Introduction to the Primary Care Network Initiative

A Primary Care Network (PCN) is a geographically defined area in British Columbia in which planning and service provision for the comprehensive suite of primary care services for the community population takes place. The PCN will be designed to meet the needs of the population through the networking of Patient Medical Homes (PMHs) linked with primary care services delivered or contracted by a health authority, community-based social service organizations, and other health service organizations. Through the PCN partnerships the network of local primary care service providers (including from physician practices, health authorities' clinics, Indigenous[4] communities and health service providers, and other community providers) will work together to provide all the primary care services a population requires. The PCN partnerships will also support providers to share the workload, break down silos between health authority and GP services, and provide supports to develop their new practice or leave their practice. PCNs are key to an integrated system of primary and community care. The following eight core attributes have been identified as key foci:

Primary Care Network Core 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.

Additional detail on the vision for PCNs and general policy direction is described in **Appendix E**.

Implementation Approach

The Ministry of Health 2018/19-2020/21 Service Plan lays out the target of at least 15 PCNs to be developed in 2018/19, 25 in 2019/20 and 35 in 2020/21 (cumulative total). The Ministry, General

[4] Indigenous is a term that is inclusive of First Nation, Métis and Inuit peoples in Canada, living in communities and in urban centres.

Practice Services Committee (GPSC), health authorities and other partners will work to meet and surpass these targets.

New funding for PCNs is being invested with an expectation of measurable and substantial improvements in the attributes of the Primary Care Network. It is expected that, where an attachment gap exists in a community, the plans will focus on closing the gap as a first priority, followed by working towards the remaining PCN core attributes. Funding for the PCN is dedicated ongoing funding; as PCN work advances and outcomes and successes are demonstrated against mutually agreed upon performance measures, enhanced funding may be provided.

The PCN Service Plan is intended to provide an integrated plan to address service needs in community. This requires an understanding of the local needs, and development of non-siloed strategies which match the need.

A. Executive Summary

Geography and Population

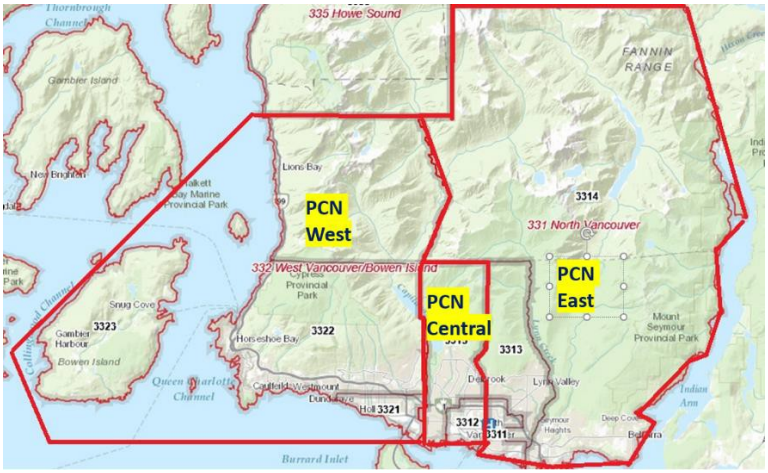
The North Shore (NS) has a growing population, which current Ministry of Health (MoH) data places at 208,023[5]. By 2025, this group is expected to increase by more than 12,000 individuals. Nearly one quarter of those 50-74 years of age have one or more chronic conditions and one-third of the population 75 years and older have one or more chronic conditions. By 2029 the population is projected to grow by almost seven percent with significant growth expected in the senior population (65 years and older).

In terms of geography, the North Shore consists of seven communities stretching over 40km along the Burrard Inlet and Howe Sound. From east to west the communities are the District of North Vancouver, the Tsleil Waututh Nation (TWN), the City of North Vancouver, the Squamish Nation (SN), the District of West Vancouver, the municipalities of Bowen Island, approximately 3 km away and accessed by BC Ferries, and Lions Bay, 20 km north of West Vancouver.

Three Primary Care Networks (PCN) are proposed for the North Shore, each with a population of 50,000-100,000, that will manage services and be accountable for population health outcomes, including primary care attachment. In addition to the population size and geography, the North Shore's significant traffic issues which create barriers for patients and staff to travel across the North Shore, were taken into consideration when planning for the three PCNs.

[5] The NS population numbers referenced throughout this document vary according to the sources used. The number here was provided by the MoH and is the number the attachment gap was based on. In other parts of the document the NS population is taken from BC stats and Stats Canada depending on the information being presented.

The North Shore PCNs will be: PCN West, PCN Central and PCN East.



Attachment Gap

After careful data analysis, the North Shore PCN partners and the MoH concluded that the attachment gap is 33,779 residents across the three PCNs. The MoH has identified that, based on this number of unattached residents, the North Shore qualifies for the funding equivalent of 27 General Practitioners/Nurse Practitioners (GP/NP).

The unattached First Nations on-reserve people are not included in the agreed upon attachment gap. In discussion with the MoH it was agreed additional GP/NP full time equivalents (FTE) would be required to meet the First Nations' attachment gap. Therefore, the North Shore is requesting an additional 1.5 GP/NP FTEs based on the following rationale:

- There are approximately 1100 unattached residents on-reserve
- Approximately 700 unattached are status First Nations and approximately 400 unattached are non-status residents
- The panel size of a GP for this population is approximately 800 patients.

Priority Populations

The North Shore PCN partners recognise that the initial priority is to attach the unattached residents. As well, three priority populations have been identified requiring additional services to support attachment and comprehensive care. The populations listed below were prioritized based on available data and input from primary care providers, Vancouver Coastal Health (VCH) staff and the community:

- Frail in Community, High Complex with Frailty & High complex without frailty.
- Low and Medium complex conditions
- Severe Mental Health & Substance Use (MHSU).

While the unattached in the Frail and High Complex category is a relatively small number (approximately 640), through various engagement events with physicians and VCH staff, we have heard that providing appropriate care for these clients is very time consuming and it is challenging for primary care providers to manage or take on these types of patients without support. At the same time, the importance of having access to comprehensive primary care for this population is recognized as crucial to better health outcomes.

The high volume of unattached people in the Low and Medium Chronic conditions category (approximately 7900), combined with an analysis of the number and type of chronic conditions was a primary driver for selecting this population group. Moreover, low to moderate mental health conditions (anxiety and depression) play a significant role in multimorbidity and can be another challenging patient population for primary care providers to manage. Furthermore, it is well-evidenced that Aboriginal patients have high levels of trauma, mental illness and addictions. The current health care experience for many Indigenous people is one of disconnection from their culture and traditions. Traditional healing and practices and cultural preservation all play a key role in Mental Health and Wellness across the Aboriginal population; however, at present, access to culturally appropriate care is extremely limited.

The number of unattached residents within the Severe Mental Health and Substance Use (MHSU) population is small (approximately 585), but due to the complexities involved in their care, the challenges in finding primary care providers willing to take them as patients, and feedback from physician consultation events, these individuals were identified as a top priority for enhanced services.

Overview of development process

The North Shore Division of Family Practice (NSDoFP) and Vancouver Coastal Health (VCH) have worked collaboratively, co-leading the planning and development of the service plan. Representatives from First Nations Health Authority as well as for Squamish and Tsleil-Waututh Nations have been integral to the work as it relates to the inclusion of the Nations in the PCNs. In addition to Collaborative Services Committee (CSC) meetings, this collaborative planning process has included but, is not limited to:

1. The formation of the PCN Steering Committee, a sub-committee of CSC, in Fall 2016. Regular meetings have been held for the past three years, thereby fostering relationships and building trust amongst the partners. The committee currently meets bi-weekly and membership includes:
    - NSDoFP: physician lead, physicians, project staff, evaluator, and executive director
    - VCH: directors and managers of community and aboriginal programs, communications, NP lead, medical health officer, project managers, and practice support program(PSP)
    - Squamish Nation (SN)
    - Tsleil-Waututh Nation (TWN)
    - First Nations Health Authority (FNHA)
    - General Practice Services Committee (GPSC) Liaison
2. Weekly project team meetings;

3. Bi-weekly Working Group meetings with representatives from VCH, NSDoFP, PSP, SN, TWN, and FNHA, focusing on detailed operational planning, with key decision-making items brought forward to the PCN Steering Committee;
4. GP Focus Group that meets on an as needed basis to provide broader physician input into the design of the service delivery model;
5. VCH & NSDoFP representation at the Aboriginal Primary Care Network's semi-annual partner and stakeholders meeting;
6. Engagement events and activities:
    - A NSDoFP PCN "kick off" event September 2018, whereby guest speakers from Alberta were invited to speak to NSDoFP members about PCN's. The 4-hour event provided an opportunity to introduce the concept and gather feedback from 63 physicians;
    - Ten small group physician engagement sessions totaling 50 members.
    - Meetings with numerous physician practices and clinics;
    - A consultation session with the UBC Family Practice residents;
    - Four community and patient engagement forums with 50 participants;
    - Several meetings with local community organizations;
    - Five VCH staff engagement sessions and four staff focus groups Meetings with three municipal mayors (District of West Vancouver, District of North Vancouver, City of North Vancouver);
    - On-line surveys for physicians, patients, and organizations unable to attend engagement sessions in-person.

Overall community goal or vision

The vision of the North Shore PCNs is to create an integrated and coordinated health care system built on the foundation of comprehensive primary and community care that targets population needs, is person-centered, culturally safe, trauma informed and delivers a quality service which is easy to understand for those who use it and those who work in it.

Value Proposition

Through a coordinated, comprehensive primary and community health care system:

1. Population health and wellness will improve.
2. Continuity of care will improve.
3. Residents who want a primary care provider will have one.
4. Access to primary care during early mornings, evenings, weekends, and statutory holidays will be available.
5. Same day access for urgent primary care needs will be available.
6. Access to care, in person and virtually will be available
7. Community members will receive trauma informed, culturally safe and appropriate care
8. Both patients and primary care providers will be supported through a network of Patient Medical Homes (PMH) practicing team-based care with seamless linkages to specialists and specialized services.

New Services and Improvement Strategies

The budget amounts below include salary, overhead and where required, one-time costs.

First Nations Services

The Tsleil-Waututh Nation (TWN) and Squamish Nation (SN) primary care teams will be expanded to include a range of primary care services and access to many allied services. A holistic approach to health and wellness through both on and off reserve primary care clinics, providing both western and traditional medicines in a culturally safe environment will increase attachment and improve overall health outcomes for all Indigenous peoples. Access to Mental Health and Wellness services is imperative to the Aboriginal population as it encompasses more than the absence of mental health conditions or illnesses – it takes a holistic model of care to build resilience amongst Indigenous community members that focuses on the physical, spiritual, emotional and mental teachings. These elements will be achieved through the meaningful inclusion of the essential medical positions of Elders and Traditional healers which have been included within this Service Plan.

As guided by the First Nations communities, the clinics will be enhanced by increasing the resources to allow them to be open five days per week at both clinics with extended hours for some evenings and weekends (based on resourcing availability). These additional resources will also allow for an estimated increased attachment of 2,000 FN people living on and off reserve.

As partners in the development of the NS PCNs, the NS First Nations have developed a plan to meet the primary care needs of the NS First Nations Communities. While this will be integrated within the North Shore PCNs, for ease of reading, the First Nations plan has been attached at the end of Section G.

Supporting Existing and Recruiting New Primary Care Providers (all population health segments)

The goal of this funding is to increase the number of primary care providers (PCPs) on the North Shore, including Bowen Island, and to better support existing PCPs in Patient Medical Homes (PMH) through team-based care. By recruiting ten new PCPs via the Ministry of Health's HealthMatch and establishing them within existing North Shore practices and integrating Registered Nurses (RN) or Behavioural Health Clinician(BHC)/Social Worker(SW)/Mental Health Clinician(MHC) in twelve of the 'early adopter' practices, an additional 18,150 patients will be attached to PCPs in the NS PCNs. Further support to the PCPs will be provided by the PCN teams in each network. There is existing space available to offer all of the net new PCPs a PMH in which to work.

Primary Care Network Teams

Through engagement with North Shore physicians, VCH staff, and community members, the need to support people with mild to moderate mental health concerns, specifically anxiety, depression and life

adjustment challenges came up repeatedly, demonstrating the significant gap in services for this patient group. Based on the identified need, the PCN teams will be comprised of 15 Social Workers/Behavioural Health Clinicians/Mental Health Clinicians – 5 for each PCN.

There will also be clinical pharmacists working in each PCN to support the primary care providers and PCN teams.

HOpe Primary Health Clinic – Incubator/ Teaching Clinic

The Hope Primary Care Clinic aims to provide a new PMH on the North Shore, while maintaining the focus on education through UBC's experiential learning for residents within their Family Practice Resident program.

Early career physicians need to consolidate their skills and grow their patient panel. The model proposed will allow for three 'new to practice' physicians to work for a period of up to 2 years within a team-based environment while being mentored by experienced physicians. Education opportunities for working within a team-based care model will be provided to other professions including Nurse Practitioners (NP). The clinic will be an attachment hub for local residents with referrals coming from the new Urgent & Primary Care Clinic (UPCC), the provincial waitlist and the NSDoFP's attachment mechanism - GP Link. The attachment target of the clinic is 4250 patients every two years.

HealthConnection Clinic (HCC) Expansion

HealthConnection Clinic (HCC) is a PMH for the most vulnerable and marginalized populations on the North Shore. These clients are particularly challenging for general practices to manage well as they are very time-consuming, present with multiple conditions and require robust wrap around supports to deal with the full range of their needs and conditions, including chronic diseases, substance use, extreme poverty, lack of housing, and social supports. Due to the complexity of the clients served, the PCPs at HCC cannot assume the attachment rate specified for a general practice.

Currently, HCC operates 5 days per week and there has been an identified need for increased access for this population. The program will be enhanced by increasing the resources to allow HCC to be open 7 days per week with extended hours. There will also be an increased attachment of 1650 of North Shore's most vulnerable people.

Foundry NS and Youth Clinic Expansion

The youth accessing primary care services through Foundry are very complex, most with mental health and substance use issues, and visits are typically 30-60 minutes in duration. Foundry primary care providers spend considerable time on care coordination for these complex youth and their families and as a result, the PCPs cannot assume the attachment rate specified for a general practice.

Although there are youth clinics operating on the North Shore, they focus exclusively on sexual and reproductive health. These clinics do not have the scope to provide for more complex primary care needs nor the mental health needs of the youth that attend.

Currently, primary care services are offered at Foundry Monday to Thursday 9:00-12:00 and 2:30-5:00. The enhancement of Foundry resources will allow the clinic to open five days per week, nine hours/day and will attach an additional 550 complex youth. Furthermore, the development of a new satellite team will allow comprehensive primary care with mental health and substance use support to be provided at youth clinics.

Supporting the Redesign of Primary Care Service

Significant change is required to transform the current system into three PCNs with inter-disciplinary, team-based PMHs. The introduction of new programs, services and staff will not be successful without the support of roles to build the new infrastructure and manage the change process.

The roles identified in the Change Management Request are necessary for the successful development of North Shore's PCNs. These roles will help operationalise the networks, assist practices in meeting the 12 attributes of a PMH, and provide the support required to allow the integration of team-based care. Transformation of the primary care system to effectively meet the needs of the population will also require the integration of new technologies and support to ensure these technologies are optimised.

Virtual Care Service – WELTEL Prototype

Many patients have challenges accessing the traditional medical office due to the North Shore's geography, access to transportation, traffic, time, work, childcare commitments and more. These challenges also apply to team-based care, specialty visits and follow-ups, family and team meetings, and a range of other health care encounters. Virtual care increasingly allows the attachment gap to be closed, especially for vulnerable/marginalized populations including youth, single parents, those with MHSU issues, people who are homeless, and those living in poverty. Optimized virtual care tools and platforms are known to improve communication, patient engagement, along with creating efficiency for PMH offices and teams, across a range of activities - supporting vulnerable, complex and healthier populations to create and maintain primary care attachment, and to access timely care.

Weltel is a BC-based, internationally known, well researched non-profit virtual care platform. They are prepared to help deploy a prototype in one or more North Shore PMHs, and if successful, expand to include others as uptake and capacity allow. Budget and resources for this service are not yet known or understood but will be developed by the virtual care coordinator in collaboration with Weltel, and the PCN partners once the service plan is approved.

Total FTEs and Budget

Total FTEs

	*GP/NP FTE	*NP FTE	*GP FTE	Allied Health FTE	RN FTE	FN Traditional Healer/Elders FTE	Pharm-asists FTE	Other FTE
Service								
Supporting Existing and Recruiting New PCPs			9	3	12			
Bowen Island	1							
PCNT				15			4	
HOpe Clinic			3		1			
Health Connections Clinic		2	1	1	3			
Foundry	1.5			1.3	0.5			
First Nations		1	1.5	2	1	3		
Change management roles								15
WelTel								
Totals	**2.5**	**3**	**14.5**	**22.3**	**17.5**	**3**	**4**	**15**
The FTE calculations above are based on the MoHs identification that, to close the attachment gap, the North Shore qualifies for the funding equivalent of 28.5 GP/NP and that in planning for team-based care 1 GP/NP FTE can be 'exchanged' for 3 RN/Allied FTEs.								

*While some programs/services have specified which profession will be recruited (GP or NP) it is recognised that there could be recruitment challenges for both and there will be flexibility when recruiting to meet the attachment gap.
The column titled GP/NP reflects that, for these services, there has been no specification made for GP or NP.

Please note: The MoH provided the North Shore with the opportunity of establishing an UPCC prior to the completion of this service plan. This project is currently in the planning stages and expected to open early summer 2019.