Surrey-North Delta
Primary Care Networks

2021 | 2022

PCN SPECIAL REPORT

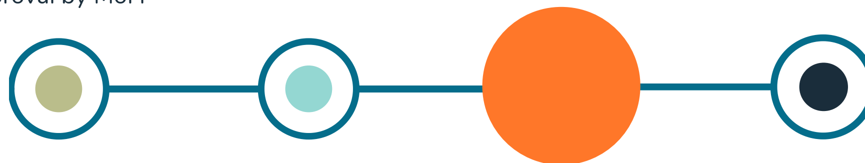
What is PCN?

A Primary Care Network (PCN) is a network of local primary care service providers within a community. These providers partner with community organizations, allied health care providers and health authorities to deliver coordinated care to patients in the community. PCNs focus on providing a team-based approach to primary care.

Our PCN Journey

Expression of Interest (EOI)
- Invitation from MoH to create
- Completion and submission with partners
- Approval by MoH

PCN Service Plan: Phase 2
- Reviewed by MoH
- Negotiations with FH and Division
- **Approved by MoH**



PCN Service Plan: Phase 1
- Development funded by MoH
- Completion and submission with partners

PCN Service Plan: Phase 3
- Design and implementation carried out by Division and FH
- Planned for 2022-2023

Key Achievements

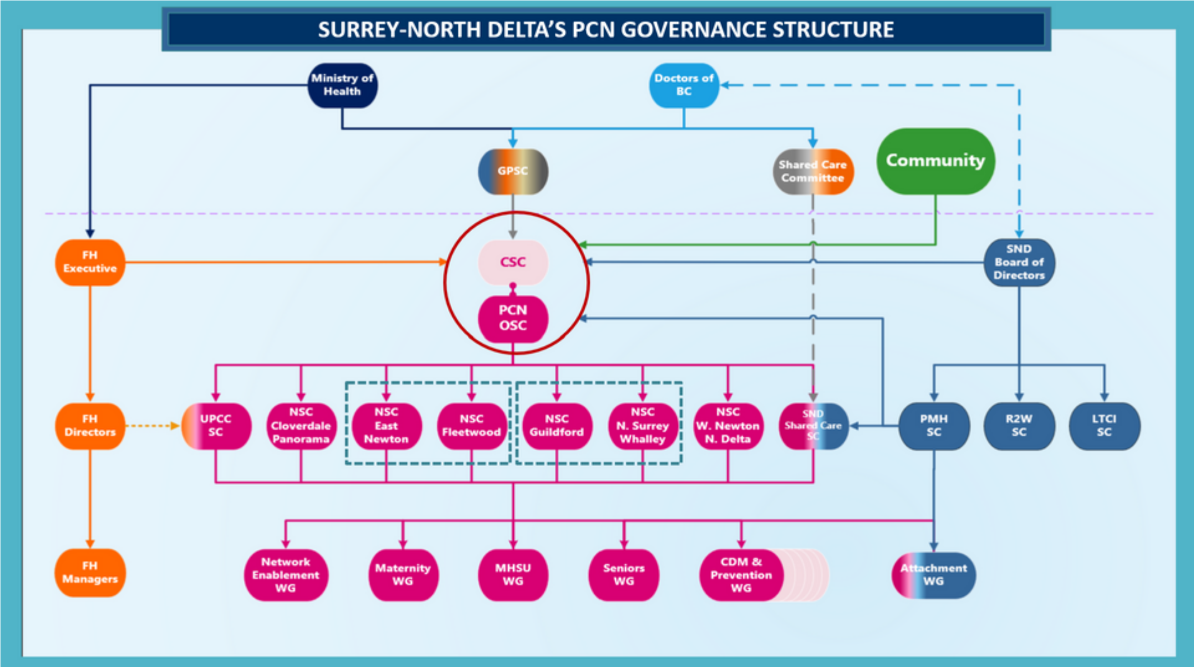
- Engagement of over 150 Family Physicians in PCN development.
- Building partnerships with Fraser Health Authority, First Nations Health Authority, and Community partners around Primary Care Networks.
- The development of the PCN Service Plan and the vision for the future of the SND community as a PCN community.
- Engaging SND Senior Leadership (community organizations, Division, FHA) in sharing collective strengths/gaps/opportunities/needs and designing a new governance model with the vision of 'Aligning a collective strategy with the purpose of delivering sustainable community wellness and healthcare.'

2021-2022 saw the approval of the proposed PCN Service Plan by the Ministry of Health.

PCN Governance Structure, Roles and Activities

With over 50 physicians participating in different committees and working groups, SND Division members and staff are working diligently to ensure that our six PCNs reflect the needs, concerns, and ingenuity of our Family Physicians and their patients.

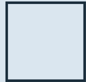
PCN Governance Structure



CSC = Collaborative Services Committee
OSC = Overall Steering Committee
NSC = Neighbourhood Steering Committee
PMH = Patient Medical Home
R2W = Recruitment, Retention & Wellness
LTCI = Long-term Care Initiative
WG = Working Group

> Having been in this neighbourhood for a decade, I have felt the isolation of carrying a heavy burden in an under-resourced environment. I can feel the excitement of change, forming connections, exploring existing and new resources, and creating an environment of support and community.
>
> -Dr. Niazi, Overall Steering Committee Chair

PCN Governance Structure, Roles and Activities

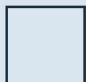


Physician Leadership Team

The PCN physician leadership team has been our cornerstone in the design and development of the SND PCN. It has inspired other community physicians to be involved in PCN and work together.

Physician Leadership has been and continues to be present across the formal and informal structures that support PCN, including:

- **Our Board of Directors**
- **The Patient Medical Home Steering Committee (PMH SC)**: 18 FPs leading and voicing the FP perspective in the development and implementation of PCN
- **The PCN Neighbourhood Steering Committees (NSC)**: 3 local FPs on each of the six committees partnering with their FH counterparts to provide leadership at a neighbourhood/PCN level.
- **The PCN Overall Steering Committee (OSC)**: the chair of our division board and the six Physician co-chairs of the six PCN NSCs, partnering with their FH counterparts to provide leadership at a community level.
- **PCN Working Groups (WG):** several FPs have volunteered to help shape and design the future of Primary Care in SND via PCN Working Groups.
- **PCN physician leadership engagement events**



Overall Steering Committee

The overall steering committee played an instrumental role in guiding and overseeing the PCN approach and PCN Service Plan development and endorsed the Service Plan submission to the MOH for approval. Moving forward, it will continue providing governance and strategic decision-making to the PCN implementation and operations.

PCN Governance Structure, Roles and Activities

Neighbourhood Steering Committees (NSC)

In addition to the overall steering committee, we worked closely with our **six neighbourhood PCN steering committees** - one for each of our six PCNs – to develop the PCN Service Plan.

The goal of the NSCs is to provide leadership and guidance in matters at a neighbourhood level and to feed and influence the conversation and decision-making happening at the OSC.

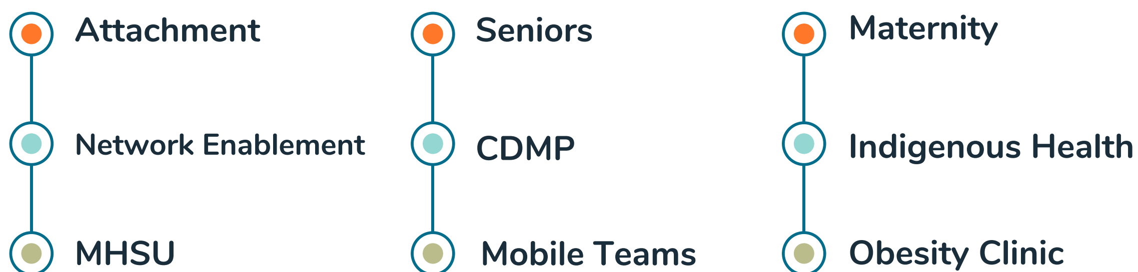
Patient Medical Home Steering Committee (PMH SC)

The purpose of the Patient Medical Home Steering Committee (PMH SC), as a physician-only committee, is to represent the family physician perspective and provide recommendations to the Division's Board of Directors and the PCN Overall Steering Committee. The PMH SC plays an instrumental role in providing the direction in the development, design, implementation, and sustainment of the SND PCN, supporting the principles and full enablement of the attributes for all Patient Medical Homes operating within Surrey and North Delta.

PCN Governance Structure, Roles and Activities

Working Groups

Working groups continued developing the PCN Service Plan and defining the SND PCN strategies. In addition, working groups supported the Roots Community Health Centre (CHC) development as part of the SND PCN initiative.



PES Team Support

The Physician Engagement and Support (PES) Team supported the leadership committees with the following :

- **Leadership building events:** one in-person and one virtual for our PCN physician leads
- **Community physician engagement and events**, including:
  - Townhall in June 2021
  - Team-based care session in Dec 2021
  - Townhall to discuss PCN approval in May 2022.

PCN Service Plan

The PCN Service Plan is the master document that describes the vision of the future redesigned primary and community care services in the community of Surrey-North Delta.

This is followed by the context that shapes our decisions and proposed strategies, including community demographics, needs assessments, existing community resources, and providers' readiness for change.

The Surrey-North Delta PCN Service Plan is the product of a shared vision of the key strategic partners, including the Surrey-North Delta Division of Family Practice and our members, Fraser Health, First Nations Health Authority, and community services, to establish Primary Care Networks as a foundation of an integrated system of primary and community care. That vision is of a robust healthcare system deep-rooted in primary care and prevention, integrated with community services and programs, and truly accessible to our residents.

Our vision for Surrey and North Delta as a PCN community is to build an integrated healthcare system where the community's residents, including newcomers and refugees, the marginalized and overlooked, feel confident and safe in accessing timely, quality, and culturally appropriate care. We aim to build a connected, full-service primary healthcare system that addresses the health needs of our community and attracts innovative and dedicated practitioners. The PCN community we hope to build will recognize Surrey and North Delta as a full-fledged community with its own needs and complete health care and wellness resources to serve its residents.

After nearly 2 years of broad stakeholder engagement, on June 30th, 2021, we submitted our PCN Service Plan for review to the Ministry of Health. It was successfully approved by the MOH in March 2022.

PCN Service Plan

The PCN Service Plan Executive Summary communicates key highlights from the Service Plan, including health data for Surrey-North Delta, our planning and engagement process, and the key proposed strategies.

SND PCN Strategies

Strategy	Description
Attachment	Attachment strategies and mechanisms to attach new patients to primary care providers improve patient and provider experience and ultimately lower healthcare costs.
Network Enablement	Enablement of team-based care and efficient operation of the PCNs.
Team-based care for MHSU	Enhancement of existing MHSU services in the community to facilitate attachment and increase and streamline access to the MHSU services in the community.
Mobile Teams	Establishment of Mobile Teams to provide primary care and MHSU services to the homeless population and unattached homebound patients.
Integrated CDMP Program	Enhancement of existing health programs and services to provide quality care to patients living with chronic conditions and facilitate their attachment to community FPs and Nurse Practitioners (NP).
Obesity Clinic and Behavioural Health Coaching Program	Establishment of an Obesity Clinic and Behavioural Health Coaching program to better support patients struggling with obesity and facilitate their attachment to community FPs and NPs.
Maternity Wellness Centre	Establishment of the SND Maternity Wellness Centre to increase attachment of moms and their babies to community FPs and NPs and improve access to maternity health care services.
The PCN Seniors Team	Creation of the PCN Seniors team to facilitate attachment to community FPs and NPs and provide team-based care to the senior population by bridging system gaps and supporting care plan coordination.
Enhancement of Indigenous Health Services	Enhancement of existing Indigenous health services by augmenting primary care and Allied Health Capacity (MHSU) to address the attachment gap and increase access to MHSU services.

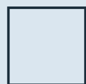
PCN Service Plan

SND PCN Key Performance Indicators

Attribute	Indicator	Reporting
Attachment	1. # Patients attached (total attachment) 2. New-to-Practice FPs and PCN NPs Panel size	1. Quarterly 2. Annually
Extended Hours	#/% Clinics in each PCN offering services outside of 8 am-6 pm	Annually
Same Day Access	1. % Clinics with same-day appointments available 2. Perception/ satisfaction with access	1. Annually 2. Quarterly
Virtual & Face-to-face Care	% Clinics offering virtual care	Annually
Comprehensive Care	1. Types of services provided 2. Total # visits 3. Total unique patients	Quarterly
Coordinated Care	1. Types of services provided within PCNs a. # NTP FPs hired b. # NPs hired c. # RNs hired d. # AHP hired (and role) 2. Types of patients supported 3. i.e., % MHSU, high complexity, frail	Quarterly
Communication Within Network	1. Perception of PCN (patients) 2. Perception of PCN (team(s)) 3. Perception of PCN (care providers)	Annually
Culturally Safe/Relevant Care	1. # Traditional Elder in Residence/Cultural Advisor hired 2. # Unique patients served by PCN Indigenous strategy	Quarterly

The PES Team supported the development of the PCN Service Plan by looking at space needs and availability to host PCN resources; analyzing statistics for different neighborhoods; and supporting most levels of the PCN steering committee

PCN Readiness Activities



UPCCs

UPCCs are one of the PCN constructs and play an important role in filling an urgent/after-hours access gap and providing a mechanism to attach vulnerable and complex patients to the UPCC FPs and NPs in the community.

This year, we continued to support both Surrey-Whalley and Surrey-Newton UPCCs in improving and streamlining their clinical service model to strengthen access to same-day urgent primary care services, including evenings and weekends, and address the attachment gap for vulnerable and multi-barriered population groups.

The PES Team contributed to this work by supporting the recruitment of providers to accommodate the expansion of two UPCC schedules.

PCN Readiness Activities

Community Partner Engagement

The strength of our PCN depends on engagement with community services and resource providers. Carried out by the PES Team, community partner engagement this year has included a number of activities.

Engagement Events Supported by the PES Team

- **One in-person PCN physician leadership engagement session**
  - **Date:** August 2021
- **Two community partner engagement sessions on stigma.**
  - **Dates:** September 2021 and February 2022
- **One event detailing the role of community partners in PCN**
  - **Date:** June 2021
- **One in-person PCN event to engage community partners' senior leadership**
  - **Date:** March 2022

Up to
23
Community Organizations joined each of these 5 events

Foundry BC

Foundry BC is a province-wide network of integrated health and social service centres for young people ages 12-24. Foundry centres provide a one-stop-shop for young people to access mental health care, substance use services, primary care, social services, and youth and family peer supports. Pacific Community Resources Society has stepped up as the lead community partner, hosting Foundry in Surrey-North Delta. The SND Division is a strategic partner in the design and development of the Foundry in Surrey, which is aiming to open its doors in 2023.

PCN Readiness Activities

Roots Community Health Centre

Roots Community Health Centre (Roots CHC) provides person-centred, longitudinal care to multi-barriered newcomers through an interdisciplinary, culturally safe, and trauma-informed care team of family practice physicians, clinicians, specialists, allied health, and social service professionals. Roots CHC also facilitates Patient Medical Home (PMH) attachment services.

The current service delivery model is continuously evaluated to align with the MoH Patient Medical Home (PMH) and Community Health Centre (CHC) models. Roots CHC continues to engage community partners and patients to better understand the barriers that patients face while accessing healthcare services and to build pathways between healthcare and social/community services supporting social determinants of health.

Roots CHC proposes the following objectives:

- Ensure timely access to primary care
- Support unattached patients through attachment mechanisms
- Collocate with PCN Teams at the PCN Neighbourhood Wellness Hub to further enhance collaborative decision-making and coordination of care
- Coordination of care and seamless transition between services
- Address health equity needs in the community and coordinate with other primary and community care services
- Community governance structure to address the health needs of the community
- Improve health outcomes of newcomers and refugees
- Integrate services provided by community partners, including those addressing health inequities and social determinants of health
- Incorporate and optimize virtual care with the interdisciplinary team to enhance access to services
- Remove financial barriers for those without MSP who are unable to pay for services.

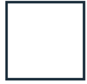
PES Team Support

PCN CHC service plan and project support has been provided by the PES Team, which has:

- coordinated meetings with community partners to complete CHC service plan submission
- facilitated connection with community partners
- leveraged community resources for patients

The Roots CHC plan was approved by the MOH, and implementation is scheduled to commence in Fall 2022.

PCN Readiness Activities



Panel Management

The Panel Management Program is a self-paced, three-phase program that helps physicians organize, understand, manage and optimize their patient panel. Each phase could take up to 15 hours of physician or staff time to complete, and the total time commitment may be up to 12 months.

During 2021-2022, the SND division worked closely with our Practice Support Program (PSP) partners to expand the number of division members engaging in the process, which is foundational in supporting success and informing possible changes in the implementation of PCN in our community.

As of June 2022, 109 of 296 eligible Family Physicians in Surrey-North Delta have completed the Panel Management Program, with 35 completing quality improvement projects between January and June 2022. To connect with PSP, contact your PES Team Lead.

PES Team Support

The PES Team supported Panel Management efforts in the SND Division this year by:

- **Promoting panel management as part of PCN planning** and its anticipated patient referral to PCN services, including a division hosted Practice **Preparing for a Primary Care Network session** with the PSP, HDC and DoBC team-based care team. (Dec 2021)
- **Working with PSP to compile and address challenges** from community physicians
- **Improving awareness of need for clean data** for HDC and to better inform PCN neighbourhood decision making

> "Initially I was hesitant to do the panel management because I thought it would be a tedious process. Once I started, it was the opposite...I highly recommend panel management to other physicians." - Dr. Ajit Sandhar