Primary Care Network Name:

[PCN NAME]

Primary Care Network Partners:

[Division Name] DoFP, RHA, FNHA

Date Submitted:

February 2019

PCN SERVICE PLAN TEMPLATE

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# Message to Primary Care Network Planning Partners

In Spring 2018, the Government of British Columbia announced the development of an *Integrated System of Primary and Community Care*, a transformational health care strategy aimed at improving access to everyday health care services and achieving better health care outcomes for all British Columbians. The *Primary Care Strategy* is the cornerstone of this system reform, and a top priority for the Ministry of Health (the Ministry).

The *Primary Care Strategy* aims to put patients at the centre of health care delivery by transforming the way primary care is delivered in the province both in person and virtually, based on a culturally safe, team-based care model. The goal of team-based care is person and family-centred and collaborative care that provides the right care in a sustainable system at the right time and in the right place.

Team-based care offers advantages for patients and providers alike:

* Team-based care can improve continuity of care by strengthening the relationship between patient and their primary care provider and members of the health care team
* Primary care teams collectively increase a community's capacity to attach patients to a primary care provider.
* Patients get timely access to continuous, comprehensive care and appropriate supports to support their health needs
* Increase the efficiency of practices and streamline processes to maximize time and capacity.
* Primary care teams work to their strengths and support and rely on each other to give patients the best care.

Shifting to team-based care, primary care providers ensure that a full range of services are available to patients, including illness prevention, primary reproductive care, minor or episodic illnesses, chronic disease management, support for seniors, mental health and substance use, and palliative care.

The Ministry of Health is committed to implementing the *Primary Care Strategy* through the development of Primary Care Networks (PCN) across all regions of the province. The Ministry will work in collaboration with the Family Practice Services Committee (FPSC), Divisions of Family Practice, Health Authorities, and other partners to meet these commitments.

A PCN is an organized network of primary care services, including Patient Medical Homes (PMHs), that are linked together with health authority and other community services in a defined geography and collectively plans, organizes, coordinates, and delivers primary care services to meet the needs of community members.

PCNs are locally planned and governed through partnerships that include health authorities, divisions of family practice, First Nations, and other partners based on local context. In this way, they will be connected to community and able to work together to meet local needs.

New funding for PCNs is being invested with an expectation of measurable and substantial progress toward achieving culturally safe, team-based, longitudinal primary care in communities throughout the province. It is expected that, where an attachment gap exists in a community, there will be a focus on closing the gap as a priority. It is also expected that the communities will improveaccess to primary care, including expanded after-hours care. The remaining PCN core attributes will also be covered over time as the PCN develops (see [Primary Care Network Core Attributes](#_Primary_Care_Network)).

# Planning & Implementation Approach

The PCN Service Plan intends to provide an integrated plan to address service needs in community. An understanding of the local needs, and development of collaborative strategies which match those needs will be required.

Please ensure the service planning template is completed collaboratively with participation from and endorsement of all partners before submission to the Ministry.

***Instructions***

To support PCN planning partners, the PCN template has been prepopulated with information on the proposed Community Health Service Areas (CHSAs) to be included in the PCN(s), the population, First Nations communities, estimated or determined attachment gap, and estimated clinical resources envelope available (based on the 'Ministry's PCN planning parameters). In addition, the link to the most recent [Local Health Area Profile](https://connect.health.gov.bc.ca/lha/2018-19) information is accessible through the use of a [BCEID](https://www.bceid.ca/). Where estimates are used, the final attachment gap and resources may vary once confirmed.

Please note the finalization of CHSA populations and attachment gaps will be through an iterative information gathering process between the Ministry of 'Health's Health Sector Information, Analysis, and Reporting (HSIAR) team and the community PCN partners. To expediate the service planning process, potential PCNs may be provided with the service planning template before the finalization of the CHSA population and attachment gap information. The typical length of data analysis is a minimum of 4-6 weeks once the completed service plan has been submitted by the PCN and accepted by the Ministry.

Please follow the instructions when completing this document:

* Complete all sections of this template using the tables and guidelines provided.
* Submit one document in Microsoft Word format (.doc or .docx) for the Service Plan, and one Excel document for the Budget. Letters of support from community partners leading the PCN planning table should be submitted as separate documents.
* Further supporting documents may be found on the [PCN Toolkit Site](https://www.pcnbc.ca/pcn).
* Once completed, with the support and endorsement of all partners, please submit your complete Service Plan, Budget and letters of support to your Ministry of Health Regional Director, and to the FPSC at fpsc@doctorsofbc.ca.

# Section A: PCN Overview

A PCN is an organized network of primary care services linked together with health authority and other community services in a defined geography and collectively plans, organizes, coordinates, and delivers primary care services to meet the needs of citizens. PCNs may include several different team-based primary care service models:

* **Community Longitudinal Family Practices/Patient Medical Homes (PMHs)** – a family practice that operates at an ideal level to provide longitudinal patient care, leveraging virtually enabled care, electronic medical records and team-based care, including nurses and allied health professionals.
* **Urgent and Primary Care Centres** – providing full-service team-based primary care and urgent access for any episodic needs and serving as 'community 'hubs' that can make connections to other essential services (e.g., mental health and substance use).
* **Community Health Centres** – team-based primary care clinics rooted in social determinants of health approach and typically with a strong connection to local communities and neighbourhoods and often focussed on meeting the needs of complex patient populations.
* **First Nations Primary Health Care Centres** - team-based primary care rooted in partnership with local First Nations and incorporating traditional cultural practices as part of the team-based approach.
* **Nurse Practitioner Primary Care Clinics** – team-based primary care clinics led by NPs in partnership with FPs and other nursing and allied professionals to provide comprehensive primary care services.
* **Foundry** – team-based primary care clinics for youth between the ages of 12-24 living with mental health and substance use (MHSU) conditions. Services include access to mental health care, substance use services, primary care, social services, and peer support.

The PCN partnerships will also support providers in sharing the workload, breaking down silos between Health Authority and FP services, and providing support to develop their new practice or join a team-based group practice. PCNs are key to an integrated system of primary and community care. The following eight core attributes are key requirements for all PCNs:

##

## Primary Care Network Core Attributes



## Overview & Service Needs Identification

***Instructions***

***(Max 2 pages)***

Please provide the following information in this section: partner organizations, number of proposed PCNs, name of the PCNs, the population (including First Nations) and the primary care service gaps/needs in this geography. Please describe how the gaps were identified. Please consider the inequities in health status experienced by Indigenous peoples and other populations when documenting service gaps/needs.

*Gaps in the primary care system can be identified using Ministry provided data, family practice EMR data, health authority, and other health system data and patient surveys, or other engagement-related information such as information from Indigenous members or others.*

**Partner Organizations**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Primary Care Network Information**

|  |  |
| --- | --- |
| Number of proposed PCNs:  |  |
| Name(s) of proposed PCN(s):*\*Please also indicate locations if there are multiple PCNs in different geographical areas.* |  |
|  |
|  |
|  |

**Population Data**

|  |  |
| --- | --- |
| ­­­­­­­­­­­­­­­Overall population |  |
| First Nations and Indigenous |  |

**Primary Care Service Gaps/Needs**

*Add rows as required.*

|  |  |
| --- | --- |
| Gap/Need | Rationale |
|  |  |
|  |  |
|  |  |

## Overview of Funding Parameters

The Ministry utilizes standardized PCN funding parameters to support PCN development throughout the province. The funding parameters are based on extensive consultations with urban and rural health care providers, administrators, rural residents, the First Nations Health Authority (FNHA) and reviews of data available in other jurisdictions.

There are different funding parameters for PCNs in urban and rural regions and specific enhanced funding for priority populations within a PCN. The specific parameters are based on a combination of criteria, including rurality, population density, population health status, health and public transportation infrastructure, disruption in health services due to geography and weather, and scope of practitioner practice (e.g., full-scope family practice).

The number of patients that each provider is expected to attach is lower in rural areas, and lower still where vulnerable populations are present, to account for the challenges in health care provision that is typical in these areas.

Critical components of the funding parameters include:

* Attachment gap – utilized to determine the number of net new Most Responsible Providers (MRPs) – Family Physicians (FP) or Nurse Practitioners (NPs) – available for the primary care service models in the PCN geography;
* Population – utilized to determine the number of net new primary care team members, Nursing and Allied Health Care Providers (AHPs) available for the primary care service models in the PCN geography;
* Priority population – utilized to determine the number of net new MRPs, Nursing and AHPs as well as Indigenous care providers available for the primary care service models in the PCN geography;
* Administration and governance – utilized to support PCN with reporting and monitoring of PCN activities to the Ministry and to facilitate collaborative governance between partners.

These components result in the development of an annual operating budget. In addition to the steady state funding, the Ministry provides one-time change management funding to support the initial implementation of team-based care over a four-year time frame. In terms of overall operational funding, PCNs will be incrementally funded over four years in progressively greater amounts until the PCN is fully funded and operational in year four based on the final approved funding package. Operational funding is then considered ongoing and will continue through the fourth year and into the future. The change management funding falls under a one-time four-year envelope and does not continue past the fourth year.

**Estimated Clinical Resource Envelope for Primary Care Services**

The Ministry has one funding envelope available for primary care investments in British Columbia. In addition to PCNs, the Ministry recognizes that other primary care service models are required to serve the unique primary care needs of some populations. The primary care service models that are eligible for primary care funding include Patient Medical Homes (PMH), Urgent and Primary Care Centres[[1]](#footnote-2) (UPCC), Community Health Centres (CHC), Nurse Practitioner Primary Care Clinics (NPPCC), First Nations Primary Health Care Centres (FNPCC), and other primary care service models including Foundry Clinics. ***Table 1*** shows the Ministry's parameters to establish a standard process for funding primary care service models across British Columbia.

***TABLE 1:*** ***Primary Care Parameters for MRP and AHP FTEs***

|  |
| --- |
| **PCN – Urban Parameters** |
| **General Population** | **Panel Size (MRP)** | **Type** | **Attachment per FTE** |
| Family Practitioner (FP)  | 1,250 |
| Nurse Practitioner (NP) | 1,000 |
| Registered Nurse (RN\*) | 500 |
| **Allied Health Professionals & Team-based Care** | **1 AHP per 12,000 general population +****1 AHP per CHSA with population less than 10,000** |
| **Vulnerable/Priority Population\*\*** | **Panel Size (MRP)** | **Type** |  |
| FP  | 650-800 |
| NP | 600-700 |
| **Allied Health Professionals & Indigenous care providers**  | **1 per 325-400 unattached population** |

|  |
| --- |
| **PCN – Rural/Remote Parameters** |
| **General Population** | **Panel Size (MRP)** | **Type** | **Attachment per FTE** |
| Family Practitioner (FP) | 800 |
| Nurse Practitioner (NP) | 800 |
| Registered Nurse (RN)\* | 400 |
| **Allied Health Professionals & Team-Based Care** | **1 AHP per 8,000 general population +****1 AHP per CHSA with population less than 10,000** |
| **Vulnerable/Priority Population\*\*** | **Panel Size (MRP)** | **Type** | **Attachment per FTE** |
| Family Practitioner (FP) | 650-800 |
| Nurse Practitioner (NP) | 600-700 |
| **Allied Health Professionals & Indigenous care providers**  | **1 per 200-250 unattached population.** |

\*RNs support attachment to an MRP rather than attaching their own panel.

\*\*Pertains primarily to population groups experiencing vulnerability due to social determinants of health.

Up to one Clinical Pharmacist will be available to each PCN, dependant on the size of the PCN.

The Ministry will work with the PCN to determine an estimate of the attachment gap[[2]](#footnote-3) and population for the PCN geography.

***TABLE 2: Attachment Gap by CHSA***

|  |  |  |
| --- | --- | --- |
| **CHSA** | **Census Population** | **Attachment Gap** |
| *e.g., 5141 – Smithers Town Centre* |  |  |
|  |  |  |
|  |  |  |
| **Total** |  |  |

***TABLE 3: First Nations Population\****

|  |  |  |
| --- | --- | --- |
| **First Nations Community** | **CHSA** | **In Community Population****(source FNHA)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **TOTAL** | **NA** |  |

**\*** ***There is widespread acknowledgement that the Indigenous/FN/Inuit/Metis peoples numbers are often unreported and not being captured accurately. Please provide any additional rational or data uncertainties here in providing your response for Table 3.***

**Table 4** provides information on the estimated clinical resource allocation for all primary care in your service area. The information provided in this document is for PCN planning purposes only. The Ministry will determine the final funding envelope.

It is anticipated that other primary care service models may be required within the geographic area of the PCN to meet population needs. **PCN planning partners need to determine if any other primary care service models are required within this service area and the attachment and clinical resources for these service models must be allocated from within the available envelope outlined in Table 4**. Existing and future Primary Care Initiatives in the area are considered to be one overall PCN budget, (Foundry, Community Health Centres, UPCCs (longitudinal), NP Clinics and First Nations Led Initiatives.

***TABLE 4: Estimated Attachment Gap and Estimated Clinical Resource Allocation available for all Primary Care service models in these CHSAs.***

|  |  |
| --- | --- |
| **Resource Type** | **FTE** |
| ***General Population Attachment Gap: [General Pop. Number]*** |
| ***Priority[[3]](#footnote-4) Population Attachment Gap: [Vulnerable Pop. Number]*** |
| ***FTEs for Priority Population*** |
| Most Responsible Providers (FP/NP) |  |
| RN\*, Allied Health Professionals & Indigenous care providers |  |
| ***FTEs for General Population*** |
| Most Responsible Providers (FP/NP) |  |
| RN\* and Allied Health Professionals |  |
|  |  |
| **Net new RN and Allied Health Professional** |  |

\*Registered Nurses, unlike other Allied Health Professionals have attachment targets, as they facilitate attachment to FP and NP. For the purposes of the modeling this has not been taken into consideration.

# Section B: Existing Primary Care Services in the PCN

*The following section will help the partners identify the current state of resources in PCN service area, including Family Physician practices, First Nations Health Centre primary care resources, Community Health Centres, UPCC, Foundry, NP Clinic resources and other primary care services. It is anticipated that planning partners will identify net new clinical resource requirements in light of the current primary care resource complement in the service area.*

***Instructions***

Please provide the requested information in the tables below:

***TABLE 5: Family Physician Practices***

|  |  |
| --- | --- |
| **Element** |  |
| Number of practices[[4]](#footnote-5) within the PCN geography[[5]](#footnote-6)‡ |  |
| Number of practices2 participating in the PCN‡ |  |
| Number of participating practices offering extended hours of services to their patients |  |
| Number of participating practices offering extended hours of services to other patients |  |

***TABLE 6: First Nation Primary Care Resources\****

|  |  |  |
| --- | --- | --- |
| **First Nation Community** | **FTEs** | **Provider Type** |
|  |  |  |
|  |  |  |
|  |  |  |

**\*** ***There is acknowledgement that the Indigenous/FN/Inuit/Metis primary care resources can be subjective. Please provide any additional any rational or explanation you would like here in providing your response for Table 6.***

***TABLE 7: Other Primary Care services/resources***

|  |  |  |
| --- | --- | --- |
| **Organization** | **FTEs** | **Provider Type** |
|  |  |  |
|  |  |  |
|  |  |  |

Section C: PCN Services & Strategies

**\*Suggest 1 page per Strategy maximum**

*When identifying services/strategies to be added or strengthened within the PCN, refer to the primary care service gaps identified in Section A. It is anticipated that most PCNs will have a strategy that focuses on enhancing primary care for priority populations, including First Nations, in the PCN geographic area. Proposed additional services should align with the comprehensive primary care services set out on Appendix A.*

*In-practice supports such as panel management and in practice coaching for physicians and teams, and other support as provided by the FPSC, are* ***not*** *eligible for additional service plan funding.*

***Instructions***

Please follow the steps outlined below for any services/strategies you propose:

**Step 1: Identify Service Opportunities –** Create a list of services/strategies that collectively meet the identified service gaps/needs. All PCN attributes (page 3) need to be met across the proposed strategies; a strategy can meet more than 1 PCN attribute. Once a list has been created, indicate how the services align with the eight PCN Core Attributes. Additionally, identify which services could be implemented via redeployment of existing resources or the addition of minimal new resources.Opportunities need to consider addressing inequities in health status.

**Step 2: Select the Services –** Determine which services/strategies will be prioritized for implementation in the first year of PCN operations, referencing their alignment with the eight PCN Core Attributes (the PCN Core Attributes are in order of priority excluding 7 and 8, which should underpin all of the work); summarize the selected services; create a rationale for the selection of each service including a high-level description of the constraints, opportunities, and considerations that were taken into account during this process. Please also note any desired plans for any UPCC, CHC, Foundry and FNPCC initiatives (along with any possible estimated resource allocation). Please describe if these are existing services? Are you expanding services? Or is this proposed net new service.

**Step 3:** For **each of the services/strategies** identified in Step 2, complete the table below.

***Note:*** *If you have more than three services/strategies please copy and paste the Service/Strategy table below to create additional tables. Do not build your own tables.*

|  |  |
| --- | --- |
| **Service/Strategy #1:**  | ***PLACEHOLDER Example Priority Populations***  |
| Desired Outcomes/Expected Results for above Strategy (50-100 words only) | RATIONALE FOR STRATEGY:*The**Ministry and FPSC take a learning and quality improvement approach to PCNs; keeping that in mind answer these questions: How do you expect your community to change as a result of implementing this Strategy? What is the expected timeframe you expect this outcome/results to be tangible in the community? OPTIONAL What are the key-indicators that you would like to be tracking?* |
| Description of Service Delivery Model/Approach(50-100 words only)  | *Which PCN attributes does this align to?* *How will you go about executing this plan?* *What are the existing resources in the community that you will leverage? Or is this a net new resource?* *Will you partner with existing service providers?* *How will you engage with the community?* *What is the 'community's need for this?* |
| Health Human Resources (HHR)/Clinical Health Resources Proposed | *Are you requesting MRPs? AHPs? Full FTEs? Will these clinical resources be given an attachment target?*

|  |  |  |
| --- | --- | --- |
| *Clinical Human Resource* | *FTEs being Requested* | *Attachment Target* |
| *FP* |  |  |
| *NP* |  |  |
| *RN* |  |  |
| *(add AHP here)* |  |  |
| *(add AHP here)* |  |  |
| *(add Indigenous care provider here)* |  |  |

*Remove any lines not required for the Strategy* |

|  |  |
| --- | --- |
| **Service/Strategy #2:**  | ***Name and/or Function*** |
| Desired Outcomes/Expected Results for above Strategy (50-100 words only) | RATIONALE FOR STRATEGY: *The Ministry and FPSC take a learning and quality improvement approach to PCNs: keeping that in mind, answer these questions: How do you expect your community to change as a result of implementing this Strategy? What is the expected timeframe you expect this outcome/results to be tangible in the community? OPTIONAL What are the key indicators that you would like to be tracking?* |
| Description of Service Delivery Model/Approach(50-100 words only)  | *Which PCN attributes does this align to? How will you go about executing this plan? What are the existing resources in the community that you will leverage? Or is this a net new resource? Will you partner with existing service providers? How will you engage with the community? What is the 'community's need for this?*  |
| Health Human Resources (HHR)/Clinical Health Resources Proposed | *Are you requesting MRPs? AHPs? Full FTEs? Will these clinical resources be given an attachment target?*

|  |  |  |
| --- | --- | --- |
| *Clinical Human Resource* | *FTEs being Requested* | *Attachment Target, if relevant*  |
| *FP* |  |  |
| *NP* |  |  |
| *RN* |  |  |
| *(add AHP here)* |  |  |
| *(add AHP here)* |  |  |
| *(add AHP here)* |  |  |

*Remove any lines not required for the Strategy* |

|  |  |
| --- | --- |
| **Strategy #3:**  | ***Name and/or Function*** |
| Desired Outcomes/Expected Results for above Strategy (50-100 words only) | RATIONALE FOR STRATEGY: *The Ministry and FPSC take a learning and quality improvement approach to PCNs: keeping that in mind answer these questions: How do you expect your community to change as a result of implementing this Strategy? What is the expected timeframe you expect this outcome/results to be tangible in the community? OPTIONAL What are the key-indicators that you would like to be tracking?* |
| Description of Service Delivery Model/Approach(50-100 words only)  | *Which PCN attributes does this align to? How will you go about executing this plan? What are the existing resources in the community that you will leverage? Or is this a net new resource? Will you partner with existing service providers? How will you engage with the community? What is the 'community's need for this?* |
| Health Human Resources (HHR)/Clinical Health Resources Proposed | *Are you requesting MRPs? AHPs? Full FTEs? Will these clinical resources be given an attachment target?*

|  |  |  |
| --- | --- | --- |
| *Clinical Human Resource* | *FTEs being Requested* | *Attachment Target, if relevant*  |
| *FP* |  |  |
| *NP* |  |  |
| *RN* |  |  |
| *(add AHP here)* |  |  |
| *(add AHP here)* |  |  |
| *(add AHP here)* |  |  |

*Remove any lines not required for the Strategy* |

Section D: Administration and Governance

***Maximum 1 page.***

While the majority of PCN funding is expected to augment direct service expenditures, it is recognized that funding may be required to support PCN administration and governance. Dedicated funding to support administration and governance, on top of the clinical resource allocation, is available to the PCN in discussion with the Ministry for these expenses. A specific funding envelope for these functions will be provided to the Collaborative Service Committee (CSC) and resources will be utilized by PCNs based on needs identified by the CSC. Together, the clinical resources, administration and governance are considered the 'PCN's ongoing annual operating costs.

***Instructions***

Briefly describe the proposed collaborative governance model for the PCN and include any supporting documentation around governance as an appendix (e.g., visible governance models). Please include information on the decision-making process to be used for the PCN.

# Section E: Change Management

To develop PCNs, initial funding or other resources are often required to support change. Shifting from the traditional solo model of independent primary care practices to networked practices delivering care through teams to meet the population needs of a community is a fundamental shift in the way primary care has been delivered.

All change management expenditures will need to be fully itemized against PCN Service Plan deliverables and disclosed in detail as part of the PCN Annual Progress Report.

|  |
| --- |
| **Ministry Funded Change Management Supports**Change management costs considered in-scope for Ministry funding are activities required to transition from the status quo to full PCN approved service plan implementation (except for out-of-scope costs). These include:* Clinical service model development, including transition to team-based models of care and development of team workflows, protocols and integration within FP/NP practices
* Cross provider service delivery
* Recruitment and training for FPs, NPs, nursing and allied health providers
* Patient engagement
* Community partner engagement
* Communications including public awareness, advertising, and marketing with provincial PCN branding
* Engagement with Indigenous Health providers
* Evaluation
* Nurse Practitioner integration

**FPSC-funded Change Management Supports**The following is an overview of the activities that are considered within scope for FPSC funding. Please note, the funding is meant to cover the physician's contribution to these activities. Supports within scope should be funded through divisions' existing F*PSC Physician Engagement in PMH & PCN Development* funding; this section is not intended as an application for additional FPSC funding. Additionally, this list is subject to final FPSC approval and may change. FPSC Physician Engagement in PMH & PCN Development funding can be used to support divisions to sustain the active involvement FPs and FP leaders in the local development and implementation of PMHs within the PCN strategy. The following types of activities are within scope:* FP participation in leadership/administrative roles in supporting PMH development, group practice and network development
* FP participation in team developmentFP participation in working groups
* Locally informed and delivered FP cultural safety and copentency training
* Coaching and mentoring of FPs for non-clinical work
* Development and set up of PMH networks (e.g. developing a call group or linking with in-hospital, maternity and residential care networks, or with 811)
* Support for shifting practice and business models to better serve local populations (e.g., support for transitioning to new funding models)
* Participation on local and cross-organizational steering committees (e.g., PCN steering committees)
* Development of local and regional patient attachment mechanisms
* Development of local and regional recruitment strategies along with participation in recruitment activities
* Development of locum coverage coordination strategies
* Organization of, and attendance at, member engagement activities and events

Funds may be used for:* FP and MOA time (sessional payment) and travel expenses
* FP and MOA professional development (training)
* Meeting expenses
* Staffing needs (staff salary, consultant fee), up to 50% of the funding
* Administration to manage the funds, up to 10% of the funding

*Please reference the FPSC Physician Engagement in PMH & PCN Development* funding guidelines for additional details, including activities and expenses that are not within scope.**Out of scope for change management funding**Change management costs associated with activities provided by another entity within the health system are considered out of scope for Ministry funding. These include:* Divisions resources (for example the Executive 'Director's salary) that are covered by infrastructure funding
* Health authority staff costs to be managed from within health authority global budgets
* Supports and services already provided by other programs, such as the Practice Support Program or the Doctors Technology Office
 |

A four-year, one-time money envelope for change management will be determined based on 5% of the ongoing annualized funding envelope for Clinical, Administration and Governance resources per year.

***Instructions***

Please complete one table per change management strategy being proposed.

***Note:*** *If you have more than three change management strategies, please copy and paste the table below to create additional tables. Do not build your own tables.*

|  |  |
| --- | --- |
| **Change Management Strategy #1:**  | **Name and/or Function** |
| Proposed Change Management Plan and Desired Outcomes(50-100 words only) | The Ministry and FPSC take a learning and quality improvement approach to PCNs: keeping that in mind, answer these questions: How will you support PCN implementation? How will new and existing staff be trained and integrated into the PCN? How will you involve stakeholders? How will you evaluate the effectiveness of your initiatives? |
| Partners Engaged as Part of Change Management(50-100 words only)  | This can include but is not limited to, First Nation communities, Métis Chartered Communities, Practice Support Program, the 'Doctors' Technology Office, the Rural Coordination Centre of BC, local non-profits, etc. |
| Resources Required to Implement this Strategy  | Questions for consideration: Do you need additional FTEs? What is the goal for the resource? When does this need to begin?

|  |  |  |
| --- | --- | --- |
| Resource | Description | Budget or FTE |
| **Example:**Evaluator | 1.0 FTE evaluation contract. An evaluator will help on several fronts: -evaluation is research to inform decisions—it will provide an opportunity to push for adaptations and mid-course corrections that will maximize success-Evaluation results benefit the immediate project as well as enhance future initiatives with lessons learned. | 1.0 FTE |

 |

|  |  |
| --- | --- |
| **Change Management****Strategy #2:**  | **Name and/or Function** |
| Proposed Change Management Plan and Desired Outcomes(50-100 words only) | The Ministry and FPSC take a learning and quality improvement approach to PCNs: keeping that in mind, answer these questions: How will you support PCN implementation? How will new and existing staff be trained and integrated into the PCN? How will you involve stakeholders? How will you evaluate the effectiveness of your initiatives? |
| Partners Engaged as Part of Change Management(50-100 words only)  | This can include but is not limited to, First Nation communities, Métis Chartered Communities, Practice Support Program, the 'Doctors' Technology Office, the Rural Coordination Centre of BC, local non-profits, etc. |
| Resources Required to Implement this Strategy  | Questions for consideration: Do you need additional FTEs? What is the goal for the resource? When does this need to begin?

|  |  |  |
| --- | --- | --- |
| Resource | Description | Budget or FTE |
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| **Change Management****Strategy #3:**  | **Name and/or Function** |
| Proposed Change Management Plan and Desired Outcomes(50-100 words only) | The Ministry and FPSC take a learning and quality improvement approach to PCNs: keeping that in mind, answer these questions: How will you support PCN implementation? How will new and existing staff be trained and integrated into the PCN? How will you involve stakeholders? How will you evaluate the effectiveness of your initiatives? |
| Partners Engaged as Part of Change Management(50-100 words only)  | This can include but is not limited to, First Nation communities, Métis Chartered Communities, Practice Support Program, the 'Doctors' Technology Office, the Rural Coordination Centre of BC, local non-profits, etc. |
| Resources Required to Implement this Strategy  | Questions for consideration: Do you need additional FTEs? What is the goal for the resource? When does this need to begin?

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| --- | --- | --- |
| Resource | Description | Budget or FTE |
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# Section F: Growth Plan

*If your current PCN Service Plan does not include all CHSAs/communities within the geography of your CSC, please detail here the plan to expand and include other providers and geographic regions within the PCN or if you plan to develop additional PCN(s) over the next three years.*

***Instructions***

Please explain which practices or regions will be added to the PCN(s), and consider what supports are necessary to make that happen (PCN resources, PSP and divisional resources, Ministry support). Please complete the table on the following page to assist with this work.

***GROWTH PLAN TABLE***

Use this template to briefly describe your 'PCN's growth plan

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **What is the target community, CHSA, FFS site, or community organization?** | **Who from the PCN Team will lead the engagement?** | **What is needed from and for this site/organization to participate in the PCN?** | **What can be done now to ensure their needs are addressed before they join the PCN?** | **Understanding Your Patient Panel requirements for site/organization to participate in the PCN?** | **Timeline** |
| *e.g. Target FFS practice X to join PCN, Specialist engagement* | *Dr. Small & PCN Lead/executive sponsor* | *Advanced Access training and EMR implementation* | *PCN Information/engagement session with primary care providers in X community; Advanced Access training; Exploring EMR interest and options* | *Participating physicians have an accurate and up-to-date list of patients for whom they are confirmed as the Most Responsible Provider (e.g. Empanelment)* | *Year 2 – June 2020* |
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# Section G: One-Time Costs

While it is anticipated existing space and equipment will primarily be used, we acknowledge that some potential new investment in capital assets such as facilities, equipment and IMIT may be required to implement the PCN Service Plans. Please contact your Ministry PIO Manager or Director to discuss any potential capital funding requirements before service plan submission.

All one-time cost requests are reviewed on a case-by-case basis for possible funding and are generally approved through a different funding mechanism than PCNs. Please contact your FPSC Primary Care Transformation Partner to discuss the use of FPSC Minor Tennant Improvement funding, the Group Family Practice Development Grant and the Team-Based Care Grant to support PCN development.

***Instructions***

Please detail any one-time costs associated with your identified strategies, including the Strategy it applies to, how important it is to implementing the Strategy, the type of cost (e.g., infrastructure, renovation, IMIT, etc.) and cost estimation in the table below.

***TABLE 8 Estimated One-Time Costs and Importance to Strategy Success***

|  |  |  |  |
| --- | --- | --- | --- |
| **Strategy (Number)** | **Importance (rate from 1 – 5)**where 1 is minor importance and 5 is integral to the ' 'Strategy's success | **Description (tenant improvements, medical supplies/equipment, office equipment and furniture, etc.)** | **Estimated Cost** |
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# Section H: Budget

When you are ready to discuss your proposal, please connect with your Ministry PIO Manager or Director for the excel budget template, which will provide a financial summary of your entire proposal. Your Ministry of Health PIO Manager will also discuss with you some of the key elements of your overall funding envelope.

# Section I: Ministry Expectations for PCN Implementation

The following additional activities will be required prior to full implementation.

**Health Connect Registry (Registry)**

After the implementation of the PCN, the partners will need to collaborate with HealthLink BC to implement the Registry in a timely manner. The goal of this system is improving patient attachment and access to primary care services, while facilitating a learning and quality improvement approach to attachment and access across the region and the province. The Health Connect Registry functions as a centralized registry for patients looking for attachment to a primary care provider. Registration is available online at HealthLinkBC.ca or by calling 8-1-1. HealthLink BC will work with PCNs to merge existing community waitlists to the Health Connect Registry. . Specific patient attachment funds are available through FPSC to support developing this service.

**UBC-Pharmacist Initiative**

As part of the PCN approval package, Ministry has approved the allocation of up to one Clinical Pharmacist per PCN, depending on the size of the PCN, or as per the required need of the governing tables. This initiative is being administered by the University of British Columbia (UBC) as part of a larger partnership with the Ministry. At this point, priority is PCNs that began implementation in 2018/19 (i.e., Wave 1). When more positions become available for the subsequent phases of PCNs, the PCN partners will be contacted to assess readiness to hire a pharmacist and UBC will work with partners on the hiring process.

**PCN Website, Communication & Outreach**

The PCN will work in partnership with HealthLink BC to create website content for the Primary Care Online initiative that includes information about PCN geography, services provided, participating clinics, where extended hours of care are offered, how to access urgent primary care services and information related to access and attachment for the community. These efforts will be a part of a broader regional and provincial communications plan for promoting primary care networks.

**Monitoring and Reporting**

The Ministry will monitor the implementation of the PCN against the service plan approval and implementation schedule on a period, quarterly and annual basis through an online portal developed and maintained by the Ministry; Health Authority financial reporting will take place through the Health Authority Management Information System (HAMIS). Reporting is a collaborative effort between the Division of Family Practice, Regional Health Authority and other PCN partners.

Section J: Annexures **(if required)**

***Instructions***

Please include annexures as relevant to support your proposal, inclusive of the governance structure (as per Section D). Please also include in this section any letters of support from partners and/or stakeholders.

## **APPENDIX A**: PCN Policy Direction

**ESTABLISHING PRIMARY** **CARE NETWORKS**

With implementation commencing in 2018/19, the Ministry of Health’s transformational team-based primary care strategy, envisioned to increase patient attachment and access to quality, comprehensive, culturally safe and person-centered primary care services across the province is well underway. This strategy was initially developed in response to challenges including increasing numbers of British Columbians without a regular primary care provider, fragmented and varied care across multiple providers and increasing levels of clinician and provider burnout. The strategy includes a number of different team-based primary care models:

* Full-service Family Practices/Patient Medical Homes (PMHs)
* Urgent and Primary Care Centres (UPCCs)
* Community Health Centres (CHCs)
* First Nations Primary Care Centres (FNPCCs)
* Nurse Practitioner (NP) Primary Care Clinics (NPPCCs)
* Foundry Centres

These clinical service models and all primary care providers in a defined geography will be aligned together in local Primary Care Networks (PCNs) in order to better coordinate and leverage existing and new providers and services to better meet the needs of local citizens. Taken together, these clinical models operate within a PCN, linking to other community and specialty services. Along with PCN general policy direction, PMHs, UPCCs and CHCs are accompanied by supportive policy direction.

**POLICY OBJECTIVE**

Primary Care Networks (PCNs) will be established across British Columbia to provide comprehensive, person-centred, culturally safe, quality primary care services to the population of a Community Health Service Area (CHSA) and, as required, coordinate patients’ access to Specialized Community Services Programs (SCSPs), the Surgical Services Program (SSP) and the broader health system.

A PCN is a network of Patient Medical Homes (PMHs) linked with primary care services, and other clinical models, delivered or contracted by a health authority and community-based social and other health service organizations. Taken together, these clinical models operate within a PCN, linking to other community and speciality services. PCNs are the foundation of an integrated system of team-based primary and community care. In most instances, an individual’s primary care needs will be met by their PMH though some aspects of care may be provided within the broader network.

PCN services will be designed and maintained to meet the needs of individuals, families, and caregivers to improve population health at sustainable per capita costs.

*Expected Impact on Health Outcomes and Service Attributes*

It is expected that establishing PCNs will achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key service attributes (accessibility, appropriateness, acceptability, safety, efficiency). Measurable expected impacts include:

1. *Accessibility:* The population within a CHSA:
	1. Are attached to a regular primary care provider who is most responsible for overall coordination and continuity of care;
	2. Have timely access to appointments (same-day or at a scheduled time, as appropriate) with their regular primary care provider or another in-practice interdisciplinary team member; and
	3. Are able to access (in person or virtually) primary care advice and the provision of, or direction to, needed care 24 hours a day, 7 days a week, as close to home as feasible.
2. *Appropriateness:* Improved patient, family and caregiver experience outcomes through access to comprehensive, evidence**-**informed primary care delivered by interdisciplinary teams.
3. *Acceptability:* Improved patient, family and caregiver experience outcomes through access to person-centred and culturally safe care.
4. *Efficiency:* All appropriate ambulatory care needs are met in the community.

**KEY DEFINITIONS**

*Attachment*: The documented existence of a clear ongoing care relationship between a patient and a most responsible practitioner, a family practice or health authority primary care clinic.

*Community Health Service Area (CHSA):* CHSAs are geographic units providing the most granular level of data available at the Ministry of Health. The boundaries of this geography were developed through extensive consultation and are meant to reflect where people live and the communities where they identify themselves as belonging. Where this policy references community, it is referring to the community residing within the boundaries of a CHSA unless otherwise specified (i.e. a community of specialized need that might be served by a particular Community Health Centre but whose patients reside across multiple CHSAs).

*Culturally Safe*: Providing care based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.

*Patient Medical Home (PMH):* A family practice or health authority primary care clinic which has a majority of the person-centred service attributes (commitment, contact, comprehensiveness, continuity, coordination) and relational attributes (team-based care and networks) of the BC PMH model.

*Primary Care Network (PCN):* PCNs are an organized system of primary care where PMHs and other clinical models are networked with each other and with primary care services delivered or contracted by health authorities and community-based social and other health service organizations. Patients, families, and caregivers can access comprehensive, person-centred, culturally safe, quality primary care within a PCN. In their organization and structure, PCNs maintain clear pathways and linkages with specialized community services programs a and the broader health system.

*Primary Care Provider*: Primary care providers are family doctors or nurse practitioners, who attach patients and provide longitudinal care in team-based settings that may also include nurses, clinical pharmacists, social workers, physiotherapists, occupational therapists, registered dietitians, traditional wellness healers, midwives, and other allied health professionals. Benefits of having a continuous relationship with a primary care provider and team include improved disease management, positive health outcomes and improved experiences of care.

*Team-based Care*: Multiple health care providers from different professional backgrounds work together with patients/clients, families, caregivers and communities to delivery comprehensive health services across care settings. Effective teamwork is a critical enabler of safe, high quality care and supports a patient’s ongoing relationship with their primary care provider (a family physician or nurse practitioner)

**SCOPE**

This policy covers the comprehensive suite of population based, primary care services (see *Appendix A*) needed throughout an individual’s life and across health service areas. This policy applies to family practices, health authority primary care clinics, primary care services delivered or contracted by health authorities (including the First Nations Health Authority) and community-based social and other health service organizations (e.g. Community Health Centres, walk-in clinics).

**POLICY DIRECTION**

**PCN Design**

1. PCNs will be designed to meet the needs of individuals and ensure the comprehensive suite of primary care services (see *Appendix A*) are accessible by the community population they serve. Each PCN will serve approximately 10,000 to 50,000 people in rural and remote areas, and 50,000 to 100,000 people in urban areas of British Columbia.
2. Ministry of Health will work with each local PCN steering committee to determine the PCN’s size, scope and service composition based on a number of design principles. These include person- and family-centredness; that comprehensive primary care will be delivered as close to home as possible; stable and professional inter-personal working relationships can be built among providers; and financial and other resources are distributed in an equitable and optimal manner.
3. In rural and remote communities, a smaller PCN may be able to provide comprehensive primary care services through a single PMH linked with health authority primary care services.
4. Consideration will be given for physical accessibility (e.g., rural and remote travel distances, public transportation, and limited mobility) and significant efforts will be made to reduce and mitigate access issues through the use of a variety of models, including virtually-enabled care, mobile services, group visits, and other design elements.PCN service design will consider both existing patients and those without access. PCNs will identify unattached individuals and families in the community and have a centralized primary care waitlist and protocols for patient-provider attachment.
5. PCN design will align with regional and provincial guidelines that will be co-created with health system partners, including patients, families and caregivers, to ensure comprehensive services are available on a human scale while taking into consideration local context (geography, population, Aboriginal Self Identification, etc.).
6. Within a CHSA a PCN will provide the community population with:
	1. An explicit, ongoing care relationship (i.e. attachment/relational continuity) with a regular primary care provider who is most responsible for their care for all people who want one;
	2. Comprehensive primary care services (see *Appendix A)* ensuring that services and care plans are holistic, person-centred, culturally safe and responsive to individual needs (including consideration of the social determinants of health);
	3. Timely access to appointments (same-day or at a scheduled time, as appropriate) with their regular primary care provider or another in-practice interdisciplinary team member;
	4. Access to primary care advice and provision of, or direction to, needed care 24 hours a day, 7 days a week through a variety of mechanisms (e.g. HealthLinkBC 8-1-1, email access, call networks);

e. Extended hours of care (including evenings and weekends) possibly through PMHs and/or linkages with walk-in clinics, Urgent and Primary Care Centres, and Community Health Centres;

1. Coordinated service delivery including timely appointments for investigations, treatments and consultations in other health service areas;
2. When more specialized care is required by a patient, ensure effective transitions of care as appropriate to the local or nearest SCSP (cancer care, mental health and addictions, and complex medical/frail) or Surgical Services Program, diagnostic facilities, medical specialists, hospital services, community-based

service organizations, and agencies (including on- and off-reserve First Nations and Aboriginal); and,

1. Clear mechanisms and protocols for the patient’s regular primary care provider to maintain continuity of care (relational, informational, and management)

through contributing to care planning delivered through SCSPs or SSP, hospitals, and regional and provincial programs;

1. Regular opportunities for patients, families, and caregivers to be engaged and give feedback for quality improvement activities.
2. PCN design will include implementation and sustainment of the following functions:
	1. Interdisciplinary team care (in-practice and network) to optimal scope of practice;
	2. Technology-enabled solutions with virtually-enabled care embedded into daily operations to link patients and providers (e.g. home health monitoring);
	3. Informational continuity (e.g. appropriate information sharing, single patient health record) and management continuity (e.g. longitudinal care planning, integrated team planning, team-based case management), including working towards linked electronic medical records;
	4. Case finding to identify individuals requiring care prior to crisis or hospitalization, including consistent use of upstream assessment tools (e.g. frailty scales);
	5. Provider access to rapid and optimal consultation services from SCSP or SSP, and regional and provincial services, to support the primary care team to appropriately and effectively meet mild to moderate needs of patients, address problems as they arise, and avoid the need for specialized care where possible.
	6. Partnership with the local community including school-based health promotion programs, Community Health Centres, and community initiatives with citizens, local government, and other organizations focused on areas such as:
		1. healthy eating, food security and healthy weights,
		2. physical activity and non-sedentary living,
		3. tobacco and vapour product use prevention, cessation and enforcement,
		4. social/emotional health and resiliency,
		5. culture of moderation of alcohol use, and
		6. injury prevention.

**Patient Medical Home** (see *Patient Medical Home* policy)

1. Within a PCN, all family practices and health authority primary care clinics will be supported to become a PMH as defined by the attributes of the BC PMH model.
2. All practices and clinics within a CHSA are considered a part of the PCN, both before and after they have attained PMH attributes.
3. In a PMH, individuals are attached to a regular primary care provider, a family physician or nurse practitioner, who is most responsible for the overall coordination and continuity of the individual’s care across the life course. The regular primary care provider maintains this key role regardless of health service area or whether the required care is provided within the PMH or by other health professionals (e.g. specialists) in the system.
4. Primary care services delivered in a PMH will meet the majority of the populations’ primary care needs. The balance of comprehensive primary care services required by a geographic population will be met through PMH being networked with each other and with other primary care services being delivered or contracted by health authorities as part of a PCN.
5. Coordinated and consistent PMH indicators and metrics will be applied across PCNs.

**PCN Administration**

1. PCN steering committees will be established, building on existing local structures (e.g. collaborative services committees) or sub-groups (e.g. local action teams) with a clearly defined local governance model. This includes joint planning, decision making, and accountability to regional and provincial governance structures for reporting and monitoring.
2. A PCN steering committee will start with a core membership representing the health authority and practices (i.e. division of family practice). Steering committee membership will expand as the network develops in the community to include patients/families/caregivers and additional community organizations in the PCN, for example the First Nations Health Authority, walk-in clinics, Community Health Centres, Urgent and Primary Care Centres, and community-based social and other health service organizations (on- and off-reserve).
3. PCN steering committees will have effective communication with municipal bodies, including First Nations councils, to inform planning for primary care services to address community needs.
4. PCN steering committees will design and maintain primary care services that meet the needs of individuals and improve population health at sustainable per capita costs through joint planning, implementation, resource management, quality improvement, and reporting.
5. Locally developed PCN implementation plans will be reviewed and finalized regionally and provincially, in alignment with PMH, SCSP and SSP implementation.
6. PCN steering committees will implement plans in a sustainable, incremental process within and across geographic areas, leveraging existing assets and services, new innovations and local or regional opportunities as they occur.
7. PCN steering committees will consistently use data and evidence to inform planning and quality improvement activities at a professional, practice, community, and system level. The necessary information sharing agreements will be in place to support quality improvement and evaluation work.

**LINKAGES**

*Health Human Resources*

PCN interdisciplinary care teams will provide wrap-around, person-centered care using available HHR resources, optimized scopes of practice and where necessary and appropriate virtually-enabled care to achieve service objectives. Based on the population served, interdisciplinary care teams may be comprised of, but are not limited to, the following health care providers:

1. Audiologists
2. Counsellors
3. Dentists
4. Dietitians
5. Medical laboratory and diagnostics professionals
6. Medical office assistants
7. Midwives
8. Nurses and nurse practitioners
9. Occupational therapists and physiotherapists
10. Optometrists
11. Pharmacists
12. Psychologists
13. Physicians (mainly general practitioners)
14. Respiratory therapists
15. Social workers
16. Complementary and alternative providers (e.g. Traditional Wellness Practitioners)

*Organizational Capacity Data Analytics and Reporting*

Service delivery data collection and submission should be comprehensive, accurate, and timely to support adequate and thorough understanding of population and patient needs and baseline service levels, and to plan for and assess improvements over time.

Data and analysis will be provided by the Ministry of Health to support service delivery planning at both the Local Health Area and CHSA levels. Collaboration and dialogue on these products can be used to inform strategic planning, gap analysis, and subsequent roll-out in a range of environments. These tools can also be used to understand the baseline for performance.

Integrated analytics will support performance monitoring, reporting and evaluation in line with the strategy for health system performance management.

# PERFORMANCE INDICATORS

Initial performance indicators have been developed in collaboration with the Ministry and external stakeholders to measure the expected outcomes of the service attributes of accessibility, appropriateness, acceptability, and efficiency. <Insert Number> performance indicators to report on the Primary and Community Care Strategic Initiative include:

1. TBD

In addition to the above indicators, Ministry and external stakeholders will continue to collaborate to identify additional indicators that provide insight into the performance of both the Establish Primary Care Networks General Policy Directive and the Primary and Community Care Strategic Initiative overall.

# REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed three years from date of implementation and following completion of the summative evaluation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.
3. Information from the annual evaluation will be used to understand the performance of the strategic initiative, areas of success and areas for continuous quality improvement.
4. The Ministry will work with the program area to develop a quality improvement plan where necessary and will support the program area to manage the review and quality improvement process.
5. The Ministry will lead any monitoring of outcome measures that are identified in the quality improvement plans developed.

## APPENDIX B: Comprehensive Primary Care Services

The list of comprehensive primary care services which the network is expected to provide is as follows:

|  |  |
| --- | --- |
| **Population** | **Primary Care Services** |
| **Staying Healthy** | 1. Supports to address health literacy, self-care and self-management
2. Supports to address factors that contribute to health status

advocacy for healthy public policy, supportive environments and communities1. Population health assessment of the PCN population, including the identification high-risk sub-populations and clinical preventive maneuvers as required
2. Implementation of the [Lifetime Prevention Schedule](http://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/current-health-topics/lifetime-prevention) for the general asymptomatic population including immunizations, screening (e.g., perinatal depression, cancer, etc.), behavioural interventions (e.g., tobacco cessation), preventive medications/devices (e.g. statins)
3. Nutrition counselling
4. ***Reproductive care:***
5. sexual health, including prevention and management of sexually transmitted infections
6. health promotion services and supports before, during and after pregnancy (e.g. nutrition, exercise, hypertension, smoking cessation and substance use, birth planning)
7. low-risk maternity care
8. antepartum and postpartum care
9. contraception, safe abortion services and post-abortion care
10. ***Healthy early childhood development:***
11. implementation of guidelines for [developmental surveillance](http://canadiantaskforce.ca/guidelines/published-guidelines/developmental-delay/) and case finding (see the SPD: Healthy Start)
12. provision of information about child health, growth and development and parenting
13. breastfeeding and child nutrition education and support
14. health promotion services (e.g. immunizations, hearing and vision screening, dental services)
 |
| **Getting Better** | 1. Assessment and treatment services for minor illnesses
2. Access to diagnostic services, including point-of-care testing where practical
3. Basic in-office emergency services
4. Linkages to community-based resources, including peer and group support
 |
| **Living with Illness or Disability** | 1. Outpatient diagnostic imaging and laboratory services, as appropriate
2. Early detection, intervention, education and support for self-care
3. Guideline-based chronic disease management and service coordination
4. Post-cancer treatment care and support
5. Pre- and post-surgical care (e.g. pre-habilitation, optimization and rehabilitation services).
6. Local surgical services, as appropriate
7. Use of existing standardized care pathways (e.g. hip surgery)
8. Ongoing monitoring, including medication
9. Support for care provided in hospital and long-term care facilities
10. ***Care for mental health and substance use:***
11. screening, assessment and management of mild to moderate conditions and stable severe or complex disorders including concurrent physical health conditions,
12. individual, group and online counselling,
13. pharmacological treatment and medication monitoring,
14. rapid access to crisis intervention services,
15. harm reduction resources,
16. tools to increase resilience,
17. opioid agonist therapy services.
 |
| **Optimally Coping with End of Life** | 1. Serious illness and quality of life conversations
2. Palliative approach to care (e.g., pain management)
3. Support for the terminally ill
 |

## APPENDIX C: Data Sources and Sourcing Requirements

**Instructions for Completing ""*Section C*"" of Your Service Plan Submission**

Service plan proposals must include references to statistics presented in tables, figures, or in the body of text from published sources (e.g., report name, author, publication date). Include hyperlinks for online publications. Statistics from unpublished work must be documented to indicate the timeframe, the population included, data source(s), definitions of concepts presented, and the organization's name that generated the information.

The organization(s) putting forward this proposal is responsible for collecting information to support its service plan.

**Information Products to Support your Submission**

There are many available information products available that can support your work in preparing a service plan proposal. For your convenience, some of these are described below.

Identifying the Gap in Attachment

Please contact your Ministry representative to receive the 'Ministry's initial estimate of the primary care attachment gap (see *Section D* above).

Primary and Community Care Profile: Your Community

This report focuses on data specific to understanding primary care needs and services to support the development of Primary Care Homes in BC. It provides analysis that can inform planning at the local level for an integrated and coordinated primary and community care service system.

This report is available by Local Health Area. Email MOHAnalytics@gov.bc.ca with the Local Health Area(s) of interest if you would like a copy.

Local Health Area (LHA) Profile

The 'Ministry's LHA Profile summarizes the characteristics of and health care services used by populations within an LHA. It has a strong focus on Ministry priority areas with much of the analysis segmenting the population into four groups: Healthy, Getting Healthy, Living with Illness and Chronic Diseases, and Towards End of Life.

This report is available by Local Health Area. Email MOHAnalytics@gov.bc.ca with the Local Health Area(s) of interest if you would like a copy.

FNHA Data Set

FNHA has developed regional data packages on the health status and primary care attachment and access of Status First Nations on an FNHA Sub Regional level and Local Health Areas level are available for you to access at your FNHA regional office. Review of the FNHA data set as well as connecting with Indigenous partners, including Regional Health 'Authority's Aboriginal Health teams and FNHA regional teams, can identify inequities, service gaps and service opportunities.

Chronic Disease Registry Annual Report

The BC Ministry of Health Chronic Disease Information Working Group creates and maintains chronic disease registries annually. Currently, there are 37 chronic disease or procedure reports available, including most common chronic conditions, such as diabetes, hypertension, heart failure, and COPD.

This report is available by Local Health Area. Email MOHAnalytics@gov.bc.ca with the Local Health Area(s) of interest if you would like a copy.

Information Resource Manual

The Information Resource Manual is published annually by the Ministry and contains statistics based on fee-for-service payments made to BC practitioners for services provided to MSP registrants during the fiscal year. The manual can be accessed at:

<http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/irm_complete.pdf>

'PHSA's Community Profile

The Provincial Health Services Authority (PHSA) and its partners developed the BC Community Health Profile to provide local data for health authorities and local governments to support community health planning and decision making.  The profiles provide an introduction to community health data, presented at the lowest geographic level available (Census subdivision or LHA, when possible). The profiles can be accessed at: <http://www.phsa.ca/our-services/programs-services/population-public-health/community-health-data>

Planning Guide for PCNs – Preventive Care

The Ministry has developed a document to guide collaborative planning by the PCN to deliver preventive care. Please contact your Ministry Liaison if you require a copy.

BC Stats

BC Stats is the central statistical agency of the Province of British Columbia. Its website contains a wealth of information on demographics, economics, labour and social statistics. The area profiles produced by BC Stats (<http://www.bcstats.gov.bc.ca/Search/AreaProfiles.aspx>) can be generated for a community or region of interest. The website also provides links to national organizations with additional data sources. More details can be found at: <http://www.bcstats.gov.bc.ca/Home.aspx>.

Statistics Canada

Statistics Canada is a national statistical agency that is responsible for the collection and dissemination of information from the Census of Population, National Household Survey and the Canadian Community Health Survey, among other surveys and databases. This agency produces several products that are available to the public at: <http://www.statcan.gc.ca/eng/start>.  Some reports of interest include:

* National Household Survey Profile <https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E>
* Health Summary Tables <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/ind01/l2_2966-eng.htm?hili_none>
* Health Indicators <http://www.statcan.gc.ca/pub/82-221-x/82-221-x2013001-eng.htm>

BC Vital Statistics Agency Annual Report

The data in this publication are based on information collected from registrations of live births, stillbirths, deaths, and marriages, as registered by the Agency for events occurring in the 2015 calendar year. It contains selected information about the vital events taking place in British Columbia. Although some information related to vital events occurring within the province includes visitors, such as marriages, the majority are specific to residents of BC.

The report presents key indicators for the 'province's health authorities (HA), health service delivery areas (HSDA) and local health areas (LHA). It includes a detailed glossary, defining the terms used in the body of the publication, and a methodology section explaining the statistical computations in the main body. The report is available at: <https://www2.gov.bc.ca/gov/content/life-events/statistics-reports/annual-reports>

Canadian Institute for Health Information

The Canadian Institute for Health Information (CIHI) is a not-for-profit organization that provides information on 'Canada's health system and the health of Canadians. Information produced by this organization describes the types of care, health system performance, health workforce, spending and other factors influencing health. More details can be found at: https://www.cihi.ca/en. Some reports and information tools of interest include:

* Physicians in Canada <https://secure.cihi.ca/estore/productSeries.htm?pc=PCC1140>
* Your Health System (<http://yourhealthsystem.cihi.ca/>) is an interactive tool that allows users to select regions and indicators for display of comparison data.

Patient, Family, Caregiver and Public Engagement Planning Guide

The Ministry has developed an Engagement Planning Guide based on international best practices**:** <https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/patients>

## APPENDIX D: About Primary Care Networks

The PCN is defined by the PCN General Policy Direction. 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.
 |
| 1. Provision of extended hours of care including early mornings, evenings and weekends.
 |
| 1. Provision of same day access for urgently needed care through the PCN or an Urgent Primary Care Centre.
 |
| 1. Access to advice and information virtually (e.g. online, text, e-mail) and face to face.
 |
| 1. 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.
 |
| 1. 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.
 |
| 1. Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.
 |
| 1. Care is culturally safe and appropriate.
 |

## APPENDIX E: Determining the Attachment Gap in Local Communities

The first goal of the PCN Service Plan is to close the attachment gap in community. The attachment gap will be determined through the following steps:

1. Identify which Community Health Service Area(s) (CHSA) will be served by your Primary Care Network.
2. To determine the attachment gap, the PCN Planning Team should provide the number of practicing providers, including those that serve sub-populations (i.e. Indigenous, maternity), practice status (full-time/part-time), and other relevant information to practitioners currently availableto provide primary care for the population within the PCN(s) and provide the information to the Ministry liaison.
3. The Ministry will provide a data package outlining the primary care attachment gap for the PCN and a Health System Matrix Summary by CHSA to the CSC at the start of Service Planning. This information will be prepopulated into the PCN Service Planning template to support resource planning and allocation. \*Please note that delays in receiving the information in item 2 may impact the 'Ministry's ability to provide this package within the noted timeframe.
4. FNHA will provide regional data packages on the health status and primary care attachment and access of Status First Nations on an FNHA Sub Regional level and Local Health Areas level. The data package will be provided to the PCN Planning Team.
5. A meeting to review and discuss the attachment gap and associated data will be scheduled and will include the PCN Planning Team, Ministry liaison, FPSC community liaison and Ministry analytics staff.
1. Longitudinal care component of UPCC are in scope for this estimated funding envelope. Additional funding will be provided for urgent care component. [↑](#footnote-ref-2)
2. Where attachment gap has not been confirmed, the letter (E) indicates that attachment gap is an estimate only, intended to support planning. The attachment gap will be confirmed with planning partners during the service plan process. [↑](#footnote-ref-3)
3. Priority populations include populations that experience inequities in health status due to social determinants of health (e.g., First Nations, insecurely housed, significant mental health and/or substance use conditions). This is based on a 15% calculation that the MOH uses. [↑](#footnote-ref-4)
4. Practice, site, or clinic where primary care is provided [↑](#footnote-ref-5)
5. ‡Include sites/clinics/practices that serve specific sub-populations (e.g., Indigenous, maternity, mental health, substance use). [↑](#footnote-ref-6)