quality Council summer intern student, Vanessa McLennan, has completed her work term. Several components of her work have supported the full proposal, which has been drafted and sent to the Boards for review. We continue to support knowledge dissemination for Dr. Mason's study. At the suggestion of DoBC, we have drafted an article for submission to the BCMJ. I discussed this referral project with the Digital Health Strategy team, and we confirmed our place in their plan. We have organized regular meetings to ensure that we stay aligned as their and our work progresses.	
Committee-Directed Work/ Other	The Committee also discussed new areas of work they could look into that does not fit into a project format. Three areas were identified: 1. CHS – Dr. Leah MacDonald is working on improvements to documentation and reports distribution within Community Health Services. CT co-hosted a meeting between FPs and CHS to discuss FPs needs and the gaps they are currently experiencing. Next steps are internal to Island Health but CT offered support for physician sessionals if further consults are required. – no next steps for the committee this month	

	2. Patient summaries – as described above 3. MOST – met in August and identified potential work around patient education re: goals of care; increasing comfort/capacity in FP to have goals-of-care conversations; PSP support for completing and sending in MOST to hospital; working with Island Health to advocate for write-access to PowerChart for advance care plans, substitute decision-makers, and MOST; and developing a feedback loop back to FP for when MOST status changes. We are working through our meeting notes to draft a workplan and send back to a core group of attendees who expressed a desire to be part of an ongoing working group. **Can Screen BC**: Dr. Stuart Bax and Dr. Cal Shapiro of CanScreen BC are submitting their EOI in September. **Acute care volume:** Phil Lawrence requested assistance with a multidisciplinary working group to identify ways to reduce acute care volume. Phil will present findings from his analysis of ED data to the SC in September. The committee is welcoming Dr. Bonnie Szeto from Telus Health (virtual episodic care).	

Next Steps

Opioid Users: Develop workplan and evaluation framework; one-on-one meetings with Island Health nursing, toxic drug crisis response team, downtown PCN lead. Patient Summaries: Submit manuscript; messaging to members encouraging re-uptake Long Term Care Transitions: Updates to database from LTCI; continue to push for improvements to LTC placement form. Coordinating Complex Care: Evaluation and final report, submission of Supportive Cardiology Project EOI to Shared Care Specialist Referrals: Submission of full proposal Committee-Directed Work: MOST work plan; acute care volume meeting and associated work; reach out to PCN re: Indigenous representation.