Primary Care Network Service Plans Executive Summaries:

- Saanich Peninsula
- Western Communities

South Island
Division of Family Practice
A GPSC initiative

An expression of interest (EOI), from the South Island Collaborative Services Committee (Partners for Better Health), to begin Primary Care Network service planning was submitted to the Ministry of Health (MoH) on February 1, 2018. The EOI was approved in April 2018 and a deadline for submission of the service plan was set for October 1, 2018.

The South Island Division of Family Practice (SIDFP), with the support of our partners, submitted two separate service plans. This was due to the distinct and vast geographies (different LHAs), variations in local population demographics and needs, the physical separation of the two communities and the two distinct Island Health operating geographies, in which the services are delivered. The planning processes proceeded in parallel with distinct family physician, health authority and community partners across two steering committees. However, the Partners for Better Health's (CSC) review took into account the commonalities and variations and our submission reflects those constructs.

The service plans leveraged existing work – an example is the Saanich Peninsula Primary Health Care Society, an output of the 'A GP for Me' initiative. This model is in the process of being spread to other communities on the South Island, including the Western Communities.

Our local First Nations partners were key to the planning and will be instrumental in the implementation. It is our hope that the collaboration between the First Nations Health Authority staff and local First Nation community leaders will serve as a template for other communities across BC.

Here are a couple of key items presented in the plans:

WESTERN COMMUNITIES:
With a population of nearly 110,000 people and an annual community growth averaging 3%, simply using current gap analysis from even two years ago misses the target by two to three full time equivalent (FTE) Family Physicians (FP) each year. As such, using the 2016 data ("current gap") and extrapolated for population growth and retirement, we are planning to attach a target of nearly 50,000 unattached by the end of the first year of implementation, March 31, 2020. Taking into account new models of care and funding for FPs + allied health practioners, with a focus on attachment and capacity building + the change management funding required to achieve these targets, our annualized budget is approximately $14M. This results in a cost per attached patient of $325 and a cost per resident of $129.

SAANICH PENINSULA:
With a rapidly aging population of nearly 65,000 people plus the population being served by our FPs in the Saanich neighbourhood of Quadra/Swan Lake the total population within the service plan is over 71,000. Combined with a significant number of ready to retire FPs, we are planning to attach a target of over 18,000 unattached by the end of the first year of implementation, March 31, 2020. Taking into account new models of care and funding incentives for FPs + allied health practioners, with a focus on attachment and capacity building + the change management funding required to achieve this our annualized budget is approximately $13M. This results in a cost per attached patient of $604 and a cost per resident of $154.
Recognizing the difference in starting points, the efforts of retaining ready to retire FPs and variations in population growth and aging, the two plans result in variations of approach and costs. We examined the per attachment rate variations within the planning process, and are confident that the variation is real, and not simply an artifact of different planning processes.

PURPOSE OF THE PRIMARY CARE NETWORK

The primary care network (PCN) is a network of local primary care service providers (a partnership between health authorities, physicians, and other community providers) working together to provide all the primary care services a population requires.

The vision for the integrated system of care is that by 2021, substantial progress across all 89 LHAs will be made to create a quality, integrated and coordinated delivery system for primary and community care that is patient-centred, effective in meeting population and patient needs, delivers a quality service experience for patients – a system that is easy to understand for those who use it and those who work in it. PCNs are foundational to achieving this vision.

The PCN is defined by the PCN General Policy Directive. The following eight core attributes have been identified as key foci for our PCN:

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.

EXECUTIVE SUMMARY – Saanich Peninsula PCN

The planning and implementation of the Saanich Peninsula PCN is envisioned to occur in two phases:

Phase 1: Closing the Attachment Gap

Phase 1 will focus on the eight attributes of the PCN with a specific initial priority on attachment. An attachment gap has been identified for the Saanich Peninsula and the majority of this Plan highlights the community and the primary care providers necessary to close that gap. Phase 1 will also put in place the basic structural elements to support delivery of the core attributes set out above.

Phase 2: Redesigning the System

Phase 2 will build off the successes of phase 1, turning to enhance the system of primary and community care and identify how resource deployment can be rethought to further strengthen and optimize a team-based focus. This will support better patient experience, provider experience and system sustainability. Phase 2 will be iterative and focus on gradual additions and improvements with a refreshed action plan each year.

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1. OVERVIEW OF THE SAANICH PENINSULA

Population and Geography: The current estimate of population size on the Saanich Peninsula is 63,016, which represents 8% of the Island Health region population.

- 5% of the Saanich Peninsula population identify as Aboriginal.
- Life expectancy is 86.3 years for women and 82.5 years for men.

People aged 75+ currently make up 14% of the population. This demographic is expected to increase by 80% over the next 20 years (Saanich Local Area Health Profile, 2015) putting distinct pressure on existing and future primary care services. The Saanich Peninsula is located on Southern Vancouver Island. It extends from Sidney in the north to Victoria in the south, is 33 km long and averages 4 km in width. 90 per cent of the Peninsula's perimeter is fronted by sea.

2. PATIENT ATTACHMENT GAP

The following table represents the Attachment Gap agreed upon by the South Island Division of Family Practice (SIDFP) and the Ministry of Health for the Saanich Peninsula Primary Care Network (PCN) Community Health Service Areas (CHSAs) including 4117 – Quadra/Swan Lake.

Table 1. Method 2: Ministry Attachment Algorithm	
CHSA	**Unattached patients**
4131 Royal Oak/Cordova Bay/Prospect	3,382
4132 Central Saanich	3,645
4133 North Saanich	1,953
4134 Sidney	1,684
Total without 4117 Quadra/Swan Lake	**10,664**
4117 Quadra/Swan Lake Total	4,097
Total	**14,761**

The Saanich Peninsula attachment gap is further complicated by:

Physician Retirement

- Prior to 2016, there were a handful of physician retirements on the Saanich Peninsula, leaving many residents orphaned due to large panel sizes. With no physicians on the Peninsula accepting new patients, this left many patients reliant on walk-in clinics, as well as the ED of SPH, for their care.
- Since 2016, there has been a net loss of a further six physicians from the area, with the additional imminent closure of a key walk-in and family practice clinic in Sidney.

Providing care to residents from other health areas

- Saanich Peninsula FPs provide primary care services to 14,391 patients who are not residents of the Saanich Peninsula. Additionally, half of all attached Saanich Peninsula residents are attached outside of their community.

High growth rate of seniors (age 65+)

- Over the past 15 years, the population growth rate was relatively low at 3.6%. However, the growth rate in the number of seniors (65+) during this same time frame was 44%. In combination with the increased number of unattached Saanich Peninsula patients, this leads to two results:
  - The increased number of seniors, and therefore complexity, in the community means that, overall, there is increased stress on the primary care system, and
  - There is an increased number of unattached seniors, seeking both regular primary care for their complex conditions AND episodic care from Walk-in Clinics.

3. SAANICH PENINSULA PCN DEVELOPMENT PROCESS

Since submitting the Expression of Interest in February, 2018, the process to develop a Primary Care Network on the Saanich Peninsula has evolved to include new partnerships and committees, as well as meetings with local governments. The core committees central to the PCN development are:

- Partners for Better Health (Collaborative Services Committee)- Meets monthly
- Saanich Peninsula Primary Care Network Steering Committee – Meets bi-weekly
- Saanich Peninsula Physician Leadership Working Group- Meets bi-weekly

- Saanich Peninsula Community Engagement Committee – Meets quarterly
- South Island MHSU Specialized Care Service Plan Working Group – Meets biweekly

These committees are comprised of representatives from the following partner organizations:

- The South Island Division of Family Practice
- Island Health Regional Health Authority
- The First Nations Health Authority
- Tsawout First Nation
- Tsartlip First Nation
- The Saanich Peninsula Primary Health Care Society
- The Saanich Peninsula Hospital Foundation
- BC Patient and Family Caregivers Society
- Beacon Community Services

Two team mapping sessions were held to help develop team-based care initiatives (e.g. Primary Care Networks, and Patient Medical Homes) and describe how teams could be structured. Using Patient Personas, these highly interactive sessions helped describe how roles work together in team-based care projects. Following these sessions, the Steering Committee held an all-day planning session in July to bring the service plan and vision forward along with the physician leadership committee.

4. SAANICH PENINSULA PRIMARY CARE NETWORK VISION:

Aspire to relationship-based care - placing patients and their families at the heart of every interaction as partners in directing their own care

Bring together what matters most- the individuals and communities of the Peninsula who receive, support and provide care to transform how we promote the health of our population and deliver quality, culturally-safe care

Challenge the status quo and create equity

5. STRATEGIC OVERVIEW OF PCN

A. Increase Attachment, Access and Team-Based Care.

The PCN will be comprised of one Network with three neighborhoods. Each Neighborhood would have 2-3 large Patient Medical Homes with one of them being a larger Primary Health Care Centre. To increase access to primary care services for **all** people residing on the Saanich Peninsula. This will be achieved by: increasing hours of service in select locations from 8:00 am to 8:00 pm; Implementing a FP after-hours call group in all 3 PCN Neighbourhoods; and increasing access to walk-in services to 6 days per week at all 3 PCN Neighbourhoods.

The PCN strategy is looking to attach patients through a multi-disciplinary care team model which includes adding 5 family physicians (using traditional recruitment and fee for service payment programs), expansion of youth clinic sessionals, increasing 2.0 nurse practitioners and 0.8 FTE W̱SÁNEĆ Family Physician Service Contract expansion for the W̱'SÁNEĆ communities plus MOA supports. The PCN attachment strategy is also enhanced by the addition of 12 nurses in practice as well as 16 clinical workflow associates to facilitate better patient flow through the system and reduce FP time spent on administrative tasks. The request is for the existing 39 engaged physicians at $64/existing patient (31,906) which is $2.041M, plus the anticipated attachment of 18,186 patients which amounts to $3.205M. It is anticipated that 100% of current physicians will engage in the PCN if this were to be offered. We are requesting an overhead subsidy budget for the remaining 18 physicians (19,450 patients) in the amount of $1.24M, for a total $4.450M annually.

- **PURPOSE:** Reduce the existing gap of 14,761 unattached patients, plan to increase capacity for future physician retirements and population growth.
- **NEW PROVIDERS:** 5.0 FTE new GPs (to be recruited), 2.0 FTE NPs, 12.0 FTE RNs, 16.0 FTE Clinical Workflow Assistants, 3.0 FTE Clinical Pharmacists, 3 MHSU Consultants, 3 Social Workers
- **ATTACHMENT COMMITMENT: 18,186 new attachments and retention of existing attachments**
- **BUDGET: $10.063M**

B. EMBED CULTURAL SAFETY AND HUMILITY

- **PURPOSE:** As we plan for the future, we are looking to do so in a way that truly embeds cultural safety and humility into the work of the PCNs. This includes continued appropriate engagement with the W̱SÁNEĆ communities, and adherence to the cultural safety guidelines outlined in the *Declaration of Commitment, Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal People in BC*.
- **NEW PROVIDERS:** .5 FTE Cultural Safety Facilitator, 1.0 FTE Indigenous Wellness Supports Coach, 1 GP Sessional/ month for Physician Cultural Safety Lead, 3.5 Hrs/month MOA Cultural Safety Lead
- **ATTACHMENT COMMITMENT:** In the absence of data regarding the attachment rates of Indigenous peoples on the Saanich Peninsula, it is difficult to quantify attachment capacity for these resources. Our expectation is that increasing the opportunity for FN patients to attach to a GP or NP at a FN Health Centre in their own community will result in **detachment** from GPs in Sidney and Central Saanich, creating capacity for new patients in those practices.
- **BUDGET: $.168M**

C. CHANGE MANAGEMENT

- **PURPOSE:** As we plan for the future, we are looking to establish Primary Care Network Operations and facilitate change and evaluate our results. There is a need for tenant improvements to achieve a Primary Health Care Centre in each neighborhood (cost of $1M per year for 3 years). A physician engagement and recruitment strategy is fundamental to this strategy as well as a public awareness campaign.
- **BUDGET:**
  - Year 1 - $ 1.142M
  - Year 2 - $ 1.805M
  - Year 3 - $ 1.765M
  - Ongoing -year 4: $0.765M

D. PHASE 2 – REDESIGNING THE SYSTEM

- **PURPOSE:** Add Adult including Seniors Based team to support rising risk population, expand Diabetes Education clinic and outreach services, expansion of Seniors Outpatient Clinic-Geriatric Specialty Services, establish Seniors Support Groups, establish Isolated Seniors Program, establish Volunteer Driver Program, and implement Mental Health Substance Use SCSP (moderate to severe population)and Complex Medical Frail SCSP in years 1-2 and align PCN with Public Health and Child, Youth, and Family services in year 3.
- **NEW PROVIDERS:** 3.5 FTE Registered Nurses, 1.6 FTE Dietitian, 4.0 FTE Licenced Practical Nurse, 1.2 FTE Occupational/Physiotherapist,1.0 FTE Social Work, 1.0 FTE Recreation Therapist, 0.5 FTE Rehab Assistant, and Facilitator for Seniors Support Groups
- **BUDGET: $1.649M**

BUDGET SUMMARY:

Budget summary				
	2018/19	2019/20	2020/21	Ongoing Annual Costs
Change Management	$ 1,142,199	$ 1,805,914	$ 1,765,914	$ 765,914
Phase 1 Attachment	$ 2,242,701	$ 10,232,321	$ 10,232,321	$ 10,232,321
Subtotal	**$ 3,384,900**	**$ 12,038,235**	**$ 11,998,235**	**$ 10,998,235**
Phase 2 Redesign	$ 361,479	$ 1,649,246	$ 1,649,246	$ 1,649,246
Grand Total	**$ 3,746,378**	**$ 13,687,482**	**$ 13,647,482**	**$ 12,647,482**

Cost of Attachment per Unattached Saanich Peninsula Resident – 14,761: $745

Cost of Attachment per Planned Attachments - 18,186: $604

Cost per Saanich Peninsula Resident – 71,124: $154

EXECUTIVE SUMMARY – Western Communities PCN

Overview of Geography and Population

The Western Communities is a collection of suburban and rural communities in the Capital Regional District. Included are the following six Community Health Service Areas (CHSA): 4112 Esquimalt/View Royal, 4121 Colwood, 4122 Metchosin, 4123 Langford/Highlands, 4124 Sooke, and 4125 Juan de Fuca Coast. The large (109,833 residents - 2016) and growing population is currently served by 27.4 FTE Family Practitioners. The area faces challenges to the provision of primary care services, including significant mental health and substance use, an aging population with increasing health care complexities, a geographically disparate population, and a notable population of children and youth facing mental health challenges. The current situation is dire: Unless significant attachment successes are gained, it is anticipated that the number of unattached residents in the Western Communities will grow to nearly 50,000 residents by 2022.

Agreed-to Attachment Gap

The South Island Division of Family Practice (SIDFP) and the Ministry of Health (MoH) have defined the number of unattached patients in the Western Communities as **29,976**. This gap, however is based on 2016 population data and does not take into consideration the rapid rate of population growth in the region (3% per annum) and the attrition rate of current practicing physicians (estimated to be 8% per annum). As a result, the actual attachment gap for the term of the PCN Service Plan (2018/19 - 2021/22) will grow to approximately 49,293. This equates to an actual gap of 39 physician FTEs, considerably higher than the 24 estimated using the 2016 data. For year 1 of the Service Plan (2018/19 - 2019/2020), it is estimated that the actual attachment gap will be 43,489 residents. Strategies in the plan have been identified to address this gap.

WESTERN COMMUNITIES PRIMARY CARE NETWORK

A. PURPOSE

The Western Communities is home to a variety of primary care services including full-service physician practices, urgent access clinics, public and community health services, First Nations health services and the soon to open West Shore Urgent Primary Care Centre. The purpose of the PCN is to create an integrated network of primary and community care to support patient attachment and address gaps in care for the residents of the Western Communities.

B. MODEL

Four neighbourhoods are proposed within the Western Communities PCN: Colwood (Metchosin), Langford (Highlands), Esquimalt/View Royal, and Sooke (Juan de Fuca Coast). Each neighbourhood consists of patient medical homes supporting one or more urgent access clinics. The neighbourhoods are networked within the PCN which provides comprehensive primary care services including maternity, inpatient, residential, mild/moderate mental health and substance

use, preventative care as well as outreach services for high cost/highly complex patients, and includes linkages to specialized community services programs.

C. PHASE 1 STRATEGIES TO ADDRESS ATTACHMENT GAP

PHASE 1, PART 1

i. Expand primary care capacity and clinic space for Patient Medical Homes
Significant net new resources are required in the Western Communities to meet the existing and projected attachment gap:

Primary Care Supports within PMHs:

Totals for Primary Care Supports within PMHs		
Net New Providers/FTE	**Attachment Capacity**	**Ongoing Annual Budget**
Family Physicians (21.5 FTE)	26,875	$7,202,500
Nurse Practitioners (5.0 FTE)	3,500	$1,210,554
Nurses in Practice (12.0 FTE)	2,400	$1,596,811
Clinical Workflow Coordinators* (8.0 FTE)	3,000	$742,627
Social Worker (0.6 FTE)	150	$80,117
Totals	**35,925**	**$10,832,609**

*Clinical Workflow Coordinators directly substitute primary care provider time and add capacity by pre-filling forms, sorting/prioritizing incoming documents, ensuring continuity of patient journeys, and gathering business and quality improvement metrics. 100 patient attachments per physician.

Sooke Clinic Expansion Capital Improvement Costs:

Request for Capital Improvements: In an effort to increase patient attachment, there is a need for additional clinic space in Sooke, BC. Currently there is only medical clinic in Sooke. Capital costs to expand that clinic into adjacent space are estimated to be:

Total for Sooke Clinic Expansion Capital Improvement Cost
One-Time Cost: $523,800

ii. Develop team-based care supports within the Primary Care Network
Team-based care supports for the Western Communities will both improve quality of care and increase primary care provider attachment capacity. New providers for team-based supports in the PCN include:

- **High Complexity Care Team:**

- **PURPOSE:** A multi-disciplinary Primary Medical Home for high-cost and/or high-needs, unattached patients requiring additional resources. Potential yearly cost-savings of several millions of dollars, and significant offload for other existing services
- **ATTACHMENT CAPACITY: 700**
- **BUDGET: $686,938**

- <u>**Mental Health/Substance Use Same Day Access Clinic:**</u>

  - **PURPOSE:** A rapidly accessible and geographically close MHSU same day service, with collaborative consultation and care planning with primary care providers that will greatly enhance coordinated care for patients. The intent of the Access Clinic is to be available to support individuals when primary care providers are not as available, and therefore includes evening and weekend accessibility.
  - **NOTE:** A portion of the Access Clinic has already been funded through the letter received by Island Health from the Ministry of Health for the West Shore Urgent Primary Care Centre, dated September 17, 2018. Separately funded positions include 1.39 Mental Health Clinician (Grid 14) and 2.76 FTE Mental Health Clinician (Grid 11). This PCN Service Plan requests support for the remaining portion of the Access Clinic: 1.39 FTE Peer Support Worker, 1.39 Administrative Support, and sessionals for Psychiatric Consultations, tenant improvements, and ongoing annual operating costs. These positions are critical supports so that all clinical positions can work to top of scope.
  - **ATTACHMENT CAPACITY: 875**
  - **TENANT IMPROVEMENT COSTS: $349,425**
  - **BUDGET (including leased space costs): $303,263**

- <u>**Seniors Team-based Care and Memory Service:**</u>

  - **PURPOSE:** A number of Nursing/Allied PCN positions will be created to enable the necessary care and support for seniors and adults with complex conditions by providing: (a) focused monitoring and support for clients cared for within the PCN that are at risk for functional decline or health crisis but who may not require receiving health authority services; and (b) additional support for seniors and rapid response
  - Registered Nurses (4.0 FTE), Social Worker (2.0 FTE), Dietitian (1.0 FTE), Physiotherapist/Occupational Therapist (0.9 FTE);
  - **ATTACHMENT CAPACITY: focus is on quality of care**
  - **TENANT IMPROVEMENT COSTS: $497,025**

- **BUDGET (including leased space costs): $1,142,540**

- **Community Clinical Pharmacist:**
  - **PURPOSE:** Integrating pharmacists into primary practice will contribute to the care of complex patients with frailty, polypharmacy issues, opioid use issues, and other drug therapy challenges. The expectation is that by adding a co-located pharmacist to the PCN will: (a) improve patient health outcomes through timely access to pharmacists with expertise in optimizing drug therapies; (b) relieve pressure on family physicians by having a pharmacist to help manage complex cases; and (c) reduce strain on the health care system through pro-active care to complex patients
  - 1.0 FTE
  - **NOTE:** The Western Communities PCN is interested in participating in the UBC Clinical Pharmacy Plan
  - **ATTACHMENT CAPACITY: 100**
  - **BUDGET: $163,349 (included in budget, but separately funded through UBC Pharmacy Plan)**

Additionally, the **West Shore Urgent Primary Care Centre (UPCC)** is slated to open on November 5, 2018. The proposed attachment of 866 for the NP will likely be drawn from the entire urban Greater Victoria area, not only the Western Communities. Note that additional patients will attach to the clinic and further clinician attachment will be provided when the primary care pods open later in the year. Funding for the UPCC has been provided in a separate funding letter to Island Health from the Ministry of Health.

- **ATTACHMENT CAPACITY:** 866 (for the NP, additional patients will attach to the clinic and further clinician attachment will be provided when the primary care pods open later in the year)

Totals for Team-Based Care Support within PCN		
Attachment Capacity	**Tenant Improvement Costs**	**Ongoing Annual Budget**
2,541	**$846,450**	**$2,350,784**

iii. Advance cultural safety and humility initiatives and integrate Indigenous perspectives on health and wellness into the PCN

- **PURPOSE:** As we plan for the future, we are looking to do so in a way that truly embeds cultural safety and humility into the work of the PCNs. This includes continued appropriate engagement with the First Nations communities, and adherence to the cultural safety guidelines outlined in the

Declaration of Commitment, Cultural Safety and Humility in Health Services delivery for First Nations and Aboriginal People in BC

- **NEW PROVIDERS:** 0.5 FTE Cultural Safety Facilitator, 1.0 FTE Indigenous Wellness Supports Coach, 1 GP sessional/month for FP Cultural Safety Lead, 3.5 hrs/month MOA Cultural Safety Lead.
- **ATTACHMENT COMMITMENT:** In the absence of data regarding the attachment rates of Indigenous peoples in the Western Communities, it is difficult to quantify attachment capacity for these resources. The new services outlined above are interconnected roles that will work as part of the larger system to establish relationships with non-attached community members, support culturally safe practice, and enable access to cultural supports and traditional healers/practitioners. These supports will work in collaboration with family physicians, pharmacists, and other care providers to provide a seamless, holistic and culturally safe approach to health and wellness.

Total for Cultural Safety & Integrating Indigenous Perspectives within PCN
Annual Ongoing Budget: $172,286

PHASE 1, PART 2:

In years 2 and 3, PCN staff will develop a business case for the incorporation of telehealth as a methodology to further enhance physician capacity. Additionally, years 1 & 2 will also require a focus on physician recruitment for Esquimalt due to an upcoming closure of 1 of 2 clinics in that region. Additional attachment capacity is forecasted.

D. PCN GOVERNANCE, OPERATIONS AND CHANGE MANAGEMENT

The focus of the PCN Service Plan during Phase 1 is attachment. Resources will be needed in order to establish the structures required to implement the strategies outlined above, including tenant improvement costs to co-locate the PCN Administration team. PCN administration, change management, committee and working group expenses, and physician sessions are estimated at:

Totals for PCN Governance, Operations, Change Management		
Tenant Improvement Costs	Budget Q4 2018/19 & 2019/20	Ongoing Annual Budget
$253,125	$967,048	$775,729

E. BUDGET SUMMARY AND CONSIDERATIONS

Budget summary					
	Capital Improvements	2018/19	2019/20	2020/21	Ongoing Annual Costs
Change Management	$ -	$ 150,082	$ 816,966	$ 775,729	$ 775,729
Phase 1 Attachment	$ -	$ 2,927,272	$ 13,362,347	$ 13,362,347	$ 13,362,347
Subtotal	**$ -**	**$ 3,077,354**	**$ 14,179,313**	**$ 14,138,076**	**$ 14,138,076**
Sooke Clinic Expansion	$ 523,800	$ -	$ -	$ -	$ -
Tenant Improvements PCN Admin, Seniors Team-based Care MHSU Access Clinic	$ 1,099,575	$ -	$ -	$ -	$ -
Grand Total	**$ 1,623,375**	**$ 3,077,354**	**$ 14,179,313**	**$ 14,138,076**	**$ 14,138,076**

PHASE 1:

Total Annualized Costs for Phase 1 (including Change Management): $14,138,076
Estimated Cost of Attachment per Unattached Western Communities Resident: $325
Estimated Cost per Western Communities Resident: $129

Member Participation in the PCN Planning Process:

Alicia Power
Amanda Naismith
Ambrose Marsh
Andre du Toit
Andrea Lewis
Andrew Kwasnica
Anton Rabien
Azaria Marthyman
Brennan McKnight
Bridget Reidy
Charlie Lamb
Charlotte Mursell
Chris Dowler
David Harrison
Elizabeth Rhoades
Ernie Chang
Ewan Cadger
Fiona Coleman
Gord Christie
Hagen Kluge
Ian Bridger
Ian McKnight
Jaron Easterbrook
Jeffrey Pocock
Jennifer Ross
Jennifer Tranmer
Jeremy Piemontesi
John Coburn
Judith Jones
Juliane Riemer
Kate Evans
Keith Losie
Kelley Minish
Krista Stogryn
Kristi Herrling
Laura Birdsell
Laura Ritonja
Liesl Roome
Lora Morrice
Mark Sherman
Matthew Ward
Micah Simcoff
Michael Dillon
Michal Pawlik
Mike Putland

Thank you