South Island PCN

Saanich Peninsula and Western Communities

May 2023

Clinic Leads Meeting Summary

Clinic Leads meetings cover a wide range of topics important to understanding the PCN, how it impacts clinic operations and how we can support primary care in the South Island, including:

- Understanding RN Role and Scope
- Working with Unionized Employees
- How to Refer to the CARES Clinic
- MOA Benefits Program
- PCN Membership Criteria
- Overhead Process
- Island Health Technology
- Specialist Communication
- MOA/Office Managers/FP training
- Sessional Rates for Training
- New Billing Model/Locum Rates
- MD Expense Database Survey
- Cares Clinic
- EMR Form Mapping

Last month's meeting focused on finding collaborative solutions to issues such as:

Operational protocols around safe care for youth during legal separations
In a joint custody situation, it can be unclear whom to contact regarding care. The group will poll paediatric FPs for guidance with this issue and report back. Also see CMPA's resource, Family Disputes and the Physician: Staying Focused on Safe Care for more information.

Locum LFP overhead rates
The group is looking to collaborate on overhead rates for all Locums to keep wages consistent and decrease competition in clinic recruitment.

IT Support for Clinics
Clinics struggle with integrating Pharmanet and Power Chart, etc., and need help downloading/creating/implementing forms. The group is working together for solutions to these ongoing IT concerns.

Optimization of RN Role/Scope.
The group is working collectively to ensure all RNs are operating at the top of their role and scope, and to share successes within the primary care networks.

Primary Care Networks

The South Island has been leading the way in primary care transformation at the community level since early 2020. By being innovative, collaborative, and flexible, clinical resources are integrating in clinics across South Island PCNs while establishing supports for success

Learn More!

25,246

South Island residents attached to a new patient home since 2018

18,409
Western Communities
6,737
Saanich Peninsula

PCN Pharmacists

The South Island PCNs now have two pharmacists supporting primary care: one in the Western Communities and one in the Saanich Peninsula. The PCN pharmacists are excellent resources for patients who need pharmaceutical support.

In order to maximize the time PCN pharmacists can provide patient support, please direct general inquiries to the **BC Drug Information Line at 1-866-298-5909** instead of to the PCN pharmacists. When your question is related to a client referral, please contact the PCN pharmacist for your area directly.

Drug Information

Drug Information Line for BC Healthcare Professionals Only

1-866-298-5909 or
604-707-2787
(Mon-Fri, 9am-4pm)

- Clinical Practice Guidelines
- Drug Product Listings
- Safe Medication Use
- Adverse Reaction Reporting
- DI Perspectives Newsletter
- Drug Desk Newsletter

VGH Antenatal Multidisciplinary Clinic for Unattached Patients

- Patients who do not have a maternity care provider can call the Clinic at: **250-727-4000, extension 16034** The phone is answered and messages returned Monday to Thursday, 8:00 AM to 4:00PM
- If you have provided initial patient care and have patient info to share, it can be faxed to: **250-727-4441, attention: VGH Urgent Antenatal Clinic**
- If you would like to speak with MFM or OB, please call the switchboard: **250-370- 8699**

PCP Engagement Opportunities

The Team-Based Care Working group is integral to the development of the South Island PCNs. PCN work requires a solid engagement framework, strong leadership, change management, and collaboration with those who will contribute to, and are impacted by, new process and resource allocations. We need your voice to inspire, activate and create shared understanding, support process changes, and recommend the best way forward to the Operations Committees.

The Team-Based Care Working Group is seeking PCP participation at the following meetings:

May 11, 2023, 1200-1300 (Zoom) | Sessional Compensation

- Review and evaluate EOI Submissions received for Western Communities PCN remaining resources.
- Make recommendations to the Operations Committee for approval and allocation of remaining resources.

June 8, 2023, 1200-1300 (Zoom) | Sessional Compensation

- Review proposed Allied Health Visit Guidelines and make recommendations.
- Identify work and processes required to align OH&S polices and procedures for Clinics and Island Health.

Please contact Jeneen Hunt, PCN Manager, to join.

Western Communities PCN LAST CALL for Clinical Resources Expressions of Interest (EOI)

Available Resources:

- 0.5 FTE Allied Health
- 1.0 FTE Registered Nurse
- Nurse Practitioner call out - Clinics interested in a Nurse Practitioner joining their practice and wish to have their clinic attached to the generic NP Job Posting.

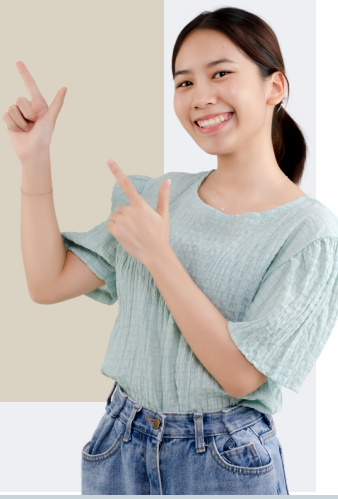
- NOTE - If you have a physician or nurse practitioner already interested in joining your practice, please know that you can request a PCN Contract at any time. NPs ready to commit to a PCN Clinic will take precedence for Committee Approvals.
- ALSO NOTE: you can request allied resources at any FTE size 0.2-1.0 FTE. If you have questions around allied health resources and what they can do, please contact your change manager – Kelly Aucoin.

Clinic Leads if you are interested in any of the resources above, please submit your Expression of Interest through the EOI Template attached via:

- Email: pcnadmin@sidfp.com
- FAX: (F) 250.658.3304
- Contacting your PCN Change Manger to submit for you, at Kelly.Aucoin@sidfp.com, or 902-844-0100

Clinics that have resources already allocated, ARE eligible for additional resources under this call for proposal

Item	Date
EOI Submission Deadline to request up to 0.5 Allied Health Resource	**May 5, 2023**
EOI Submission Deadline to add your clinic to the Job Posting for Nurse Practitioners	**May 5, 2023**
EOI Submission Deadline to request 1.0 FTE Registered Nurse	**June 2, 2023**



Attaching Clinic Staff to an FP/NP

Do you have a clinic staff member (including PCN clinical staff) who is also a patient at your clinic and you are looking for a fellow FP/NP with whom to attach them?

Clinics within the South Island PCNs whose staff and PCN clinicians need to switch their attachment to another clinic FP/NP can contact Kim Brown, our PCN Project Manager, and she will connect your staff to local clinics based on a reciprocal attachment agreement.

Please contact Kim at kim.brown@sidfp.com.

Good News!

Our PCNs are FULL of good news: patient successes, problems solved, new ways of providing care.

We want to hear about it! Drop a line to communications@sidfp.com to share your successes, your good news, your humblebrags, and we'll share it with your community members.

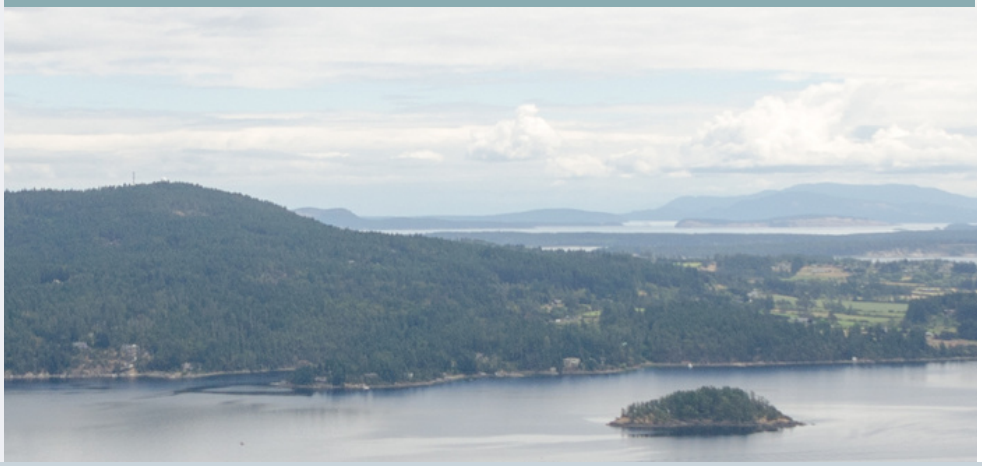
Contact Us

- Leslie Keenan, Executive Director
  Executive.Director@sidfp.com
- Aspasia Zabaras, PCN Director
  Aspasia.Zabaras@sidfp.com
- Jeneen Hunt, PCN Manager
  Jeneen.Hunt@sidfp.com
- Kelly Aucoin, Change Manager
  PCN Western Communities
  Kelly.Aucoin@sidfp.com
- Merlyn Maleschuk, Change Manager
  PCN Saanich Peninsula
  Merlyn.Maleschuk@sidfp.com
- Kim Brown, Project Manager, PCN
  Kim.Brown@sidfp.com
- John Bayaca, Attachment Coordinator
  John.Bayaca@sidfp.com
- Tina Dickson, Admin Coordinator
  PCN Western Communities
  Tina.Dickson@sidfp.com
- Pardeep Virk, Admin Coordinator
  PCN Saanich Peninsula
  Pardeep.Virk@sidfp.com
- Julie Lambert, Communications
  communications@sidfp.com

Mental Health Or Substance Use Support for Minor Patients

According to recent communication from the Ministry of Health, PCN Mental Health and Substance Use (MHSU) consultants can only see patients 18 and older; if you have a patient under 18 in need of mental health or substance use support, they can be referred to Child and Youth Mental Health.

The PCN Social Worker can see patients of all ages, including patients under 18.



Expression of Interest for South Island PCNs

A Primary Care Network (PCN) is a clinical network of providers in a geographic area where patients receive expanded, comprehensive care and improved access to primary care. PCNs include FPs, NPs, and allied health care providers in patient medical homes (PMHs), First Nations communities, health authority services and community health services. Providers and clinicians work together to provide primary care services for the local population. The South Island PCNs is a partnership between Island Health, First Nations Health Authority and the South Island Division of Family Practice. The South Island PCNS are comprised of two Networks: Western Communities and Saanich Peninsula. Each network is run by their respective local Operations Committee with decision-making flowing through the PCN Steering Committee reporting to the Partners for Better Health (Collaborative Services Committee).

Eligibility

We recognize there is a wide variety of providers, organizations and settings that deliver South Island residents' primary care. Therefore, for South Island's Primary Care Networks we are defining a patient medical home broadly and consider it to be a community practice where patients get the majority of their care, including FP offices, walk-in clinics, health centres in First Nations communities, and community organizations. All types of Patient Medical Homes in South Island can apply for PCN membership and are eligible to apply for PCN resources. Any PMH can apply at any time.

Membership

When joining the South Island PCNs, members can decide which level of participation they prefer. Each level of membership comes with different benefits and expectations for members. There are two levels of membership – Basic or Regular.

- Basic membership stay informed about PCN news and get connected to other members
- Active membership includes basic and also accessing or requesting to access PCN clinical resources either in clinic or remotely for attachment and/or team-based care.

The responsibilities of each level of membership are in the table below:

Membership Responsibilities/Criteria	Basic	Active
If PMH (FPs) are members of the South Island Division of Family Practice	■	■
Practices within the South Island PCNs area or will within 6 months of approval	■	■
Agrees to adhere to the principles of the PCN and Patient Medical Home (see Appendix A)		■
Demonstrates a commitment and willingness to increase learning with respect to cultural safety and humility	■	■
Commitment to ensure care is delivered in a culturally safe manner	■	■
Implements a strategy for panel management and team-based care e.g. PSP		■
Documentation is a single clinic EMR-electronically based		■
Agrees to attach patients from within the PCN geography and reporting target attachment achieved against this. Strongly encourages to use HCR		■
Agrees to work within the policies and direction as defined by the Governance Committee		■
Demonstrates capacity to onboard – orientation, EMR training, workflow development		■

Membership Responsibilities/Criteria	Basic	Active
Agrees to participate in PCN evaluation and reporting as identified in the Fund transfer agreement, Evaluation framework* and/or by PCN Governance Committees		
Completes the Team Charting with Island Health if applicable.		
Completes the Service Agreement* with Island Health if applicable		
Adheres to college standards and practices within the Canada Health Act e.g. will not charge a fee for attachment purposes		

*Currently being developed Provincially

To receive PCN clinical resources, the Patient Medical Home will need to meet all responsibilities before receiving resources. Anti-Racism work is also something that has to be consistent and on-going.

If you would like to become part of the South Island Primary Care Networks, please complete this form to indicate the level of interest you have in joining and indicate the type of resources you are interested in accessing or incorporating into your current clinic if you want to become a regular member. These PCN funded health care resources are funded by the Ministry of Health (MoH) and comes with the expectation of team-based care and attachment targets.

Please send signed and completed copy to pcnadmin@sidfp.com.

Membership level	Please X select level	Instructions
Basic	☐	Please complete Section A
Active	☐	Please complete Section A and B and appendices

Section A:

Please indicate how you are currently operating as a PMH:

- ☐ I have a solo Practice and will be completing as an individual
- ☐ I work independently in an office with multiple Primary Care Providers and will be completing as an individual
- ☐ I work with a group of other providers who would be interested in applying for shared PCN resources and will be completing on behalf of my clinic
- ☐ I am a Community Organization and will be completing on behalf of my organization

My practice is located or will be located in:

- ☐ View Royal
- ☐ Esquimalt
- ☐ Sooke/Juan de Fuca
- ☐ Colwood
- ☐ Langford
- ☐ Metchosin
- ☐ Sidney/North Saanich
- ☐ Central Saanich
- ☐ Royal Oak/Cordova Bay

What has your Patient Medical Home done this year or in the past to increase your awareness of the Indigenous population that lives in your geography? Please describe what cultural safety and humility learning/ training your Patient Medical Home have undergone and detail what experience your Patient Medical Home has working with Indigenous communities.

Please describe how you intend to provide culturally safe care or indicate what supports you might need (e.g. access to training/learning opportunities for yourself or other staff within your clinic, guidance from a cultural safety facilitator).

Practice Description

Practice Name		Street Address Including: City and Postal Code	
Telephone		Fax	
Office Email Address		Web Site	
Primary Clinical Contact Person		Primary Administrative Contact Person (if applicable)	
Existing MOA, RN, or other Team Member Compliment		Electronic Medical Record System/s	

Primary Care Provider Information:

Combined PMH Patient Panel Number: _____

Detailed Breakdown				
Name of Family Physician(s) and Nurse Practitioner(s)	FTE	Days of Work	Panel Size	Provider Payment Model (NTP FP Contract, FFS, NP Contract etc.

*please provide information on additional pages as required

Current Office Hours

Day	Hours
Monday	
Tues	
Wed	
Thurs	
Friday	
Sat	
Sun	

Please list the providers in clinic who want to be in the PCN at the same level and whether they are SIDFP members. Note if requesting an NTP FP contract the entire clinic needs to sign the contract:

Section B:

The new to Practice FP and NP contracts are facilitated through Island Health Contracts team and have attachment target expectations associated – see table below. The PCN RN and Allied Health clinicians are hired by Island Health through a MoH PCN Funds Transfer Agreement. The purpose of these supports is to enhance patient care using a team-based approach to care, support others to work to their strengths, enhance coordinated care, support clinic capacity around high needs patients to improve capacity to attach new patients, and to help link patients to supports in other parts of the health system.

Island Health, through PCN Funding pays the salary and benefits for each RN, and the clinic commits to attaching PCN residents by the end of fiscal year 23/24. As well, the participating practice and Island Health will sign a GPSC Team Charting Agreement and a Service Agreement that includes workplace safety.

Roles to be Allocated to Clinics	Primary Care RNs	New to Practice FP Contracts	NP Contract
Target attachment by end of fiscal year 23/24	500 patients attached to clinic per RN	1250 patients on panel per contract	1000 patients on panel per contract

This document also gives members an opportunity to express interest in accessing the PCN Allied Health resources. These resources support mild to moderate primary care needs through the expertise of Social Workers, MHSU Consultants, and a Pharmacist.

Requests are submitted and review by an evaluation committee and will be submitted to the local PCN Operations Committee for consideration and approval. The Committee meets once a month. The PCN team will contact you to provide the outcome of the discussion.

Patient Medical Home Requests:

☐ Registered Nurse	☐ NTP FP Contract	☐ NTP NP Contract	☐ Allied Health Resource Access
FTE:	#	#	

Additional Information on Hours, Providers, or Panel Size: (please indicate if there is a provider in your office who will not be accessing PCN resources)

If Requesting Additional PCN Resources (please respond to the below applicable sections highlighted):

**Note: Request for additional resources is subject to availability within the PCN.*

For All Clinical Roles - PCN Attributes (Appendix A)

1. *Please indicate if your PMH has been able to meet the attributes of the PCN. If not, please indicate which attributes have not been met and why.*

2. *Please describe the patient experience of the current PCN Resources at your medical home. (Are patients satisfied with different care team members supporting them).*

Registered Nurse

1. *Please describe the training and onboarding process to support the current RN.*

2. *Please explain the RN scope of practice implemented to date.*

3. *Please attach RN Encounter Codes (last 3 months) submitted for the PCN RN(s) currently attached to your clinic.*

4. *Please advise the average number of patient visits provided per day in the last month per RN.*

5. *Please indicate if your clinic has met the requirement to attach an additional 500 patients per clinic per 1.0 FTE PCN RN. Y/N*
    - How many attached?
    - Are you on schedule to meet your attachment targets?

6. *If not, please provide a reason for consideration:*
    - What challenges have you faced in meeting the attachment targets?
    - How can we help support you to overcome these challenges?

Allied Health Clinician (MHSU HC, Social Worker, Pharmacist etc.)

1. *Please identify Allied Health resources currently accessed by your PMH (i.e. clinical roles, FTE etc.)*

2. *What additional Allied Health resources are being requested at this time?*

3. *Please describe the need for additional Allied Health resources for consideration (reference where applicable PCN attributes)*

Nurse Practitioner

1. *Please confirm the amount of FTE of PCN NP services currently allocated to your PMH?*

2. *Please describe the need for additional NP services at your clinic. How have current resources been maximized to date? (reference where applicable PCN attributes.*

Describe the Status of Your Clinic's Panel Management.

Describe the clinical environment to support Team Based Care Work and Work to Come. Include examples of how you envision team-based care to be implemented:

Describe the Space the Clinic has to Accommodate the Addition of a PCN Team Member

Describe the Clinic's Capacity to onboard a new Clinic member, provide training on EMR and Develop Workflows

(If RN) How will an RN assist the Clinic to Reach an Increased Attachment of 500 Patients? Please complete appendix B.

Clinic Signature:

Signature of the Person Submitting this Form

Contact Info:

Email of person signing for PCN Clinic

Date of Signature

MM *DD* *YY*

Appendix A

A patient medical home (PMH) is a community practice where patients get the majority of their care. It builds on what GPs are already doing and takes the practice to the next level. FPs get more consistent support from teams, networks, and clinical services in the community and use data to inform decisions. A primary care network (PCN) is a clinical network of providers in a geographic area where patients receive expanded, comprehensive care and improved access to primary care. PCNs include FPs, NPs, and allied health care providers in patient medical homes (PMHs), First Nations communities, health authority services and community health services. Everyone works together as a team to provide all of the primary care services for the local population.

Primary Care Network (PCN) Attributes:

1. Process for ensuring all people in a community have access to quality primary care and are attached within a PCN.
2. Provision of extended hours of care including early mornings, evenings and weekends.
3. Provision of same day access for urgently needed care through the PCN or an Urgent Primary Care Centre.
4. Access to advice and information virtually (e.g. online, text, e-mail) and face to face.
5. Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.
6. Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.
7. Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.
8. Care is culturally safe and appropriate

Please initial the attributes you are committing to adhere to:

☐	**Access and attachment to quality primary care** (PCN Attribute 1): The practice has a clearly defined attachment process and improved access through opportunities such as virtual care or team-based care. Process for ensuring all people in a community have access to quality primary care and are attached within a PCN.	
☐	**Extended hours** (PCN Attribute 2)**:** Provision of extended hours of care including early mornings, evenings and weekends. The practice demonstrates extended hours through before or after normal hours care, on-call response, or walk-in opportunities.	
☐	**Same day access to urgent care** (PCN Attribute 3)**:** Practice provides opportunities for same-day access to primary care.	
☐	**Advice and information** (PCN Attribute 4)**:** Practice uses in person, virtual, email, text, or online communications to support the sharing of information and advice to patients.	
☐	**Comprehensive primary care** (PCN Attribute 5)**:** Practice will network with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.	

☐	**Coordinated care** (PCN Attribute 6)**:** Practice Demonstrates coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.	
☐	**Clear communication** (PCN Attribute 7)**:** Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.	
☐	**Culturally safe care** (PCN Attribute 8)**:** Care is culturally safe and appropriate.	

Appendix B

RN CHECKLIST - Please check all that apply:

Intake:

- ☐ Conduct suicide risk screening (IS PATH WARM)
- ☐ Take Blood Pressure
- ☐ Administer point of care test for blood glucose
- ☐ Select and conduct suitable screening tools (e.g. health history questionnaire, immunization history, home safety, cognitive issues, suicide risk, abuse, neglect)
- ☐ Conduct BPMH
- ☐ Gather medication list

Assessing the Client

- ☐ Set up the assessment
- ☐ Determine what resources are needed
- ☐ Confirm Client's need(s)
- ☐ Conduct History assessment (as per scope and client's need)
- ☐ Conduct health history assessment as per scope of practice & client's needs
- ☐ Gather medication list including over-the-counter medications, alternative medications, and supplements, intolerances and allergies
- ☐ Conduct BPMH
- ☐ Identify social determinants of health barriers & strengths

Conduct physical assessment (as per scope of practice and client's need)

- ☐ Take vital signs as needed per assessment
- ☐ Assess disease-specific nutritional requirements
- ☐ Conduct physical assessment of bowels - auscultate, palpate, insert instrument beyond anal verge
- ☐ Perform venipuncture for the purposes of establishing intravenous access, maintaining patency or managing hypovolemia **
- ☐ Administer point of care testing (POCT) as applicable for blood glucose, urine chemstrip, urine pregnancy test, HIV testing **
- ☐ Provide routine pelvic exam and cervical cancer screening / pap test **
- ☐ Conduct psychosocial assessments as indicated
- ☐ Review goals of care with client and link to current health status

Provide treatment /intervention

- ☐ Completing Section 3 (Assessors Report) of the persons with Disabilities Designation Application to determine eligibility for the Person with Disabilities designation under the Employment and Assistance for Persons with Disabilities Act
- ☐ Carry out an electrocardiogram

- [ ] Provide uncomplicated nail and foot care
- [ ] Provide ear syringing – ear irrigation using water and bulb
- [ ] Provide basic skin & wound care (includes cleansing, irrigating, proving, debriding, packing, and dressing a wound)
- [ ] Removal of sutures & / or staples
- [ ] Provide Hepatitis A & B / travel health vaccinations
- [ ] Provide immunizations > 18 years age (includes influenza/pneumococcal]
- [ ] Facilitate client connection to community resources and support
- [ ] Provide basic life skills education (i.e. cooking, budgeting)
- [ ] Provide client/family psycho-education
- [ ] Organize & lead client/family community care conferences
- [ ] Provide supportive counselling

Appendix C

Allied Health Team

The scope of practice for this team is at the primary care level, therefore, crisis or urgent referrals should be made to Island Health's MHSU Access and Crisis services or emergency departments. If it is unclear whether a client is suitable for the service, please contact the program to schedule an inter-service consultation.

About the team:

This team works closely with patients of Primary Care providers on Saanich Peninsula who are participating in Primary Care Network (PCN). The team consists of social workers, MHSU consultants, and a Pharmacist. Referrals are received directly from primary care providers participating in PCN.

Services

- Psycho-Social support, short-term counselling for mild to moderate depression, anxiety, grief, substance use, family systems, caregiver fatigue, etc.
- Financial advocacy and assistance with federal, provincial and regional benefits.
- Support with accessing community resources from food banks to recreation life passes, counselling and peer groups, programs and services to support mental and physical well-being.
- Chronic disease self- management
- Advance care planning
- Support and information for Substitute Decision Makers.
- Adult Guardianship Act (AGA) support, public guardian navigation and advocacy
- Service navigation and support for child, youth, adults, and seniors (Community, CYMH and MHSU).
- Participation in family conferencing with providers.