Implementation of the Integrated System   
of Primary and Community Care

Expression of Interest Information and Template

for Primary Care Networks

February, 2023

# Expression of Community Readiness and Interest

The vision for primary care in BC is to enable access to quality primary health care that effectively meets the needs of patients and populations, with the patient medical home as the model for care delivery within a broader, integrated system of primary and community care.

A key component for achieving this vision is the implementation of Primary Care Networks (PCNs) across the province as part of an overall approach to create a more simplified system of health care for the people of BC, and with specific attention to enhancing capacity and patient access through team based primary care services.

PCNs are clinical networks that provide a well-coordinated and integrated **team-based** delivery of primary care that include a mix of full-service primary care practices and clinics (patient medical homes), community health centres (CHCs), urgent and primary care centres (UPCCs) and First Nations (FN) primary care clinics that provides access to a basket of comprehensive primary care services based on patient and community population health needs.

PCNs will meet the comprehensive primary care needs of a geographic population and be linked and integrated with a range of specialized community service programs starting with programs focused on serving complex medical and/or frail adults; and mental health and addictions patients.

Patient Medical Homes (PMHs) are the cornerstone of the PCN. PMHs are the evidence- based practice model for delivering key service attributes associated with full service primary care and offered by family physicians and nurse practitioners working to their full scope and complimented by a team of nurses and other health care professionals.

**COLLABORATION ON PRIMARY CARE NETWORKS**

The members are committed to improving primary care access and attachment, patient experience, and health outcomes for British Columbians through the establishment of local PCNs, which consist of PMHs and other models of care – such as UPCCs, CHCs and FN primary care clinics – networked to each other and linked to health authority (HA) primary and community care services, Indigenous health organizations and community-based health and social services.

There is a long history of collaboration in primary care in BC, expressed provincially through the Family Practice Services Committee (FPSC), representing the strategic partnership of the Doctors of BC and the Ministry, supported by the health authorities, including First Nations Health Authority. This collaborative approach is expressed locally through Collaborative Services Committees (CSC), representing divisions of family practice, health authorities, First Nations and local community partners as key stakeholders, supported by the Ministry, Doctors of BC, the FPSC, and regionally through the CSC Interdivisional Strategic Councils.

As the BC health system is redesigned around patients and their interactions with primary care, the members have made a commitment to the following principles in how the system changes through PCNs will be planned, designed, and delivered:

* The patient is at the centre of the PCN. Care is designed to be patient centered and culturally safe, through shared design and delivery of primary health care with First Nations in BC, consistent with the Government of BC’s commitment to true, lasting reconciliation with First Nations in BC by fully adopting and implementing the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and Calls to Action of the Truth and Reconciliation Commission.
* The local PCN recognizes the importance of family and community in supporting patient care.
* The local PCN is intended to respect and preserve the longitudinal relationship between patients and their family physician or nurse practitioner.
* All partners in the local PCN will participate in information sharing and reporting within and between the local PCNs and with the rest of the health care system, based on provincial collaborative direction (under development), to support optimization of direct patient care, as well as quality improvement and planning at the community level. This is not a tool for quality assurance.
* The local PCN acknowledges and respects the clinical and business autonomy of a primary care practice.
* Standardization and consistency of provincial policy direction are set by the Ministry, and implementation is enabled through local decision making and flexibility in response to prioritized community needs.
* Support for implementation will occur through current collaborative structures and relationships, expanded to be inclusive of the local broader primary care service context as appropriate. New structures will be established only as needed to allow effective functioning of the system.
* The local PCN is intended to be inclusive of multi-disciplinary providers, where all providers are able to work to optimize their scope of practice.
* The local PCN will support the optimization of Patient Medical Homes, as the foundation of the local PCN, in the best interests of patients and the local population.
* The local PCN will support the optimization of UPCC, CHCs, FN PCC, NP Clinics and Foundry Clinics as key models of primary care service in the community. Ongoing iterative adjustments will be made as approaches are developed and tested, and measurement and evaluation metrics will be co-developed by the Parties.
* The local PCN will consult and engage with their community to ensure the needs of the community are met.
* The local PCN will seek to address disparities in primary care access, including, but not limited to, rural and First Nations patients.

**MEMBERS**

The initial members committing to become part of the Primary Care Network (PCN) must include:

* local division of family practice,
* local regional health authority, and
* patients and families.

Where health services are provided to First Nations communities and/or urban Indigenous populations (by the Nation, Band, First Nations Health Authority, regional health authority, contracted agency) or by First Nations or Indigenous health service organizations), it is expected that leaders of these groups/organizations will be invited to participate as full members (or in another agreed upon capacity) at the onset in the development of the PCN. Refer to *Appendix A* for an overview of First Nations/Indigenous engagement and partnership considerations.

Other members to be involved in planning are the health authority population and public health department (usually represented by the local Medical Health Officer), and nurse practitioner representatives if NPs practice in the community. Other members may be brought onto the PCN Committee as it matures.

The members are committed to improving primary care access and attachment, patient experience, and health outcomes for British Columbians through the establishment of local PCNs, which can consist of PMHs, UPCCs, CHCs, and FN primary care clinics networked to each other and linked to health authority primary and community care services, Indigenous health organizations and community-based health and social services.

**PART 1: MEMBERS OF THE PCN**

**Primary Contact**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Phone Number** | **Email Address** |
| **Primary Contact for Submission** |  |  |  |

**MEMBERSHIP OPERATIONAL OVERSIGHT**

Is there an existing body that can serve as the PCN Committee (generally, the Collaborative Services Committee)?

Yes/No:

If Yes, what body:

**Division of Family Practice**

**Name of Division:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Phone Number** | **Email Address** |
| **Division Lead** |  |  |  |
| **Division Executive Director** |  |  |  |

Total Division GPs/NPs actively practicing in community:

How was this measured?

Division GPs/NPs (total number and percentage) willing to participate in PCN:

How was this measured?

Approximate number of patients currently cared for by willing Division GPs/NPs:

How was this measured?

**Regional Health Authority**

**Name of Regional Health Authority:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Phone Number** | **Email Address** |
| **PCN Lead** |  |  |  |
| **Additional Key Contact** |  |  |  |

**First Nations and Indigenous Members**

Identify all First Nations and/or urban Indigenous health service organizations in the PCN geographic region and outline engagement and partnership actions/approaches undertaken. It is expected that all Nations and/or urban Indigenous health service organization administrators will be invited to participate as full members (or in another agreed upon capacity) at the onset in the development of the PCN. Refer to *Appendix A* for information on First Nations/Indigenous engagement.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Name** | **Contact** | **Phone Number** | **Email Address** | **Engagement and partnership actions/approaches undertaken** | **Current status of relationship** |
| **First Nations/ Indigenous Organization** |  |  |  |  |  |  |

Please duplicate rows as necessary to accommodate additional members

|  |  |  |  |
| --- | --- | --- | --- |
| **Other Key Contacts** | **Name** | **Phone Number** | **Email Address** |
| **Regional Health Authority Aboriginal/Indigenous Health Contact** |  |  |  |
| **First Nations Health Authority Contact** |  |  |  |
| **Urban Indigenous Organization Contact** |  |  |  |
| **Other First Nations/Indigenous Partner Contact** |  |  |  |

**Patients and Families**

**Organization(s) identified to engage patient participants:**

**Describe plan to engage patients and families:**

**Other Members\***

Please duplicate as necessary to accommodate additional members

Member organization:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Phone Number** | **Email Address** |
| **Organization Director** |  |  |  |
| **PCN Lead** |  |  |  |

Member organization:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Phone Number** | **Email Address** |
| **Organization Director** |  |  |  |
| **PCN Lead** |  |  |  |

Member organization:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Phone Number** | **Email Address** |
| **Organization Director** |  |  |  |
| **PCN Lead** |  |  |  |

\*Communities are not required to identify any other members. Members may continue to onboard to the PCN as it matures.

**PART 2: COMMUNITY DETAILS**

**GEOGRAPHY**

Please provide the names and population numbers of the Community Health Service Areas (CHSAs) that will make up the geography of your PCN. Ensure that you have included the name of First Nations communities, number of people living in communities, as well as size of urban Indigenous population (if applicable). Engage Regional Health Authority Aboriginal/Indigenous Health team to ensure that you have accurately reflected First Nations and Indigenous demographics.

|  |  |  |
| --- | --- | --- |
| **CHSA Name** | **CHSA Population Size** | **First Nations Community & Population Size (if applicable)** |
|  |  |  |
|  |  |  |
|  |  |  |

**EMR USAGE**

Please indicate how many physicians (total number and percentage) in your community have been using an EMR for at least 12 months\*:

Please indicate how many members (total number and percentage) using an EMR are willing to participate in the PCN:

How many different EMRs are in use by GPs/NPs in your community?

\*If you do not have this data readily available please contact the Doctors Technology Office ([dtoadmin@doctorsofbc.ca](mailto:dtoadmin@doctorsofbc.ca)), as data from the 2015 PITO Database may be available as a starting point.

**PANEL MANAGEMENT\***

Please indicate how many physicians (number and percentage) have committed to completing the three phases of PSP Panel Management:

Please indicate how many physicians (number and percentage) have Phase 1 or 2 underway, and how many have completed both.

\*See Appendix B for an overview of the three phases of PSP Panel Management.

**CULTURAL SAFETY**

Please indicate how many physicians and other providers that will work within the PCN have completed PHSA [*San’yas Indigenous Cultural Safety Training*](http://www.sanyas.ca/):

**PART 3: ADDITIONAL READINESS CRITERIA**

Please tick the following criteria to indicate your eligibility to participate in forming a PCN:

* Members are willing to jointly work toward the Integrated System of Primary and Community Care, proceed to next steps including service planning, and to inform provincial processes.
* The division of family practice and the regional health authority both commit to forming and actively participating in the PCN, and you have attached letters from the division chair and health authority CEO signifying this commitment.
* There is a general understanding of patient and population needs across defined geographic areas (i.e. attachment, access and care gaps) that will be further developed as part of the service plan process.
* All partners in the local PCN will participate in information sharing and reporting within and between the local PCNs and with the rest of the health care system, based on provincial collaborative direction (under development), to support optimization of direct patient care, as well as quality improvement and planning at the community level. This is not a tool for quality assurance.
* Members are willing to participate in an attachment process, including a centralized waitlist, and to attach patients off the waitlist as capacity allows.

**SUBMISSION CONTACT INFORMATION**

Please submit your interest to the FPSC at [fpsc@doctorsofbc.ca](mailto:fpsc@doctorsofbc.ca).

*If you do not feel ready to submit a proposal, but are interested to explore this initiative further, you are invited to contact* [*Kelly McQuillen*](mailto:Kelly.McQuillen@gov.bc.ca) *or* [*Alana Godin*](agodin@doctorsofbc.ca)*, who will put you in touch with a member of the team who can answer your questions and /or meet with your stakeholders**.*

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# Appendix A: Engaging with First Nations and Indigenous Communities

The intention of engaging First Nations and Indigenous partners in the development of Primary Care Networks (PCNs) is to ensure:

1. First Nations and Indigenous stakeholders, including patients, families, caregivers, Elders, Traditional Healers, community leaders, Health Directors, etc., have the opportunity to collaborate with and contribute information, advice, and guidance to the PCN;
2. PCN services are culturally safe and meet the needs of its Indigenous members; and,
3. First Nations and Indigenous health service organizations that deliver components of comprehensive primary care services within the geographic service area of the PCN have the opportunity to: participate in developing the PCN service plan; contribute to the PCN operations and governance; and receive resources as part of the PCN.

It is the expectation that First Nations and Indigenous health service organizations will be engaged and invited to participate as full partners (or in another agreed upon capacity) in the development of the PCN.

**B.C. First Nations and Indigenous populations**

For many thousands of years, First Nations in B.C. enjoyed good health and wellness. Due to the historic and ongoing impacts of colonialism and racism, including residential schools and intergenerational trauma, the health and wellness of First Nations in B.C. has been disrupted. This has resulted in substantial health disparities between First Nations and non-First Nations people and distrust in B.C.’s health system and its associated governance structures. In order to ensure success of the implementation of B.C.’s Integrated System of Primary and Community Care, meaningful engagement and collaboration must occur with First Nations and Indigenous partners.

**Collaboration and Engagement**

There is not a one-size-fits-all approach to relationship building and meaningful engagement with First Nations and Indigenous peoples in BC[[1]](#footnote-1). Meaningful connection is founded in the practice of cultural humility and is often best achieved through direct relationship building with community representatives, including Health Directors, administrators and/or Chief and Council. The following organizations may be able to facilitate introductions or provide information on engagement considerations and protocols: First Nations Health Authority, Regional Health Authorities, Nation satellite offices, Métis Nation BC, and Indigenous health service organizations such as the BC Association of Aboriginal Friendship Centres.

PCN planners are expected to align their work with the information presented in the newly released Indigenous Engagement and Cultural Safety Guidebook: A Resource for Primary Care Networks, which is now available as part of the PCN Implementation Toolkit.

**Engagement Process Considerations**

* Prior to connecting with community leaders, seek information to understand the local First Nation/Indigenous community’s governance structures, as well as their partnerships and perspectives on health, healing and wellness.
* Focus on relationship building as a starting point and engage in-person when possible.
* At minimum, it is expected that PCN planners will meet with the local First Nation(s) in their own community/ies, with the aim of developing a good understanding of current services and outstanding needs that could be met through the PCN.
* Consider cultural safety and protocol. Meet with First Nations/Indigenous representatives on their territory, co-develop documentation (agendas, proposals, etc.) and respect protocol for First Nations/Indigenous community members to open and attend meetings.
* Seek information from relevant partners on positive or existing engagement processes.
* Respect the Nation/community’s right to self-determination, as reflected in their right to determine the degree to which they wish to be involved.

**Appendix B: Panel Management Overview**

Three phases of PSP Panel Management:

1. **Empanelment:** Empanelment is about establishing patient-provider relationships. Physicians have an accurate and up to date list of “active” patients for whom they have been confirmed as the Most Responsible Provider. Panel size should be assessed to ensure balance of supply/demand for physicians’ time.
   1. Completion definition: Active Patients list has been reviewed and updated (e.g. status review and update as inactive where appropriate). Clinic sets up process to regularly confirm MRP and patient contact information. Current and ideal panel size calculated based on estimated demand and calculated supply of available appointments. Clinic has documented processes in place for maintaining their patient panel.
   2. Clinic roles: Physicians and MOA work together to update patient status and contact information. MOA can confirm with patients and physician gives final approval.
   3. Estimated timeframe to complete\*: One month
2. **Initial panel-clean up:** Physicians have accurate and up to date disease registries for 3-5 chosen disease indicators from the PSP tools.
   1. Completion definition: Physician has 3-5 disease registries completed. Each registry accurately reflects all patients within the physician’s panel that have that condition and are properly coded with the correct ICD-9 code within the EMR.
   2. Clinic roles: Clinic team gains consensus on standard processes for coding patient data in the EMR. Physician is responsible for overseeing the review of patients’ charts and ensuring accurate diagnosis and code use; MOA can support with updating charts under the supervision of the physician.
   3. Estimated timeframe to complete\*: One-two months
3. **Panel optimization:** Physicians have accurate disease registries for a total of 10-15 indicators to support planned pro-active care (e.g. recalls or care planning). Clinic identifies 5 pro-active care goals to implement based on identified needs of their registry.Clinic has dedicated time and has assigned roles for ongoing panel maintenance and management.
   1. Completion definition: 10 to 15 disease registries are accurate and up to date. Clinic has acted upon identified care needs using their EMR for 5 improvement goals.
   2. Clinic roles: MOA or Panel Manager runs regular reports, and monitors recall processes. Physician makes recommendations based on patient care gaps, clinical guidelines, panel reporting trends and practice needs.
   3. Estimated timeframe to complete\*: Six to nine months

\*Timeframe may vary depending on EMR level and identified needs of the clinic that lead to additional QI educational activities.

**Appendix C: Definition of Funding Models**

**Population Based Funding (PBF)**

Population Based Funding (PBF) is a patient-based funding model. PBF compensates group practices (clinics), based on panel complexity. This model allows the sites the discretion to determine the appropriate services, how they are delivered (i.e., in person, telephone, etc.) and by which team member to improve quality of care, increase patient attachment and improve access for registered patients.

The Ministry of Health makes payment at the clinic level. The clinic determines the compensation paid to individual physicians and nurse practitioners, as well as their staff nurses, and other health providers, and administrative support. Funded services relate to a defined set of ‘core’ primary care services, with the flexibility to provide extended services. There is greater flexibility to deliver virtual care, deal with multiple conditions in a single visit, and to put emphasis on preventative services.

*Program Components*

1. *Registered Patient Panel* – PBF clinics receive payments based on the complexity of the panel for registered patients within a defined area. The complexity of each patient is calculated using the diagnostic coding submitted on FFS and PBF encounter claims. Using the Adjusted Clinical Grouping® (ACG) model, patients are assigned to categories based on the combination of patient age, gender, and all diagnoses submitted through MSP.
2. *Fee-for-Service* – for services outside the ‘core basket’ for paneled patients, and all services for non-paneled patients.
3. *Outflows* – payment deductions when a paneled patient receives core primary care services from another General Practitioner within the clinic’s catchment area.

*Electronic Medical Record (EMR) Requirement*

* Enhanced EMR: Telus Wolf; IntraHealth Profile; and, Telus Med-Access

The Ministry is undertaking foundational work to support onboarding to PBF. In addition, pursuant to the 2019 Physician Master Agreement, the Ministry of Health will be consulting with the Doctors of BC with respect to the PBF model.

**Northern Model (NM)**

The Northern Model is a patient-based funding model. The Northern Model compensates primary care teams based on panel size and complexity and quality improvement indicators. It supports the delivery of high-quality integrated and coordinated health services that are team-based.

The services covered by the Northern Model funding relate to a defined set of ‘core basket’ primary care services. Like PBF, there is greater flexibility to deliver virtual care, deal with multiple conditions in a single visit, and greater emphasis on preventative-type services.

*Program Components*

1. *Base Core Payment* – based on the number of patients attached to the clinic.  Funding is intended to be used to cover a significant portion of overhead expenses, professional fees, and the hiring of other health professionals to care for patients.
2. *Pay for Panel Care* – based on a unique complexity index derived from the EMR problem list and patient encounter information.
3. *Quality Payment* – a quality improvement and activity payment to the clinic based on proscribed targets.
4. *Fee-For-Service* – for services outside the ‘core basket’ for paneled patients, and all services for non-paneled patients.
5. *Outflows* – Payment deductions when a paneled patient receives primary care services (including emergency visits) from another Practitioner within the clinic’s catchment area.

The Northern Model is being prototyped in one Northern BC community.

*EMR Requirement*

* Currently MOIS only.

**GP and NP Service Contracts**

Service contracts have been developed for physicians and nurse practitioners to support the development and implementation of Patient Medical Homes (PMHs) and Primary Care Networks (PCNs). The Ministry has developed a provincial service contract template that is administered by the regional health authority. Under the service contract the practitioner will provide longitudinal, full service primary health care and is responsible for meeting service deliverables including enhanced access and patient attachment targets. The contract is intended for practitioners who do not currently have a patient panel. Practitioners are expected to join an existing group practice or set up a group practice with other practitioners to work together in a team-based environment.

*Program Components*

1. Service Contract – Practitioners engaged through service contracts will be independent contractors. They will not be health authority employees.
2. Payment – Payment is based on the time spent delivering services, and practitioners must commit to a minimum 0.5 FTE. The health authority is responsible for ensuring payments flow to the contracted practitioner or designated representative.
3. Term – The contract is for an initial 3-year term.
4. Reporting – Practitioners are required to submit attachment records and encounter records to the Medical Services Plan/Health Insurance BC via Teleplan. In addition, practitioners will report hours worked to the Health Authority.

*EMR Requirement*

* No product-specific requirement, but the practitioner must use an EMR.

In addition, the Ministry of Health has committed to developing a contract for physicians with existing patient panels. Pursuant to the 2019 Physician Master Agreement, the Ministry will be consulting with the Doctors of BC with respect to the contract.

1. Approximately 6% of British Columbians (about 270,000 people) self-identify as Indigenous, which includes First Nations (172,500), Métis (89,400) and Inuit (1,600) peoples. [↑](#footnote-ref-1)