Victoria Division of Family Practice
An FPSC initiative

MONTHLY PROJECT REPORTS TO THE VICTORIA DIVISION BOARD OF DIRECTORS

Ending
February 29, 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

Victoria Division of Family Practice
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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	• During the last WG meeting the group discussed learning objectives (and potential speakers) for four potential events they want to offer next fiscal year: ○ Getting the most out of Pathways ○ Your Victoria PCN supports and contacts (including HCR) ○ Creating a trauma-informed workplace ○ Holiday social (future event planning and world café) • A short survey is going out to FPs of PCN clinics regarding their feedback on what supports, resources and learning initiatives they would like to see the Network prioritize next fiscal.	
Island Medical Program (IMP)	• EOIs for VDFP/SIDFP FPs interested in joining the Student Engagement WG are going out in the next respective Newsflashes (one vacancy per Division). • The larger group will reconvene once more after the EOI process to select the new FP SEWG members.	
Physician Wellness *Led by Kristin Atwood*	The Peer Support Pilot launched on Feb. 16 and 12 matches have been facilitated. A sustainability plan is in place. The Joint Committee met on Feb 23 to finalize planning for 2024/25. A budget has been prepared and submitted. The following is included in the draft workplan: ○ 1 x 8-week mindfulness group, virtual with in-person introductory and celebration dinners – spring or fall ○ 3 x in-person wellness workshops on topics such as grief and loss – Fall 2024, Winter 2025, Spring 2025 ○ Informal social gatherings every other Saturday from May-September: committee members and other volunteers to commit to showing up, similar to SIMSA walks. Variety of activities (e.g., paddleboarding, swim) ○ Welcome and Thank You and BBQ with SIMSA ○ Subscription to the Physician Wellbeing Index and trial as a tool for understanding member needs ○ Engaging with municipalities to propose physician discounts for	

Area	Details	Progress
	recreation. Finalized planning for the half-day wellness retreat (March 2) at the University Club – 45 registered, including speakers.	
Non-longitudinal family physician Member Engagement *Led by Kristin Atwood*	Survey complete and analyzed. Report prepared and distributed to Board and Staff. Will inform planning for next fiscal.	
Recruitment & Retention	Regional R&R collaborative • Preparation is underway for the start of the conference season. • Conversation continues around support for the expanding PRA BC program Local R&R • Local R&R continues to be steady with physicians from the UK interested in moving to Vancouver Island	

Urban Locum Pilot (ULP)	**Highlights**
	• ULP Participants have been informed of the pilot extension to March 31, 2025.
	  ○ 10 days of coverage will be available to hosts during the extended period (no ability to carryover unused days from previous phases).
	• Work is underway to solidify second midpoint evaluation timeline and KPIs.
	Mentorship
	• The February 26 in person mentor meeting went very well. Two mentors and seven locums attended. One of the locums spoke about her experiences with the program (taxes, burnout, having difficult conversations, 3rd party billings) and there was lively discussion.
	• Based on feedback gathered recently, project staff are suggesting we refine the mentorship program component. Notable changes could include:
	  ○ Transitioning from 'mentorship' to 'peer support and coaching', which better reflects the expanded scope to include other locums as valuable resources.
	  ○ Additional locum-locum sharing opportunities.
	  ○ Additional opportunities for clinical feedback.
	  ○ A year of scheduled topics/sessions for easier planning and prioritizing attendance.
	• Staff are meeting with original program mentors on March 11 to discuss changes and check in about ongoing interest and availability.	

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An FPSC initiative

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 engagement with existing PMHs regarding RN in practice. • RN allocation to Tuscany Medical Clinic approved by Steering Committee 02/06/24.	
Clinical Pharmacists (CP)	• Planning to support the growth and improvement of the PCCP 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. • Supporting CPs with current workflows and scheduling. • Program evaluation: started planning with support of Island Health CP coordinator and Katherine from Reicherts and Associates.	
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 1-6 to enhance team connections, scope clarity, and ultimately TBC. • Ongoing baseline, 1 month and 3 month and 6 month check-ins with clinics and their team members. • EMR specific training sessions with the support of PSP Health Technology coach for Med Access (including RNs and PCCPs). • Space assessment of 911 Yates with expanding interdisciplinary team growth is in progress. • Cohort 4: Ongoing change management to support this clinic and these clinicians. MHSU HC support is not available at this time and the 2nd clinic has been updated by both the PCN and IH leadership. Continued attempts to engage with 1 of 2 clinics. • Cohort 6: SW receiving referrals and is supporting patients. Scheduled meet & greet with clinics for MHSU HC and SW.	

Area	Details	Progress
	• Cohort 7: begun discovery meetings with clinics	
Indigenous Health	• PCN Manager meeting 1:1 with new staff to discuss Indigenous Cultural Safety • PCN staff and clinicians are volunteering at VNFC Soup Luncheon Fridays • Dates confirmed for 2024 Indigenous Cultural Safety Learning Journey • Reichert's and Associates working with the VPCN Manager– Indigenous Health, meeting with focus groups and individual sessions • Aboriginal Coalition to End Homelessness developed a posting for their 1 FTE • Continued community outreach to Indigenous organizations and First Nations communities • Indigenous Cultural Conversations with Len Pierre Series Sessions 1 & 2, January and February respectively. Third virtual session planned for March 2024. In-person event planned for April 2024	
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. • Attachment Coordinators are now being sent the provider capacity report from HLBC. The Provider Capacity report is an excerpt from the Panel Registry in which FPs can indicate if they have capacity to attach more patients. The • Attachment Coordinator reaches out to them if they indicate they have capacity. This is a new process that has just commenced and will be monitored for accuracy and efficacy. • Number of ACTIVE registrants on the Victoria HCR: 33,166; number of Priority referrals received: 1612. Number of Maternity/Postpartum referrals received for the month of January 2024: 76. • Number of patients invited to attach: 6109, of which were priority patients: 899.	

Next Steps

None at present.

Victoria Division of Family Practice
An FPSC initiative

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 February 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 convened in Feb 22 2024 to review call statistics. -Calls for urinary concerns have increased. The LTCI team is developing an care home education plan to raise awareness about the LTC choosing wisely guidelines and asymptomatic bacterium -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	

Area	Details	Progress
	-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 to LTC Fee Codes -LTCI has applied for several new fee codes specific to LTC. Specifically, time spent on admissions, family counselling, death, and special populations LTCI and Care Transitions -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. There is an opportunity to expand this to include more assisted living information, LTCI is exploring	
Practice Model Innovation	Summary: -36 of 39 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 -LTCI team works with sites to support regular quality meetings where the interdisciplinary team reviews the best practice expectations. View the BPE commitments here -Saltspring Island has joined the South Island Division of Family Practice. Jessica met with Dr. Peter Verheul to discuss how the LTCI program can best support LTC in their region. The additional of Salt Spring brings the Vic-SI LTCI bed count up to 3600 -Cat Ryan met with the DOCs of the two care homes, discussed current state and areas for improvement. The Care home teams expressed excitement to access LTCI resources and learning series materials -Next steps for Salt Spring include surveying LTC physicians for barriers to practice	
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	

Area	Details	Progress
	-The event on Feb 7 focused on Care Conferences, refining the IDCC toolkit 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 is meeting with new LTC recruits one-on-one. 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 SC met again in February to flesh out how the resident and family work will look and be incorporated into the budget	
	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-located CHC -Cynthia and Jessica are planning to meet and discuss how LTC and PCN and collaborate	
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	

Area	Details	Progress
	- 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 -The Information/Recruitment Event was held March 5th and attended by 25. There were a number of newer to practice FPs and residents. Next steps include one-on-one meetings with each recruit in March to determine next steps Saanich Peninsula -Group convened 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 high suggesting an opportunity for education -Group discussed exploring a secure messaging service, and developing a reasons for call FAQ to be attached to the SBAR for facilities	

Next Steps

March 5: LTCI Information/Recruitment Event March 13: LTCI Learning Series – Ethics in LTC

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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. The meeting between Cerner, HIM, and Medical Affairs failed to clarify privileges for the new role and we are now advocating that Island Health enable the functionality for only pilot participants so that we can begin testing it while they sort out the access definitions. Another meeting is scheduled for March.	
Transitions for Opioid Using-Patients (OUP)	ED Quality Improvements: • Withdrawal Management Protocol: ○ Triage sign explaining to patients why they are being asked about opioid use has been posted in the EDs ○ Trial of the protocol has commenced. • Education: ○ Posted signs advertised Addictions education opportunities for ED clinicians ○ Distributed “Addictions Pearls every Victoria ERP should know” document. A similar document for nurses has been created and is waiting for sign off from management – no change this month ○ Planning is underway for a mandatory training event for nurses in the ED – working on logistics • MSHU Referrals: ○ RNs are editing the referrals document after trialling its use as it was found the length made it cumbersome to employ ○ Continuing to seek the right contact in Island Health to improve the algorithm for SURF auto-referrals. • Suboxone Starts: ○ An information request to Interior and UBC has gone out to gather	

Area	Details	Progress

	details about date stability data for microdose suboxone to-go packs.
	• Peer Support:
	  ○ Exploring possibility of expanded peer support presence in the ED (through Moms Stop the Harm and/or Umbrella) – no progress this month.
	Community Quality Improvements:
	• RAAC Referrals to UPCC:
	  ○ Initiated a conversation with downtown UPCC to identify best practices (Downtown is already attaching OAT patients referred from RAAC)
	  ○ Meeting planning for presentation to Gorge UPCC is in progress
	  ○ Created a one page document for James (change lead – PCN) to use when introducing the project to physicians in PCN clinics.
	• Priority Attachment:
	  ○ Working on messaging to ensure ERPs and RAAC know how to identify addictions patients as priority referrals for attachment
	Other
	• Liaising with Jessica Swinburnson to stay abreast of the work being done in LTCI to support opioid-using/OAT patients in LTC. One of the LTC physicians who cares for OUP is attending the ED working group.
	• Data request to Decision Support to assist with evaluation is in progress (to gather baseline data).	

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 which will begin regular meetings in March. Our manuscript on patient summaries was submitted to Health Information Management Journal and we have received a Revise and Resubmit. We have sent a direct communication to all those who are currently sending in summaries to remind them they can bill under the LFP as well as a more general communication to all members. An area of future focus is increasing uptake for proactive summaries.	
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 collaborated with Island Health on a memo to our members announcing these changes. Island Health confirms that as of Feb. 27, training for the case managers is completed and the new process has launched.	
Heart Failure: Supportive Cardiology	The working group convened in February. Terry met with Pathways and the Health Data Coalition about using data for evaluation. Pathways suggested enhancements to the provider tool based on feedback they have received on the documents, and	

Area	Details	Progress
Project	the committee is reviewing this information. This month, Terry also engaged with the PCN as a starting point to learn more about how allied health providers are working with FPs, as there is a role for AHP in serious illness conversations.	
Specialist Referrals	This month was spent analyzing the rich data that came from our initial event and determining how to engage with the 45 individuals who indicated they would like ongoing involvement. The working group has decided to create two subgroups (technology and process). We are organizing two focus groups with episodic care (WIC through the Episodic Care Task Force and telehealth through our Steering Committee member who works at Telus). Pathways has soft-launched a new messaging feature that we would like to trial with our 45 volunteers. The Steering Committee would like to see this expanded to hospitalists as well (incentive of Pathways access may encourage hospitalists to join the Division as well). A report-back to the membership and specialist community has been prepared for the VDFP, SIDFP, and SIMSA newsletters. The event format has led to interest from both FP and SP in some kind of regular networking opportunity where physicians can workshop specific issues together - a working meeting, as opposed to social or education opportunity ("Fix and Feast" as opposed to "Dine and Learn"). As this project include subsequent events, we can trial this idea in the coming year. The Physician Leads would also like to start SP Tips and Tricks about common referrals issues. I discussed this project with the Digital Health Strategy Digital Referrals and Orders team, and we confirmed our place in their plan. We have organized regular meetings to ensure that we stay aligned. Next meeting at the end of March. Identified that Eugene Leduc is on the DRO Clinical Advisory Group. At the suggestion of DoBC, we have submitted an article summarizing findings from Dr. Mason's study to the BCMJ which has been accepted for publication.	
Committee-Directed Work/ Other	1. CHS – Leah MacDonald working on improvements to documentation and reports distribution and Phil Lawrence looking at improved CHS referrals from ED. We connected Leah to the Dine and Learn team to plan an education session on CHS services. The committee would like to formalize work with CHS into a project structure, starting with an EOI to in 2024/25. 2. Patient summaries – see above 3. Goals of Care (MOST) – five physicians have been connected with PSP support. A sixth willing to trial write access but does not want a full PSP QI. a. Planning three group medical visits for patient education with a PCN social worker in March, April, and May. FP/NP in the PCN who have cohort allied health supports have been invited to refer patients. b. We have been accepted into the Quality Forum to present a storyboard on this work. Draft is currently with the designer.	

Area	Details	Progress
	4. Community Pharmacy – the Committee discussed the importance of engaging community pharmacy as partners in health care and would like to begin identifying stakeholders and undertake initial engagement in 2024/25 5. Plastics Referrals Improvements: plastics was identified as a 'special case' for referral pathways due to the need for biopsy before referral which many FPs cannot do. Need a pathway from FP to FP colleagues that do biopsy, to plastics – and sometimes dermatology is more appropriate. Since this is a complex referral pathway the committee would like to apply for EOI funding in 2024/25 to engage all partners and determine potential solutions. 6. Indigenous engagement - Cynthia advised that Victoria PCN is developing its own Indigenous Circle; we will wait to see how that develops before reaching out about Indigenous representation at Care Transitions.	

Next Steps

Opioid Users: Presentation to Gorge UPCC (March); meeting with Moms Stop the Harm (March); participation in Interdivisional Addictions event (Sara seeking invitation); finishing ED QI work around nurses "Pearls" document and MHSU referral pathways; outreach to PCN clinics who would like an addictions presentation for their clinic (starting point to identify FP/NP champions for OAT; starting in April).
Patient Summaries: DOBC meetings, work on promoting proactive summaries to members
Long Term Care Transitions: Updates to database from LTCI; monitoring LTC placement form roll-out
Supportive Cardiology Project: PSP engagement re: panel management for patient identification; revisions to provider tool in Pathways; PCN engagement
Specialist Referrals: Episodic care focus groups; establishing subgroups; work and evaluation plan for Pathways messaging pilot; ensure hospitalist access to Pathways via VDFP membership before the pilot.
Goals of Care: Recruitment, distribution of resources, work plans with PSP for individual participants, evaluation planning, group medical visits for patient education
CHS: Phil will report back in May about his referrals project. If endorsed by the Board, start EOI application.
Dine and Learn planning via Leah