Central Okanagan
Division of Family Practice
A GPSC initiative

CENTRAL OKANAGAN DIVISION OF FAMILY PRACTICE

PCN ORIENTATION 2021

WHAT IS THE DIVISION OF FAMILY PRACTICE?

- **Who are we?**
  - community-based family physicians
  - Collaborative work with community and health care partners
  - Support for patient and physician satisfaction for physicians.
- **Where are we?**
  - 35 divisions in BC
  - representing more than 230 communities,
- **What are we?**
  - funded by the **General Practice Service Committee** (GPSC),
  - one of four joint committees that represent a partnership of the **Ministry of Health** and **Doctors of BC.**

CENTRAL OKANAGAN DIVISION OF FAMILY PRACTICE

- Incorporated on July 23rd 2010
- Membership consists of 295 physicians working in about 60 clinic
- Includes family physicians from Kelowna, West Kelowna, Lake Country, and Peachland.
- Governed by a board of directors, consisting of nine family physicians.
- Day to day operations are led by the Board Physician Lead and the Executive Director, supported by CODOFP staff.
- Initiatives are governed through the CODOFP board of directors, initiative working groups, the Collaborative Services Committee, the Inter-Divisional Steering Council, Shared Care working groups, and the Central Okanagan Health Coalition.

Vision

- Excellence in care, vibrant communities, strong collaborative family medicine.

Mission

- The Central Okanagan Division of Family Practice is a non-profit society governed by local family physicians who identify areas to improve care of patients and work with partners towards improving health in our community.

Values

- Quality and integrity in medical care
- Advocacy: for patients and for the role of the family physician as a key component of primary care
- Visionary planning
- Transparent communication
- Collaboration: among family physicians, partners and patients

CENTRAL OKANAGAN DIVISION STAFF

- **Divisions Team**

- **Dr. Mike Koss:** Board Physician Lead
- **Tristan Smith:** Executive Director
- **Amanda Stickland :** Admin Support
- **Monica McLean:** Members Engagement and Recruitment
- **Jen Bitz:** Long Term Care Project Manager

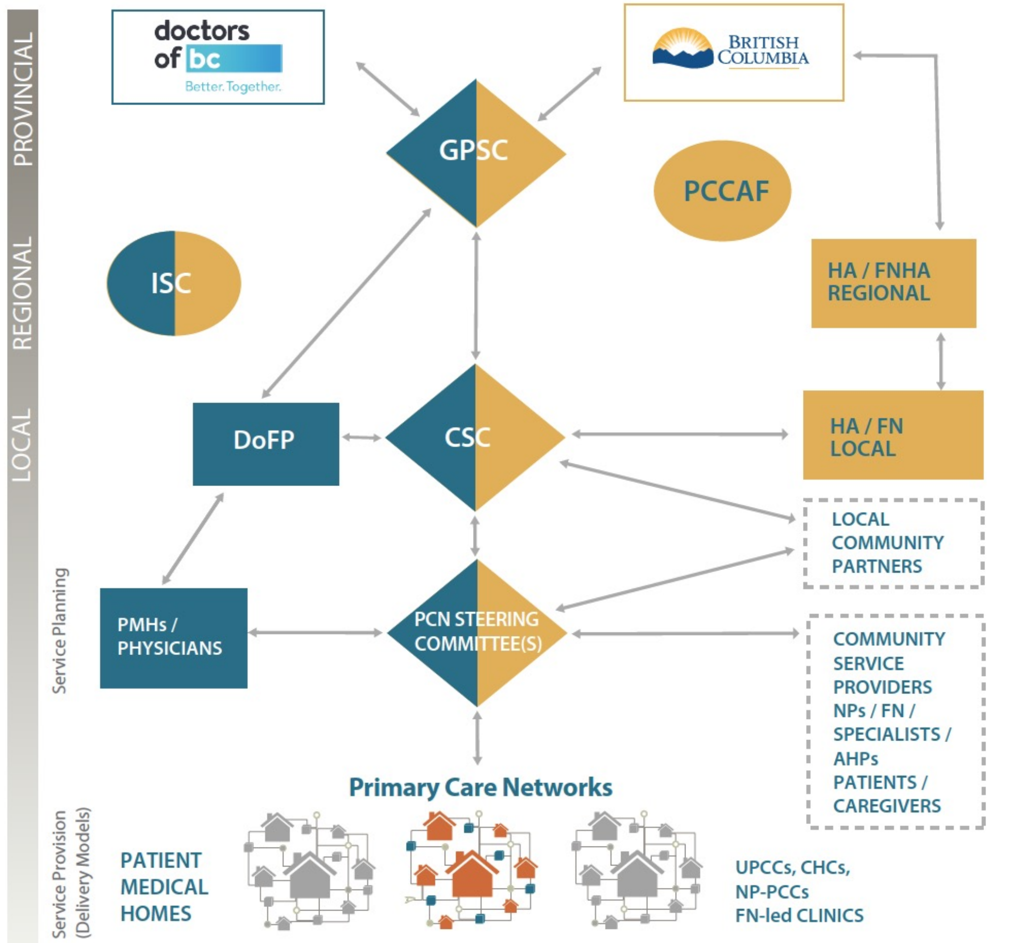
PCN Team within Division:

- **Beth Whalley:** Senior Manager
- **Scott Tucker:** Admin Support
- **Tara Muncey:** Project Lead
- **Maria Cihlar:** Change Lead
- **Julia Hunter:** Clinical Lead

WHAT IS A PRIMARY CARE NETWORK?

- Network of Family Care Providers, with **patient medical homes** (PMHs) as the foundation.
- Partnership between Divisions of Family Practice and Health Authorities.
- Physicians, NPs, Allied Health, Health Authority, and Community organizations work together to provide the primary care services.
- Together, they:
  - Enhance patient care using a **team-based approach to care.**
  - Support each other and work to their strengths.
  - Link patients to other parts of the system,
  - Increase attachment: Increase capacity of care providers and create greater access to care for people without a primary care provider.

Primary Care Networks Governance



= Decision-making committee
= Formal entity / organization
= Advisory Table
= Accountability
Bi-coloured = Collaborative Table

GPSC - General Practice Services Committee
PCCAF - Primary & Community Care Advisory Forum
ISC - Interdivisional Strategic Council
CSC - Collaborative Services Committee
DoFP - Divisions of Family Practice
HA - Health Authority
FNHA - First Nations Health Authority
FN - First Nations

PMHs - Patient Medical Homes
PCNs - Primary Care Networks
UPCC - Urgent & Primary Care Centres
CHC - Community Health Centres
NP-PCC - Nurse Practitioner Primary Care Cinics

PCNS ACROSS THE PROVINCE

Wave One began 2018

- Burnaby
- Fraser Northwest
- Ridge-Meadows
- Prince George
- Comox
- South Okanagan-Similkameen
- Kootenay-Boundary
- Vancouver (Part 1)
- Richmond, and South Island

Wave Two began 2019

- Central-Interior Rural
- East Kootenay
- **Central Okanagan**
- Oceanside
- Cowichan
- Vancouver (Part 2)
- North Shore
- Chilliwack
- White Rock South Surrey
- Northern-Interior Rural
- North Peace, Haida Gwaii, and Mission

THE 8 CORE ATTRIBUTES OF A PCN:

1. Access and attachment to quality primary care
2. Extended hours
3. Same day access to urgent care
4. Advice & information
5. Comprehensive primary care
6. Culturally safe care
7. Coordinated care
8. Clear communication

REQUIREMENTS FOR PARTICIPATING IN A PCN

- **Panel Management:** Physicians will be required to complete Phase 1 of panel management
- **Family Practice:** Physicians must provide longitudinal care (cannot participate if solely provide walk-in services)
- **EMR:** Must be using an electronic medical record (EMR)
- **Committed to supporting TBC:** Physicians and clinics must commit to supporting ongoing education and mentorship for Team Based Care

PCN SERVICE PLAN WAS APPROVED BY THE MINISTRY OF HEALTH FOR IMPLEMENTATION IN CENTRAL OKANAGAN FOR SPRING 2020

Three unique PCN Hubs: PCN 1Central Kelowna, PCN 2 Rutland/Lake Country, PCN 3 West Kelowna/Peachland

- 37 FTE Nursing to be co-located in Family Practice Clinics
- 19 FTE Allied Health to be located within the Hubs
- 3 FTE Clinical Pharmacists
- 3 FTE Indigenous Health Coordinators, hired by partnering agencies
- 7.8 FTE Nurse Practitioners (1.8 for Indigenous Partners)
- 4 FTE Family Physicians

SUMMARY OF SUPPORT OCT 2020-MARCH 2021

Allied Health Support:

- 2.0 FTE Social Work
- 1.8 FTE Registered Dietitians (3 people)
- 0.5 FTE Physiotherapist
- 3.0 FTE Indigenous Health Coordinators

Nursing Supports:

- 9.4 FTE RNs co-located in Family Practice (10 people)
- 2 RNs hired for Outreach Urban Health and Rutland Aurora Clinic
- 1.6 FTE RN Team Leads (2 people)

Family Practice Supports:

- 4.8 FTE Nurse Practitioners (1.0 in Family Practice Clinic, 0.8 Indigenous Support, 3.0 in IH sites)
- Creation of onboarding manual for Family Practice Clinics to prepare for Nurse Coordinator

CLINIC ENGAGEMENT: WHAT DIVISIONS HAS DONE TO DATE

- Change Managers have reached out to 85% of clinics across Central Okanagan through face to face meetings, emails, phone calls or Zoom meetings
- Creation of Readiness Assessment, assisting clinics to identify areas for support
- Visionary and Planning meetings scheduled prior to engaging in Interior Health Hiring process
- Structured meetings with MOAs and Office managers to prepare and coach staff on principles of PCN, provide role clarity and discuss TBC Billing
- Support for EMR training for new IH staff
- Coaching, mentorship, education/orientation for IH staff around fee for service structure and culture
- regularly provide update in DOFP monthly newsletter about PCN,

LEARNINGS

- Invest in office staff and culture. Involve MOAs, Office Manager up front
- Nominate a Physician Champion. This creates clear lines for communication, follow up and mentorship
- Provide a manual for clinics prior to RN hiring. "One Stop Shop"
- Hire Interior Health staff in cohorts. This leads to better learning and stronger teams
- Allow physicians an opportunity to network
- Don't Make Assumptions
  - RNs have little exposure to fee for service clinic
  - Physicians have little exposure to unionized process
  - IPCC RNs needed full PCN orientation

Relationships are always the key ingredient

LEARNINGS FROM NURSE COORDINATOR

- Acknowledge and appreciate the differences in workplace culture
- Acknowledge and appreciate the adjustment of a two models coming together (Private Fee for Service and Union Health Authority)
- Acknowledge and appreciate the adjustment of a collaborative management model
- The value and necessity of quality shadowing of all pertinent team members
- Explicit communication with schedule (Fill out calendar, notify immediately to physicians, MOA/office manager-of out of clinic time)
- To get to a high functioning team level -it takes time, specific phases, and initiative, humility
- Purposeful education for Nurse Coordinators is needed to understand allied health scope of practice-get to know them on personal level

PCN BILLING

Fee for Service

- For every patient assessed and procedure/service provided, physicians are required to submit their electronic billings to Teleplan.

Encounter Code Billing

- PCN nurses are required to submit billing codes (zero fee) to Teleplan in order to account for the services they provide to patients.

Team-based Care Billing

PCN NURSE COORDINATOR ENCOUNTER BILLING (SAMPLE)

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) (inludes oral polio vaccine, etc.)
38045	NIPCP CLIENT CONTACT FOR ADVERSE EVENT FOLLOWING IMMUNIZATION
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 - Liasing with community and hospital pharmacies in an effort to provide seemless care for a patient (ie coordinating refills, obtaining prescriptions, providing up to date information on the patient's current drug therapy, dispensing medic ation, obtaining approval for medications)
38064	NIPCP MEDICATION INFORMATION- Answering patient-specific medication information questions from health care professionals and patients (ie 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 (ie provision of drug information sheets, setting up weekly dosettes, setting up medication timers). **Claim must state start and end times**

COMPETENCY TRIANGLE

HELPFUL LINKS

- Central Okanagan Division of Family Practice
- Doctors of BC
- General Practice Services Committee
- PCN BC Planning and Implementation Guide
- PCN Tool Kit
- JCC Resource Catalogue
- Practice Support Program