VANCOUVER PRIMARY CARE NETWORKS

PCN 4,5,6 Engagement Forum

Empowering Care Across Life's Moments

November 28th, 2023

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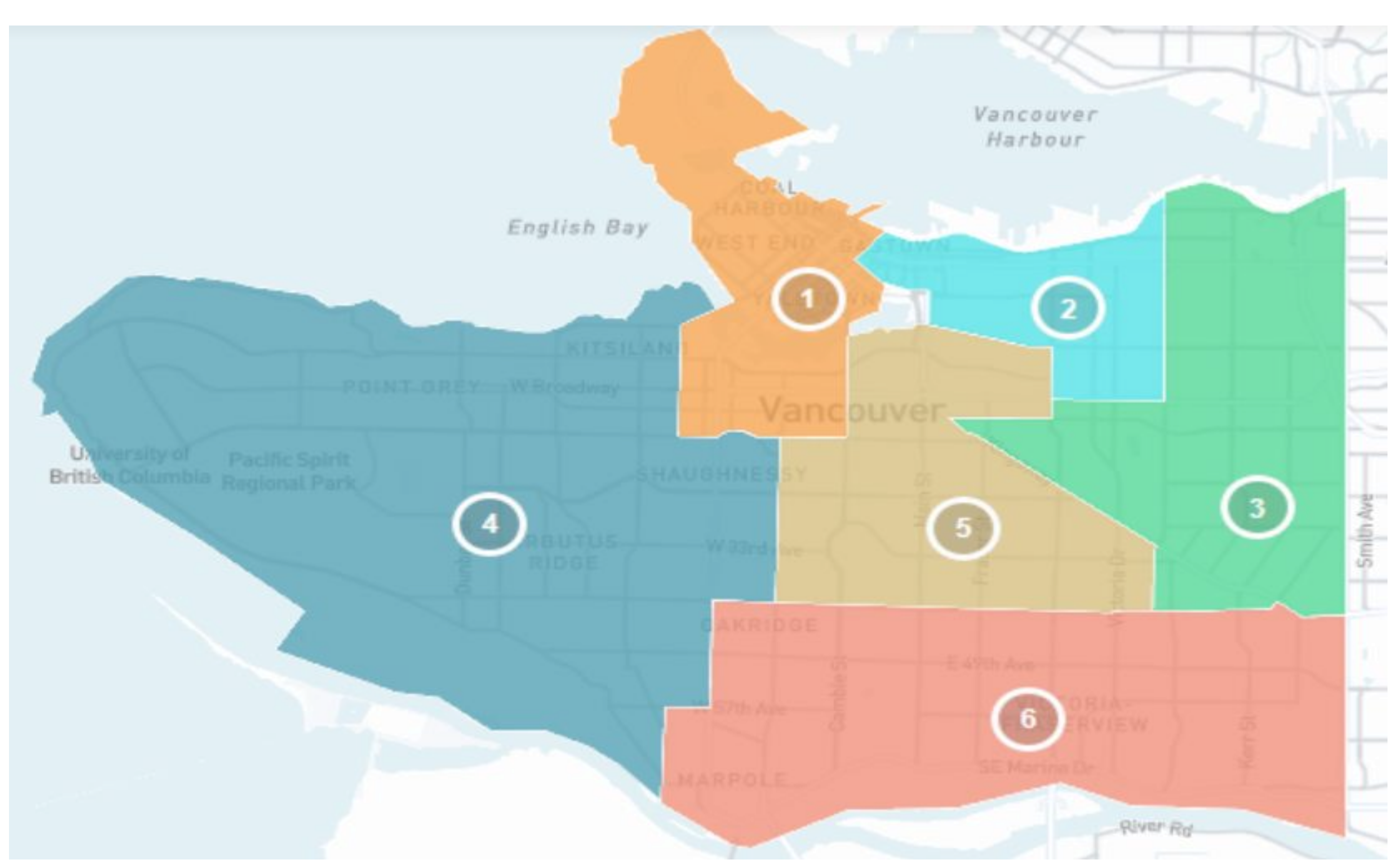


Introduction

The Vancouver Primary Care Networks (PCNs) are being implemented as part of a collaborative partnership between the Vancouver Division of Family Practice (VDoFP), Vancouver Coastal Health (VCH), the Ministry of Health and the First Nations Health Authority. Beginning in early 2020, VDoFP and VCH have been working collaboratively with local primary care providers and Patient Medical Homes to rollout PCN resources to support patients in the community.

In November of 2024, the PCN Team had the opportunity to partner with two VDoFP Committees to engage members of the PCN community on the care of two patient populations that need more support from the primary care system: maternity patients and seniors & frail elders. PCN Engagement Forums were planned collaboratively with the Maternity Committee, the Seniors and Frail Elder Committee and VCH to gather input from the community. Input provided by the community will help us to understand how we might better support these patient populations through the PCNs. The event for PCN 4, 5 & 6 communities was held on November 28th.

74 people attended the event which included Family Physicians, Nurse Practitioners, PCN Registered Nurses, Clinic Leads/Managers, Patient Partners and representatives from Community Led Health Centres.

The first half of the event allowed for connection and networking, as well as presentations to update attendees on PCN development, and inform them on the work of the two committees. These updates would support discussions that happened in the second half of the event.

Vancouver PCN Update

PCN Director Rose Gidzinski from VDoFP and PCN Manager from VCH Brian Richter gave an update on the PCNs, sharing key updates on the PCN Interprofessional Team Program and the Registered Nurse in Practice Program. The year ahead the PCN Team will work on refreshing the PCN Steering Committees, conducting annual program evaluations, increasing capacity and access, supporting Team Based Care, expanding community engagement initiatives, and focusing on patient populations whose primary care needs increase at specific points in their healthcare journeys.

Maternity Committee Update

Next, Belinda Boyd an Engagement Consultant with the VDoFP presented on the work of the Maternity Committee. This included an overview of the EASI Maternity Care Project (Effective and Seamlessly Integrated). They also shared updates on two EASI Maternity Care Initiatives that were undertaken to support maternity care in Vancouver.

But I Don't Do Maternity Care is a CME workshop series (do-at-your-own pace and live case discussions) on 8 topics across the pregnancy journey from preconception to postpartum/newborn care. pregnancyvancouver.ca is a new public facing website with reliable information and resources to support patients through the maternity journey.

Seniors & Frail Elder Committee Update

Dr. Lisa Weger from the Seniors & Frail Elder Committee presented on some of the key stats impacting seniors and their ability to stay safe and healthy in the community. She also shared a helpful resource that the committee has produced for family caregivers and primary care providers to support aging patients: The Frailty Roadmap for Families.

To view all of the presentations from the event click here.

What we asked

A world café approach was used to hold table discussions during the second half of the event. Presenters posed questions for each of the discussion topics as follows:

Maternity

1) **What services do you feel are most needed by maternity patients?**
2) **What services do you struggle to find?**

Seniors & Frail Elders

1) **What are the biggest barriers to keeping seniors living in the community?**

Discussions that occurred on each of these topics were energetic and produced some great input on barriers and solutions for both patient populations.

What we heard

Following are the top themes that came from the table discussions in order of prevalence.

Maternity – what services are most needed?

- **Maternity Support** – support for primary care providers to deliver maternity & newborn care (e.g. RACE Line, resources, guides)
- **Mental Health Support** – access to mental health support when patients need it in their maternity journey
- **Timely Access to Care** – support needed during pregnancy is time sensitive. Wait times are long and sometimes needed after hours
- **Resource List/Navigation** – support to know what resources are out there and how to navigate resources
- **Primary Care Providers** – not enough providers to support maternity patients
- **Patient Education** – standardized education for patients, education for first time parents, more accessible information and education
- **Post Delivery Care** – less home visits from Public Health Nurses, post-partum support
- **Lactation Consultants** – post-partum breastfeeding support
- **Obstetrician Support** – more Obstetricians, list of Obstetricians to refer to, patients requesting Obstetricians
- **Access to Testing** – genetic testing, pelvic ultrasounds, long wait lists

Maternity – What services do you struggle to find?

- **Patient Education** – printed materials for patients, information on OB vs. Midwife vs. Primary Care Provider, Baby's Best Chance
- **PCN Support –** maternity support from Social Work and Pharmacist (time sensitive)
- **Resource List/Navigation** – central resource list or database, literature list for patients, pre-natal toolkit on Pathways
- **Timely Access to Care** – wait times for ultrasounds, midwives, genetic counselling, time sensitive supports
- **Access to Testing** – genetic screening, ultrasounds, NIPT
- **Obstetrician Support** – patients want an OB, OB internal medicine, what support does OB provide?

- **Access to Programs** – waitlists for programs, what programs are available, eligibility, cost

Seniors & Frail Elders – What are the biggest barriers to keeping seniors living in the community?

- **Accessing Programs/Support** – eligibility to and availability of adult day programs, social programs, transportation programs, exercise programs
- **Home Support** – Flexibility of support, more support to check in on seniors at home, continuity of providers
- **Caregiver Support & Burnout** – family caregivers provide care but need support to avoid burnout, not everyone has support from family
- **Socialization** – need for friends and social connections, ability to stay with senior partners, low barrier socialization programs
- **Affordability** – cost to accessing services & supports is prohibitive to seniors & caregivers, housing costs
- **Safety at Home** – safe environment in the home, maintaining their home, increased complexity and accessibility needs, ability to live independently, senior caregivers
- **Transportation** – mobility and independence, access to transportation support to get to appointments, accessibility needs
- **PCN Support** – access network of allied health providers, team based care, social workers, awareness of IPT program, pharmacy support
- **Community Supports** – tap in to community resources and organizations, seniors-friendly communities (Dementia Village), volunteer visits
- **Resource List/Navigation** – understanding what services are available and how to access, all resources on Pathways, patient & caregiver information

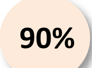
All input gathered at the event can be viewed in Appendix A at the end of this report.

Evaluation

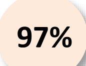
We received a total of 32 evaluation responses for this event. Overall, the event was well received. Below are some high-level responses.

of respondents felt they had a clear understanding of the purpose of the engagement

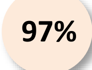
of respondents felt there was enough opportunity to participate in discussions



of respondents felt better informed about PCNs as a result of their participation



of respondents were satisfied with the engagement event



of respondents were satisfied with the facilitation of the event

respondents said they would attend another PCN Engagement Event in the future

Attendees were also asked what they liked about the event. Overall, participants enjoyed the ability to

connect with new people and network, as well as the discussions and the topics discussed.

“[I liked] the general introduction to the topics followed by the collaborative discussions…Learned a lot and it was fun!”

“Meeting in person. The venue was excellent. The topics were well presented.”

“It was nice to network with other PCN members and discuss ways to improve care and access in the PCN.”

We also asked attendees what could have improved the event. Suggestions for improvement centred mainly around logistics, such as catering needs and acoustics in the room, that we will consider when planning our future events. We are very grateful for all the feedback provided.

Click here to view the full evaluation summary for the event.

Next Steps

A companion event was held on November 15th for PCNs 1, 2 and 3. We will be sharing all the input from both events with the Maternity Committee and the Seniors and Frail Elder Committee early in the new year. While we recognize that not all the input provided falls within our scope, we will use it to identify opportunities and support planning as we continue to work together to improve PCNs and support these patient populations within. We'll continue to update the community on developments and other opportunities to be engaged.

The PCN Team would like to thank all the participants who attended and shared their wisdom and experiences, as well as the VDoFP's Maternity and Seniors & Frail Elder Committees and VCH for collaborating on the events and discussions. We look forward to hearing more from the community in the year to come.

RESOURCES/LINKS

pregnancyvancouver.ca

EASI Maternity Care

Walk through of pregnancy Vancouver by Dr. Ashoor Nagji

Register for But I Don't Do Maternity Care in person session – Feb 7th, 6:30 – 8pm

Register for But I Don't Do Maternity Care online session – Feb 13th, 6:30 – 8pm

How to Choose a Maternity Care Provider (FP/NP, Midwife, OB)

Early Pregnancy Care Pathways

Frailty Roadmap for Families

When Your Loved One Has Dementia – A Roadmap for Families

Appendix A

PCN 4,5,6 Engagement Event – Nov. 28th, 2023

Table Discussions – Raw Notes

Maternity

Q1: What services are most needed?

- Capacity for patients – PCN 4
- Changes in demographics have resulted in lower number of patients
- Many patients need post-partum care
- Undocumented persons, refugee status – difficult to find FPs
- Increasing comfort levels of FPs with newborn care
- Mental health services – wait times are too long for services
- Counsellors, Social Worker – these services are not available or in a timely manner
- Public Health – home visiting of newborns - unless they have a midwife
- RACE line for maternity informal
- Counselling
- Post partem breastfeeding support
- Social network – group support
- Resource navigation
- Genetic testing – central process/sites
- Private consultation/options
- Language access (culturally safe)
- Navigation for patients (maybe an app)
- More OBs
- Access to info for 1st time parents – portal to go to for links & websites
- Resource navigation e.g. Mother's from out of province needs support with information and education
- A clear pathway for referring pregnant patients
- Record/continuity of care in the transition from FP/NP to maternity care
- Post-Natal/Lactation Consultants
- Mental Health
- Hard to fit immunizations for well baby checks
- Pre-conception/prenatal – formal standardized education
- Provider guidance for those that don't do maternity
- List for providers – what to order when
- More family doctors who can provide support
- Early pregnancy services
- After hours support
- No OBGYN – list resource would be helpful
- Supports for complicated pregnancies
- More Pelvic ultrasound – wait times too long

- Mental Health supports – not prioritized during pregnancy
- No info for first time moms
- Correct and updated info and wait time info
- Social Media Strategy around pregnancy supports and info?
- Basic consultation – 1st visit is longest (time)
- Long waitlists for services (ultrasounds)
- Low risk but request OB at 20 weeks
- Routine care 1x per month
- Doctors must call before patients could book clinics
- After discharge – before family doctor visit
- After delivery – breast feeding
- Mental health management – counselling
- Female health issues "Is this normal?"
- Access to midwives post delivery
- Health Authority restrictions re: patient location and access to hospital for delivery (e.g. Burnaby patient with Vancouver doctor must go to Burnaby Hospital
- Finding provider
- Addressing the past COVID baby-boom
- GP after 6 months
- NO MSP access – where can they go? What resources are available
- Mental Health – depression anxiety diagnosis, wait times
- Reproductive health
- GP/OB/Midwives – navigating where to go/send patients
- Child care, childcare costs

Q2: What services do you struggle to find?

- Follow up of newborns after birth – discharge
- Mentor program for FPs to have follow up for post-partum and newborn care
- Substance use services post partum
- Patient central resource
- Printed materials – language needs
- Patient education on midwife vs. doctor vs. obgyn
- Post-partum – culturally specific, evidence-based
- Social work & pharmacy (PCN?)
- OBs
- Mental Health/Psych services – wait times are long
- Wait times for Midwife clinics would be helpful
- More Midwives & maternity care providers access on Pathways
- Timely ultrasounds
- Pelvic floor physio & coverage for patients
- Lactation consultants (costly)
- 1 page resource on primary care/OB/Midwife
- If patients change their mind half-way through – services

- Baby's Best Chance booklet – early pregnancy – post-partum
- List of literature for providers to give to patients
- Differences in services – usually just want an OB
- NIPT – want to pay – doctors order
- New mom community – low barrier "findamom.com" (Pregnancy Vancouver?)
- OB Internal Medicine
- Time sensitive supports – services you can get maternity patients in the time that they need them (pregnancy is only 9 months)
- OBs (Vancouver a little better than other areas)
- Routine care
- Timely ultrasounds
- Education on risk factors
- Genetic screening facilities
- Comparison guide – private vs. public
- Mental Health (post-partum included)
- Breast feeding – clinic closed
- Prenatal classes -in person (not virtual)
- More info for FPs for low risk patients – referral – Pregnancy Vancouver
- Med to High risk referrals – older, IVF, etc.
- Physios who will see pregnant people
- Referral for employment issues related to pregnancy
- Pharmacist support – "what can I take?"
- Could pregnancy Vancouver expand to include metro Vancouver?
- Navigating Pathways (prenatal toolkit)
- Pregnancy Vancouver
- Pre-conception genetic counselling – 2 year wait
- Food/nutrition support for children
- Medication exposures during pregnancy -used to be mother risk no longer exist
- In time support – database for resources

Seniors & Frail Elders

What are the biggest barriers to keeping seniors living in the community?

- Couples aging together and trying to keep it together and need to access long term care in a timely manner but with appropriate living arrangements (for couples)
- COLA expense to find facilities
- Lack of home support – need more than the basic care range of services that are needed beyond the minimal care
- Home support staffing is a challenge
- Families are transient or not available to provide care
- Adult day program space is limited
- Safety – falls and risk
- Mobility – public safety service announcements (clutter, bath, falls)

- Friends and social connections
- The digital world not as accessible for seniors (QR codes, booking online)
- Home visits by FPs – Home Vive
- PCN – resources of a network of health providers
- EHS – other home visiting providers to do home checks with seniors
- Broaden the network to share the load
- Language needs/cultural differences/requirements
- Maintaining a home – staying in their home with the upkeep
- Better at Home – more capacity needed
- Transportation support – lack of access
- Handy Dart application – physicians signature required – cost
- Social planning – community planning to engage Senior Friendly communities
- Hearing loss – isolation – access to hearing support costs are prohibitive
- Mobile and interactive exercise groups
- Cognitive impairment – cost of facilities can be high $15,000 per month
- Lack of family/close friends
- Day programs
    - Don't know they exist
    - More education for providers
    - Access?
    - Pathways? Is this on Pathways?
    - Usually referred through case manager through Home & Community Support
- Respite – really challenging for patients, hard to access location
- Budget for patients/families/caregivers is a lot – barrier
- Public respite required trial and can be challenging
- Home visits can be a challenge
- Virtual care (have not seen patient in person for a while)
- Hard to support family/caregiver virtually
- Patient has no other option
- Medication management in community for home health – continuity of support person
- Keeping active/balanced – more programs – missing physios, Ots, social workers (e.g. Step Up)
- Resources for 64 and under
- Community centres with senior activities, drop in programs with food
- System expectation of caregivers isn't fair, what they are expected to navigate is very challenging
- Home support
    - Access of information how to navigate virtual world
    - Laundry
    - Visit times limited
    - Support workers can't afford to live in Vancouver
- Frail Elder Mental health – Geriatric Psychiatric Outreach Team very good at follow up phone conversations, great program
- Access for 64 and under?
- IPT Advance Care Planning
- NIDUS (Advance Care Planning)

- Resources on Pathways
- Difficult to navigate communications resources on Pathways
- Home support access – public, consistent
- IADL
- Caregiver supports
- Closed loop communication for Home Health patients – ADP access
- Social networks
- Cost of services
- Accessing services such as palliative care can be difficult for frailty/dementia
- Mental health supports
- Complexity of patients living at home
- Caregiver existence and capacity is key – need services that work for them to avoid burnout e.g. BC 211
- 1st step the service exists, 2nd step is FPs knowing about the service
- Home Support – OT, fall risk, refer to VCH Central Intake
- Services to keep someone independent (don't qualify for other Home Support services) – e.g. take them shopping, they can feed themselves
- provide early intervention
- Publish any existing services on Pathways
- Case managers (and FPs) could benefit from "google for seniors" like EASI mat care website
- More senior centred – social supports, mental health supports, "seniors helping seniors" with languages that seniors speak
- FPs with longitudinal practices – talk with patients as they age re: how to stay healthy
- Subsidized private homecare
- Geriatrician referral – St. Paul's
- Social determinants of health: supports for homebound seniors
    - Language barriers
    - Home care/quality in variables
    - Family and friends
    - Caregivers supported – respite/breaks
    - Transport for caregiver (covered)
    - Socialization groups – referrals to some groups are long as they are small
- MH support
- LTC facilities not enough
- Culturally some communities don't think about care until the last second
- Mental health for the elderly – too much criteria
- Coordination of care – older adult mental health, home care nurses
- First Link – caregiver respite – dementia
- Financial support
- Meals on Wheels affordable – culturally appropriate meals included
- Finances – housing, seniors housing
- Mobility – transport
- Mobile lab services
- Social connection – a seniors network – potentially online
- Meal prep

- More time @ appointments
- Caregiving support – services accessibility/literacy for seniors
- Eligibility for services
- Staff turnover – need to familiarize – comfortability
- Living alone
- Navigating between HAs – EMRs/lack of communication
- IT support
- Lack of familial support
- Access to care
- Can't transport to appointment
- Hard to access Home Care & Home Vive
- VCH Central Intake form workflow – no confirmation care received for referral
- Awareness of IPT resources and referral program
- Reminder – you can refer to Adult Day Programs
- STAT referral – 3 – 4 hour/day rec program and health support
- Older Adult Mental Health group
- Adult Day Programs – working families need support – emergency social services
- Home Vive
- Home assessment – both medical and allied health
- Resource Navigation and availability – support for family members
- Seniors want to stay at home – more flexibility in care and support for patient needs
- Elderly patients are themselves caregivers
- Family based supports – person and family centred care
- Innovative ideas like "Dementia Village"
- Services too limited by time – home support
- Liaising with community led organizations
- Cost of socializing can be a barrier – free transportation for seniors and companions
- Food security – Community Fridges for seniors
- Visiting seniors – high school students get credit for volunteering with seniors – this socializes aging and supporting seniors as a community
- Lack of social supports/engagement
- Home Support – lack of funding
- Food/meals, cleaning support
- COVID anxiety – lack of re-opening of programs
- Preventative fall strategies
- Transportation – better accessibility
- Better medication management
- Better understanding of system
- More pharmacy support
- Better provider social work support for older patients
- Limited ability for provider home visits
- Home Vive expansion
- Diminished Home support Management – more supports

- Better support for groceries, home care
- Better education for patient resources
- Earlier dementia engagement and support (non-urgent access)
- Volunteer driving program for seniors
- Elderly patient navigation
- Elder group sessions