PRIMARY CARE NETWORKS
Richmond

Primary Care Network Orientation Toolkit

for

All PCN Clinicians, Administrative & Change Management Staff

Version: 4
Date: January 14, 2021

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Purpose of PCN Orientation Toolkit

The Ministry of Health (MoH), Richmond Division of Family Physicians (RDFP) and Vancouver Coastal Health (VCH), in partnership, are working towards an integrated system of primary and community care through the establishment of three Primary Care Networks (PCNs) within the geographical area of Richmond. PCN clinicians, administration and change management staff will work with Richmond Family Physicians (FP) and Nurse Practitioners (NP) towards a model of integrated, team-based care for all Richmond residents with the goal of meeting the MoH PCN General Policy Directive of 8 core attributes of a PCN.

The PCN team, consists of primary care providers (FPs and NPs) and a variety of healthcare professionals (HP) including chronic disease management nurses, nurses, mental health counsellors, physiotherapists, occupational therapists, social workers and dieticians. Clinical pharmacists will be joining the team in the future. The PCN Team will respond and adapt to clinical needs identified by FPs and NPs and will function as a "wrap around" team supporting the clinical practice of the FP and NP.

This toolkit provides orientation to the Richmond Primary Care Network for all PCN clinical, administrative and change management staff and is meant to be used in conjunction with an orientation checklist and orientation manual from the respective employer as follows:

Position	Orientation Toolkit – All PCN Staff	Orientation Toolkit – FP/NP	RDFP Orientation Manual	VCH Orientation Manual	Relevant Checklist
PCN Manager	✓	✓	✓		Manager
Clinical Staff	✓			✓	Clinician
Admin Staff	✓		✓		Admin
Change Management Staff	✓		✓		Change M.
** PCN FP/NP		✓			FP/NP

** PCN FP/NP are independent contractors and are not considered "staff". In Richmond, they receive orientation to the PCN, team-based care and will meet the PCN team.

Definitions

In this toolkit, the following terms will have the following meanings:

a) **"Attachment"** means "net new" attachment of Richmond residents who are currently not attached to a Richmond primary care provider (FP or NP). Attachment is defined as an ongoing longitudinal relationship where the patient's provider (1 FP or 1 NP) provides most of their care. See section – Attachment for additional details.

b) **"Expression of Interest"** is an invitation by the PCN program for Practices, FPs or NPs to register their interest in participating in the PCN. The Expression of Interest describes the opportunity and seeks information from interested parties that demonstrate their ability to meet requirements.

c) **"Most Responsible Provider"** in primary care this refers to the physician, or nurse practitioner, who has overall responsibility for directing and coordinating the care and management of an individual patient.

d) **"Non-Governmental Organization (NGO)"** is any non-profit, voluntary citizens' group which is organized on a local, national or international level. NGOs provide a variety of services and humanitarian functions, bring citizen concerns to Governments, advocate and monitor policies and encourage political participation through provision of information.

e) **"Nurses & Nurse Practitioners of BC (NNPBC)"** is a not-for-profit society registered in BC. NNPBC advocates for healthy public policy, promotes excellence in nursing practice, increases nurses' contribution to shaping the health system, and influences decisions that affect nurses and the public they serve.

f) **"Primary Care Network FP"** or **"PCN FP"** is an independent General Practitioner or Family Physician contracted by VCH on behalf of the Richmond PCN.

g) **"Primary Care Network NP"** or **"PCN NP"** is an independent a Nurse Practitioner contracted by VCH on behalf of the Richmond PCN.

h) **"Practice"** means a solo FP or NP, or group of FPs or NPs, or any configuration of FPs and NPs, operating a clinic/practice.

i) **"Host Practice"** means a solo FP or group of FPs operating a clinic/practice that is hosting a PCN NP or PCN FP in their practice.

j) **"Primary Care Network Team"** or **"PCN Team"** includes PCN clinical staff, administrative and change management staff.

k) **"Patient Medical Home (PMH)** are optimizing medical practices where most a person's care needs can be met. PCNs are built on existing PMHs. Additional information for PMHs may be found at this link.

l) **"Team-Based Care"** has the meaning set out under section – Team Based Care.

m) **"FP" and "GP"** – in this toolkit FP and GP may be used interchangeably.

PCN Mission, Vision & Values

This work assists the PCN team in terms of planning and implementing and will be updated when PCN operations are fully in place.

Mission: To design and deliver an accessible and integrated system of primary care with Patient Medical Home as a foundation for the Richmond Community.

Vision: Transforming primary care for patients and providers, to ensure every interested Richmond resident can access longitudinal integrated team-based care in their Patient Medical Home.

Values:
1. Access for all
2. Culturally Safe and Appropriate Care
3. Locally Rooted

Primary Care Network - About

The MoH's policy objective is to establish Primary Care Networks (PCNs) to provide better access to quality healthcare services to all of BC's communities. PCNs are the next step to achieving an integrated system of primary and community healthcare for area residents. This section describes primary care, provides the evolution to PCNs and details of the Richmond PCN.

What is Primary Care?

Primary care is the day-to-day healthcare available in every local area and the first-place people go when they need health advice or treatment. The main purpose of primary care is to improve the health of the public by providing easy access to medical care to stay healthy, get better, and/or live with illness/disability. It also focuses on the whole individual rather than on the illness of a specific organ, system or disease.

Primary care (healthcare) is provided by a medical professional (such as a general practitioner, family practitioner, or nurse) with whom a patient has initial contact and by whom the patient my be referred to a specialist or specialty service.

What is a PCN?

PCNs are the next step in the evolution of continually developing and supporting the delivery of primary healthcare. The first and foundational step for PCNs involved Patient Medical Homes (PMHs). These were then followed by the Neighborhood Network strategy. The implementation of the PCN has leveraged these existing initiatives to continue the evolution of quality care for residents.

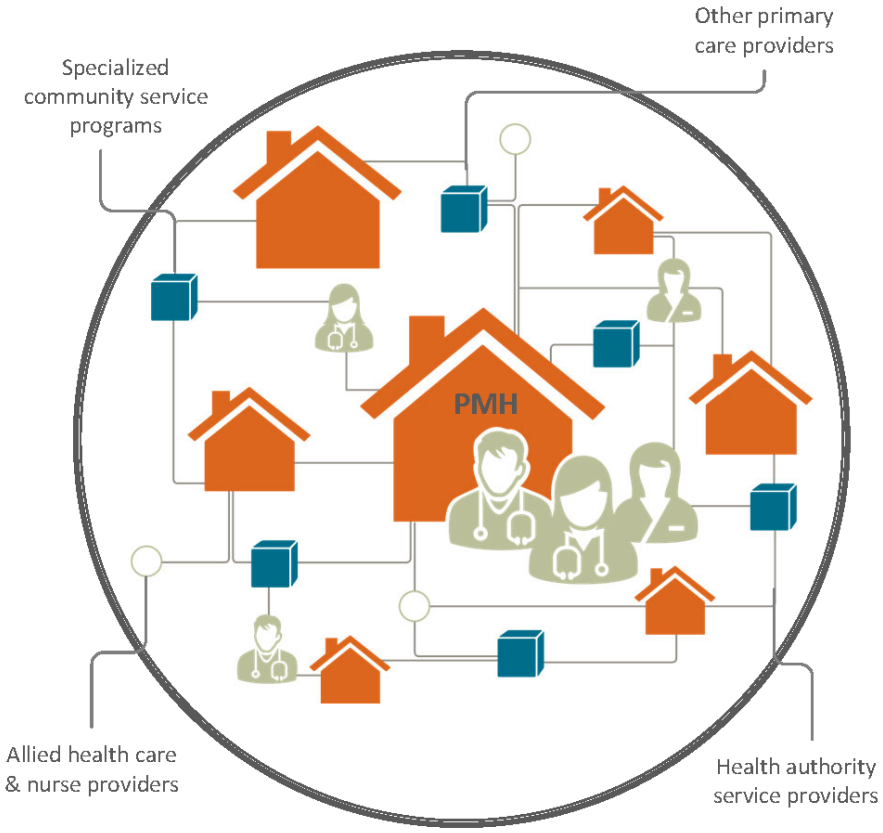
A PMH is a family practice that operates at an ideal level to provide longitudinal patient care.[1] It has twelve attributes defining how it can support patient care. With the key attributes of a PMH, FPs/NPs get more consistent support from teams, networks, and clinical services in the community and use data to inform decisions. PMHs also help FPs/NPs get relief from caring for patients alone, which can help avoid burnout, and make the most of Practice resources, time, and capacity. Becoming a PMH facilitates participation in a PCN.

Neighbourhood Networks are individual Patient Medical Homes (PMHs) linked together in RDFP-led collaborations where FPs share resources and better manage workload. Practices participating in Neighbourhood Networks either meet or are close to meeting the PMH attributes. They have already started to improve access through cross-coverage and call group arrangements, practice team-based care by hosting clinicians in family practice, and support patients to receive culturally competent and safe care.

A PCN is a clinical network of primary care providers in a geographic area where patients receive expanded, comprehensive care and improved access to primary care. PCNs include FPs, NPs, chronic disease nurses and allied health care providers in Neighbourhood Networks, Patient Medical Homes (PMH), First Nations communities, health authority services and community health services. Everyone works together as a team to provide all the primary care services for the local population. A helpful infographic that outlines the relationships between PCNs and PMHs and community-based practice may be found on the GPSC website.

[1] Patient Medical Homes, GPSC Website, https://gpscbc.ca/what-we-do/system-change/patient-medical-homes

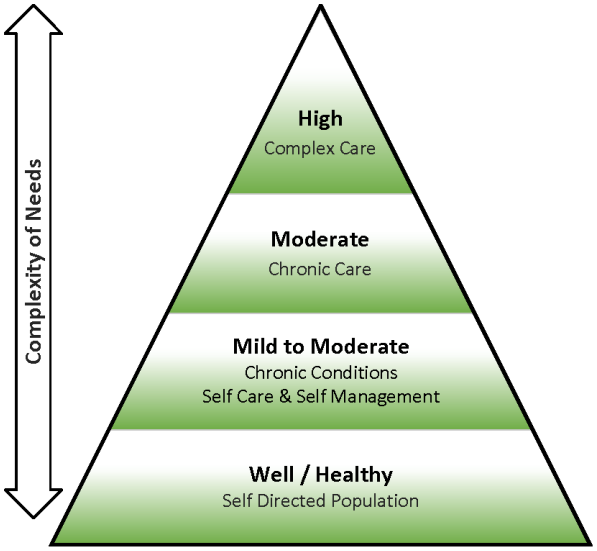
Primary Care Network



When participating in a Richmond PCN, FPs and NPs will be able to access integrated PCN team-based healthcare professionals (HP) and support staff including:
(Note: Clinical Pharmacists will be soon joining team.)

i. Chronic Disease Management Nurses
ii. Physiotherapists
iii. Occupational Therapists
iv. Social Workers
v. Dieticians
vi. Clinical Pharmacists (coming in near future)
vii. Rapid access to PCN Mental Health Counselling Service (up to 10 visits)
viii. Administrative staff for scheduling, attachment and other supports
ix. Change Management staff for coaching, technical support or patient panel management.

PCNs are focused on vulnerable patients with mild to moderate and moderate needs. The needs triangle below depicts where these patients fit on the complexity scale.



To align with the MoH's priorities as described in the MoH PCN General Policy Directive all PCNs must meet eight core attributes.

	Primary Care Network Core Attributes
1.	Process for ensuring all people in a community have access to quality primary care and are attached within a PCN.
2.	Provision of extended hours of care including early mornings, evenings and weekends.
3.	Provision of same day access for urgently needed care through the PCN or an Urgent Primary Care Centre.
4.	Access to advice and information virtually (e.g., online, text, e-mail) and face to face.
5.	Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.
6.	Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.
7.	Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.
8.	Care is culturally safe and appropriate.

PCNs in Richmond

Helpful information about the primary care landscape in Richmond:

- Richmond has a growing population, currently sitting at 224,889 (August 2019) with an annual increase of approximately 1.3%.
- Richmond has the highest concentration of immigrants of all municipalities in BC, measuring over 60% of all residents, with most immigrants coming from Asian countries.
- Richmond also has the fastest growing aging population in BC with approximately half the city's population experiencing a chronic disease.

- More than 95% of Richmond FPs belong to the RDFP - approximately 216 FP members. There are 99 FP practices (60 clinics) and 127 specialists in Richmond.
- In terms of geography, Richmond is an island community that contains both a high-density urban region and a wide-spread rural area. The BC Community Health Profile for Richmond contains additional information regarding the Richmond population.
- Richmond has a significant number of walk-in clinics and an Urgent Primary Care Clinic is in development for the community.
- Richmond Hospital offers 210 in-patient beds and there are 5 public long term care facilities offering 600 beds.

The Richmond PCN has been approved for a total of 70 new health care providers over the next four year. This includes new FPs and NPs developing practices in our community as well as the successful recruitment of clinical staff, administrative and change management staff.

There will be three PCNs in Richmond all linked and coordinated under a central PCN structure. The table provides 2018 population within each PCN and the second graphic illustrates the neighbourhoods as well as the number of unattached residents in each PCN region.

PCN	Geography	Population 2018
1 – West	Steveston, Seafair/Thompson, Blundell	81,290
2 – Centre	City Centre	59,595
3 – East	Broadmoor/Cambie/Bridgeport/Hamilton/Gilmore/Shellmont	79,905

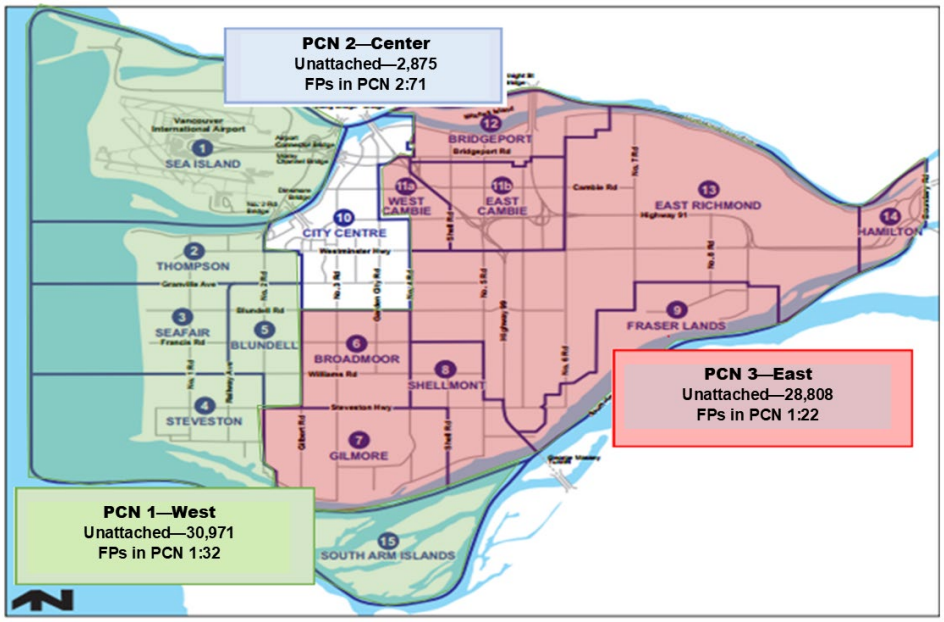


Diagram of three Richmond PCN areas (2018 Stats).

The Richmond PCN will meet the specific needs of the community, with some priorities being:

- Increased attachment for Richmond residents to an FP or NP.
- Enhanced co-ordination of primary and community services with a focus on improving care for seniors.

- Enhanced cultural safety and culturally appropriate care for Indigenous and immigrant residents; and
- Increased team-based resources to better meet the needs of people with mild to moderate chronic disease/conditions. These resources include health promotion services that respond to population health needs.

PCN Partnership - RDFP & VCH

The MoH, VCH and RDFP are the main partners in the Richmond PCN. The operational leadership and governance of the Richmond PCN is a partnership between VCH and the RDFP. It is built on the strength of mutual commitment and demonstrated history of successful partnerships in integrating primary care resources. The partnership has worked collaboratively to co-develop and co-plan the Richmond PCNs.

The PCN Steering Committee, consisting of membership from RDFP, VCH and First Nations Health Authority (FNHA), oversees PCN governance.

The PCN also partners with other community partners and agencies in supporting primary care and the residents of Richmond.

Richmond Division of Family Practice

The RDFP represents family physicians in Richmond, BC, providing a collective voice to influence health care delivery and policy with the aim of improving patient access to local primary care, and to work on member-driven projects that enhance both patient care and physician support.

Through the Division local physicians have an opportunity to work collaboratively with the Health Authority, the General Practice Services Committee (GPSC) and the MoH to identify health care needs in the local community and develop solutions to meet those needs.

Vancouver Coastal Health

VCH provides health care services through a network of hospitals, primary care clinics, community health centres and residential care homes.

VCH serves over 1.25 million people (that is nearly 25% of BC's population), including the residents of Vancouver, Richmond, the North Shore and Coast Garibaldi, Sea-to-Sky, Sunshine Coast, Powell River, Bella Bella and Bella Coola.

Other Community Partners

Additional community partnerships with the PCN include the City of Richmond, iCon (inter-Cultural Online Network), SUCCESS and others. Many of these partners are represented on the PCN Advisory Committee.

PCN Team

Team-based care is an essential element of the PCN, with two or more healthcare professionals working collaboratively to achieve care that is safe, effective, patient-centered, culturally sensitive and appropriate.

The Richmond PCN team is being recruited in phases and includes FPs, NPs, clinical and non-clinical staff to support the changes needed for a PCN.

Primary Care Providers

PCN contracted primary care providers, FPs and NPs, are being recruited via Expressions of Interest (EOI). These new PCN FPs and NPs will be located in host practices and as Most Responsible Provider (MRP), will be a vital part of the net new attachment goals for the PCN. They are responsible for meeting all requirements of their service contract.

Clinical PCN Staff

Other healthcare professionals (HPs) working with as part of team-based care include chronic disease management nurses, nurses, social workers, mental health counsellors, physiotherapists, occupational therapists and registered dietitians. Clinical pharmacists are part of future recruitment. The FP's or NP's patient panel will be utilized to determine patient populations that would benefit from seeing one of the PCN HPs. FP's and NP's may access the team through access forms (see section re Access). Currently, clinical staff chart patient encounters in the VCH Paris application and forward reports to FPs and NPs.

Who is on the team and what services can they provide?

Frail Seniors Team (FS Team): The FS Team consists of a variety of disciplines that work to keep seniors safely managing in their private residents. Each clinician, regardless of discipline, becomes primary contact with physicians/patient and will bring in other disciplines as appropriate (from either the FS Team or PCN clinicians).

Chronic Disease Management Nurse (CDMN): A CDMN is a registered nurse who specializes in the management of chronic diseases such as diabetes, heart failure, hypertension and weight management. CDMNs provide education and help develop self-management strategies that are unique to each individual.

Social Worker: A social worker assists individuals and families in addressing social determinants of health that may impact their health status. These factors may include finances, housing, and social supports. Social workers can assist with advanced care planning and make referrals to community programs (i.e., SUCCESS, CHIMO).

Mental Health Counsellor: Through the *PCN Counselling Service*, a mental health counsellor supports clients with anxiety, depression, relationship issues, and grief/loss for up to 10 visits. Through conversation, a counsellor introduces new perspectives and provides tools to cope with personal issues more effectively.

Occupational Therapist: An occupational therapist helps clients overcome challenges performing everyday activities (i.e., bathing, toileting, personal care, money, transportation, medication and meal management). Support can be provided through home environmental screens, adaptive strategies, energy conservation techniques, and stress management. Patient independence and safety is increased through the many areas of daily living that an occupational therapist covers.

Physiotherapist: A physiotherapist addresses any musculoskeletal (i.e., arthritis and musculoskeletal injuries) or neurological (i.e., stroke, Parkinsons, MS) conditions. Home exercise programs may be created to help clients maximize physical function. A physiotherapist can also teach falls prevention strategies and recommend appropriate gait aids. Clients may have up to 10 visits with the physiotherapist.

Dietitian: A dietitian provides nutrition assessments and consultations to improve eating habits, prevent/delay chronic conditions, and enhance your nutrition knowledge. A patient's unique nutrition needs, and goals can be met through ongoing support and guidance.

Clinical Pharmacist: (Future hire) A clinical pharmacist conducts medication assessments to ensure prescriptions are suitable for the patient's condition. Pharmacists can also provide advice regarding proper dosing and possible adverse reactions to medications.

Clinical Educator: A clinical educator will support the clinicians in their educational needs and work with the team in the development of clinical workflows and/or models of care.

Support PCN Staff

PCN support staff consist of PCN Manager(s) and Administrative Coordinators. They work with and support clinician team members in their patient care activities and in meeting the goals of the PCN. A brief description of each support team member is provided below.

PCN Manager: The PCN manager will oversee day-to-day operations of the PCN and PCN team. They will be the initial contact for PCN feedback from Practices and PCN staff. The PCN Manager will have assistance from Professional Practice Leads (VCH or MoH Regional supports) who will provide support for the respective healthcare professionals as this is outside the scope of the PCN Manager.

Admin Coordinator(s): The admin coordinator assists with coordinating and scheduling the resources within the PCN. This position also performs the day-to-day work of implementing the attachment mechanism, ensuring that residents in Richmond who are seeking a primary care provider have a point of contact after registering their interest, and are ultimately match with an available FP or NP.

Change Management PCN Staff

These team members support the PCN and Richmond practices. For FP/NP practices, they provide the structural, change management supports that enable them to become PMHs, which are the building blocks of functional PCNs. Leveraging readiness of partners and building change management strategies to build capacity in the primary care system as well as sustaining sustain new models of care. A brief description of each change management team member is provided below.

Community Developer: The community developer establishes partnerships and works closely with community agencies and NGOs to create opportunities to better support patient populations. He/she will conduct community needs assessments, as well as strengthen awareness and linkages between PCNs and community agencies/NGOs as it relates to health promotion/chronic disease prevention.

Innovation Coordinator (Quality Improvement Coordinator): The innovation (quality improvement) coordinator assists with continuous quality improvement activities which will lead to improved health care outcomes within the PCN. Some examples include working with practices to design, direct and oversee implementation of clinical quality improvements within practices; or supporting PCN team members in developing and implementing the necessary tools and quality care process changes to support "wrap-around" patient care.

Technical Support Coordinator: The technical support coordinator assists FP/NP practices, PCN clinicians and support staff in the usage of technology. Some examples include assisting practices in identifying and

adopting technological solutions that will support the practice in the delivery of patient care; supporting virtual care delivery; and assisting with training support and problem resolution.

Team Composition – PCN 1, 2, 3

Each of the Richmond PCNs will have an assigned team of clinical and support staff, for example an admin coordinator, CDMN, SW, etc. There are a few positions that only have one individual (e.g.: dietitian or Innovation Coordinator). These individuals will work across all three PCN's. A list detailing which team members are assigned to which PCN will be supplied with the orientation package.

Position	PCN 1 – West	PCN 2 – Centre	PCN 3 – East	Across ALL PCNs
PCN Manager				✓
Administrative Coordinator	✓	✓	✓	
CDM Nurse	✓	✓	✓	
Mental Health Counselor	✓	✓	✓	
Social Worker	✓	✓	✓	
Physiotherapist	✓	✓	✓	
Clinical Pharmacist	✓	✓	✓	
Frail Seniors Team	✓	✓	✓	
Occupational Therapist				✓
Dietician				✓
Innovation Coordinator				✓
Technical Support				✓
Community Developer				✓

Host Practices

FP practices that are hosting a PCN NP or FP are called "host practices". FP practices, either solo or group, may apply to host a PCN NP or FP by contacting the RDFP or answering an Expressions of Interest (EOI) on Health Match BC.

Becoming a PCN host practice involves a discussion between the Practice and PCN Operations Committee to review mutual expectations and responsibilities and to determine how best to support the PCN FP or NP. The PCN Steering Committee and host practice have a reciprocal partnership agreement.

Host practices interested in participating in the PCN initiative will partake in components such as the Provincial patient attachment initiative, utilize their EMR to participate in panel management activities and participate in reporting and PCN program evaluations. They may also work with the PCN team to conduct Plan, Do, Study, Act (PDSA) cycles together to identify optimal team-based workflows that support the PCN program in team-based patient care.

PCN FPs and NPs situated in a host practice will also work with the PCN Team. Part of their PCN orientation will be to meet with members of their PCN Team to understand how they may work together in a team-based manner.

Attachment

A priority of the PCN is increasing patient attachment for Richmond residents to a regular primary care provider. Unattached numbers as of 2018 are included in the table below. PCN2 – Center shows a negative number of unattached due to the high volume of walk-in clinics and the way data is collected by MoH (E.g.: patients will attend multiple walk-in clinics instead of receiving longitudinal care by an MRP).

PCN	Geography	Unattached 2018	Attachment Code
1 – West	Steveston, Seafair/Thompson, Blundell	30,971	97619
2 – Centre	City Centre	-2,875*	97620
3 – East	Broadmoor/Cambie/Bridgeport/Hamilton/Gilmore/Shellmont	28,808	97621

PCN contracted FPs and NPs will participate in the Provincial attachment program that is administered by the RDFP. Patient "net new" attachment for the Richmond PCN is defined as the attachment of a Richmond resident that is currently not attached to a Richmond primary care provider (FP or NP). Attachment is defined as an ongoing longitudinal relationship where the patient's provider (1 FP or 1 NP) provides most of their care. An attachment record is submitted for each newly attached patient. PCN FP/NPs will enter an attachment code in the patient's electronic medical record to indicate a new attachment.

PCN Encounter Coding

All PCN CDMNs are required to submit both attachment (as appropriate) and encounter records in the format approved for electronic submission through Teleplan. As of November 2020, the Paris system does not have the functionality to capture and submit codes to the MoH through Teleplan. Discussions are currently underway to determine alternative ways of capturing clinical work related to patients as required by the MoH.

Culturally Safe Care

Part of the PCN goals and values is providing culturally sensitive care. One way this is being accomplished includes ensuring culturally appropriate services are built into PCN policy and service design. The establishment of a multicultural and multidisciplinary team is another contributor. In addition, the PCN team is engaging and collaborating with patients, families and community partners to ensure the development and delivery of culturally safe care.

Our PCN team members, including contracted FPs and NPs will have access to cultural safety & competency courses and information for our diverse population, including Indigenous, Chinese, South Asian and seniors.

If you wish to learn more about courses and reading for culturally safe care include:

Indigenous Cultural Competency: PHSA Aboriginal Health (Online Course)	Register on the PHSA Learning Hub.
Indigenous Cultural Safety Workshop (VCH – In Person)	Registration information is to be determined.

Languages

The Richmond PCN has several clinical and non-clinical staff that speak several languages. Languages spoken include Cantonese, Mandarin, Punjabi, Hindi and Farsi. FPs and NPs can indicate a preferred language for their patient when accessing the PCN.

Team Based Care

To place the patient at the center of care, health care delivery requires interprofessional collaboration and coordination[2]. The PCN is a structure of interdisciplinary health care providers and support staff with team-based care as an essential attribute. Having a clear direction and vision for the team is the starting point for an effective interdisciplinary team (see Mission, Vision, Values section). Collaborative partnerships, role clarity among the team and engagement of patients, families and caregivers are also key components. Collaborative planning, continuous evaluation and quality improvement is fundamental to the success of the team.

Typically, team-based care is practiced with all team members being co-located at a single location. Due to space constraints within Richmond practices and the emergence of the COVID-19 pandemic, the PCN is delivering team-based care in a variety of ways. Recently, virtual care has been the prime method of care delivery, including telephone and video conferencing. As the pandemic situation improves PCN team members will be able to work in physician practices. They may also see patients at 8100 Granville Avenue, Garratt Wellness Centre or perform home visits, where possible. Personal Protective Equipment (PPE) will be utilized as appropriate to protect PCN team members and patients. The frequency of visits may vary depending on the patient needs identified at individual practices.

The Richmond PCN team is still evolving and while healthcare professional disciplines, role and scope have been identified, input from all team members will ensure the team is working at an optimal scope. Some things to consider include:

a) Appropriate use of practitioners and support staff
b) Communication that promotes effective team functioning
c) Role interdependence while respecting individual and overlapping scopes.
d) Patient voice, choice and representation
e) Appropriate care processes and management infrastructure
f) Team culture and atmosphere of trust.

Benefits of team-based care include:

a) Provide preventative care, disease management and counselling, and arrange for follow-up services in the community.
b) Increase support for patients with complex and/or chronic health conditions.
c) Work to team member's strengths, and support and rely on each other to give patients the best care.
d) Collectively increase a community's capacity to attach patients to a primary care provider.

Courses that address interprofessional practice including collaborative practice, communication, conflict management, collaborative leadership, role clarification, team functioning, and patient centered care are available on the PHSA Learning Hub, GPSC , and the Practice Support Program (PSP).

[2] MoH Interdisciplinary Team-Based Care Policy Direction (2017)

Communications & Engagement

To assist with engagement, communication materials have been developed or are in development. One-pagers will include:

- Description of PCN overall
- PCN Team-Based Care (for patients)
- PCN Team Scope
- PCN Individual Clinician Scope
- PCN Methods of Care Delivery

In addition, webinars for physicians will be utilized to help with education on PCN team scope, both clinician and non-clinician supports, as well as providing an opportunity to interact with questions about the PCN.

Information about the PCN may also be found on the RDFP website.

How to Access the PCN Team

In the future, the PCN clinical team will be an extension of the physician host practice and will not require an access request. During the implementation phases and with the COVID-19 pandemic, access/referral tools have been developed to request access to any of the PCN team members or services. For ease of use, it will be possible in the future to incorporate this simple tool into the physician EMR.

Methods of access to the PCN team include:

Access Method	Comments
1. PCN Team Access Request Form (Appendix A)	This form comes in printable or electronic form. It may be completed electronically and submitted by email from physician practices.
2. PCN Mental Health Services Referral Form (Appendix B)	This form is for the rapid access PCN Counselling Service. This form comes in printable or electronic form. It may be completed electronically and submitted by email from physician practices.
3. Contact main PCN office at: Email: rmdpcn@vch.ca Phone: 604-233-5686	

Reminder: This information is also available on the Pathways website.

Evaluation & Reporting

An extensive framework has been developed for PCN evaluation and quality improvements reporting. Information/metrics will be collected by/for the MoH for the following:

- Program Effectiveness
  - Achievement of the eight PCN attributes
  - Team-based care
  - Patient and provider experience
- Impact on health system and patient outcomes
- Quality improvement
  - Identify successes/best clinics that may be more widely adopted.
  - Identify populations that may need additional attention/resources.

In addition, PCN operational reports will be produced to monitor implementation progress, for example utilization data based on available capacity.

Plan, Study, Do, Act (PDSA) cycles will be utilized to facilitate improvements in a variety of processes including team-based care methodology.

PCN Policy and Procedure Manuals

Policy and procedure manuals, including standard operating procedures are currently being developed. To support the team and attain the goals of the PCN, all PCN Team members need to become familiar with these policies and procedures that describe the daily operation of the PCN. Reviewing and understanding this material will be a significant part of the orientation process.

Orientation Checklist

An orientation checklist pertaining to individual PCN team member positions will be provided and will guide new team members through the PCN orientation process.

Please review the orientation checklist carefully as it will contain additional orientation items not covered in this document.

Contact Information

Name	Contact Information
PCN Main Office	**Phone: 604-233-5686** **Email: rmdpcn@vch.ca**

Additional Resources

Following are links to resources that new PCN team members may find useful:

- Richmond Community Health Profile developed by Provincial Health Services Authority (PHSA)
- Richmond Division of Family Practice (RDFP) website.
- Vancouver Coastal Health (VCH) website.
- Primary Care Network Toolkit – PCN Planning and Implementation Guide with supporting documents. (GPSC/MoH/Doctors of BC).
- Pathways website.
- BC Community Health Profile Richmond
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Appendixes

Appendix A – PCN Team Access Request

Richmond Division of Family Practice
A GPSC initiative

PCN TEAM ACCESS REQUEST

vancouver coastal Health
Promoting wellness. Ensuring care.

During the COVID-19 pandemic, the Primary Care Network (PCN) team of allied health care professionals (HCP) is available to work with and support Richmond primary care physicians and their patients. PCN HCPs may help patients with chronic conditions, mental health issues, social and non-medical issues, musculoskeletal issues, activities of daily living, home based exercise, COVID-19 education and resource information or just reaching out to your vulnerable patients. All patient contact by PCN HCPs will be charted and submitted to physicians. For additional information on HCPs scope of patient management, please contact the PCN Main Office.

Primary Care Network Main Office Intake Options:

Telephone: (604) 233-5686
Fax: (604) 244-8599
Email: rmdpcn@vch.ca **Submit by Email**

Internal Use Only:
Date Received: _____
PCN HCP: _____ Paris ID: _____

Note: A Clinic Summary may be attached/sent in lieu of filling out this form.
Note: For PCN Counselling Services please use the PCN-Mental Health Services Referral Form.

PATIENT INFORMATION

Last Name: _____ First Name: _____

PHN: _____ DOB: _____ Gender: ◯ M ◯ F ◯ Transgender

Address: _____

Primary Phone: _____ Patient Speaks English: ◯ Yes ◯ No

If no English, Preferred Language: ☐ Cantonese ☐ Mandarin ☐ Punjabi ☐ Farsi ☐ Other_____

Alternate Contact (if applicable): _____ Phone Number: _____

Relationship: _____ Reason for Alternate: ☐ Language ☐ Cognitive Impairment ☐ Other_____

Does patient have an open ICBC or WCB claim? ◯ No ◯ Yes
Note: Referrals related to an ICBC or WCB claim are not eligible for this service.

PHYSICIAN INFORMATION

Name: _____ Email: _____

Phone: _____ Fax Number: _____ Communication Preferred by ◯ Fax ◯ Email

HEALTH CARE PROFESSIONAL(S) BEING REQUESTED

☐ CDM Nurse (referral criteria) ☐ Physiotherapist ☐ Occupational Therapist ☐ Social Worker ☐ Dietitian

☐ Mental Health Counselor (Note: For referrals to PCN Counseling Service please use the PCN-Mental Health Services Referral Form.)

REASON FOR ACCESS & HISTORY OF PRESENTING PROBLEM

Urgency of Access: ◯ within 1 week ◯ within 2 weeks ◯ over 2 weeks

RISK FACTORS/SAFETY CONCERNS (E.g.: high risk of falls, aggressive towards others)

The content of this fax/e-mail, including any files attached, is confidential and may be privileged. Any unauthorized copying or distribution is strictly prohibited. If you receive this email in error, please contact the sender immediately and delete this email.

Ref: Form—PCN Team Access Request V6.pdf (October 2020)

Appendix B – PCN Mental Health Services Referral Form

Richmond Division of Family Practice
A GPSC initiative

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Primary Care Network – Mental Health Services Referral Form #340 – 8100 Granville Ave, Richmond, BC, V6Y 3T6 **Tel:** (604) 233-5686 **Fax:** (604) 244-8599 **Submit by Email to:** RMDPCN@vch.ca	Internal Use Only Paris ID: _____ Date Received: _____ Notification of receipt Sent By: _____

Patient Information

Last name: _____ First name: _____ Initial(s):_____

PHN: _____ DOB: _____ Gender: _____

Address: _____

Primary Phone: _____ Is the client aware of this referral? ○ Yes ○ No

Does patient have open claim with ICBC or WBC? ○ No ○ Yes

Note: Referrals related to an ICBC or WBC claims are not eligible for this service.

Alternative Contact

Best person to contact if patient is not appropriate or available: _____

Phone Number: _____ Relationship: _____

Reason to contact alternative:

☐ Hospitalized ☐ Language: _____

☐ Need parental consent ☐ Cognitive Impairment ☐ Other: _____

Referring Physician Information

Name: _____

Phone Number:_____ Fax Number: _____

Reason for referral and History of presenting Problem:

(Medical or psychiatric diagnosis including of client is on extended leave; impairments, cognition, sleep and mood- as applicable. Please outline symptoms, severity, level of functioning and contributing factors)

_____

Urgency of Referral: ○ within 1 week ○ within 2-3 weeks

Optional: Assessment Completed Score:

☐ PHQ9: ____ ☐ BDI: ____ ☐ GAD: ____ ☐ Other: _____

Previous professional consultation (eg. : psychiatric): ○ Yes (attach reports) ○ No

Safety Concerns Significant Risk of harm to client ○ Yes ○ No

(includes self-harm, impulsive behaviours, using opiates alone, medically frail, risk of harm from others and suicide risk)

Significant Harm to others ○ Yes ○ No

(may include homicidal ideation, escalating violence towards others such as biting, hitting, physical altercations, etc.,)

Current medications:

Ref: Form - Mental Health Counselling Referral Form V3 - Fillable.pdf

Email Form