Victoria
Division of Family Practice
An FPSC initiative

MONTHLY PROJECT REPORTS TO THE VICTORIA DIVISION BOARD OF DIRECTORS

Ending
January 31, 2024

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 work plan and priorities for 2023-2024. 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

Program Name: PMH Development

Summary

***Physician Leads**: various*
***Board Liaison:** various*
***Director:** Helen Welch*

Program summary in development.

Key Program Areas and Progress in Last 30 Days

Area	Details	Progress
MOA Network	There are 42 MOA Network members (↑20) • The MOA WG decided to expand scope to include all PCN clinics, with FSFP clinic MOAs receiving priority RSVPs for events. Unfortunately, the January 17 Mindfulness event was canceled due to the snowstorm and travel challenges. We are working to reschedule. Another event has been scheduled for March 18: Navigating interactions with difficult people. Budget for year2 of the network will be similar to the first. Priorities will be member engagement and membership, communications (e.g., newsletter, communication hub), and seeking input from members for year3+ planning.	
Island Medical Program (IMP)	The planning group decided on a single Student Engagement WG (SEWG) that will operate similarly to the Resident Engagement WG and feed back to respective division Boards. Next steps include finalizing the SC TOR and sending out an EOI to VDFP/SIDFP members for available physician roles. The larger group will reconvene once more after the EOI process to select the new SEWG members.	
Onboarding new VDFP members and Mentorship	Planning underway.	
Physician Wellness *Led by Kristin Atwood*	The Peer Support Pilot launched on Feb. 16 and 12 matches have been facilitated. • Developed a sustainability plan involving SIMSA maintaining the web form and staff continuing to informally collaborate to share contact information to volunteer peer supporters who are part of a What's App group The Joint Committee met on January 18 and began planning for 2024/25. They have identified a theme for the coming year's events: "Cultivating a culture of compassion: Caring for ourselves, our patients, and our community." Planning	

Area	Details	Progress
	for specific activities will occur at the February 21 meeting. Finalized the date for the half-day wellness retreat (March 2) at the University Club. • Secured speakers with a focus on compassionate leadership/joy in work and supporting colleagues. • The retreat is co-sponsored by the Joint Wellness Committee, SIMSA, and the Peer Support Pilot Program. Costs will be shared and VDFP is covering the deposit for the space. • The invite for the retreat went out on Jan. 25 and 24 people have registered as of January 29, 2024.	
Non-longitudinal family physician Member Engagement *Led by Kristin Atwood*	Completed identifying non-LFP members and discussed plan for next steps based on group: • Students/ Residents: engage through existing mechanisms (e.g., RWG) • Retirees: reach out with invitation to participate, e.g. in mentorship • Non-LFP practicing members: survey of needs was distributed on Jan. 25 and will be in field until Feb. 7	
Recruitment & Retention	Regional R&R collaborative • The regional collaborative held one of its quarterly in person meeting on January 25. Emma Issac from Island Health joined to discuss how we can support PRA BC IMG physicians in the years ahead. The group agreed to draft a workplan and costing to determine what the program will cost. It is still to be determined where additional funding will come from. • Victoria Division staff are finalizing the FPSC funding submission to support the R&R collaboration. It will be submitted in February. Local R&R • Interest in relocating to Victoria continues to be steady. • REWG held it's first meeting of 2024 on January 3, agenda topics include exploring how we can integrate the work of the REWG with the newly formed IMP WG and Steering Committee.	
Urban Locum Pilot (ULP)	**Highlights** • The VDFP has received an amended FTA for the ULP confirming the pilot will run until March 31, 2025 • The ULP Oversight Committee (OC) agreed on a governance restructure that will convert the OC to a Steering Committee which will be more involved in ongoing decision making. Additionally, rather than a bi-weekly WG meeting (VDFP staff, FPs, FPSC), project staff will continue to meet and call on FP representation only as needed. **Mentorship** • Two mentors and five locums attended the January 29 mentor meeting (in person) to provide feedback on the first year of the pilot (likes/dislikes) as well as interests and career and learning needs as they progress into year2.	

Area	Details	Progress
	• Attendees provided thoughtful feedback and also maximized remaining time to discuss important community resources (RACE, etc.) with two locums who moved to Victoria for the ULP Pilot from Ontario. • Once feedback is synthesized, the project team will meet with program mentors to discuss what year2 mentorship structure should look like and their ongoing capacity.	

Next Steps

Continued recruitment to ULP.

Program Name: PCN

Summary

***Physician Leads**: various*
***Board Liaison:** Anna Mason*
***Director:** Cynthia Durand-Smith*

Program summary in development.

Key Program Areas and Progress in Last 30 Days

Area	Details	Progress
Registered Nurse in Practice (RNiP)	Ongoing RNiP change management. Assess readiness of other clinics interested in RNiP support. Development of PCN RN Community of practice and development of future RN learning opportunities	
Clinical Pharmacists (CP)	Supporting the growth and improvement of the CP program with cohort model implementation. Connected with CPs regarding program changes. Meetings with 12 clinics regarding cohort model and connecting with their new team CP. Successful transition from UBC EMR to PHSA EMR (MOIS). Development of new MOIS EMR workflow. VPCN took on MOA support. Communicated changes to all PMHS, UPCCs, and CHCs (new fax number and new workflow for HCOY & James Bay UPCC regarding patient booking)	
MHSU & SW programs:	Successful implementation of Jane App workflow for booking appointments and patient reminders. Planning Advanced Care Planning group education sessions for patients by the SWs. Interdisciplinary team member meetings for cohorts 1-5 to enhance team connections, scope clarity, and ultimately TBC. Ongoing baseline, 1 month and 3 month check-ins with clinics and their team members. EMR specific training sessions with the support of PSP Health Technology coach for Oscar (including RNs and PCCPs). Program Evaluation: Ongoing meetings and planning of program evaluation, including onboarding evaluation, pre and post TBC training session evaluation and overall program evaluation (including panel data, HDC data, AHP stats tracking, AHP and FP/NP surveys.	

High Complexity Care Team	Victoria HCCT team is operational and has hired all positions except nurse practitioner. HCCT seeking to swap NP for FP resources. Received MoH funding letter week of 12/04/23. Beth-Ann Parmar working with IH contracts to get an agreement in place to flow the money.	
Indigenous Health	Art distributed to clinics in recognition of Truth and Reconciliation Day. 5 First Nation communities, PMHs, CHCs, and UPCCs. January 26 - Indigenous Cultural Conversations with Len Pierre, Session 1: Working with Indigenous Artists and Installing Indigenous Art in a culturally safe way Urban Indigenous Needs Assessment – Reichert & Associates on task. Creating Elders Circle. 4 Indigenous Wellness Providers currently working at VNFC need to be integrated into the PCN – working on this with VNFC.	
Health Connect Registry	The new HCR is still in its stabilization phase. Reports from the new system are not able to produce the same data as the previous system. This is causing more work for the attachment coordinators; having to cross check patients against 2 systems. HLBC are working on resolving this. Number of ACTIVE registrants on the Victoria HCR: 29,817; number of Priority referrals received: 1404. Number of patients invited to attach: 4829, of which were priority patients: 764.	

Next Steps

None at present.

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. Margaret Manville*
LTCI Steering Committee members: *Dr. Ian Bekker, Dr. David Brook, 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 January 2024, the Vic-SI LTCI is active at all 39 local long-term care sites, with **69 LTCI physicians** acting as MRP for 93% of all 3,441 local residents. These 69 physicians represent approximately 66% 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, Addictions in LTC -March, Ethics in LTC -April, Alcohol in LTC -June, Opioids 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 call groups will convene in Feb 22 2024 to review call statistics -Call volume hasn't increased but it appears call quality has decreased. This is likely due to LTC staffing shortages (new staff, inexperienced staff, agency nursing) 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 for nursing 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 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	

Area	Details	Progress
	to LTC Fee Codes -LTCI is applying for several new fee codes specific to LTC. Specifically, time spent on admissions, family counselling, death, and special populations LTCI and Care Transitions -Care Transitions and the Long-term Care Initiative (LTCI) have been working together for the past four years to advocate for a better Long-term Care Placement form and the new process has gone live. The "Medical History Request" form which was previously completed by FPs will be and replaced by the "Health History for Clients Entering Long-term Care and/or Facility Respite". The new form will be completed by a patient's Case Manager and not FP -LTCI has collaborated with Island Health on the LTC directory project. There was confusion in hospitals about assisted living and LTC and the different supports available. The LTCI program is updating information in this directory on an ongoing basis to ensure hospitals have the information on hand to better inform transitions into LTC	
Practice Model Innovation	Summary: -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 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 is exploring cross coverage at non-TORCH sites (TORCH is the only model with explicit cross-coverage) using the above communication tool. The purpose is to solidify processes that help recruit other physicians into LTC homes -So far two non-TORCH homes have implemented the communication tool and agreed to cross cover one another -LTCI team works with sites to support regular quality meetings where the interdisciplinary team reviews the best practice expectations. View the BPE commitments here -Two new private care homes have opened in Victoria. LTCI program consultants have been meeting with them to discuss medical coverage and setting them up to participate in the after-hours call line -Saltspring Island has joined the South Island Division of Family Practice. Jessica has scheduled a meeting with Dr. Peter Verheul to discuss how the LTCI program can best support LTC in their region	
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, Hip Fractures, and Skin -The next event Feb 7 will focus on Care Conferences, refining the IDCC toolkit	

Area	Details	Progress
	developed by the LTCI in 2018 and expanding the physician role. The aim is to optimize care conferences, clarifying what defines an ideal one -Physician lead Dr. Ian Bekker will be meeting with new recruits one-on-one in the New Year. Newer to practice physicians often have young families or other evening commitments so engaging with them via the traditional evening meeting has been difficult. These meetings aim to discuss the COP guidelines with the dual purpose of supporting and mentoring newer to practice LTC physicians	
Program Admin	Evaluation: -The LTCI participates in the quarterly FPSC evaluation surveys -The provincial evaluation and QI group of which Jessica is a part has been placed on hold until the work on the LFP has abated	
	Governance: -The Steering Committee (SC) met in November to discuss next steps for program planning. Previous meetings had focused on what makes a LTC center of excellence, and mapping what work is already occurring in these areas, read our summary here. The SC iterated support for increasing energy and time spent on resident and family satisfaction with medical care -The SC meet again in February to flesh out how the resident and family work will look and be incorporated into the budget -The SC have written a letter to Island Health Leadership regarding the changing demographics in LTC. Specifically, changes are being reported at Owned and Operated sites who have less flexibility to turn residents away. LTCI has heard that sites are seeing an increase in younger populations with mental health or substance use disorders. The SC iterates that these changing demographics need to be acknowledged by Island Health with increased supports for physicians and nursing staff -Doctors of BC reached out for data on the physicians who practice in LTC. 30 of the 109 physicians who have residents in LTC will not be eligible for the LTC LFP if the eligibility criteria requires 250 community patients. These 30 physicians cover 70% of the LTC beds in Vic-SI	
	Project Management: -HR: -Team huddles every week -Team is also supported by Gillian (coordinator 28 hrs/week), Sunita (admin 37.5 hrs/week), Cat Ryan (consultant 10 hrs/week) -Communications: -LTCI Newsletters go out quarterly -LTCI website with resources and learning series recordings here: https://vicsi-ltci.ca/	
	LTCI & PCN -LTCI & PCN collaborated to pilot LTC residents receiving medical coverage by Luther Court CHC. Read the SBAR outline the issue here -As MOH indicated there are no contractual barriers to CHC providers assuming care of LTC residents, one panel (16) LTC residents are now cared for by the CHC. The eventual aim is for all resident care to eventually be provided by the co-	

Area	Details	Progress
	located CHC	
System Coordination and Sustainability	-The LTCI Physician Workforce and Practice Planning Committee aims to focus on recruitment, retention, and retirement. -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 - As of January, 300 beds in LTC are seeking MRP coverage. Most of these beds are covered temporarily but are looking for a more permanent MRP -Two new physicians have been recruited into LTC in 2024 and are assuming panels at Glengarry Hospital. The TORCH model sites and associated scheduling and structure make it easier to incorporate a LTC panel into an existing full service FP -The PWPP working group met in January and iterated support for a recruitment event in early March - Recruitment 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 -The new LTC resident elective spearheaded by the LTCI has now launched and two has had two participants! Read the elective overview here Saanich Peninsula -Group will be reconvened in February to discuss SP AHCG results, specifically looking at opportunities for QI around common reasons for call in the community. Specifically, calls for urinary concerns are much higher on the Peninsula than Victoria suggesting an opportunity for education	

Next Steps

February 7: Community of Practice Meeting – Care Conferences February 13: LTCI Steering Committee February 23: Victoria AHCG 2023 Review February 29: Saanich Peninsula AHCG 2023 Review

Program Name: Care Innovations

Summary

Physician Leads: *Laura Phillips, Leah MacDonald, and Lisa Veres (Care Transitions SC)*
Board Liaison: *Ami Brosseau (Care Transitions SC)*
Director: *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. The remainder will go live after IHealth activation. Back office numbers have been included in the first release of a new provider database which is the source for PowerChart. However, these data are not yet flowing through to PowerChart records. HIM has a new project to provide FPs with write-access to PowerChart. We are coordinating to use the Goals of Care project as a test along with the LTCI after-hours care group. We are awaiting a meeting between Cerner, HIM, and Medical Affairs, scheduled for Feb. 1, which will define privileges for the new role.	

Transitions for Opioid Using-Patients (OUP)	Made progress on several QI activities in the ED:
	• As part of the Withdrawal Management Protocol:
	  ○ Triage sign explaining to patients why they are being asked about opioid use (waiting for sign off from ED management).
	  ○ Conversion sheet of street drug amounts of fentanyl into hydromorphone, to help clinicians request the appropriate amount of medication for preventing withdrawal.
	• As part of education promotions:
	  ○ Posted signs advertised Addictions education opportunities for ED clinicians
	  ○ Emailed all ED physicians the "Addictions Pearls every Victoria ERP should know" document that describes opioid withdrawal management, SURF referrals, suboxone microdose protocols, RAAC and Umbrella referrals; information about street drug slang to help ERPs assess what and how much a patient is using more easily, and addictions training opportunities – also created a poster format to display in the ED
	  ▪ A similar document for nurses has been created and is waiting for sign off from management to post and send to Nurses.
	  ○ Planning is underway for a mandatory training event for nurses in the ED – working on finalizing dates and speakers	

Area	Details	Progress
	On the community side, Sara has created a work plan with the physician lead, beginning with meetings with the UPCCs. They have initiated a conversation with the Downtown UPCC about how they are managing stabilized OAT patients in order to identify best practices that can be spread to other clinics. Following this, the team will be presenting to Gorge UPCC in March. Also, Sara has created a one page document for James (change lead – PCN) to use when introducing the project to physicians in PCN clinics. Stakeholder engagement also continues. Sara has started attending monthly CAT meetings and is presenting to the RJH Harm Reduction team next month.	
Patient Summaries – Sustainability and Spread	Continuing to meet with the Digital Health Strategy (DHS) and Canada Health Infoway. Lisa and Laura have accepted co-lead roles for the Clinical Advisory Committee and are hosting a general information session for all DoBC members on January 31. Infoway has requested more information about how many physicians continue to send in summaries and why, which Alyssa is compiling. Our manuscript on patient summaries was submitted to our second-choice journal, Health Information Management Journal. EMR Connect provides a monthly data feed to update on the number of patient summaries being sent. We have sent a direct communication to all those who are currently sending in summaries to remind them they can bill under the LFP, and have followed this up with a general communication to all members that will come out in the Newsflash soon.	
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. Alyssa is overseeing the work remaining. LTC Placement Form: Island Health's solution is to have nursing staff complete the form rather than a FP. Jess/Kristin provided input into form changes for those instances where a FP is still required to complete and these changes were approved. New timeline for training to launch is late January 2024. We have collaborated with Island Health on a memo to our members announcing these changes, which should be published in the Newsflash on Feb. 1.	
Heart Failure: Supportive Cardiology Project	This month's working group meeting was delayed due to scheduling difficulties and the group will not convene until Feb. 5. However, they were able to meet with the Health Data Coalition to discuss how HDC could support a cohort of participating physicians to track heart failure patients.	
Specialist Referrals	On January 30, we held our introductory event aimed at improving collegiality between FP and SP, with 104 people in attendance (~70 FPs and 34 SPs). The event went very well and initial feedback suggests it succeeded in creating a collegial atmosphere that can serve as a foundation for joint quality improvement work going forward. A fulsome analysis of what was heard at the meeting is forthcoming, but initial key themes include the recognition of the administrative burden of referrals	

Area	Details	Progress
	for both FP and SP, the importance of collegial communication and transparency (e.g., around wait times), and the necessity of closed-loop communications (e.g., referral receipts). There is a significant amount of information to delve into that will set the stage for specific QI initiatives in the project. 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. We continue to support knowledge dissemination for Dr. Mason's study. At the suggestion of DoBC, we have submitted an article to the BCMJ which has been accepted for publication.	
Committee-Directed Work/ Other	1. CHS – Dr. Leah MacDonald is working on improvements to documentation and reports distribution within Community Health Services and Phil Lawrence is looking at improved CHS referrals. 2. Patient summaries – as described above 3. Goals of Care (MOST) – We have identified five physicians through the PCN who would like to participate in the pilot and are connecting them with PSP support. A sixth physician is willing to trial write access to PowerChart but does not want a full PSP QI project. We are planning three group medical visits for patient education with a PCN social worker who has experience in providing these sessions. The first will take place on March 14 at Monterey Rec Centre, followed by sessions in April and May in Esquimalt and Gordon Head. FP/NP in the PCN who have cohort allied health supports will be invited to refer patients and will be provided with a poster, as well as with follow up information about the pilot and other resources after each session. a. We have been accepted into the Quality Forum to present a storyboard on our emerging work around goals of care.	

Next Steps

Opioid Users: following up on leads for community physician champions will be a major focus in the next few months, as the various QI initiatives in the ED (withdrawal protocol, referral pathway, etc.) make their way through review, approval, and initial implementation.
Patient Summaries: DOBC meetings, preparation of highlights for Infoway
Long Term Care Transitions: Updates to database from LTCI; LTC placement form transition to nursing staff (monitoring as it rolls out)
Supportive Cardiology Project: First working group meeting (February), evaluation plan, stakeholder engagement.
Specialist Referrals: Establishment of broader working group, determining priorities for QI, MOA engagement, begin planning for second event.
Goals of Care: Recruitment, distribution of resources, work plans with PSP for individual participants, evaluation planning, group medical visits for patient education