



Primary Care Network

Primer

Land Acknowledgment

The South Island Division of Family Practice acknowledges that we work on the traditional, ancestral, and unceded territories of the Pacheedaht, T'sou-ke, Scia'new, Songhees, Esquimalt, Tsawout, Tsartlip, Tseycum and Pauquachin First Nations, and home to the Métis and many diverse Indigenous communities.



What is the PCN?: A Primary Care Network Primer

What is the PCN?

A Primary Care Network (PCN) is a network of clinic providers working together to provide all the primary care services a population requires. Each family practice clinic within a PCN is a Patient Medical Home (PMH) that provides longitudinal patient care while meeting the ten PCN attributes listed below. The PCN is a partnership between Physicians/Divisions of Family Practice, Nurse Practitioners, First Nations Health Authority, Island Health, Indigenous Communities, family/caregivers and patient partners, and other community providers. The PCN supports patient attachment and addresses gaps in care for people living in that PCN community. This program is guided by a Service Plan approved by the BC Ministry of Health that includes expanded team-based care, with the addition of new health providers and services to support patients and local physicians.

Within each PCN, local partners work together to achieve the following ten core attributes:

- 1 Longitudinal Care:** Delivery of longitudinal primary care to everyone within a PCN via attachment to a primary care provider or enrollment to a clinic (where applicable).
- 2 Coordinated Care:** Coordination of primary care across all parts of the health system, including, for example, community service programs, specialist care, diagnostic services, emergency services, hospital care, facility-based care.
- 3 Timely Access:** Access to episodic or longitudinal primary care within 24 hours for urgent, non-life-threatening conditions, and within 7 days for non-urgent appointments.
- 4 Extended Hours:** Availability of extended clinic service hours for in-person primary care services during weekdays (5 pm to 8 pm), weekends (9 am to 5 pm) and statutory holidays (9 am to 5 pm); and access to virtual services after-hours.
- 5 Comprehensive Care:** Access to a full-range of comprehensive primary care services including clinical screening, diagnostic testing and treatment provided through different clinical settings (e.g., community-based clinics, virtual care services, mobile outreach, long-term care facilities, in-patient care facilities).
- 6 Team-Based Care:** Intentional commitment to health care practitioners from different professional backgrounds (e.g., physicians, nurse practitioners, nurses, allied health providers, traditional wellness providers and administrative staff) working together as integrated primary care teams within clinics and across the network.
- 7 Population Health Promotion:** Commitment to improving population health outcomes at a community level through collaboration in primary care and with other sectors.
- 8 Digital Enablement:** Support innovation and improvements in care, and in particular, information continuity across care settings and team members, through the adoption of provincially/regionally endorsed digital technology solutions.
- 9 Culturally Safe Care:** Commitment to truth, reconciliation, and humility, ensuring provision of care that is culturally safe, addresses and eliminates racism and discrimination, and respects the dignity, well-being, and unique health care needs of Indigenous Peoples.
- 10 Equitable Access:** Removal of systemic barriers to ensure everyone is supported in achieving good health and wellbeing, regardless of age, ability, socio-economic status, ethnicity, gender, sexuality, or geographic location.

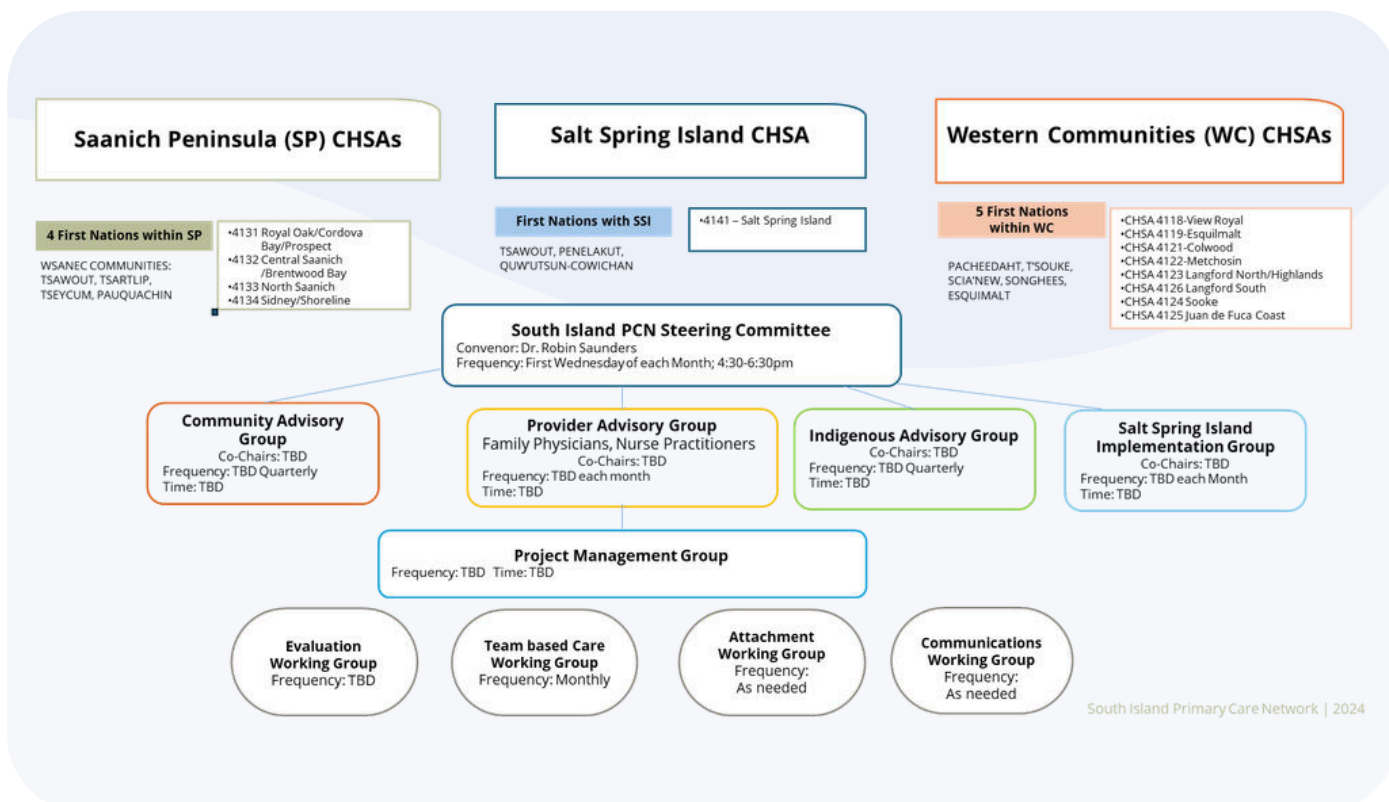
The South Island PCN

In 2018, the South Island Division of Family Practice (SIDFP), Island Health and the First Nations Health Authority (FNHA) partnered to submit a PCN Service Plan to the Ministry of Health (MoH) for Western Communities (WC) and the Saanich Peninsula (SP) to implement a PCN in each community. These plans were approved and funded in April 2020, though the Ministry did not approve all requested resources, making the South Island underfunded compared to newer PCNs.

The South Island contains four PCN Neighbourhoods: two in Western Communities, one in Saanich Peninsula, and as of 2024, Salt Spring Island. The South Island PCN is overseen by the Steering Committee with backbone support provided by the South Island Division of Family Practice. The Steering Committee, chaired by an appointed Family Physician, is responsible for managing the implementation and operations of the PCN program including allocation approvals to clinics. When a proposal is outside the original PCN Service Plan, the Steering Committee needs to approve the request before submitting to the MoH for funding consideration. The Steering Committee meets monthly and is comprised of members of the SIDFP, Family Physicians, Island Health and an Indigenous Partner. Each clinic lead within the PCN is a part of decision making.

The W'SANEC Health Director group and the Indigenous Collaborative (WCs) provide direction on the Indigenous wellness resources. The purpose of the collaborative groups is to provide the expertise and direction on Indigenous engagement, Indigenous resources, and Indigenous cultural safety within the South Island PCN. The Indigenous Collaborative makes decisions and updates the South Island PCN Steering Committee and the Victoria PCN Steering Committee to ensure collaborative planning and service coordination for all Indigenous, Metis, Inuit and urban Indigenous Peoples south of the Malahat and on Salt Spring Island.

South Island PCN Governance Structure



What Resources are Available within the PCN?

The approved Service Plans expect each PCN to meet the attributes of the PCN and to close the attachment gap in their geographical area. Western Communities’ attachment gap was 36,475 and Saanich Peninsula’s was 14,300. Salt Spring Island’s attachment gap is 3,411 with a population of 13,174. To date 19,047 patients have attached in Western Communities and 7,009 patients attached in the Saanich Peninsula; however, the attachment gaps remain as new people move into the area and FPs retire or leave practice. MoH does not track patient detachments.

To help with attachment, access and support team-based care models, a set number of resources were allocated to each PCN including:

Resource	WC PCN	SP PCN	SSI PCN*	Total
New to Practice Family Physician (NTP FP) Contracts	14.5	14.8	-	29.3
PCN FP Contracts	5.0	1.0	-	6.0
Nurse Practitioner (NP) Contracts	10.0	4.0	-	14.0
Registered Nurses	13.5	13.8	-	27.3
Social Workers	5.5	4.0	-	9.5
Mental Health & Substance Use Consultants (MHSU)	3.5	4.0	-	7.5
Pharmacist	1.0	1.0	-	2.0
TOTAL	53.0	42.6	-	95.6

*Salt Spring Island PCN's Service Plan was approved in late 2024; planning is underway.

The FP and NP Contracts are administered through the Medical Affairs Department of Island Health. Nurses and Allied Health resources are hired through Island Health. Each PCN has a Pharmacist supporting clinics; however, the two Pharmacists have reached capacity and not all clinics can access this resource currently. A strategy is under development to address this gap.

How are Clinics Supported in the PCN?

To support the implementation of team-based care, the PCN has three Project Leads. These Leads work directly with clinics to successfully integrate staff resources, facilitate collaboration among the partners, and elevate issues as needed. They also support clinics to achieve their attachment targets and help troubleshoot any barriers.

The PCN Project Leads host a clinic leads' meeting quarterly, prepare onboarding tools and develop workflows with clinics. The Project Leads are available to assist in all areas of a practice: to consult, train, onboard, and refer clinics to the best resources. The team relies on the expertise and support of the SIDFP In-Practice Services Lead to support integration. This support includes training opportunities for clinic office staff.

The PCN team's Project Lead tracks the PCN workplan and takes on projects as guided by the PCN governance. Attachment Coordinators support clinics in the attachment process. A part-time Communications Lead prepares newsletters, updates the website and develops communication strategies for the PCN. Reichert and Associates completes external evaluation of the PCN Program as part of ongoing quality improvement work.

What are the Benefits of the PCN?

Being part of a network requires clinical leaders to support meeting the PMH attributes and working together to achieve them. The networks also share lessons and supports across clinics: for example, sharing workflows for integrating a nurse into practice or working together to determine how after-hours coverage and perinatal care will be provided in a community. The After-Hours Care Program is intended to assist with this coverage, for example.

Integrating clinical resources helps to enhance time with patients and increase access for appointments. The clinic does not pay the salary of the clinician and the clinic is provided with some overhead for the clinician in their practice.

What are the Expectations of the PCN?

Each PCN is required to close the attachment gap. Each PCN clinic must use a \$0 fee attachment code for every new patient attachment. This code helps the PCN track progress in attachment. Each NTP FP Contract implemented is expected to attach 1,250 patients in two years and each NP contract is expected to attach 1,000 patients in three years. If a clinic integrates a Nurse into their team-based care model, the clinic is expected to attach an additional 500 patients over a three-year period.

To date 19,047 patients have attached in Western Communities and 7,009 patients attached in the Saanich Peninsula; however, the attachment gaps remain as new people move into the area and FPs retire or leave practice. MoH does not track patient detachments. Salt Spring Island

Patient Attachment

The PCN uses the Health Connect Registry to attach new patients, a provincial platform operated by Healthlink BC for patients to register for a Family Physician or Nurse Practitioner. The PCN Attachment Coordinator works with clinics who have availability to attach new patients and pulls patients from the registry for the clinic. The centralized registry means that clinics no longer need to hold and maintain a waitlist, freeing up administration time for clinic staff. The Attachment Coordinator works with each PCN clinic to merge their existing waitlists with the Registry. The MoH and DoBC will provide more specific information on the new provincial patient attachment management system, and expectations for PCN participation.

Who is Part of the PCN? - Membership

All Patient Medical Homes within the Western, Saanich Peninsula and Salt Spring Island communities of the SIDFP are members of the PCN at a basic level, giving every clinic access to the Urban Locum Program, Group Contracts, etc.

Criteria for basic membership is to be a member of the SIDFP. If a Patient Medical Home accesses PCN clinical resources they become active members in the PCN, and have access to more resources, such as eligibility for the Minor Tenancy Improvement Grant. The South Island PCN includes 17 clinics in their 5th year of service plan implementation.

Membership Benefits

- Free access to Up-to-date subscription
- Discounted subscription for RxFiles
- Member-only pricing when purchasing a vehicle from the Carson Auto Group
- Support your community through our Real Estate Partnership Program
- Access to Pathways – a one-stop online directory to stay informed about providers and clinics in your area, confirm specialist wait times, and access referral processes
- Connect with colleagues at social events and receive complimentary continuing medical education events with Mainpro+ accreditation
- Access to business and practice supports
- Locum coverage through the Urban Locum Program and advertisements on our website
- Retirement planning support
- Invitations to participate in health care initiatives, such as long-term care and perinatal care
- The Wellness Hub, designed to support the mental health and well-being of family physicians

What Work is Underway to Meet the Ten PCN Core Attributes?

Attribute	Work Underway
1 Longitudinal Care: Delivery of longitudinal primary care to everyone within a PCN via attachment to a primary care provider or enrollment to a clinic (where applicable).	• Adding clinical resources provided through the Service Plan – see below. Sharing lessons and workflows to support clinics. • Implemented the Health Connect Registry (HCR) and working with clinics to use the HCR. Also created a priority referral process as part of the HCR to meet the needs of vulnerable patients.
2 Coordinated Care: Coordination of primary care across all parts of the health system, including, for example, community service programs, specialist care, diagnostic services, emergency services, hospital care, facility-based care.	
3 Timely Access: Access to episodic or longitudinal primary care within 24 hours for urgent, non-life-threatening conditions, and within 7 days for non-urgent appointments.	• The After Hours Care Pilot is moving to implementation and will help support patients in the evenings and weekends
4 Extended Hours: Availability of extended clinic service hours for in-person primary care services during weekdays (5 pm to 8 pm), weekends (9 am to 5 pm) and statutory holidays (9 am to 5 pm); and access to virtual services after-hours.	• Walk in Clinic Stabilization resources have been provided; UPCCs have been developed and one is being planned in Sooke. Planning for the Peninsula area is still needed. • Virtual care options have emerged through the pandemic.
5 Comprehensive Care: Access to a full-range of <u>comprehensive primary care services</u> including clinical screening, diagnostic testing and treatment provided through different clinical settings (e.g., community-based clinics, virtual care services, mobile outreach, long-term care facilities, in-patient care facilities).	• The Divisions on the island, FNHA and Island Health are currently working on a MHSU Task Force to develop an inventory of MHSU services at Island Health and NGO then completing a gap analysis. A Shared Care Perinatal Project is being led by the Victoria and South Island Divisions and will be integrated with the PCN.

What Work is Underway to Meet the Ten PCN Core Attributes?

Attribute	Work Underway
6 Team-Based Care: Intentional commitment to health care practitioners from different professional backgrounds (e.g., physicians, nurse practitioners, nurses, allied health providers, traditional wellness providers and administrative staff) working together as integrated primary care teams within clinics and across the network.	• Further Service mapping is needed.
7 Population Health Promotion: Commitment to improving population health outcomes at a community level through collaboration in primary care and with other sectors.	• Further Service mapping is needed.
8 Digital Enablement: Support innovation and improvements in care, and in particular, information continuity across care settings and team members, through the adoption of provincially/regionally endorsed digital technology solutions.	• Website to be updated and guidance resources to be developed.
9 Culturally Safe Care: Commitment to truth, reconciliation, and humility, ensuring provision of care that is culturally safe, addresses and eliminates racism and discrimination, and respects the dignity, well-being, and unique health care needs of Indigenous Peoples.	• Cultural Safety Contract under discussion to develop a strategy and onboard a Cultural Safety lead. Implementation throughout the PCN will follow.
10 Equitable Access: Removal of systemic barriers to ensure everyone is supported in achieving good health and wellbeing, regardless of age, ability, socio-economic status, ethnicity, gender, sexuality, or geographic location.	

How are Resources Allocated?

Clinics interested in accessing an NTP FP contract can contact Island Health Medical Affairs or their PCN Change Lead to start the contract process. If a clinic recruits an NP, they notify their PCN Change Lead to start the approval process at the Operations Committee and to request funding from the MoH as there are no more NP contracts available from the original service plans.

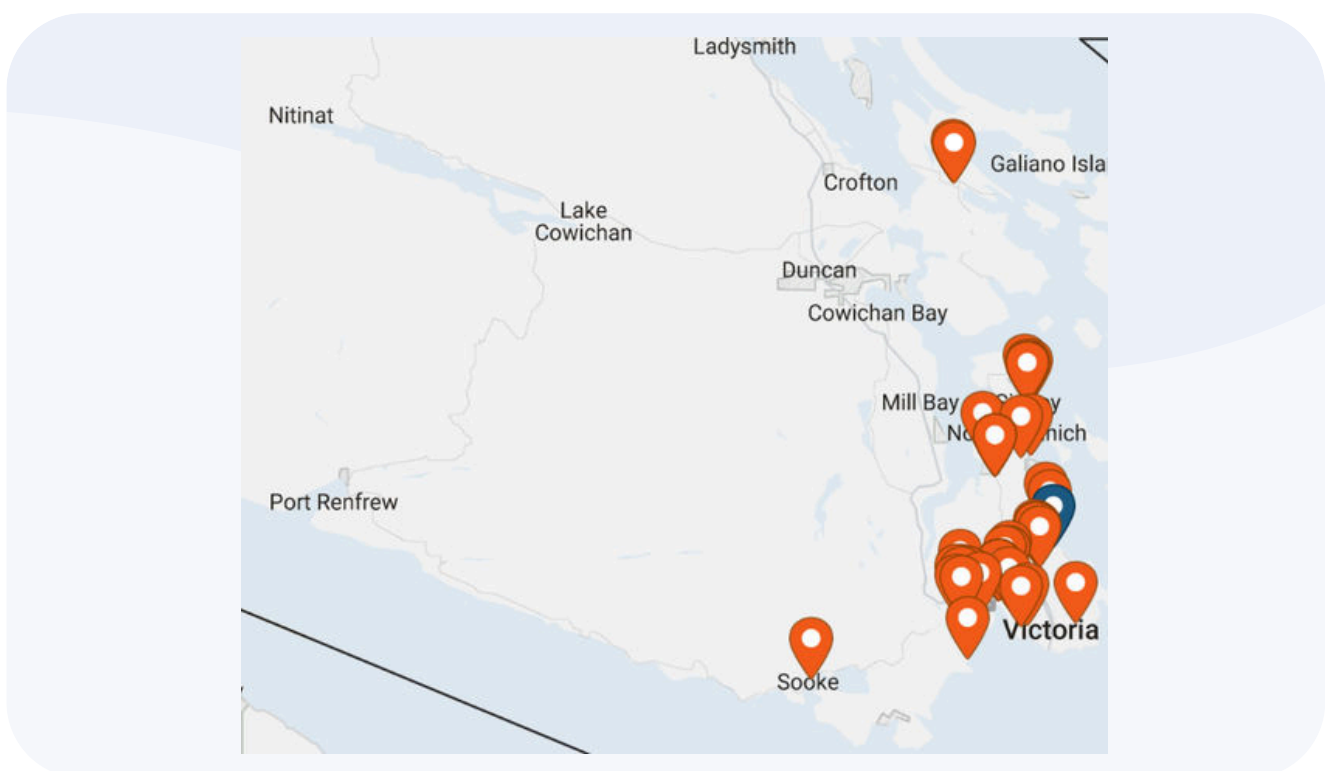
The PCN Team sends out an Expressions of Interest email with a template for clinic leads to complete if they are interested in accessing clinical resources, such as Nursing, Allied Health and Pharmacy. These resources were approved for funding from the Service Plan. As we are in the fourth year of PCN implementation, remaining resources are limited unless a clinic decides to release their resource for reallocation.

Clinics integrating clinical resources into their practice will work with Island Health to hire, onboard and train clinicians. Clinicians document in the EMR and clinics need to sign a Team Charting Agreement. Clinic leads will work with the Island Health Operational Manager to ensure the clinician works in a safe environment, is supported in their role and is helped to solve issues. Encounter reporting will be set up in the EMRs. The PCN Change Leads are available to support clinics in the onboarding process.

Which Clinics are Active in the PCN?

The South Island has a growing number of clinics active in the PCN, including perinatal, Indigenous Communities, Walk-In Clinics (WICs), Urgent Primary Care Centres (UPCCs), Community Health Centres and a High Complexity Care Team (HCCT). The PCN clinics either have, or are in the process of having, RNs and/or Allied Health consultants as part of their healthcare team, depending on the specific needs of each clinic.

South Island PCN Clinics



Western Communities Clinics and Allocated Resources

St. Anthony's	West Coast Family Medical & WIC	Eagle Creek	Wheelhouse	HCCT	Grow Health
• 3.0 NPs • 1 RN • 1 SW	• 4 NTP FP • 1NP • 3 RNs • 1.5 MHSU	• 4 NTP FP • 2 NPs • 1 RN • 0.5 SW	• 1 RN • 0.7 SW	• 1.5 FP • 1 NP • 1 RN • 0.5 SW	2.5 NTP FP 1 NP 1 RN 0.5 MHSU 0.25 SW
Esquimalt Medical & WIC	Keeler/Young/McClurg/Miller	View Royal Maternity	Westwind	Roundhouse Midwives	Pacheedaht
• 1 NTP FP • 0.5 RN • 0.25 SW	• 1 NTP FP • 0.5 MSHU	• 1 NP • 0.25 SW	• 2 NTP FP • 0.5 MHSU	• 1 NP	• 0.5 SW

Saanich Peninsula Clinics and Allocated Resources

All clinics are accessing, or are in the process of accessing, 3 SW and 3 MHSU Clinicians.

Shoreline Sidney	Shoreline Brentwood	<u>WSÁNEĆ</u>	PHU NP	Three Cedars
• 3.8 NTP FP • 2 RN	• 1.8 NTP FP • 1 NP • 1 RN	• 1 FP • 1 NP • 1 RN • 1 Physio	• 1 NP • 1 RN	• 3 NTP FP • 1 RN
Marigold	West Saanich Medical & WIC	Cordova Bay	Ocean Pier	Arbutus
• 0.7 NTP FP • 2 RN	• 1.8 RN allocated	• 1.5 NTP FP • 1 NP • 1 RN	• 1 NTP FP	• 3 NTP FP

Learn More



www.southislanddivision.ca



pcnadmin@sidgep.com



250-658-3303