VDFP
Work Plan 2024-25

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 interest holders to effect needed change at a community *and* systems level.
- Executing innovative solutions grounded in practice- *and* research-based evidence.

Priorities for 2024-25

The 2024-25 work plan reflects two priorities to achieve our vision

Victoria
Division of Family Practice
An FPSC initiative

1. Build Physician Community

RECRUITMENT AND RETENTION

Goals for new work areas	Goals for continued work	Ongoing VDFP work areas
• Support Practice Ready Assessment (PRA) BC physician program	• Expand local and regional Recruitment & Retention (R&R) activities • Create new monthly learning series for R1s and R2s • Continue to explore opportunities to engage with the Island Medical Program (IMP) • Strengthen and coordinate mentorship / peer support work through the Urban Locum Program (ULP)	Ongoing R&R activities that build physician community: • Participation at Regional R&R Collaborative • Island wide Resident engagement event • Urban Locum Program pilot (extended to 2025) • Red Carpet Welcome • Physician office relocation support • Support for Resident Working Group and Residents • Manage job postings • Local R&R activities

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ENGAGEMENT – MEMBERS

Goals for new work areas	Goals for continued work	Ongoing VDFP work areas
• Strengthen relationships between all physicians (community, all family medicine-trained, and specialists) » Invite retirees to participate, e.g. as mentors » New Care Transitions project *Improving plastics referrals (complex and unique issues)* with specialists proposed (EOI phase in 2024) • Increase membership engagement » Strengthen engagement with non-longitudinal members » Develop a comprehensive onboarding strategy for all new members • Create engagement events for IMP students • Establish an Advisory Panel (representative assembly of family medicine) to incorporate all physician voices	• Expand and coordinate communications and engagement to facilitate meaningful connections between the Division and all members • Engage specialists through Care Transitions – will continue throughout 2024/25 (Shared Care project until October 2025)	Ongoing communications and engagement activities with members that build physician community: • **Events**: AGM (remove barriers to attendance); community socials: Welcome & Thank You, BBQ, Holiday Party; Dine & Learns; LTCI member events; Care Transitions events; PCN cohort engagement meetings, FP-specialist engagement events; Resident Welcome BBQ, Retirement Planning Session, monthly Resident Lunch & Learns • **Communications**: Board socials (leverage high interest and include more members); new VDFP website – featuring community, services, staff contacts and searchable resources across VDFP; VDFP Newsflash; new News Hub; impact reports; Cheers for Peers; Family Doctor Day acknowledgment; Board videos; maintain calendar of community events • **Engagement**: member surveys and evaluation; strategic planning

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ENGAGEMENT - PARTNERS

Goals for continued work	Ongoing VDFP work areas
• Strengthen engagement with Indigenous health partners	Ongoing communications and engagement activities with partners that build physician community: • Representation at regional and provincial collaborative tables: » Collaborative Services Committee » Interdivisional Strategic Council » FPSC (Family Practice Services Committee) » Shared Care » Digital Health Strategy » Community Action Team » SIMSA (South Island Medical Staff Association) » Victoria Primary Care Network (PCN): Indigenous Circle, involving First Nations, Métis and Inuit voices in the community including Indigenous FPs, patient partners and clinics (e.g. VNFC, ACEH, Foundry)

WELLNESS

Goals for continued work	Ongoing VDFP work areas
• Strengthen the peer support pilot – moving into sustainability phase • Offer non-CME events and socials » Bi-weekly summer socials » Wellness workshops on topics such as *Grief & Loss* • Expand offers and reach of health & wellness programming » Physician Wellbeing Index	Ongoing wellness activities that build physician community: • Board socials; holiday party • Promote mindfulness groups and walks hosted by SIMSA • CBT skills group grads drop-in (monthly)

2. Strengthen family doctors' ability to meet their patients' needs

through *Practice Supports*, *Supports for Vulnerable Populations*, *Care Transitions*, *Education and Capacity Building*, *Coordination and Collaboration*

PRACTICE SUPPORTS
(business supports, clinic space, tech support, admin support, orientation, etc.)

Goals for new work areas	Goals for continued work	Ongoing VDFP work areas
• Explore opportunities for developing clinic space as an essential part of supporting FPs to set up community practices • Explore and leverage the supports offered by FPSC's Practice Support Program and Doctors of BC's Business Pathways Program to reduce administrative burden for FPs • Disaster planning	• Expand one-on-one office engagement • Continue to build out Pathways » Messaging (part of Care Transitions Specialist Referral Project) • Further the Urban Locum Program	Ongoing practice supports that strengthen family doctors' ability to meet patient needs: • PCN cohort model supports such as Registered Nurse in Practice (RNiP), Clinical Pharmacists; PCN Team Mapping sessions for Patient Medical Homes (PMHs) • PCN Attachment Coordinators connecting with PMHs to support process • Pathways • UpToDate

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SUPPORTS FOR VULNERABLE POPULATIONS

Goals for new work areas	Goals for continued work	Ongoing VDFP work areas
• Prioritize supports for vulnerable populations (may include current crises) » Maternity care » Care of the Elderly: in community and in facilities (e.g. Assisted Living (AL) and Long-term Care (LTC)) » Emergency » Child and Youth Mental Health » Walk-in clinics (WICs) – Integration with PCN • Increase integration of the LTCI within the PCN and connection with Community Health Services (CHS)	• WIC stabilization • Supportive Cardiology project through Care Transitions continuing in 2024/25	Ongoing supports for vulnerable populations that strengthen family doctors' ability to meet patient needs: • LTCI supports such as coordinated practice models, after-hours call group, QI quality improvement program • PCN cohort model: MHSU & Social Workers, Indigenous Wellness Providers • PCN cohort model extended to include WICs

CARE TRANSITIONS

Goals for new work areas	Goals for continued work	Ongoing VDFP work areas
• Expand support for patient transitions » Community Health Services – proposed Shared Care EOI to facilitate conversations and identify collaborative project to pitch to Shared Care for 2025	• Support patient transitions: » Goals of care/MOST; Opioid Using Patients project; Specialist referrals work	Ongoing care transitions activities that strengthen family doctors' ability to meet patient needs: • Communications systems improvements • Patient summaries • LTC placement form/process

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EDUCATION AND CAPACITY BUILDING

Goals for continued work	Ongoing VDFP work areas
• Continue to build capacity for Indigenous Cultural Safety • Continue to offer CME events • Offer other education series and events	Ongoing education and capacity-building activities that strengthen family doctors' ability to meet patient needs: • PCN capacity-building for team-based care: team mapping sessions • PCN Indigenous Health & Wellness: cultural safety learning plan including cultural conversations, artwork, language learnings, traditional medicines • Dine & Learns • LTCI Learning Series

CARE COORDINATION

Goals for new work areas	Goals for continued work	Ongoing VDFP work areas
• Community Pharmacists » Care Transitions proposes initial engagement, in partnership with Collaborative Services Committee (CSC). LTCI is also planning engagement with community pharmacists.	• Continue to develop MOA network to strengthen engagement and collaboration with MOAs across all Division initiatives	Ongoing care coordination activities that strengthen family doctors' ability to meet patient needs: • Continue to advance PCN cohort model of care