Ministry of Health
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URGENT AND PRIMARY CARE CENTRES

POLICY OBJECTIVE

Urgent and Primary Care Centres (UPCCs) will provide primary care services to populations of select communities throughout British Columbia, particularly in metro and urban areas. Within the UPCCs, urgent primary care services will increase same-day access to quality, culturally safe, patient-centred, urgently needed primary care for unattached patients as well as for attached patients that are unable to access their primary care provider on a timely basis.

UPCCs will enable new patient attachments through on-site full-service primary care providers and to primary care providers within the broader PCN; they will be the first place a patient can visit when arriving in the community to indicate their need for a regular primary care provider, working with the provincial ***Health Connect Registry*** as that is developed further.

UPCCs will be a highly flexible, team-based resource designed to complement and add to existing primary care capacity and fill service gaps as part of broader Primary Care Networks (PCN) to provide integrated, comprehensive, and well-coordinated primary care.

UPCCs may also fulfill other administrative, coordination, and communication functions on behalf of the PCN, such as operating as a primary care 'hub' within a community for providers and patients (i.e. group medical visits) and to physically accommodate additional team based services that will provide outreach and work with other primary care clinics within the network - especially where primary care clinics do not have the physical capacity to add to their teams.

Expected Impact on Health Outcomes and Service Attributes

It is expected that ensuring the availability of urgent and primary care services 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:* Process for ensuring all people in a given community have access to quality urgent and primary care services, including same day and/or virtual care for urgently needed services and comprehensive, co-ordinated, and continuous primary care.

2. *Appropriateness:* The population within a given community can access urgent and primary care services in the evenings, weekends, and on statutory holidays without accessing care through a hospital emergency department.

3. *Acceptability:* Patient, family, and caregiver experience is improved through clear communication about where and how to access urgent and primary care services, including laboratory, diagnostics, and imaging services outside of an emergency department and opportunities for attachment to a primary care provider are available.

4. *Safety:* Information on the urgent primary care received by a patient and necessary follow-up care is shared with a patient's regular primary care provider, including coordination of care with diagnostic services, hospital care, speciality care, and specialized community services for all patients, with emphasis placed on those with mental health and substance use conditions, those with complex medical conditions and/or frailty, and surgical services provided in the community.

5. *Efficiency:* UPCCs will ensure appropriate urgent and primary care needs are met through interdisciplinary team-based care with access to expanded primary care services and increased patient attachment to a regular primary care provider through efficient triage and office efficiency protocols.

DEFINITIONS

Urgent primary care: Primary care for injuries and illnesses that should be seen by a health care provider within 12 to 24 hours but do not require the level of service or expertise found in an emergency department. Urgent primary care tends to be provided outside of traditional primary care office hours, however, subject to community needs and patient demands, can also be available during regular business hours. Appropriate follow-up care is expected following each urgent primary care visit, including sharing the record of appointment with a patient's regular primary care provider.

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.

Comprehensive primary care: Within a community health service area (CHSA), the PCN will provide the population with comprehensive primary care services (see *Appendix A)* ensuring that services and care plans are holistic, person-centred, culturally safe and responsive to individual needs. The UPCC represents a key clinical service model in the PCN, supporting the delivery of comprehensive services, including meeting both longitudinal and urgent episodic care needs. Patients attached at the UPCC can expect to receive the comprehensive suite of primary care services through on site UPCC services combined with services provided in the broader PCN. The UPCC will ensure that following an urgent primary care visit, unattached patients are provided appropriate follow-up care as needed. This follow-up could be either in-person or over the virtually.

Culturally safe: Providing care that recognizes and respects the differences in everyone. Providers listen and learn in a way that maintains personal dignity and supports an authentic relationship of trust, respect, and teamwork to ensure people feel safe receiving health care. Culturally safe care supports access to health care services, improved health outcomes, and healthier working relationships.

Interdisciplinary team: A group of health care providers who work together in a coordinated and integrated manner with patients and populations to achieve health care goals. Effective interdisciplinary teams display collective competency, shared leadership, and active participation of each team member involved in patient care.

SCOPE

This policy covers services in Urgent and Primary Care Centres, which are a core component of comprehensive primary care delivery in local primary care networks (see General Policy Directive: *Establishing Primary Care Networks*). This revised policy is part of the renewed primary care strategy that was announced in May 2017 and applies to new Urgent and Primary Care Centres implemented during the fiscal year 2019/2020 and beyond until future policy revisions are made.

Further, the Ministry recognizes that application of this revised policy to rural areas will require additional discussion and consideration of those unique circumstances inherent to rural areas which have not been contemplated as part of this policy.

POLICY DIRECTION

Expectations

The UPCC clinical service model will provide a mix of both urgent and scheduled full-scope primary care appointments. Resources and services should be designed so that there is an emphasis on full service longitudinal care and ongoing attachment relative to the urgent primary care services. Urgent primary care will make up 30-50% of all services on site, with the majority of services focused on planned proactive full-service primary care (e.g. 50-70% of services). This later expectation includes attachment of individuals as part of ongoing patient panels.

Specifically, Urgent and Primary Care Centres will:

1. Provide Team-Based Care
    - Team-based care will be provided by interdisciplinary primary care teams who support urgent and scheduled primary care services on site and within the network;
    - Team members including physicians, nurse practitioners, registered nurses, licensed practical nurses, mental health clinicians, social workers, pharmacists or other allied providers, to provide urgent and scheduled primary care for patients during daytime and evening/weekend hours on site and within the network;
    - A triage function will be required to assess urgent care patients presenting to the clinic to ensure they are directed to the most appropriate clinician;
    - Allied and nursing staff will primarily be health authority, unionized employees;
    - Physician and nurse practitioners will primarily be supported through alternate payment approaches.

2. Provide urgent primary care to residents and visitors of local Community Health Service Area(s):
    - Individuals who have urgent primary care needs that can be managed in the community, who may otherwise seek care at the emergency department;
    - Urgent primary care users may be unattached, or attached and unable to access services through their primary care provider within 12-24 hours;

- Services at the UPCCs will be available during extended hours including early mornings, evenings, weekends, and holidays; they may also be available during the daytime hours as appropriate depending on the community needs for this service;
- UPCCs should coordinate with existing laboratory and diagnostic services where they exist, ideally within walking distance, to support patient access.

- *Basic in-office urgent care services*
  - non-life-threatening illness or injury that needs immediate treatment
  - sprains and simple fractures caused by minor accidents and falls
  - minor bleeding/cuts requiring stitches
  - mild to moderate breathing difficulties
  - minor burns
  - rapid access to MHSU crisis intervention services
- *Assessment and treatment services for minor illnesses*
  - commonly presenting conditions, e.g. respiratory infections, ear aches, eye irritation/injuries, fever or flu, severe sore throat or cough, headache
  - abdominal pain, vomiting, diarrhea, or dehydration
  - mild to moderate back pain and problems
  - skin rashes and infections
  - urinary tract infections
- *On-site or close-proximity access to diagnostic imaging and laboratory services*
  - electrocardiograms
  - x-rays
  - point-of-care testing
  - blood tests

3. Provide full service primary care and new patient attachment to GPs and/or NPs:
   - UPCCs will provide new capacity for patient attachment to full service primary care providers (GPs and/or NPs) for patients seeking longitudinal primary care;
   - The longitudinal primary care team may implement advanced access protocols to allow for same-day urgent visits of their attached population or as with other primary care clinics in the network, designate the UPCC urgent access appointments as the mechanism to provide urgent access on site for their attached patients;
   - Unattached individuals may be referred from other services or may self-identify and access services directly at the UPCC.

4. Prioritize attachment to the UPCC with support of the interdisciplinary team for a subset of the population deemed underserved and vulnerable, recognizing these populations can sometimes be difficult to attach and/or maintain appointment status in traditional practices.
   - Individuals who are identified through community services, the UPCC or local hospitals as unattached and underserved, including the medically complex/frail elderly; patients experiencing mental health & substance use issues;
   - Individuals who self-identify as unattached and vulnerable and prefer to report directly to the UPCC, as opposed to a most responsible practitioner.

5. Provide coordination and continuity of care for attached and unattached patients:

- Provide clear mechanisms and protocols for urgent and primary care providers to communicate with a patient's regular primary care provider to maintain informational and management of continuity of care (e.g. appropriate information sharing, referrals, ongoing coordination, single patient health record), including working towards linked electronic medical records;
- Identify unattached individuals and families and/or those requiring care to prevent crisis or hospitalization and provide patient-centred wraparound care ensuring that each unattached patient is provided with appropriate follow-up care as needed (i.e. beyond one-time episodic treatment). Support each patients' attachment within the UPCC or to a provider in the community.

6. Provide expanded primary care capacity linked to the broader network of primary care physicians and interdisciplinary care teams (PCN) in the community:
    - Partnerships with other primary care clinics/patient medical homes, community teams, and specialized services will help to build flow through and sustainability, as patients may be able to transition to other primary care clinics over time and will have single point of access to specialized services (MHSU/MCFE).

7. Achieve longer term objectives of primary and community care redesign (extended hours; urgent access; attachment) and extends care beyond a typical "walk-in clinic" by offering comprehensive follow-up; sharing of records with a patients' regular primary care provider; and patient-centred, team-based care with a mix of nursing and allied health professionals.

8. Provide services in underserved communities:
    - UPCC locations will be confirmed by the Ministry based on review of attachment and population health data, and CTAS 4/5 ED volumes.

9. Primarily use alternate compensation models rather than traditional fee-for-service.
    - Alternate payment models will be supported to further integrate urgent and primary care services within the PCN and to better support flexible care options for patients who may require longer appointments and team-based care.

10. Develop protocols with local health services:
    - Protocols will be developed with the local emergency department, BC Emergency Health Services, and patient transport services to ensure that patients who have higher acuity needs can be efficiently re-directed to needed services.

Service Design

1. An analysis of the available local, regional, and provincial data (e.g. ED usage by hospital by time of day, location of existing walk-in clinics) will determine gaps and opportunities for increased access to urgent and primary care services. The following factors will be considered in determining the detailed service model for the UPCCs:

    a. Geographic location and population need (attachment rates, ED usage and congestion, size of community, etc.);
    b. Supportive local primary care providers;
    c. Existing infrastructure and health human resources;

d. Proximity and access to laboratory and diagnostics;
e. Current gaps in attachment and accessibility (e.g., hours of service);
f. Opportunities to use technology-enabled solutions; and,
g. Existing services in the community relative to demand.

2. UPCCs will be primarily health authority operated and developed in partnership with local Divisions of Family Practice and other PCN partners.

3. UPCCs can also help address space issues, if other clinics within the PCN have limited opportunity in the short-term to expand, co-locate, or seek net-new premises - subject to lease agreements.

4. UPCCs can also be developed to co-locate with a Community Health Centre, to address services related to the social determinants of health needs of a community.

5. UPCCs may be used as a location for a teaching centre for medical residents supported by preceptors.

6. UPCCs will complement existing primary care services and must not disrupt or destabilize existing primary care programs. Physician staffing for urgent services will primarily be provided by a group of existing full-service family practice physicians, with each physician taking a set number of shifts at the UPCC to cover off the urgent care services (networked coverage of urgent care services). Every consideration should be given to existing providers wishing to take shifts at the UPCC to avoid the potential for full-service providers taking-on solely episodic care within the PCN. UPCCs are a primary support to closing the attachment and access gaps within the PCN.

7. An interdisciplinary team-based care approach will be taken, where team deployment is based on a primary care setting rather than an emergency services setting.

8. Urgent and primary care will be addressed as part of, or aligned with, PCN communication plans, including awareness and education for providers, patient medical homes, patients, families, and caregivers.

9. Urgent and primary care will be addressed as part of, or aligned with, PCN community/patient engagement plans, including opportunities for patients, families, and caregivers to give feedback for quality improvement activities.

LINKAGES

Health Human Resources

Urgent and primary care interdisciplinary teams will provide person-centered, culturally safe care using a mix of health practitioners, optimized scopes of practice, and where necessary and appropriate, the use of virtual care to achieve service objectives.

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 Community Health Service Area levels, as part of the broader PCN planning process. 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 are under development in collaboration with the Ministry and external stakeholders to measure the expected outcomes of the service attributes of accessibility, appropriateness, acceptability, and efficiency.

Performance indicators are currently under development for UPCCs and in the context of broader Primary and Community Care Strategic Initiatives.

In addition to the above indicators, the 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 strategy overall.

REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed three years from the 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 A: COMPREHENSIVE PRIMARY CARE SERVICES

Within a PCN, the majority of comprehensive primary care services will be provided by Patient Medical Homes. The balance of primary care will be provided in the PCN by primary care services delivered or contracted by health authorities and other community-based health and social service organizations, including UPCCs. Comprehensive primary care services provided through the PCN include::

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 communities 3. Population health assessment of the PCN population including the identification high risk sub-populations and clinical preventive maneuvers as required 4. Implementation of the Lifetime Prevention Schedule 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) 5. Nutrition counselling 6. ***Reproductive care:*** a. sexual health, including prevention and management of sexually transmitted infections b. health promotion services and supports before, during and after pregnancy (e.g. nutrition, exercise, hypertension, smoking cessation and substance use, birth planning) c. low-risk maternity care d. antepartum and postpartum care e. contraception, safe abortion services and post-abortion care 7. ***Healthy early childhood development:*** a. implementation of guidelines for developmental surveillance and case finding (see the SPD: Healthy Start) b. provision of information about child health, growth and development and parenting c. breastfeeding and child nutrition education and support

	d. 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. Home support for mild to moderate complex and frailty 10. Support for care provided in hospital and long-term care facilities 11. ***Care for mental health and substance use:*** a. screening, assessment and management of mild to moderate conditions and stable severe or complex disorders including concurrent physical health conditions, b. individual, group and on-line counselling, c. pharmacological treatment and medication monitoring, d. rapid access to crisis intervention services, e. harm reduction resources, f. tools to increase resilience, g. 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