Primary Care Network

Central Okanagan

PCN Process Manual

Clinic Onboarding Process

Disclaimer: This program is in the launch phase and will undergo continuous improvement.

Please contact Central Okanagan Division of Family Practice for the most up-to-date version at pcn@codivision.ca.

Primary Care Network

Central Okanagan

Table of Contents

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Primary Care Network

Central Okanagan

Acknowledgements

We want to acknowledge our place of work is within
the ancestral, traditional, and unceded territory
of the Sylix (Okanagan) Nation.

We also acknowledge the Métis Nation and
their contribution to the Aboriginal Way of
being and knowing in Canada.

In addition, a special thanks goes to all teams that dedicated their time to this program.

Family Practice Clinics and Staff

Nurse Practitioners (NP)

Patient Partners

Central Okanagan Division of Family Practice (CODFP)

Interior Health Authority (IH)

Westbank First Nation (WFN) / stqaʔtxwɬn'íwt sqilxw

Ministry of Health – Primary Care Division (MoH)

General Practice Services Committee (GPSC)

Primary Care Network

Central Okanagan

Program Introduction

The Central Okanagan Division of Family Practice will be working with the Interior Health Authority, and Family Practice Clinics to introduce the following resources to create Primary Care Networks by the fall of 2024:

- 37 Nurse Coordinators
- 4 Family Practitioners
- 7.8 Nurse Practitioners
- 16 Allied Health Clinicians
- 3 Clinical Pharmacists
- 3 Indigenous Health Coordinators

Central Okanagan has been divided into three PCNs:

- PCN-1: Kelowna Central
- PCN-2: Rutland/Lake Country
- PCN-3: West Kelowna/Peachland

The Allied Health clinicians will support Team-Based Care to build capacity within the Patient Medial Home. The following document has been created to aid in the standardization of the Onboarding Process.

Primary Care Network

Central Okanagan

Case for Business Process Standardization

When making changes in an organization, particularly when embarking on a new endeavor, the process can be slow and unsettling resulting in lessons learned. (Business Process Standardization, Accenture LLP, 2013)*

1. Improves Quality
2. Reduces Cost
3. Reduces Time Requirements
4. Defines Collaboration Requirements Across Tasks & Stakeholders, and
5. Delivers Process Transparency

We recognize this is a repetitious process and will require continuous improvement through a plan-do-study-act cycle. However, as we complete onboarding with each new clinic, we have been made aware of aspects of the implementation where structured support has added value for the clinics.

Primary Care Network

Central Okanagan

Total Project Stakeholders

1. Participating CODFP Family Practice Clinics
2. Central Okanagan Division of Family Practice (CODFP)
3. Interior Health Authority (IH)
4. Westbank First Nation (WFN) / stqaʔtxwɬnʼíwt sqilxw
5. Ki-Low-Na Friendship Society (KFS)
6. Métis Community Services Society of BC (MCSBC)
7. Family Practitioners
8. Nurse Practitioners
9. Patient Partners

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Primary Care Network

Central Okanagan

Summary of Process Steps

| - - - - ~1.5 Months - - - - | - - - - - - 1 Month - - - - - - | - - - - - Ongoing - - - - - →

Timeline commences once the Readiness Assessment has been completed by the Clinic.

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Primary Care Network

Central Okanagan

Process Detail Steps

STEP 1: Clinic Expresses Interest, Completes Clinic Readiness Assessment

Estimated time commitment for clinic: 1 hour

Stakeholders

1. Clinic (Physician Lead)
2. Central Okanagan Division of Family Practice PCN Manager
3. Central Okanagan Division of Family Practice PCN Change Lead

Clinic Eligibility Requirements

The first step to onboarding a PCN Nurse Coordinator is for the clinic to complete a Clinic Readiness Assessment (For more information, please consult Appendix A).

To be eligible to participate in the PCN, the clinic must first ensure the following:

- All Physicians in the clinic must be registered in the GPSC Panel Management Incentive Program (Panel Clean-up). If Panel clean-up is required, please contact your local Practice Support Program Coordinator for support and assistance.
- The clinic must be using an EMR that is compatible with the Teleplan Billing System. If the clinic is not using an EMR, please contact pcn@codivision.ca for further discussion.
- Clinic must provide workspace for a Nurse Coordinator to practice.
- All participating physicians must be members of Central Okanagan Division of Family Practice.
- Physicians must provide longitudinal patient care.
- Participating physicians must agree to participate in practice-level evaluation and reporting.
- The participating physicians must nominate a Physician Lead, who will act as the clinic's point of contact, ensure accountability within the practice, support mentoring the Nurse Coordinator, and oversee delivery of information to the Division and Health Authority as needed.

Physician Compensation

The Physician Lead will be compensated for up to eight sessional hours monthly for the first three months (this timeline may be extended based on clinic need). The Physician Lead must agree to participate in weekly check-ins with the PCN and with clinic staff, for the purpose of learning and ensuring ongoing mentorship and support.

Once eligibility is established, the CODFP will meet with the clinic to review information on Primary Care Network and the Nurse Coordinator role. This meeting will include reviewing the FAQs, reviewing the RN Scope of Practice and completing the Nurse Coordinator Clinic Skills Checklist (For more information, please consult Appendix B).

Clinics will then be requested to complete and submit the Readiness Assessment prior to recruitment. For information on the Primary Care Job Description for IH, please consult the Reference Material Section of this document for a sample.)

STEP 2: Recruitment

Estimated time commitment for Clinic: 4-6 weeks

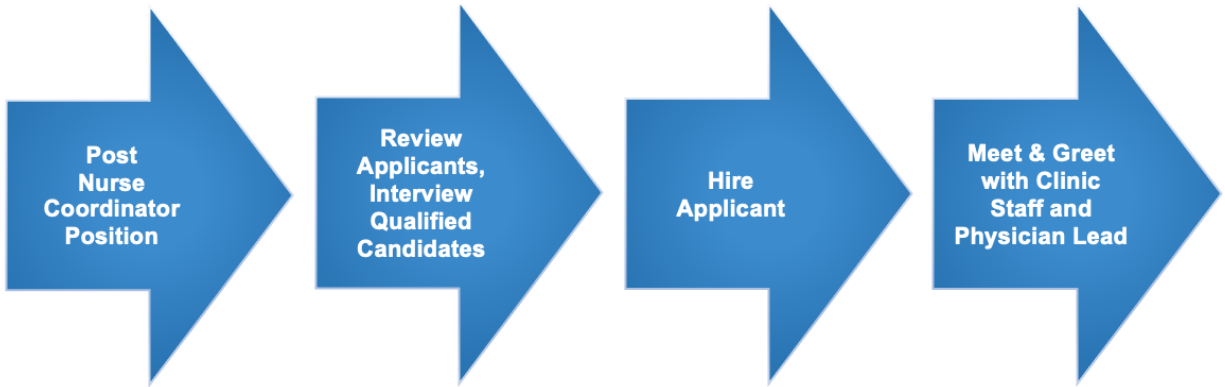
Stakeholders

1. Clinic (Physician Lead)
2. Central Okanagan Division of Family Practice PCN Team
3. Interior Health Authority PCN Manager or Team Lead

Once the Clinic Readiness Assessment is approved, the recruitment process can begin. In preparation for the posting, the clinic will provide the address and the days and times they will need the position to fill. RN recruitment will be conducted by IH, and supported by the CODFP PCN Team. Recruitment will be supportive of clinic practice area and programming. The clinic is encouraged to participate in the recruitment process. The Physician Lead (or designate) is encouraged to participate on the interview panel.

Once the candidate is hired, a meet & greet with the clinic physicians and team will be arranged. The meet & greet is an opportunity for the Nurse Coordinator and physician group to start building relationships and start developing orientation and scheduling dates.

Step 2 – Process Overview (4-6 weeks)



STEP 3: Site Preparation

Estimated timeline: ~3 hours

Stakeholders

1. Clinic (Physician Lead or designate)
2. PCN Manager and Clinic Lead
3. Interior Health Authority Team Lead

Prior to the Nurse Coordinator beginning work and during the recruitment phase, there are various site preparation activities that must take place.

Activity Response Time

Activity	Responsibility	Time Commitment
Meet with Clinic and staff: • Sample Nurse Coordinator Orientation Schedule • Review RN Competency Triangle • Review IH Patient Consent Form	CODFP IH	1 Hour
Complete the following Documents: a) Information Sharing Agreement (ISA) b) Team Charting Agreement (TCA) c) PCP Collaborative Agreement (PCA)	CODFP IH	1 Hour
Review Team-Based Care billing expectations	CODFP Physician Lead	1 Hour

Meeting with Clinic Staff

An in-person visioning meeting with clinic staff and the Physician Lead will be scheduled to discuss what they can anticipate for STEP 2 and beyond. This meeting is anticipated to take 1 hour and will provide the clinic with an overview of the orientation process and review clinic readiness (Please consult Appendix C for a sample agenda and suggested additional topics).

Education time spent with Medical Office Assistants (MOA) and/or Managers is also important for successful integration and is a key piece of the TBC/clinic orientation. This meeting is also used to identify clinic specific needs, how the scope of the Nurse Coordinator can align with those needs, and what training is required. An example: at one clinic the need for women's health procedures were identified; therefore, the Nurse Coordinator will be receiving additional training for this. The BC Ministry of Health (MoH) and the BC College of Nursing Professionals (BCCNP) have created a RN & LPN Scope of Practice to help guide nurses and clinics with the role and scope of a Registered Nurse working in primary care.

Memorandum of Understanding (MOU)

The MOU will be signed by the Central Okanagan Division of Family Practice Physician Lead, the clinic Physician Lead and participating clinic providers. The purpose of the MOU is to outline roles and responsibilities of the PCN Primary Care Clinic and the PCN Steering Committee, which is tri-chaired by First Nation partners, IH and the CODFP. The purpose is for all partners to work towards integration of Team-Based Care into clinics, and increase capacity of the primary care system while improving quality of care.

Information Sharing Agreement (ISA)

The ISA will be signed by the Central Okanagan Division of Family Practice Executive Director, the PCN Manager, and the hosting clinic. In order to support clinics in implementing Primary Care Networks, as well as to support quality improvement and evaluation of Central Okanagan PCN implementation, CODFP will request certain data from the clinic, such as appointment availability, types of appointments undertaken, rates of delivery of preventative care and panel sizes. All data regarding patients received by CODFP will be aggregate data, and used for evaluation within the PCN.

Team Charting Agreement (TCA)

The TCA will be signed by the Interior Health and the hosting clinic. The purpose of the TCA is to establish roles and responsibilities for the clinic and IH staff who will be charting in the clinic EMR and registering patients, with their consent, in Meditech, IH EMR. This agreement will ensure IH staff can access patient records, and requires patient notification as per the Personal Information Protection Act (PIPA).

Primary Care Practice Collaboration Agreement (PCA)

The PCA is signed by Interior Health and the hosting clinic legal representative and/or Physician Lead. The agreement outlines the roles and responsibilities of the clinic and IH when IH employed staff are placed or work out of the fee-for-service clinic to support the Primary Care practice patients. The IH staff are acting as an extension of the practitioners in the practice. This agreement covers roles and responsibilities related to vacation requests, staff coverage, overhead, and collaborative care for patients within the practice.

STEP 4: Orientation, Training & Development

Estimated timeline: 4-6 weeks

Stakeholders

1. Clinic (Physician Lead or designate)
2. Central Okanagan Division of Family Practice PCN Clinic Lead
3. Interior Health Authority Managers and Team Leads

Orientation

Orientation for the Nurse Coordinator accounts for RN experience, scope, and identifies clinic needs. IH and CODFP have developed a 4-week orientation plan for the Nurse Coordinator (For more information, please consult Appendix D). Clinics will prepare the following training for the Nurse Coordinator to be completed within the first 1-2 weeks in the clinic.

Activity Responsibility Timeline

Set up EMR Log-In Credentials	Clinic	1 Hour
Train Nurse Coordinator to use EMR	CODFP and/or EMR Super-User	Ongoing
Encounter Code Reporting (training)	CODFP	1 Hour
Set-up shadow shifts with Physician Lead, MOA, Office Manager, etc.	CODFP with clinic support	N/A

Encounter Reporting

Nurses are required to submit zero fee Encounter Codes to MSP (same process as Physician MSP Billing). These Encounter Codes will help to inform how the Nurse Coordinators are being utilized in physician clinics (For more information, please consult Appendix E). The PCN Change Lead will help facilitate the Nurse Coordinator application for an MSP Billing Number.

Clinic Overhead

To help the clinic prepare for the Nurse Coordinator, the clinic will receive approximately $16,000.00 annually in overhead for a 1.0 FTE Nurse Coordinator located on-site at the clinic. Overhead can be used to support the following requirements:

- Suitable space for the Nurse Coordinator to work.
- Access to the Practice's EMR and the training to use it.
- Internet costs and computer equipment at the clinic (For more information, please consult Reference Material Section of this document for a sample).
- Office equipment (including photocopier, fax machine, scanner, and telephone).
- Basic stationery and office supplies.
- Office furniture (including desks, chairs and filing cabinets as needed (For more information, please consult Appendix F).
- Clinical medical supplies and equipment (for example: gloves, gowns, safety needles/syringes, simple dressing supplies, eye rinse stations, safety signage, etc.).

STEP 5: Monitoring & Evaluation

Estimated timeline: ongoing to support Nurse Coordinator *and Clinic*

Stakeholders

1. Clinic (Physician Lead or designate)
2. Central Okanagan Division of Family Practice (CODFP)
3. Interior Health Authority (IH)
4. PCN Evaluation Team

Monitoring (first 3 months)

The CODFP and IH will be meeting with the participating Physician Lead and Nurse Coordinator on a weekly basis to facilitate discussion around what is going well, what isn't going well and how would you do things differently. These meetings will be decreased once the clinic has identified stability for the Nurse Coordinator and the Physician Lead. CODFP has also created a survey where participating members can provide feedback to outline areas of success, improvement, questions or feedback.

Evaluation

The CODFP will provide ongoing evaluation with the support of a third-party consultant, Reichert & Associates. The evaluation process will align with requirements from the MoH and will include qualitative and quantitative elements. Panel size, attachment codes and encounter billing will be used for measuring gross and net changes. For example, we will use data from the RN Encounter Codes to determine the type of work Nurse Coordinators are engaged in. We will also support interview-based evaluation for those involved. Clinic staff and physicians will be asked to participate in the evaluation as this process progresses.

Ongoing Education

PCN and clinic staff will participate in ongoing education, including Team-Based Care activities such as HUB meetings, Nurses Network, and PCN All-Staff Meetings. Some examples are: web-based learning, virtual classrooms, on-site support as able, facilitated seminars. More information about ongoing education will be provided as it develops.

Primary Care Network

Central Okanagan

Appendices

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Primary Care Network

Central Okanagan

Appendix A: Clinic Readiness Assessment

Clinic Readiness Assessment

1. Clinic Name: *

Enter your answer

2. Principle Setting of the Medical Clinic: *

- Solo, Office-Based, Family Practice Clinic
- Group, Office-Based, Family Practice Clinic
- Walk-In Clinic
- Hybrid, Walk-In/Family Practice Clinic

3. Clinic Address: *

Enter your answer

4. Clinic Phone and Fax Numbers: *

Enter your answer

5. Clinic Email Address: *

Enter your answer

6. Do all of the Physicians in your clinic have membership with the Central Okanagan Division of Family Practice? *

- Yes
- No

Primary Care Network

Central Okanagan

7. Will all the physicians in your clinic participate in the Primary Care Network? *

- Yes
- No

8. If not, please list the participating Physicians:

Enter your answer

9. Please describe your clinics interest in participating in the Primary Care Network: *

Enter your answer

10. Please describe the additional support you would like from Allied Health Professionals. (i.e. Social Worker, Dietician, Occupational Therapist, etc.) *

Enter your answer

11. Please outline the supports for the RN and the plan to integrate the RN into your practice. *

Enter your answer

12. Please describe what you envision the Registered Nurse's role might be in your clinic. *

Enter your answer

13. Is there clinic space for the Registered Nurse to practice? *

- Yes
- No

14. Does your clinic utilize an EMR? *

- Yes
- No

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Primary Care Network

Central Okanagan

15. Name of EMR: *

Enter your answer

16. What is your clinic's approximate panel size? (Please provide panel size for each participating physician.) *

Enter your answer

17. On average, how many total daily appointments does your clinic offer? *

Enter your answer

18. What percentage of your total daily appointments are done virtually? *

Enter your answer

19. Does your clinic reserve appointments for same day visits? *

- Yes
- No

20. Number of Physicians working in clinic: *

Enter your answer

21. Number of Nurse Practitioners working in clinic: *

Enter your answer

22. Number of Registered Nurses working in clinic: *

Enter your answer

23. Number of Licensed Practical Nurses working in clinic: *

Enter your answer

Primary Care Network

Central Okanagan

24. Number of Office Managers working in clinic: *

Enter your answer

25. Number of Medical Office Assistants working in clinic: *

Enter your answer

26. Number of other staff working in clinic: *

Enter your answer

27. Number of Physicians in Residency: *

Enter your answer

28. Number of physicians who have been in practice for 0-5 years: *

Enter your answer

29. Number of physicians who have been in practice for 6-10 years: *

Enter your answer

30. Number of physicians who have been in practice for 11-20 years: *

Enter your answer

31. Number of physicians who have been in practice for 20+ years: *

Enter your answer

Primary Care Network

Central Okanagan

32. Number of Physicians who have completed their GPSC Panel Development: *

Enter your answer

33. Number of Physicians who are in the process of completing their GPSC Panel Development: *

Enter your answer

34. Number of Physicians who have not started their GPSP Panel Development: *

Enter your answer

35. Approximately how much time per day do Physicians in your clinic spend on administrative tasks other than face-to-face patient care? (i.e. Practice Management tasks, filling out forms, connecting with Allied Health Providers/Specialists?) Please provide a rough average for the clinic as a whole. *

Enter your answer

36. Name of nominated physician champion: *

Enter your answer

37. Today's Date: *

Please input date in format of yyyy-MM-dd

Primary Care Network

Central Okanagan

Appendix B: Nurse Coordinator Clinic Skills Checklist

Nurse Coordinator Skills Checklist

To be completed by all Clinic providers prior to RN position posting

Nurse Coordinator Role
Allied Health Referrals
○ Initiating and completing referrals to PCN Allied Health (dietitian, social worker, physiotherapist, pharmacist, psychologist, Indigenous Health Coordinators) ○ Liaising with AH clinicians as needed ○ Following up with the PCN Allied Health referrals
Chronic Disease Management and Complex Care Support
○ Patient health history ○ Physical assessment ○ Mental health assessments ○ COPD and Asthma assessments ○ Diabetic monitoring and assessments ○ Heart Failure history and assessments ○ Capacity assessment (ie. MMSE, MOCA) ○ Patient teaching and coaching ○ Patient follow-up

For the following section please indicate which additional Nurse Coordinator skills are important for your practice:		
Additional Nurse Coordinator Skills *(For the full scope of practice of a Registered Nurse, please review the MoH RN & LPN Scope of Practice Document)* https://www.bccnm.ca/Documents/standards_practice/rn/RN_ScopeofPractice.pdf	Check which skills you would like the Nurse Coordinator to perform	Please rank your **Top 10** priorities for the Nurse Coordinator
Intake and Coordination of Health Services		
New Patient Intake		
Patient Chart/Panel Management and Review		
Booking own patient appointments		
General Health Status Assessment		
Patient health history pre/post physician visit		
Physical assessment/biometrics pre/post physician visit		
Mental health assessments		
Urine/fecal and wound sample collection		
Venipuncture		
Med reconciliation		
*Conduct BPMH		
*Capacity Assessment		
*Pain management assessment		

PCN Leadership/Orientation/Nurse Coordinator Orientation

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Primary Care Network

Central Okanagan

Nurse Coordinator Skills Checklist

Sexual Health Assessment (ideally all three if chosen)		
*Contraceptive management		
*STI assessment and testing		
*Pelvic and cervical cancer screening		
General Health Promotion and Prevention/CDM management		
Assist with Complex care visit		
Serious illness conversation and support		
Mental health support/counselling/referral		
*MHSU screening		
Screening with Lifetime Prevention Schedule Guide		
Complete consults, laboratory requisitions, diagnostic imaging requisitions with patient specific order.		
Child and youth mental health assessment		
CDM Care Planning and follow up (i.e., COPD, diabetes, CKD)		
Coaching patient self-management		
Palliative Care Planning and Follow up		
Medication adjustment with orders (i.e., INR, insulin)		
Treatment		
*Ear syringing		
Wound care and wound care referrals		
*Complex skin and wound Care (i.e., debridement)		
Suture and staple removal		
*Cryotherapy		
*Vaccine clinic (i.e., flu clinic)		
Vaccine administration		
Follow-up Management		
Post-hospital discharge/ED visit follow-up		
Coordination of health and community services		
Support transitions of care		
Obstetric Care		
*New mom and baby assessment		
*Obstetric and maternity care		
Other		
*Long Term Care visits		
*Home visits		

*Denote skills that require extra training or special consideration.

PCN Leadership/Orientation/Nurse Coordinator Orientation

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Primary Care Network

Central Okanagan

Appendix C: Sample Agenda for Visioning Meeting

Agenda Item	Lead	Time
1. Introductions	CODFP	5 min
2. **Visioning** (yesterday/tomorrow) ▪ What does the successful integration of the RN look like? How do we get there? What is needed from a) clinic, b) RN and c) PCN Leads? ▪ RN duties/scope. Purpose of the Nurse Coordinator in the PCN (review Principles of PCN) ▪ TBC – clinic and IH staff "forming, storming and norming"; how do we start the TBC journey? ▪ Role Overview: What is your role in the clinic; how do you envision working together? Role clarity. ▪ Workflow	CODFP Engagement of all	20 min
3. Workplace ▪ RN Workspace ▪ RN Phone and Computer ▪ IH Workplace Health Recommendations	CODFP IH	10 min
4. Communication ▪ With the team: Medical Office Assistant, Office Manager, Physician, Registered Nurse, Allied Health ▪ Clinical support/reporting ▪ Review Physician Lead role ▪ Conflict Resolution ▪ To Patients: introducing TBC to patients, introducing PCN RN, AH staff, patient consent ▪ Physician and office staff compensation process ▪ Clinic Timesheets	IH	10 min
5. Decision Making ▪ Clinic ▪ IH ▪ Support from Divisions	CODFP	10 min
6. Round-Table / Wrap-Up	All	5 min
Next Steps		

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Primary Care Network

Central Okanagan

Appendix D: Nurse Coordinator Orientation Objectives

The goal of orientation is to assist the Nurse Coordinator transition to work in Primary Care and specifically within the PCN and your clinic. This is a flexible schedule built around your schedule, and will include the following: combination of online and hands on learning, expanding scope of practice, meeting goals of the clinic.

Week 1:

- Meet and Greet meeting with PCN leadership
- HR documents, computer assignment, computer access
- Clinic shadow shifts with Providers/MOA/other clinic staff as appropriate (minimum 1 staff member)
- PCN orientation
    - Introduction to PCN
    - Part 1: EMR training
    - Introduction to clinic workflow, Pathways, Encounter Billing, Team-Based Care Billing
    - Clinical skills and on-line learning

Week 2

- 2 or more clinic shadow shifts
- Part 2: EMR training
- Shadow shifts with other Nurse Coordinators
- Attending HUB meetings with Allied Health
- Attending Nursing Network Education Sessions
- Independent study

Week 3

- Allied Health referrals
- 2 or more shadow shifts
- Part 3: EMR training
- Independent study

Week 4

- Ongoing clinical training as required
- Ongoing EMR training as required
- Additional shadow shifts as required
- Regional Orientation (3 half-days, may need to be booked outside of these 4 weeks)

Primary Care Network

Central Okanagan

Appendix E: RN/LPN Encounter Codes

RN/LPN ENCOUNTER CODES	
FEE CODE	**TITLE**
IMMUNIZATIONS	
38010	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV
38011	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV-HIB
38012	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD
38013	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD/IPV
38014	NIPCP IMMUNIZATION-PATIENT <19 YRS-TDAP
38015	NIPCP IMMUNIZATION-PATIENT <19 YRS-INFLUENZA (FLU)
38016	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS A
38017	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS B
38018	NIPCP IMMUNIZATION-PATIENT <19 YRS-HIB
38019	NIPCP IMMUNIZATION-PATIENT <19 YRS-IPV
38020	NIPCP IMMUNIZATION-PATIENT <19 YRS-MEN-C
38021	NIPCP IMMUNIZATION-PATIENT <19 YRS-ACYW135
38022	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR
38023	NIPCP IMMUNIZATION-PATIENT <19 YRS-PCV13
38024	NIPCP IMMUNIZATION-PATIENT <19 YRS-PPV23
38025	NIPCP IMMUNIZATION-PATIENT <19 YRS-RABIES
38026	NIPCP IMMUNIZATION-PATIENT <19 YRS-VARICELLA
38027	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-HB-IPV-HIB
38028	NIPCP IMMUNIZATION-PATIENT <19 YRS-HPV
38029	NIPCP IMMUNIZATION-PATIENT <19 YRS-ROTAVIRUS
38030	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR/V
38035	NIPCP IMMUNIZATION-MMR -PATIENT >18 YEARS OF AGE
38038	NIPCP IMMUNIZATION-INFLUENZA- ADULTS WHO QUALIFY FOR FREE VACCINE
38041	NIPCP IMMUNIZATION-PNEUMOCOCCAL POLYSACCHARIDE (PPV23) For pts > 64 yrs of age or pts > 18 years of age whose health conditions qualify them for free vaccine or who reside in residential care or assisted living facilities. (pts < 19 yrs -bill 38024)
38042	NIPCP IMMUNIZATION HEPATITIS A - ADULTS AT RISK

38043	NIPCP IMMUNIZATION HEPATITIS B - ADULTS AT RISK
38044	NIPCP IMMUNIZATION-NOS (NOT OTHERWISE SPECIFIED) (includes oral polio vaccine, etc.)
38045	NIPCP CLIENT CONTACT FOR ADVERSE EVENT FOLLOWING IMMUNIZATION

FEE CODE	TITLE
MEDICATION	
38060	NIPCP MEDICATION USAGE INTERVENTIONS- The identification of a patient's drug related problems and recommendations for their resolution (ie. inappropriate dosing, drug level monitoring, drug interactions, treatment of adverse drug reactions)
38061	NIPCP MEDICATION WORK-UP - The completion of a patient's drug history during a structured interview and through chart and Pharmanet searches (upon obtaining patient consent)
38062	NIPCP MEDICATION THERAPY MONITORING-The regular monitoring of a patient's medication adherence and drug toxicity through structured interviews, especially for patients with complex medication regimens or patients that are confused, forgetful or less compliant about medications.
38063	NIPCP MEDICATION THERAPY COORDINATION - Liaising with community and hospital pharmacies in an effort to provide seamless care for a patient (i.e., coordinating refills, obtaining prescriptions, providing up to date information on the patient's current drug therapy, dispensing medication, obtaining approval for medications)
38064	NIPCP MEDICATION INFORMATION- Answering patient-specific medication information questions from health care professionals and patients (i.e., dosing, adverse effects, drug interactions, suggestions for therapy)
38065	NIPCP MEDICATION THERAPY COUNSELING-Counseling a patient on the appropriate use of the patient's medication(s), adverse effects, and monitoring via a structured interview (i.e., provision of drug information sheets, setting up weekly dosettes, setting up medication timers). **Claim must state start and end times**

FEE CODE	TITLE
VISIT	
38070	NIPCP REQUESTING ADVICE FROM AN NP/GP - Collaborate with team members to support nurses' assessment of patient care
38071	NIPCP REFERRAL TO IN-CLINIC TEAM MEMBER - Reviews assessment with GP/NP and queries action that is outside of scope of practice
38072	NIPCP REFERRAL TO NON-HEALTH SERVICE PROVIDER - Referral to community resources (e.g., any service provider that does not require an MSP referral)
38073	NIPCP - GP REFERRAL TO NURSE
38080	NIPCP VISIT - IN OFFICE (AGE 0-1) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38081	NIPCP VISIT - IN OFFICE (AGE 2-49) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT

38082	NIPCP VISIT - IN OFFICE (AGE 50-59) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38083	NIPCP VISIT - IN OFFICE (AGE 60-69) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38084	NIPCP VISIT - IN OFFICE (AGE 70-79) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38085	NIPCP VISIT - IN OFFICE (AGE 80+) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38195	NIPCP VISIT - CHRONIC DISEASE MANAGEMENT A visit to review ongoing management of a chronic disease. Visit activities include: reviewing patient's care plan; patient's health outcomes; monitoring condition subsequent to an intervention; discussing continuing care strategies; discussing various management options, such as life style/self-care, psychotherapy, pharmacological management; etc. Activities performed in visit are generally brief discussions; however, if more elaborate discussion occurs, bill separate encounter code in addition visit encounter (e.g., education nutrition, medication therapy monitoring, etc.) **Claim must state start and end times.**
38116	NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT-Recording the medical/social history of a new patient
38117	NIPCP BODY COMPOSITION ASSESSMENT-BIOELECTRICAL IMPEDANCE ANALYSIS AND/OR ANTHROPOMETRIC ASSESSMENT (MULTIPLE SITE SKINFOLDS AND CIRCUMFERENCES).
38119	NIPCP PATIENT ASSESSMENT Evaluation of a client's condition, problem or functional status to establish a nursing diagnosis and/or identify information to support a clinical diagnosis and/or identify treatment or rehabilitation measures and/or monitor a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc. **Claim must state start and end times.**
38120	NIPCP ROUTINE PELVIC EXAM INCLUDING PAP Routine pelvic examination including Papanicolaou smear.
38123	NIPCP COMMUNICABLE DISEASE FOLLOW UP Evaluation of a client's condition, related to a previously diagnosed communicable disease, and/or monitoring of a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc.
38125	NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT Completion of all relevant documentation/forms, where there is no reimbursement from third party or direct billing, required as a result of a specific incident, or to obtain client consent.
38130	NIPCP CASE CONFERENCE Meeting with members of the health care team, representatives of other agencies involved in the management of the client, to plan and coordinate activities and services and to share information necessary to meet the client's needs/goals and expected outcomes. **Claim must state start and end times.**

38131	NIPCP CASE MANAGEMENT Multiple telephone calls to develop a comprehensive service plan, link the client to the required services, coordinate and maintain links with resources/services/supports in the client's environment, and evaluate services provided. May include activities such as searching for the appropriate resources and negotiating with potential providers (eg. probation officers, child and family services, social assistance, education, housing etc.) Claim must state start and end times.
38135	NIPCP FAMILY CONFERENCE - A conference with the patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. The intervention includes activities such as goal setting and designing resources that are required (patient may or may not be present). **Claim must state start and end times.**

FEE CODE	TITLE
EDUCATION	
38140	NIPCP EDUCATION - GROUP **-** Bill to the PHN for each patient attending the group meeting. Start and end times should be listed for each PHN **Claim must state start and end times.**
38141	NIPCP EDUCATION - CHOLESTEROL **Claim must state start and end times.**
38142	NIPCP EDUCATION - INSULIN STARTS **Claim must state start and end times.**
38143	NIPCP EDUCATION - INHALER USE **Claim must state start and end times.**
38144	NIPCP EDUCATION - RELATED TO SPECIFIC DIAGNOSIS Information provided in a structured format, to enhance knowledge and skill that directly or indirectly assists the client/family to understand, monitor and manage their condition/impairment. Includes, where applicable, provision of educational material such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38145	NIPCP EDUCATION - HEALTH PROMOTION/DISEASE PREVENT Information provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy lifestyles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos (eg. exercise, nutrition, hygiene, STD education). **Claim must state start and end times.**
38146	NIPCP EDUCATION - FAMILY PLANNING Information about contraception provided in a structured format, to enhance knowledge and skill that directly or indirectly promotes health or influences changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38147	NIPCP EDUCATION - SMOKING Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to smoking/tobacco use and their potential effect on health status, which could alter attitudes and in turn change/modify behaviour. **Claim must state start and end times.**
38148	NIPCP EDUCATION - SUBSTANCE ABUSE Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to drug use/abuse or alcohol consumption and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38150	NIPCP EDUCATION - PARENTING Information to improve parenting skills provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books, and videos. **Claim must state start and end times.**

38153	NIPCP EDUCATION - ENVIRONMENTAL ISSUES Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks related to environmental risk/injury and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38155	NIPCP EDUCATION - NUTRITION Therapeutic communication, provided to or on behalf of a patient, to enhance knowledge and skill that directly or indirectly promote nutritional health status or influence changes in unhealthy lifestyles that impact on nutritional status for the specific patient. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos that pertain specifically to nutrition. **Claim must state start and end times.**

FEE CODE	TITLE
INJECTIONS	
38160	NIPCP INJECTION, INTRAMUSCULAR - Intramuscular medications.
38161	NIPCP INJECTION, VENEPUNCTURE - Venepuncture and dispatch of specimen to laboratory, when no other blood work performed.
38162	NIPCP MEDICATION INJECTION, SUBCUTANEOUS - Subcutaneous medication, including desensitization treatments

FEE CODE	TITLE
MSC PROCEDURES	
38163	NIPCP MINI TRAY FEE
38165	NIPCP GLUCOSE - SEMIQUANTITATIVE (dipstick analyzed visually or by reflectance meter)
38166	NIPCP PREGNANCY TEST, IMMUNOLOGIC, URINE
38167	NIPCP URINALYSIS - SCREENING Urinalysis - Chemical or any part of (screening)
38168	NIPCP SYRINGING – EAR Irrigation of the external auditory meatus.
38169	NIPCP SUTURE/STAPLE REMOVAL Removal of sutures, staples, clips, etc.
38170	NIPCP DRESSING CHANGE Replacement of bandage/dressing.
38171	NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS Forms of treatment other than excision, x-ray, or grenz ray; such as removal of haemangiomas and warts with electrosurgery, cryotherapy, etc. - per visit

FEE CODE	TITLE
MSC PROCEDURES (cont'd)	
38172	NIPCP FOOT CARE
38173	NIPCP SUTURING MINOR LACERATIONS
38174	NIPCP ASSISTING WITH PRODECURES

38175	NIPCP WOUND CARE Includes cleansing, irrigating, probing, debriding, packing and dressing a wound. It also includes suturing a laceration and changing dressings.
38176	NIPCP INR MANAGEMENT
38177	NIPCP ULTRASOUND - Handheld device
38005	NIPCP LIFETIME PREVENTION SCREENING Lifetime Prevention Screening includes initiating any of the clinical prevention services for specific patient groups as outlined in the Lifetime Prevention Schedule. Encounter is used for one or more intervention provided based on patient's demographics (e.g., age, sex).
38006	NIPCP PALLIATIVE/EOL CARE PLANNING

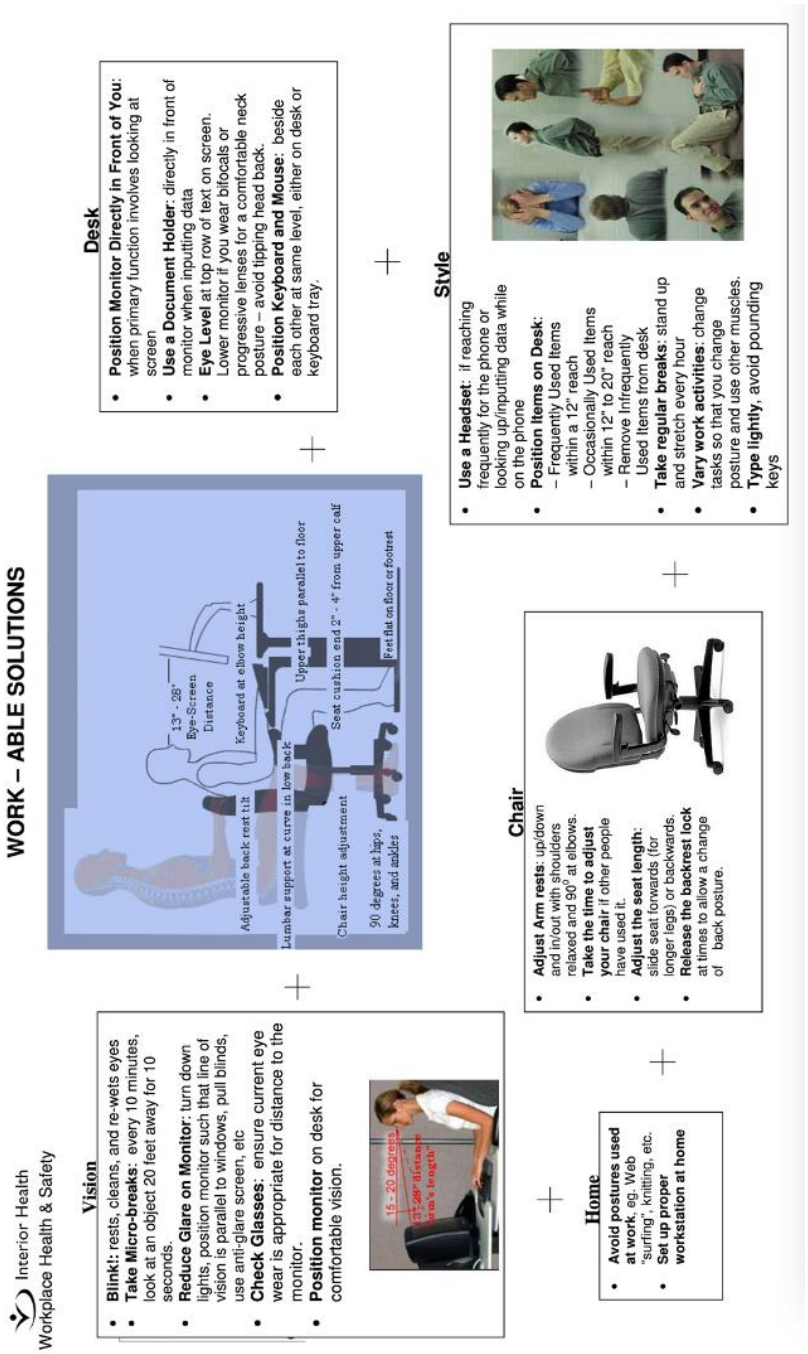
FEE CODE	TITLE
TELEPHONE	
38180	NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER Telephone contact to exchange information about a client between service providers, includes a verbal or written follow up communication with the Referring service provider (ag social worker, home care etc.)
38184	NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND A single telephone call to patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. This intervention includes activities such as goal setting and designing resources and services that are required.
38185	NIPCP TELEPHONE CONSULTATION
38186	NIPCP TELEPHONE FOLLOW-UP Telephone contact with a patient to monitor client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, etc.
38188	NIPCP TELEPHONE CALL (PHARMACY) Telephone call to initiate prescription or renew the directions and/or instructions for the preparation, dispensing, fabrication, or implementation of the pharmacological agents.

FEE CODE	TITLE
COUNSELING	
38191	NIPCP CRISIS COUNSELING Issue-or incident-specific counseling session with a patient, resulting from self, physician, health or non-health professional referral. **Claim must state start and end times**.
38192	NIPCP SHORT-TERM COUNSELING A counseling session with a patient resulting from self, physician, health or non-health professional referral. **Claim must state start and end times.**

Primary Care Network

Central Okanagan

Appendix F: Work – Able Solutions



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Reference Material

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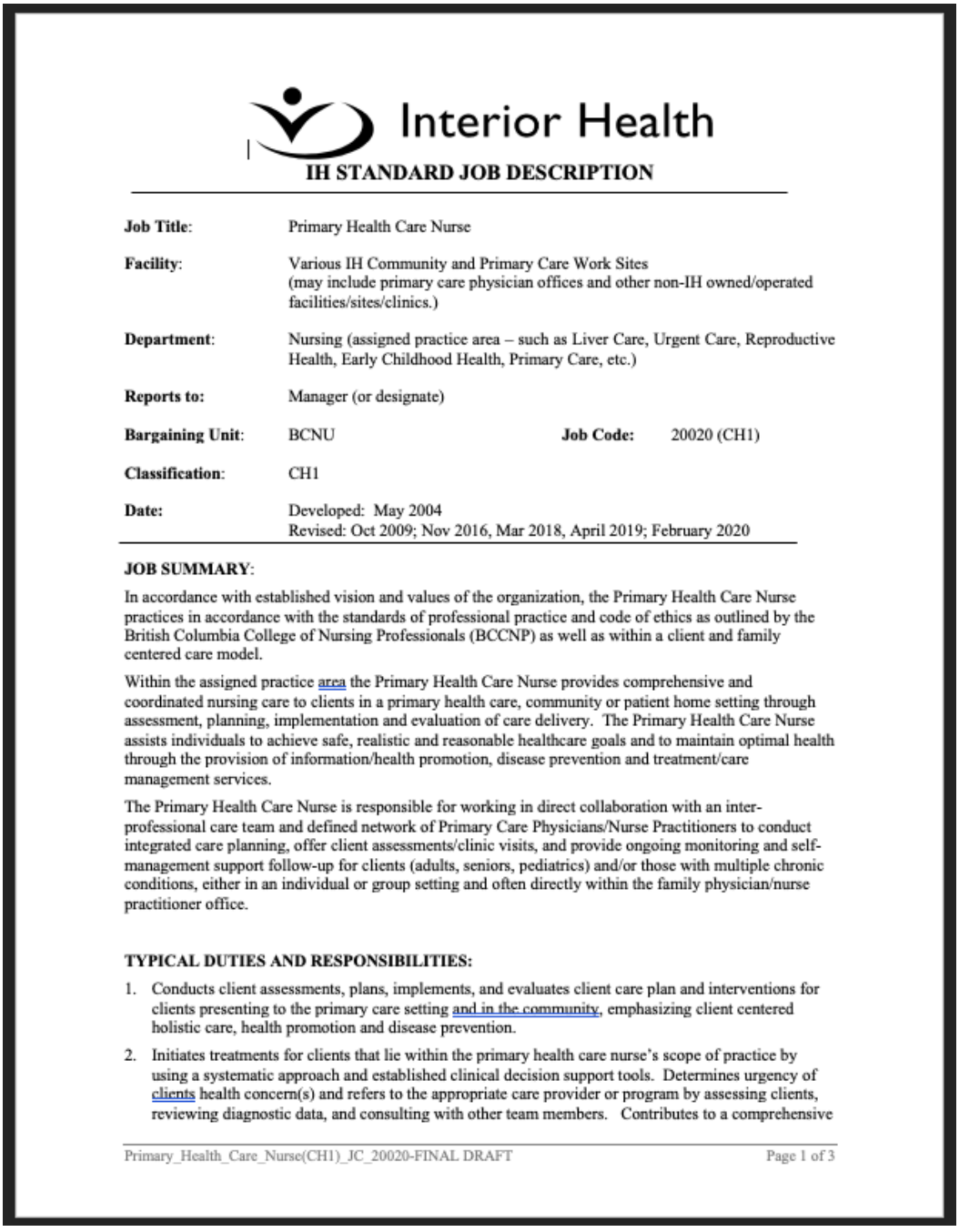
Sample Job Description: Primary Health Care Nurse



Interior Health

IH STANDARD JOB DESCRIPTION

Job Title:	Primary Health Care Nurse		
Facility:	Various IH Community and Primary Care Work Sites (may include primary care physician offices and other non-IH owned/operated facilities/sites/clinics.)		
Department:	Nursing (assigned practice area – such as Liver Care, Urgent Care, Reproductive Health, Early Childhood Health, Primary Care, etc.)		
Reports to:	Manager (or designate)		
Bargaining Unit:	BCNU	**Job Code:**	20020 (CH1)
Classification:	CH1		
Date:	Developed: May 2004 Revised: Oct 2009; Nov 2016, Mar 2018, April 2019; February 2020		

JOB SUMMARY:

In accordance with established vision and values of the organization, the Primary Health Care Nurse practices in accordance with the standards of professional practice and code of ethics as outlined by the British Columbia College of Nursing Professionals (BCCNP) as well as within a client and family centered care model.

Within the assigned practice area the Primary Health Care Nurse provides comprehensive and coordinated nursing care to clients in a primary health care, community or patient home setting through assessment, planning, implementation and evaluation of care delivery. The Primary Health Care Nurse assists individuals to achieve safe, realistic and reasonable healthcare goals and to maintain optimal health through the provision of information/health promotion, disease prevention and treatment/care management services.

The Primary Health Care Nurse is responsible for working in direct collaboration with an inter-professional care team and defined network of Primary Care Physicians/Nurse Practitioners to conduct integrated care planning, offer client assessments/clinic visits, and provide ongoing monitoring and self-management support follow-up for clients (adults, seniors, pediatrics) and/or those with multiple chronic conditions, either in an individual or group setting and often directly within the family physician/nurse practitioner office.

TYPICAL DUTIES AND RESPONSIBILITIES:

1. Conducts client assessments, plans, implements, and evaluates client care plan and interventions for clients presenting to the primary care setting and in the community, emphasizing client centered holistic care, health promotion and disease prevention.
2. Initiates treatments for clients that lie within the primary health care nurse's scope of practice by using a systematic approach and established clinical decision support tools. Determines urgency of clients health concern(s) and refers to the appropriate care provider or program by assessing clients, reviewing diagnostic data, and consulting with other team members. Contributes to a comprehensive

Primary_Health_Care_Nurse(CH1)_JC_20020-FINAL DRAFT Page 1 of 3

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inter-professional care plan for clients using systematic assessment and best practices and amends the care plan as appropriate. Develops the care plan with the client and caregiver in accordance with client goals and by utilizing relevant available data, such as: the assessment process; investigative procedures; and other members of the health care team (including medical history, progress notes, consultation reports, lab reports, verbal reports, etc.). Works directly with a network of Primary Care Physicians/Nurse Practitioners and integrated inter-professional care team, with consultation from other specialists as required to conduct assessments, undertake collaborative care planning, offer group and individual education, self-management support and ongoing action planning follow-up to clients and families. Participates in Primary Health Care strategies in Interior Health and provincially. Follows established policies and clinical decision support tools (e.g. guidelines, protocols, procedures) in accordance with nursing practice participates in education and evaluates data in order to improve client and community health and efficiencies within primary health care practice.

3. Offers health information and treatment services to clients, caregivers, and other team members by communicating and demonstrating procedures and care techniques and distributing health information or handouts. Promotes wellness and independence through discussion on lifestyle adaptations and self-care skills such as grieving, aging, family adjustments, and coping with chronic health challenges. Shares information regarding primary health care to clients, staff and community groups through Health Centre programs, in-service sessions, and client/family teaching sessions. Teaches and counsels individuals and groups on the maintenance of health, prevention of disease and disability.
4. Documents care and maintains electronic and/or other medical records to communicate care, ensure care continuity and for evaluation purposes. Utilizes established communication processes to ensure continuum of care. Provides input as requested to the Manager (or designate) regarding policies, clinical decision support tools (e.g. procedures), reference and resource materials as required for the purpose of enhancing care delivery and/or improving the health of the community.
5. Participates in related meetings and committees as requested such as continuous quality improvement, infection control, inter-professional meetings to exchange and gain information, problem solve, voice nursing concerns, offer alternatives and recommendations. Seeks out appropriate resources when presented with a situation that requires clarification, direction or confirmation. Address barriers to effective client care.
6. Adheres to safe work procedures. Cooperates in establishing a work environment free of accidents. Reports inoperable, damaged or unsafe equipment in accordance with established procedures. Reports client safety events in accordance with established policies and procedures.
7. Performs other related duties as assigned.

QUALIFICATIONS:

Education, Training and Experience:

Graduation from an approved School of Nursing with current practicing registration with the British Columbia College of Nursing Professionals (BCCNP).

Advance clinical skills training in the assigned practice area.

Three years recent related clinical nursing experience in the assigned practice area, including experience developing and providing formal education to clients, families, the general public, and other health professionals; or an equivalent combination of education, training and experience.

Current valid BC Driver's License.

Skills and Abilities:

Assessment and Intervention – Demonstrated ability to complete initial and ongoing client assessments (clinical and diagnostic reasoning) and provide nursing care through appropriate/ prescribed technical, therapeutic, safety type interventions.

Communication – Demonstrated ability to communicate effectively with the clients, families, the public, medical staff and the members of the interdisciplinary team using verbal, written and computer communication means.

Critical Thinking – Demonstrated ability to integrate and evaluate pertinent data (from multiple sources) to problem-solve effectively.

Human Caring and Relationship Centered Practice – Ability to promote client-focused care that demonstrates care for and with clients and significant others, sensitive to diverse cultures and preferences, client advocacy and social justice concerns.

Teaching – Ability to transmit information intended to instruct clients and others about topics essential to health care and well-being.

Management – Manages time and resources, implementing activities to promote cooperation among relevant others, collaboration across disciplines and related activities.

Leadership – Promotes staff morale, cooperation, assertiveness and risk-taking, creative planning for change and innovations, implementation of IH policies or other protocols, and ongoing professional development of self.

Knowledge Integration – Using factual information, prior learning and basic principles and procedures to support decisions and actions with relevant research-based evidence. Integrates best practice from nursing and health-related disciplines and the humanities, arts and sciences disciplines into professional practice.

Ability to operate related equipment including relevant computer applications.

Physical ability to perform the duties of the position.

Primary Care Network

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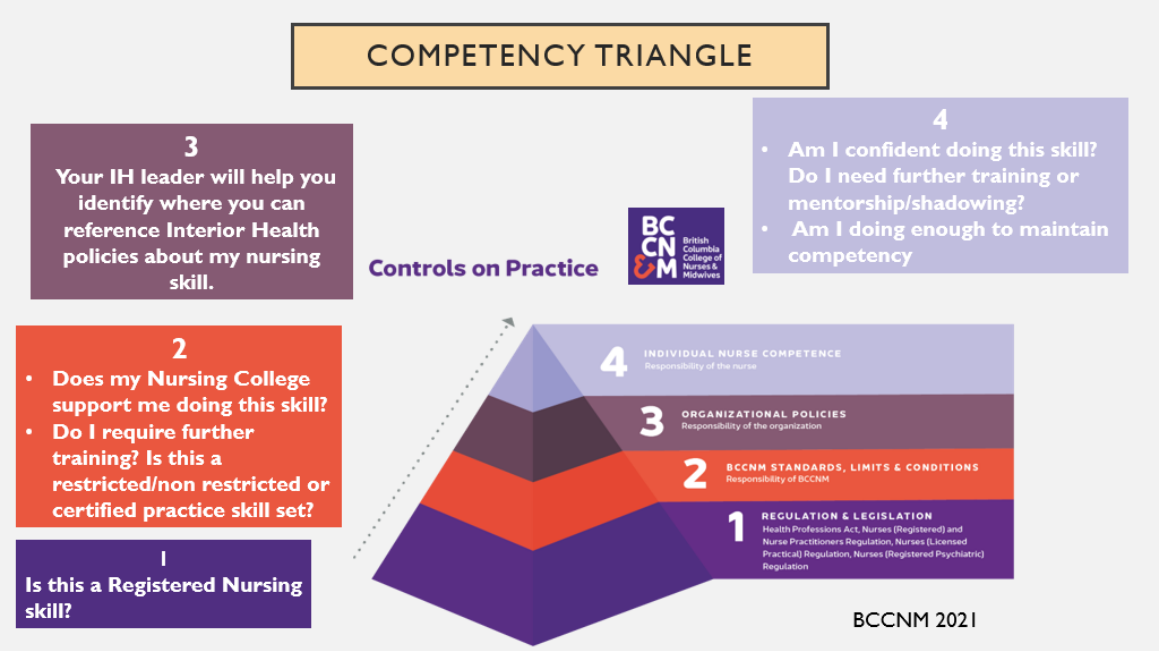
Competency Triangle



What Legislation and regulations impact my practice?

- Be aware of provincial and federal legal rules and regulations that impact your practice. For example, Ministry of Health, BC Law, Canadian Health Care Acct, Health Professionals Act, etc.

What does my nursing college tell me I can do?

- Review British Columbia College of Nurses and Midwives Registered Nurses practice and standards – scope of practice, practice standards, certified practice, and professional standards. Know what standards, limits, and conditions affect your practice. Certified practice decision support tools and competencies can be found on the Nurse and Nurse Practitioners of British Columbia website.

Does my organization have policies, procedures and guidelines in place to support my practice and am I following them?

- Know Interior Health's policy, procedures and guidelines.
- What training, supports and practices do I required to perform m care services? What do I require coaching, mentoring and education in to ensure that I am confident and competent in my practice?

Primary Care Network

Central Okanagan

Interior Health Patient Consent Form

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☐ **my minor child's patient records I am the legal Guardian for**

☐

- _____
- _____
- _____

☐

_____ _____

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Primary Care Network

Central Okanagan

PCN Nurse Clinic Equipment List

PCN Nurse Clinic Equipment List

Technology Requirements:

- Laptop or PC (**Note:** Chrome Book is not compatible with required IH technology)
  - **Note laptop/computer considerations below**
  - A suitable sized monitor (15" min. for laptop, 20" min. for desktop) for community resource navigation, case management, patient follow-up and other computer-based tasks.
  - Keyboard, mouse (optional with laptop)
  - Computer camera and working microphone for virtual meetings and virtual patient appointments
  - ***Note** if using a monitor with a laptop-compatible adapter and USB cord

Recommendations from IHA Tech Support in Consideration of IHA anywhere

- **VMware Horizon Client application**: version 5.x is required for printing support (we will support printing in version 8.x by Q2 2022). This application can be run on Windows or Mac, with specific requirements listed below:

- **Windows VMware Horizon Client**: System Requirements are found here: System Requirements for Windows Client Systems (vmware.com). In general, it requires a modern PC or laptop running a full, in-support version of Windows 10 (we have not tested Windows 11). There is a matrix for various versions of Windows vs versions of the VMware Horizon Client here: Supported versions of Windows 10 and Windows 11 on Horizon Client (58096) (58096) (vmware.com).

- **Mac VMware Horizon Client**: System Requirements are found here: System Requirements for Mac Clients (vmware.com). The Mac has to be able to run at least macOS 10.14 (currently). We have seen that as the VMware Horizon Client updates, VMware drops support for older versions of macOS, so older Mac hardware becomes less able to run the VMware Horizon Client. We do not recommend running this on an iPad (this is not specified in the above link).

- **Monitors:** The VMware Horizon Client does support dual monitors (or a laptop plus a second monitor, eg). However, we have seen issues lately with monitors with mismatched resolution and aspect ratios. My recommendation is to have full HD monitors (1080 or 1200p), and ensure that, if more than one monitor is desired for IH Anywhere itself (rather than IH Anywhere on one monitor and the clinic desktop on the other monitor), both monitors should be the same aspect ratio and resolution.

November 26, 2021 V.3

- **Network Considerations:** a stable connection to our IH Anywhere system is dependent on **good network conditions.** The things within a clinic's control are the strength and type of internal network **(eg wifi vs wired LAN, type of access points or cabling, switches),** their **router/firewall**, and their **internet service plan**. Typically, IH Anywhere can perform adequately with as little as **1 Mbps available to each concurrent user at the clinic, but things like intermittent connectivity, network jitter, and latency, all impact the actual IH Anywhere experience**. As well, the clinic needs to **have port 4172 (TCP and UDP) open in both directions.**

- **Printing:** IH Anywhere supports a wide variety of locally attached and network-based printers, via printer redirection into the IH Anywhere virtual machine. As noted above, the VMware Horizon Client version 5.x is currently required to print from IH Anywhere. This is technical guidance alone - I am not considering any privacy issues related to proper handling of patient health information when it comes to printing from IH Anywhere on a clinic printer - that is not my area of knowledge.

- **IT support**: occasionally there are issues with hardware or software which requires the clinic to troubleshoot and intervene. In these cases, the clinic may need an IT provider or otherwise to perform this work. Our team has provided guidance and worked with clinic staff and IT providers in the past to troubleshoot and fix issues, on a best-effort basis.

Other Technology

- Phone to have confidential patient conversations
  - A designated phone line is recommended
- Access to the clinic's EMR
- Ability to send/receive faxes
- Internet access
- Photocopier/scanner/printer access

Clinical/Office Space Requirements:

- Confidential workstation for patient phone calls and to carry out case management and administrative tasks
  - Storage space to keep patient handouts, education materials, etc.
  - Office chair with lumbar support
  - Basic office supplies
- Access to exam rooms for in-patient consultation
- Clinical supplies and equipment suitable for tasks required (e.g. gloves, gowns, masks, safety needles/syringes, simple dressing supplies, etc.)

November 26, 2021 V.3

Primary Care Network

Central Okanagan

Nurse Coordinator Roles & Responsibilities

Interior Health
PRIMARY CARE

Registered Nurse (RN)

Role of the Registered Nurse

Registered Nurses (RN) provide holistic, person centered, and culturally appropriate care along a continuum. They work within a team based environment, to help patients navigate through the health care system and access resources. Registered Nurses provide education and support directed at health promotion, disease prevention and management of chronic conditions.

Education and Registration

- Graduation from an approved School of Nursing with current practicing registration with the British Columbia College of Nurses and Midwives (BCCNM)
- Advance clinical skills training in the assigned practice area.

What can RNs do in Primary Care?

Within a Primary Care Network, Registered Nurses initiate, implement, and monitor health care plans in collaboration with the patient, physician and other members of the interdisciplinary team throughout the lifespan to optimize wellness. Through the Registered Nurses knowledge of community based resources, some functions may be better delivered with referrals to existing IH Specialized Community Service Programs. The list is meant to be illustrative and should not be considered exhaustive.

- Completes documentation, accurate statistical data and reports in a timely manner
- Participates in relevant meetings, committees, and network groups
- Seeks professional development opportunities consistent with current primary care practice, new and emerging issues, changing needs of patient population, and research
- Maintains and applies evidence-based knowledge to the nursing process
- Uses research findings and evidence to guide the delivery of services
- Recognizes personal attitudes, beliefs, feelings and values about health in their interactions with patients and their families
- Establishes and maintains effective professional relationships and partnerships with other organizations to benefit system integration, efficient service utilization, effective collaboration and optimal patient care.
- Follows the four levels of control on practice.
    - Regulation and legislation
    - BCCNM standards, limits & conditions
    - Organizational policies
    - Individual nurse competence

Resources

- Pathways (Includes BC Guidelines and BC Lifetime Prevention Schedule)
- Clinical Care Resources - Primary Care
- Elsevier
- Learning Plan – IH Professional Development (Learning) Plan
- Up to Date

Staying Healthy	**Indirect Care** • Health promotion and disease prevention strategies in collaboration with communities and interdisciplinary team members • Education and communication strategies to address health topics (e.g. Individual and group education, written, verbal, visual)

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Interior Health
PRIMARY CARE

	Direct Care • Health care planning in collaboration with patient and interdisciplinary team • Assess immunization status and provide or refer for immunization *(additional education)* • Care coordination and health care navigation support (community resources/referrals, PCN resources (regional resources) • Plan and participate in strategy to recall patients across the lifespan for monitoring and screening, using the British Columbia Governments Lifetime Prevention Schedule, British Columbia Governments Clinical Practice Guidelineselines, and best evidence based practice guidelines for chronic disease management • Reproductive and sexual health promotion through assessment, education and/or counselling (*additional education*) • Assess patients current knowledge, education, literacy levels, social supports, learning preferences and other factors that may affect the educational approach and plan • Provide patient-centered education related but not limited to healthy living, medications, chronic disease management, care and treatment • Document completion (eg: life insurance, workplace accommodation, extended health benefits, driver's medical fitness)
Getting Better	**Indirect Care** • Collaborate with primary care provider or most appropriate member of the health care team (eg: discharge follow up, community care) • Match community resources with patient needs and facilitates access to services in a timely and supportive manner • Gather appropriate information and prep charts for appointments – consults, labs, imaging and flag abnormal results • Complete consults and referrals (eg: laboratory requisitions, diagnostic imaging requisitions, and completed as per guideline care with patient specific order) • Provide additional supports, education, appointments for higher risk patients • Complete necessary documentation to access medications or treatments that are exception to BC Pharmacare formulary **Direct Care** • Bladder scans (post residual void/assess urine retention) • Simple/superficial skin and wound care (eg: skin tears, suture or staple removal, drain removal, peripheral line removal • Ear syringing • Adult immunizations (*additional education*) • Injections (e.g. B12, birth control) • Cryotherapy (*additional education*) • Pelvic exams, annual exams, cervical cancer screening (*additional education*) • Sexually transmitted infections (*certified practice*) community needs • Contraceptive management (*certified practice*) community needs • Epistaxis treatment • Point of care testing (glucose, pregnancy, urinalysis screening) • Insulin dose adjustments (*advanced education*) community needs • Assessment for pain, cognition, drug toxicity, chronic diseases, mental health etc.
Living with Illness and Disability	**Indirect Care** Collaborate and liaise with: • Specialized Community Service Programs (SCSPs) like MSHU, Complex Medical with/without Frailty (CMF) and Acute Care • Primary Care Provider and Home and Community Care (CMF SCSPs) for home bound patients to coordinate services. • Providers to support patients in long-term care or assisted living

Created August 17, 2022 | Tannis Andersen; Tasha Kanigan; Natasha Goldsbury

Interior Health
PRIMARY CARE

	Direct Care
	• Identify and support patients with complex health conditions
	  ○ Chronic diseases
	  ○ Frailty
	  ○ Obesity
	  ○ Mental health and substance use
	  ○ High risk
	• Support illness management following clinical practice guidelines and evidence based practices
	• Complete regular medication reconciliation
	• Counsel patients on drug therapies, side-effects, and interactions
	• Counsel and guide patients on symptom management, health maintenance and rehabilitation strategies, as well as risk factors and lifestyle changes
	• Document completion support
	• Information gathering, symptom review, treatment review, chart review
	• Disability Tax Credit, Long Term Disability forms (in collaboration with other professions)
	• Teach and coach patients to participate and manage their own care (eg: education strategies and Motivational Interviewing skills to support behavioral change)

Optimizing End of Life	**Direct Care**
	• Support advanced care planning conversations for patient and family/caregivers through assessment and support in completion of:
	  ○ MOST
	  ○ DNR
	• Support patients through life transitions including palliation and death (eg: referrals to palliative care supports, navigation through palliative care benefits
	• Assist with pain and symptom management
	• Assist primary care providers as appropriate with Medical Assistance in Dying support for patient and supports

References

Canadian Family Practice Nurses Association. *Sample Role Description for Registered Nurse in Family Practice For Adaptation to your Primary Care Practice.* https://cna-aiic.ca/-/media/nurseone/files/en/sample_role_description_e.pdf?la=en&hash=07386589D135746C0C31D120BD893D998B84D8C9 . August 14, 2019

BCCNP (2019). *Scope of Practice for Registered Nurses.* https://www.bccnp.ca/Standards/RN_NP/StandardResources/RN_ScopeofPractice.pdf

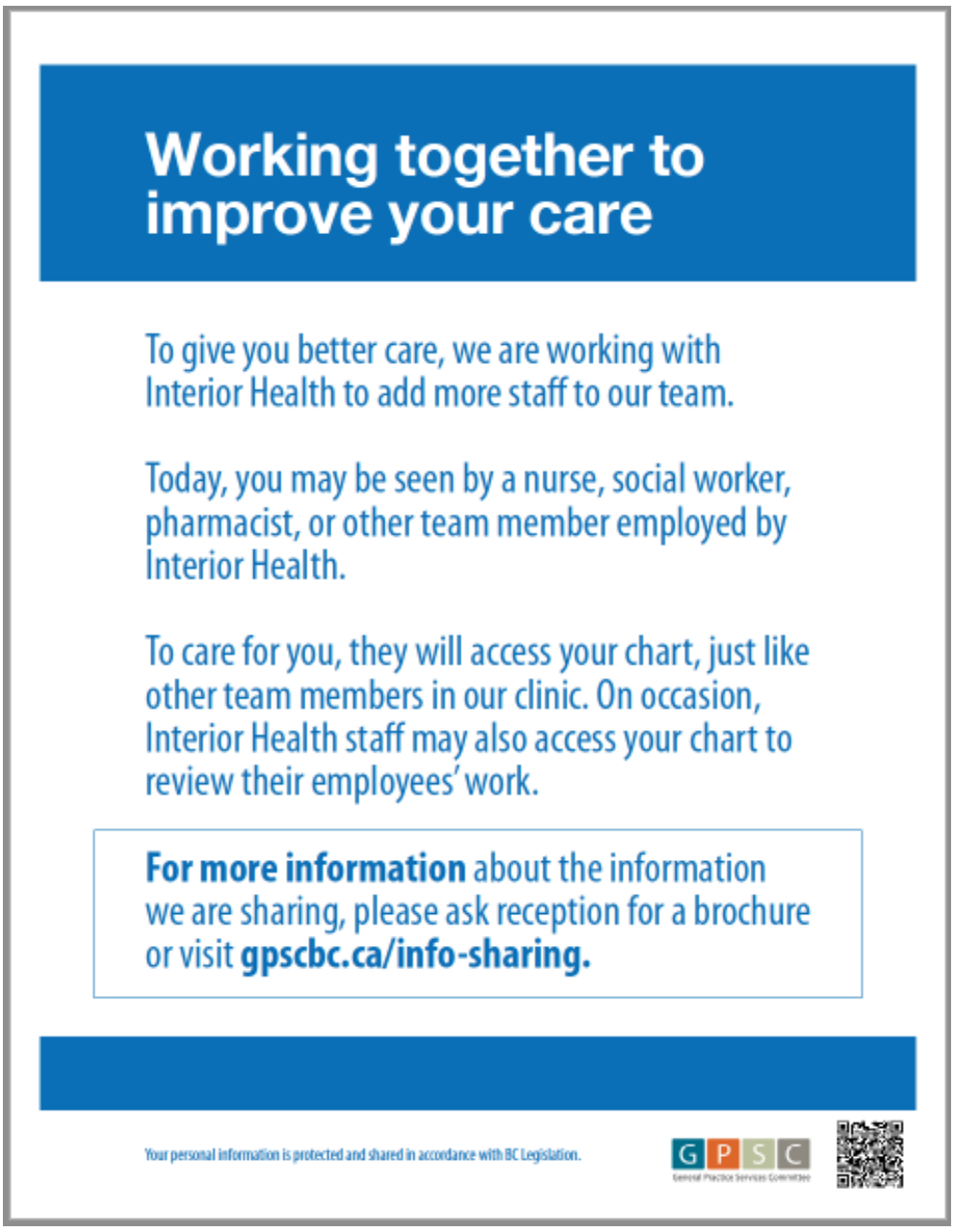
Created August 17, 2022 | Tannis Andersen; Tasha Kanigan; Natasha Goldsbury

Primary Care Network

Central Okanagan

PCN Patient Notification Poster

Note: Two paper copies of this poster will be provided to your clinic.



Created: March-2022
Last Edited: December-2022

Primary Care Network

Central Okanagan

IH Confidentiality Agreement

Confidentiality Agreement for
Interior Health Authority Employees Working in a Physician's Private Practice

I, _____, hereby agree that I will not use or disclose any personal information collected, accessed, or otherwise obtained by me at the <Physician Practice> except for the purposes necessary to carry out my contractual or employment responsibilities. I understand that my duties and responsibilities to maintain the confidentiality of information as described herein shall remain in effect even after leaving the <Physician Practice>.

I understand that I am granted temporary and limited access to patient medical records, proprietary information relating to the <Physician Practice>'s functions, employees and other business records, as required to carry out my employment or contractual responsibilities, and that those records remain under the custody and control of the <Physician Practice>.

I will abide by the <Physician Practice>'s privacy policy concerning personal information and will protect the privacy and security of confidential personal information including:

1. I will only access personal health information as required in order to carry out my contractual or employment responsibilities.
2. I will not collect, use, or disclose personal health information for any purpose other than the purposes for which the information was collected, used or disclosed, or as permitted or required by law.
3. I will protect personal health information from unauthorized access, use or disclosure, including using appropriate security safeguards as identified by the <Physician Practice>, and will adhere to the <Physician Practice>'s policies and procedures.
4. I will strive to keep personal health information that I am responsible for obtaining and entering into the <Physician Practice>'s patient medical records accurate and up-to-date.
5. Subject to any applicable policies or legal requirements with regard to retention of health records, I will securely dispose of personal health information that I create once it is no longer required.

I am aware of and will fully comply with the *Personal Information Protection Act* (PIPA) as directed by <Physician Practice>'s policies. I acknowledge and agree that any breach of this Confidentiality Agreement may result in disciplinary action, including termination of my services to the Physician Practice and in penalties as applicable under PIPA.

Interior Health Authority Employee	**Name:** (please print)	_____
	Signature:	_____
Witness (Privacy Officer)	**Name:**	_____
	Signature:	_____
	Date: (dd/mm/yy)	_____

Created: March-2022
Last Edited: December-2022

Primary Care Network

Central Okanagan

PCN Patient Card

Health goals:

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Patient Card

"For non-emergency health situations, always call your family practitioner or PCN team member first."

Patient name:

Patient medical home (clinic) & contact #:

Family provider:

Family/support person:

Nurse coordinator Name:

Nurse coordinator contact #:

Other PCN Team Members:

Other medical and community supports:

Next appointment time:

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Central Okanagan

FAQs

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Primary Care Network

Central Okanagan

FAQ's

Administrative Questions

How much RN FTE will my clinic be allocated?

- Generally, 1.0 RN FTE will be allocated per 3-4 Physician FTE.
- If your practice has more or less physician FTE, we will work with you to assist in meeting prorated RN FTE's keeping in consideration clinic and patient needs.

Who will provide the computer and cell phone?

- The Nurse Coordinator attached to your clinic will use the clinic computers, clinic phones and will be working directly in the clinic EMR. If you do not have a computer/cell phone, please inform the PCN Manager who will help you work through this.
- The Clinic will need to provide remote EMR access if the Nurse Coordinator is working virtually.

Will the Nurse Coordinator be able to work virtually?

- Yes. The Nurse Coordinator will have flexibility to work in your office, virtually with you and virtually with patients.
- This can be a mixed approach and will depend on what you determine your clinic and patients' needs to be.

Will I receive overhead compensation for having staff in my office?

- Overhead will be provided for RNs physically working out of your office; for every 1.0 FTE RN physically located in the clinic and using clinic space, computers, and phones a clinic will receive $16,000.00 annually for 1.0 FTE RN assigned to your office.

What type of office space does the Nurse Coordinator require (ie. own desk vs shared desk)?

- This will be dependent on the workflow and resources of the clinic to determine whether the Nurse Coordinator has their own desk or shares the space. They will need access to a work station for charting, a phone to make confidential calls to patients, etc. The workspace will require safe ergonomic support.

Are Physicians able to bill a full appointment in the case the Nurse Coordinator sees the patient for most of it?

- Physicians are able to continue billing for any MSP billable services they provide (not what the nurses provide). The GP does not need to see every patient the RN sees, but may need to depending on the nature of the visit and potential issues that may arise during the course of the patient's visit with the Nurse Coordinator. Here's an example that might help clarify:

Scenario: A new mother calls the clinic worried about whether her baby is getting enough to eat. The MOA suggests that she comes in to the clinic. The new mother is seen by the RN who assesses mom/baby

including taking baby's weight, checking latch, nutrition/hydration status and also assessing wellness including PPD screen.

Outcome A (not billable): Baby looks good, latch is good, and mom is tired but otherwise well. RN determines that doctor does not need to see the patient. RN provides reassurance to mom and makes a few self-care recommendations for new moms.

Outcome B (billable): Upon assessment, RN identifies that mom has mastitis. RN shares findings with GP. GP meets with mom/baby and ca see the patient more quickly as a result of the RN assessment having been completed. The GPO provides a prescription to the mom. RN calls to follow up the next day to see how mom and baby are doing.

As fee-for-service physicians, will there be limits on how many nursing consultants we can bill per day? How will billing in these instances work?

- Beyond the existing billing rules for individual fee items, there is no specific limit on how many nursing and/or allied Consultations can be billed by a physician. Having said that, there must be a formal need for the consultation directly related to the patient's care and there must not be duplicate billings for the same service. Please note that the Nurse Coordinator uses zero fee billing codes.

For more information on Team-Based Care billing, please see the GPSC Fee Summary Guide.

Primary Care Network

Central Okanagan

Clinical and Clinic Questions

What are the Reporting expectations for my practice?

- All family physicians participating in PCN are required to use the zero-fee **Attachment Code** to identify new patients attached to their practice through the PCN.
- The code is:
  - PCN-1 (Kelowna Central): **97631**
  - PCN-2 (Rutland/Lake Country): **97632**
  - PCN-3 (West Kelowna/Peachland): **97633**

How will staff document?

- Nurse Coordinators will document in your clinic EMR.
- Allied Health staff working out of multiple clinics will document in Meditech and provide documentation to the clinic via fax.
- The Nurse Coordinator will also register patients in Meditech, IH's EMR. IH will support the clinic to be registered in Meditech as a site location. Note: this process can take about up to one month to complete.
- The Nurse Coordinator will obtain individual consent from each patient to register them in Meditech.

Will the Nurse Coordinator require orientation?

- Yes. The Nurse Coordinator will attend 2-4 weeks of orientation provided by IH and CODFP.
- It is recommended that the Nurse Coordinator shadow each physician that they will work with and any other clinic staff (MOA, Office Manager, Nurse in Practice, etc.) to ensure full understanding of the clinic business flow and patient care support.

What are the Nurse Coordinator's working hours?

- The positions will be posted for 0830-1630 Monday to Friday unless otherwise noted by the clinic. Most positions will be full-time positions (unless not needed by the clinic). For an IH employee, a full-time work week is 37.5 hours (8 hours with 30-minute lunch break and two 15-minute breaks).

Can the Nurse Coordinator do group medical visits?

- Yes.

Can the Nurse Coordinator do home visits? *confirm w/Julia

- At this time, home visits are supported by the PCN in certain circumstances. If home visits are of interest, please contact the Sr. PCN Manager. IH and the PCN have reviewed the Occupation Health and Safety Standards (OH&S) for safe home visits.

How will the Nurse Coordinator's time be divided among practitioners in the same clinic?

- We recommend that the Nurse Coordinator's time be split evenly among the practitioners in the clinic; however, it will be up to the clinic's discretion on how they would like to divide the Nurse Coordinator's time for optimal productivity and fairness.

How is it decided which patients see the Nurse Coordinator or the GP?

- This will differ from clinic to clinic and will be determined by the Physician and Nurse Coordinator. For example, one clinic may have the Nurse Coordinator see all patients diagnosed with chronic disease. In another clinic the Nurse Coordinator will support patients with Covid Screen results. The goal is to off-load work from the physician to the Nurse Coordinator to optimize patient care and physician time.

How is information sharing and confidentiality addressed for IH staff working in private clinics?

- Under current privacy legislation, health care providers can share patient information with one another for the purposes of clinical care. In addition, there will be access to supports to assist with privacy issues. The Team Charting Agreement (TCA) and the Information Sharing Agreement (ISA) documents support this process.
- Nurse Coordinators will request patient consent to register patient demographic information (name, address, date of birth, health number, etc.) within the IH EMR, and Meditech. The Patient consent will be scanned into the clinic EMR. If the patient does not consent for their information to be registered in Meditech, the Nurse Coordinator will continue with care, but will not be able to access Meditech information or data for that patient.

What are the responsibilities of a Physician Lead for a clinic that would like to have a Registered Nurse in their practice?

- The Physician Lead responsibilities include:
  - A point person or contact for the Division to coordinate with for the practice,
  - Ensure accountability within the clinic,
  - Support mentoring the Nurse Coordinator (including weekly touch-base meetings),
  - Oversee delivery of information to CODFP and IH as needed,
  - Endorsing TBC Education and team process.
- The physician Lead will be compensated for up to eight sessional hours monthly, for the first three months.

Primary Care Network

Central Okanagan

Hiring Process Questions

How long will it take to get a Nurse Coordinator in my practice?

- This process will vary but from the time of the Readiness Assessment, the clinic and IH will begin working on preparation for the Nurse Coordinator. From posting the position, it will take approximately 6-8 weeks for the Nurse Coordinator to be hired. See Summary of Process Steps for details.

Will I be involved with the hiring process?

- Prior to posting positions, clinics will work with IH to identify job requirements that outline the specific needs of the clinic.
- We invite the Physician Lead (or designate) to be part of the hiring process to help IH determine who would be the best fit for the clinic.
- In situations where multiple positions are posted at the same time, we will include a Physician Lead in the interview process.
- If you are unable to participate in the hiring process, we will work with you to identify the clinic and patient needs.

Who will be hiring, training and employing the Registered Nurse Coordinators?

- Allied Health will eventually be located in the Central Okanagan PCN "HUB" sites. Currently, PCN-3 (West Kelowna/Peachland) has the only permanent physical HUB, which is located in the West Kelowna Urgent and Primary Care Center (UPCC).
- PCN-1 (Kelowna) and PCN-2 (Lake Country/Rutland) Allied Health staff will initially access Kelowna Community Health and Services Centre (CHSC) downtown.
- Allied Health staff will also be able to work within the community and be responsible to clinic and patient needs in their PCN. This means that they can see your patients virtually, at your clinic or at an IH location.

What happens if my Nurse Coordinator is ill or goes on vacation?

- Generally, the Nurse Coordinator will not be covered by another nurse during absences. IH is responsible for scheduling staff and will work with the practice to determine the appropriate schedule to meet service needs if an absence is extended longer than initially anticipated.

Primary Care Network

Central Okanagan

Allied Health Questions

What Allied Health staff are available within a PCN?

- The proposed service plan included: Pharmacist, Registered Dietitian, Social Worker and Occupational Therapist, and Physiotherapist.

How will I access Allied Health staff?

- Your Nurse Coordinator can complete a referral for Allied Health by using your EMR Consult Report. The patient will be registered and assigned to an allied health clinician. The referral process acts as an informed consent.
- You can fax a referral from your EMR to the PCN through the same process.
- The PCN Allied Health fax number is (**250) 469-6013**.

Can I access Allied Health without a Nurse Coordinator?

- Yes. If you are a member of the PCN, you can refer to the Allied Health team through your EMR. Your clinic MOA, Office Manager or Nurse in Practice would process the referral as they would other community-based referrals.

Where will the Allied Health staff be located?

- Allied Health will eventually be located in the Central Okanagan PCN “HUB” sites.
- PCN-1 (Kelowna) and PCN-2 (Lake Country/Rutland) Allied Health staff will be located in the Kelowna Community Health and Services Centre (CHSC) building downtown.
- Currently, PCN-3 (West Kelowna/Peachland) has the only permanent physical HUB, which is located in the West Kelowna Urgent and Primary Care Center (UPCC).
- Allied Health staff will also be able to work within the community and be responsible to clinic and patient needs in their PCN. This means that they can see your patients virtually, at your clinic or at an IH location.

Primary Care Network

Central Okanagan

Ongoing Support Questions

Will support be available for our clinic to help integrate the Nurse Coordinator into practice and to adapt to the new changes?

- Yes, CODFP and IH will prepare the clinic for the RN onboarding. Support will be provided in the beginning to ensure a smooth transition. Ongoing support by Clinic Leads hired by the CODFP to provide ongoing support in building Team-Based Care and Cultural Safety.

Will IH provide continuing clinical education support?

- Yes. If you have a specific clinical need, such as sexual health training or immunizations, IH will ensure the Nurse Coordinator receives this training as soon as possible.
- Day to day clinical support will be provide by IH Team Leads and CODFP Clinic Leads as needed and identified by the clinic.
- The Nurse Coordinator will attend monthly PCN education with Allied Health staff to incorporate theory of Team-Based Care into practice.
- Virtual Learning Labs are in development for physicians, clinic staff and PCN staff to attend together.

What if our clinic has issues or difficulties working alongside the Nurse Coordinator?

- As soon as issues arise, the clinic should contact the CODFP and IH for assistance in identifying solutions. Appropriate interventions and actions will follow to resolve the conflict.