Primary Care Planning

Nanaimo PCN
Service Plan Submission

Division AGM
October 29, 2020

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Process for PCN

Service Plan = High Level Plan

- Includes the proposed services and estimated resources needed
- Eligible resources are mostly known and are based on population size and attachment gap

Submission/Approval

- Date of Submission – November 2nd.
- Expect some back and forth with the Ministry prior to approval
- Possible to get funding at the start of next fiscal

Implementation - more detailed design of services

- Implementation over 3 Years
- Funding is incremental each year.

Clinical Resources Available

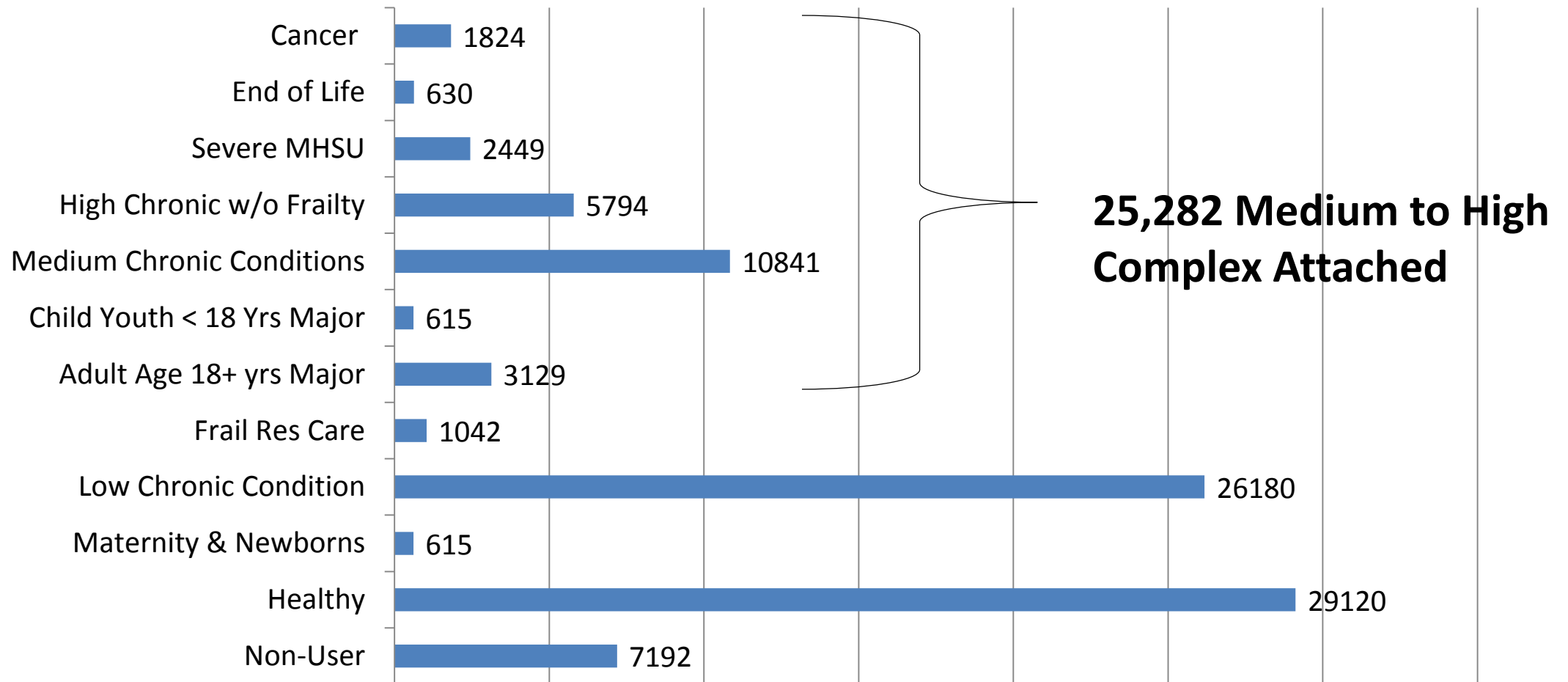| Type of Resource	PCN - Urban	Complex / Vulnerable
Attachment Providers to close the attachment gap	GP: 1,250 NP: 1,000 RN: 500	GP: 650-800 NP: 600-700 RN: 0-300
Allied Health Professionals	**Population-Based Allotment** • 1 AHP per 12,000 General Population – **9.5 FTE** • 1 Pharmacists per PCN	**SDoH Allocation** • 1 AHP per 325-400 net new attachments • **~7.7 – 9.4 FTE**

Attachment Gap Nanaimo: 20,420
Population Nanaimo: 114,000
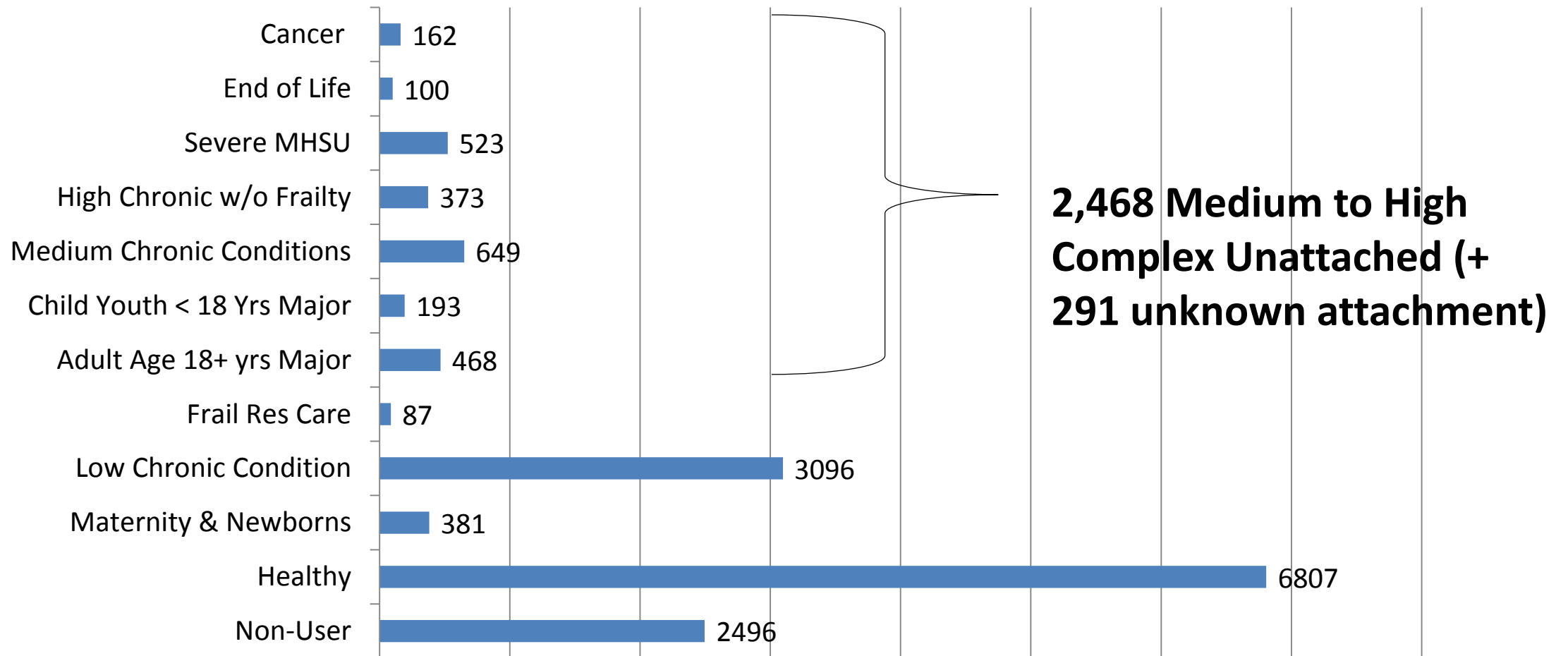
Non-Clinical Resources

Resource	Funding	
Ministry of Health Funding		
Administration • PCN Manager(s) • Program Admin(s)	$246,000 / Year (per PCN)	Salaries + Overhead
Governance	$40,000 / Year (per PCN)	Collaborative governance structure costs
Change Management • Change manager(s) • Evaluator / QI	Varies	One time funding to support change Engagement, Recruitment, Training etc. Recruit people to support change
Capital + One time Funding	Varies	Facilities, Equipment, IMIT
GPSC Funding		
Physician Change Management	$221,555 / year (3 yrs)	Physician leadership + Physician participation in planning, coaching, mentoring, team development, etc.
Division Infrastructure support	$39,098 per year (3 yrs)	Support increased demand on Division
Patient Attachment Mechanism	$35,000 / Year	Hire Patient Attachment Coordinator

Attached Patients by Health Conditions

Health Condition	Count
Cancer	1824
End of Life	630
Severe MHSU	2449
High Chronic w/o Frailty	5794
Medium Chronic Conditions	10841
Child Youth < 18 Yrs Major	615
Adult Age 18+ yrs Major	3129
Frail Res Care	1042
Low Chronic Condition	26180
Maternity & Newborns	615
Healthy	29120
Non-User	7192

25,282 Medium to High Complex Attached

Source: 2017-18 Health System Matrix Population Segment, Ministry of Health

Unattached Patients by Health Conditions

Condition	Value
Cancer	162
End of Life	100
Severe MHSU	523
High Chronic w/o Frailty	373
Medium Chronic Conditions	649
Child Youth < 18 Yrs Major	193
Adult Age 18+ yrs Major	468
Frail Res Care	87
Low Chronic Condition	3096
Maternity & Newborns	381
Healthy	6807
Non-User	2496

2,468 Medium to High Complex Unattached (+ 291 unknown attachment)

Source: 2017-18 Health System Matrix Population Segment, Ministry of Health

Service Plan Development Process

Learnings from Engagement

1. Team-based care within clinical settings
2. Caring for the unattached population
3. Shift care from hospital to home/community
4. Better supporting medical clinics to manage MHSU and SDoH
5. Create attractive places for new primary care providers to set-up practice
6. Need for additional PCPs in existing and new primary care settings
7. Create specialty clinics for unique, high needs populations

Priority Service Areas

- Team-Based Care in Primary Care Clinics – MHSU & Social Work

- Networks Supporting Primary Care

- New Team-Based Care Focused Clinic Concepts

    - Complex/High Needs, MHSU, Low Barrier & Youth

- Net New Primary Care Providers

- Youth and Family Focused Services

- Medically Complex Older Adult Focused Services

- Primary Care and Team-Based Care Supports for Unsheltered individuals

- Services for First Nations, Urban Indigenous and Metis

The Services
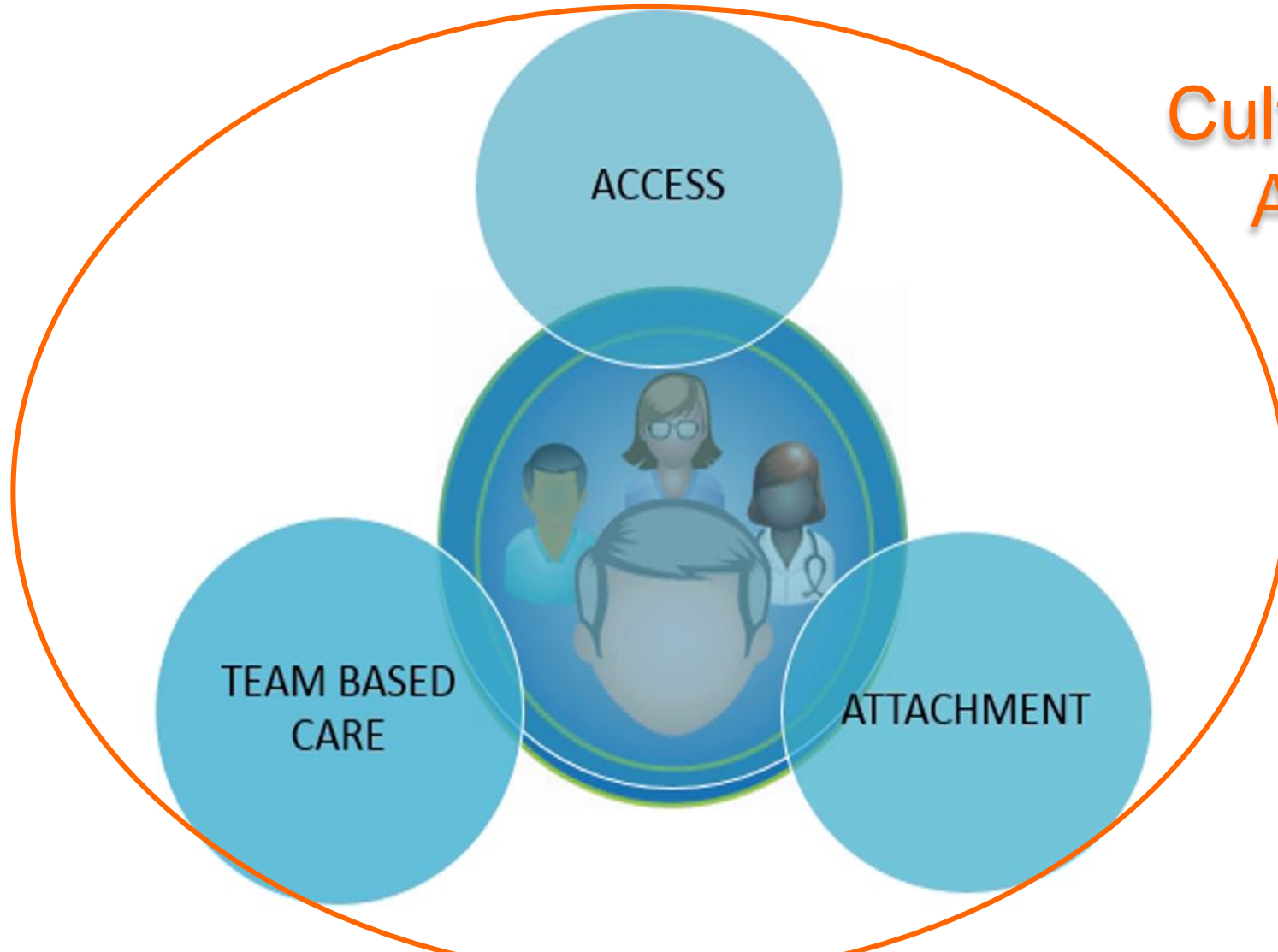
Culturally Safe & Appropriate

ACCESS

TEAM BASED CARE

ATTACHMENT

Services to Support Existing Practices

Service	Gap Addressed	New Providers	Attachment Target
Primary Care Link Allied Health Clinicians			
A team of Allied Health Providers that are connected to and/or co-located with Primary Care Practices.	• >25,000 attached complex patients • MHSU & SDoH • Navigation to Care	9.5 FTE Allied Health* 2 already approved (NP Clinic ++)	n/a
Primary Care Nurse in Practice Team			
A team of Nurses that are connected to and/or co-located with Primary Care Practices to support complex patients. Connection to Clinical Pharmacist	• >25,000 attached complex patients • MHSU & SDoH • Navigation to Care	8.0 FTE RNs 1.0 FTE Clinical Pharmacist	4000

Services to Create Attachment

Service	Gap Addressed	New Providers	Attachment Target
New to Practice Physician Practices			
Create opportunities for new to practice physicians to establish a practice on salary-based contract	• Limited space • Barriers to practice • FFS not attractive	5.0 FTE Family Physicians	6250
Primary Care Access & Attachment Clinic			
High Complex Clinic Model which provides team-based PC services and attachment to unattached, complex and vulnerable patients in Nanaimo.	• >20,420 unattached • 2759 Med-High Complex Unattached • No PCP for follow-up • Limited space in clinics • Barriers to practice	3.0 FTE Family Physicians 1.0 FTE NP 2.0 FTE RN 1.0 FTE Clinical Pharmacist 5.0 FTE Allied Health Team	2850

Services Focused on Access to Primary Care & Connection to Attachment

Service	Gap Addressed	New Providers	Attachment Target
Primary Care Home Visiting			
Network of Family Physicians providing home visits for complex/vulnerable unattached and attached patients (when MRP not available)	• Unattached & homebound • FFS - Home Visits Challenging • Primary care coordination with Home Care	0.5 FTE Family Physicians	325*
GP Psychiatry Network			
Network of FPs providing MHSU consults for Mod MHSU patients who cannot access Psych.	• Mod MHSU care in PC w/out Psych Support • Psych Waitlist • Unattached Mod MHSU	0.5 FTE Family Physicians	325*
Vulnerable Child/Youth PC Outreach			
FPs working in collaboration with existing School Health Teams to provide primary care to vulnerable children in the school setting.	• Vulnerable kids ID through Schools • Unattached to PCP • Complex Health/Social	0.3 FTE Family Physicians 0.4 FTE Social Worker	195*

* Access care through service with attachment to PC Access & Attachment Clinic

Clinic Models Supporting Vulnerable Populations

Service	Gap Addressed	New Providers	Attachment Target
Youth Wellness Clinics			
Stabilize and expand Primary Care Services based on existing models	• Access for youth • No stable funding for PC at clinics	1.0 FTE Family Physicians (increase of 0.6 FTE) 1.0 FTE Social Worker	650
Low Barrier Primary Care Clinic and Outreach			
Primary Care Team with Peers provide care to unsheltered individuals in a low barrier clinic model with outreach *Outreach team currently working under COVID Funding	• ~1000 unsheltered • Many unattached • No access to appropriate low barrier Primary Care • Trust, safety, relationships	1.0 FTE Family Physicians 2.0 FTE Registered Nurse 2.0 Peer Support Workers	650

Services for First Nations, Urban Indigenous and Metis

Service	Gap Addressed	New Providers	Attachment Target
Tillicum Lelum Health Centre – Nurse Practitioner			
Provide new Primary Care Services	• No Primary Care • 2153 Visits to Health Centre last fiscal	1.0 FTE NP	600
Snaw-Naw-As Wellness Centre – Nurse Practitioner			
Sustain and expand Primary Care Services	• Complex/Vulnerable Pop • FNHA funded NP ending March 31st, 2020	0.8 FTE NP	Prevent unattachment
Snuneymuxw Health Centre – Primary Care Team			
Provide expanded Primary Care Services	• Complex/Vulnerable Pop • Limited GP Sessionals • Funding not sustainable • 1200 unattached in Cedar/South Wellington Area	2.0 FTE Family Physicians (Increase of 0.6 FTE) 1.0 FTE RN	1300

Services for First Nations, Urban Aboriginal and Metis

Service	Gap Addressed	New Providers	Attachment Target
Indigenous Health Team			
Team of Indigenous Health Providers/Liaisons who will support patient advocacy, access to care and traditional healing and facilitate culturally safe care across the PCN.	• Limited advocacy in system • Access to traditional healing/medicine • Coordination with IH/Primary Care and FN Communities • Racism & Stigma in Health Care	4.0 FTE Indigenous Health Roles* *To be defined*	n/a

3 Year Implementation

Service	Year 1	Year 2	Year 3
PC Link Allied Health Clinicians	Design Service Model & Hire 4.5 FTE Allied Health (AHP)	Hire 5.0 FTE Allied Health	Continuous QI
PC Nurse in Practice Team	Define Role & Hired 5 FTE RN	Hire 3 FTE RN 1 FTE Pharmacist	Continuous QI
New to Practice Physician Practices	ID Interest/Plan/Start to Establish Practices 1 FTE GP	Continue to establish practices 2 FTE GP	Continue to establish practices 2 FTE GP
PC Access & Attachment Clinic	Design Clinic Model	Establish Clinic & Hire 1 GP, 1 NP, 1 RN, 2 AHP, 1 FTE Pharmacist	Hire & Continuous QI 2 GP, 1 RN, 3 AHP
PC Home Visiting	Transition & Design as PCN Service – 0.5 FTE GP	Integrate with Access & Attachment Clinic	Continuous QI
GP Psychiatry Network	Transition & Design as PCN Service – 0.5 FTE GP	Integrate with Access & Attachment Clinic	Continuous QI
Vulnerable Child/Youth PC Outreach	Transition & Design as PCN Service – 0.3 FTE GP 0.4 FTE Social Worker	Integrate with Access & Attachment Clinic	Continuous QI

Service	Year 1	Year 2	Year 3
Youth Clinic Stabilization/Expansion	Transition to GP Group Contract: 0.4 FTE GP	Recruit GPs and Expand Hours: +0.6 FTE GP 1.0 FTE Social Worker	Continuous QI
Low Barrier Primary Care Clinic/Outreach	Transition & Design as PCN Outreach Service 0.5 FTE GP, 2 RN, 2 Peers	Establish Clinic & Expand GP hours: +0.5 FTE GP	Continuous QI
Tillicum Lelum - NP	Hire 1.0 FTE NP	Continuous QI	Continuous QI
Snaw-Naw-As - NP	Hire 0.8 FTE NP	Continuous QI	Continuous QI
Snuneymuxw Primary Care Team	Increase to 1.0 FTE GP	Expand GP Hours + 1.0 FTE	Hire Nurse in Practice 1.0 FTE RN
Indigenous Health Team	Define Health Team Roles	Hire 2.0 FTE	Hire 2.0 FTE