PCN Refresh – Q&A

Contents

January 25, 2024

PCN Steering Committee (SC) Terms of Reference (ToR)

Is there a date by which PCN Refresh changes must be implemented? Is the PCN Steering Committee Terms of Reference mandatory?

- By April 1, 2024, PCNs must submit a new PCN SC ToR and membership list to pcn@doctorsofbc.ca.
- PCNs do not have to use the provided PCN SC ToR template, however the sections noted as 'required' in the template must be included in every PCN SC ToR.
- FPSC will create a repository of PCN SC ToRs (with confidential information removed), which will be visible to and shared with all PCNs to enable learning.
- The Community Advisory Group (CAG) Terms of Reference must be submitted when divisions apply for PCN Governance Support Funding Gate 2 in FY 2024/25; while there are specific required sections, the CAG ToR template is available as a guide. PCNs may utilize another template as long as the required sections are included.

Do current PCN Steering Committees need to plan for dissolution and full restructuring? If the status quo is working well (i.e., co-chair or tri-chair model), are changes still required? For communities with multiple PCNs, does the Steering Committee sit at the community or PCN level?

- It is up to the physician convener, appointed by the division of family practice, to determine how to bring the partners together in a way that ensures the requirements in the PCN SC ToR template are reflected in the PCN SC membership. This may be re-convening the PCN SC as is; however, the PCN SC will still be required to submit the ToR and membership list by April 1, 2024.
- As outlined in the ToR, the PCN SC needs to be representative of the clinics delivering primary care within the community (i.e., the geography of the PCN) and all members must be located within the PCN geography.
- Additionally, regions with more than one PCN should refer to their Service Plan and the expectations outlined in their annual PCN Funding Packages to determine the best approach for their PCN SC.
- The FPSC Primary Care Transformation Partners and Ministry of Health's Planning, Implementation, and Oversight (PIO) Regional Directors and are available to provide support, including attending meetings and providing advice. Additionally, as noted in the PCN SC ToR template, the Ministry PIO Regional Director and FPSC Primary Care Transformation Partner will be invited to the PCN SC as ex officio members.

How do communities move forward with these changes if there are conflicts between the partners of the PCN Steering Committee (i.e., division, health authority, First Nations communities)?

- If there are tensions between PCN partners that cannot be resolved locally, please connect with your FPSC Primary Care Transformation Partner and Ministry PIO Regional Director.
- Subsequently, if needed, the PCN can initiate the issues escalation process, as outlined in section 11 of the PCN SC ToR template.

What types of decisions are the PCN Steering Committees expected to make?

- As stated in the ToR, the PCN SC provides leadership for the PCN and is responsible for understanding, refining and overseeing the implementation of the PCN Service Plan for their area and working towards the PCN Core Attributes.
- Specific functions of the PCN SC include analyzing PCN issues and opportunities, setting goals, communicating expectations, evaluating, and measuring impact, and holding entities and institutions accountable.

Does the new governance approach include a performance management plan?

- Yes, the Ministry and FPSC will develop a performance measurement framework in consultation with PCN partners for PCN SCs to use in their evaluations.

How are regional health authorities represented at the PCN Steering Committee?

For example, the sample membership table included in the template has one seat for the regional health authority; however, many PCN Steering Committees have representation from other regional health authority leaders, including, for example, Specialized Community Services Programs (SCSPs), mental health and substance use (MHSU) and public health.

- The sample included in the PCN SC ToR template is an example and may not represent the specific membership of your PCN SC.
- As outlined in the template, the PCN SC membership is meant to be representative of those delivering primary care within the PCN geography.
- Generally, family doctors in clinics deliver the majority of primary care in communities. However, in some communities there might be other models of care, such as nurse practitioner clinics, health authority clinics, community health centres (CHCs) or Foundry Centres, and they might be represented on the PCN SC.
- Collaborative Services Committees (CSCs) are the table for collaboration and integration of primary care and specialized community services.

What is the difference between a Collaborative Services Committee (CSC) and a PCN Steering Committee (PCN SC?

- CSCs serve as the point of integration and collaboration between primary care and the broader health care system, including SCSPs, MHSU programs and other health authority services.
- The CSC:
    - establishes a partnered space where PCN and health authority services come together;
    - coordinates and plans how health authority services, including SCSPs and secondary/tertiary programs, can best support primary and community care; and
    - discusses how the community can come together to support challenges in acute or facility-based care settings.
- Family physicians, supported by the divisions of family practice, will convene PCN SCs, which will organize primary care in communities. The physician will lead and bring together physicians, nurse practitioners, health authority partners and community partners to collaboratively design local primary health care services that meet the needs of the population within the PCN geography.
- Local First Nations, Inuit and Métis partners will continue to be important partners and will instruct on how they would like to be involved and represented on PCN SCs.

- The PCN SC:
    - directs the assignment of PCN primary care clinical staff to support the development of effective teams;
    - coordinates the network of clinics in alignment with PCN attributes;
    - makes decisions by consensus; and
    - purposefully and regularly meets with local patient, caregiver and community representatives (via the Community Advisory Group) to ensure their voices inform the work being done by the PCN(s).
- There is no formal reporting relationship from PCN SCs to CSCs.
- Further information on CSCs and SCSPs is expected from the Ministry in the coming weeks.

Empowering Physician Leadership

Why are physicians being given the lead role as a part of the PCN refresh?

- In BC, family doctors deliver the majority of primary care services. To be successful, PCNs need strong physician leadership and robust community connections.
- The Ministry and Doctors of BC have collaborated with FPSC and a partner-led transition working group to reframe governance for PCNs, which included the determination that physicians are provided with a stronger leadership role.

In the new PCN Steering Committee structure, is the physician convener a voting member?

- As outlined in the PCN SC ToR template, PCN SCs make decisions by consensus *or* consent. The physician convenor has the same status as other PCN SC members.

The role of the convener is a significant one. Can this be a shared role, amongst two or three physicians, in order to preserve a balance with their practices? What happens if no physicians want to assume the PCN leadership role?

- Divisions and their appointed physician convenor have the flexibility to determine the optimal functioning of the PCN SC with their community partners and their physician leadership, within the parameters of the PCN SC ToR.
- If no physicians want to assume the PCN leadership role please reach out to your FPSC Primary Care Transformation Partner. Physician leadership and empowerment are core aspects of the PCN Refresh and are essential for PCNs to function optimally.

Community Advisory Group (CAG)

What do you see as the role or mandate for community members on the PCN Steering Committee?

- As noted in the PCN SC ToR template, the role of community representatives is to provide both an inward focus to the PCN agenda by planning to meet community needs and an outward focus to community to ensure voice, choice and representation through the CAG representatives at the PCN SC.
- These members will represent the views of the CAG and understand the purpose and function of the PCN SC.

- The goal of the CAG generally is to receive input and advice from key sectors of the community, or to ascertain a better understanding of key issues, challenges, or initiatives that impact the communities within the PCN geography.

Instead of creating a Community Advisory Group, can PCN Steering Committees leverage existing group(s)?

- Yes, PCN SCs can leverage existing groups. This would include asking these groups for input into PCN priorities and strategies and requesting nominations for two representatives to join the PCN SC as per the PCN SC ToR template.
- PCN SCs that are leveraging existing community and patient groups (instead of creating a Community Advisory Group) must submit a document outlining the groups they are engaging with and how they are engaging.

Will there be financial support for recruitment, engagement, and coordination of the Community Advisory Group?

- Yes, PCNs can utilize the Ministry PCN Governance Funding ($40,000 per PCN, annually). Divisions in PCN implementation may also choose to utilize the new FPSC PCN Governance Support funding, as per the FPSC funding guidelines.

Engagement with First Nations

What supports and funding will be available for Indigenous engagement?

- PCNs can use the Ministry PCN Governance Funding ($40,000 per PCN, annually) and Change Management Funding to support Indigenous engagement. Divisions in PCN implementation may also choose to utilize the new FPSC PCN Governance Support funding, as per the FPSC funding guidelines.

How can we ensure Indigenous engagement happens not just at the Band or Nation level, but also includes community engagement?

- The new PCN governance structure reaffirms the central role of First Nations, Inuit and Métis partners in the design and delivery of primary care services, aligning with the core principles established in the 2012 Health Partnership Accord.
- All PCN SCs must prioritize genuine partnerships with Indigenous communities, adhering to the principles of the 2012 Health Partnership Accord. More information is available on the PCN Toolkit.

If a PCN already has a relationship with the local First Nation(s), is there still a mandate to work with FNHA?

- FNHA is available where capacity challenges prevent local First Nations communities from engaging in the PCN.
- If a PCN has a working relationship with the local First Nations, FNHA may still be engaged as part of the PCN SC if they provide primary care services in the geography.

Will cultural safety and Indigenous wellness funds continue? Will local First Nations be able to hire their resources directly?

- Funding for Indigenous wellness providers (e.g., Traditional Healers, Elders, etc.) as approved in PCN Funding Packages will continue.
- The Ministry will continue to flow funds for Indigenous wellness providers to regional health authorities or the First Nations Health Authority (FNHA). Subsequently, regional health authorities or FNHA can flow the funds to the local Nation to enable hiring.

Strengthening Team-Based Care

Do existing PCN clinical resource allocations remain as standing? Will clinics need to re-submit requests to PCN Steering Committees?

- The current clinical resource allocations outlined in PCN Funding Packages will not change and requests do not need to be resubmitted.
- The PCN SC has the ability to pivot or reorient their resources within their approved envelop and can work with Ministry PIO Regional Directors/Managers to discuss any questions or clarifications to redirect resources where required.

For allied health providers the health authority is still the employer while the clinic directs the work. If challenges arise, how will they be navigated?

- Collaboration is key to PCN success. If challenges arise, please first reach out to your PCN Manager for support. If the challenge cannot be resolved within the PCN, please reach out to your Ministry PIO Regional Director and FPSC Primary Care Transformation Partner.

Where will PCNs secure the space needed for team-based care?

- Space is a challenge in all regions and PCNs are working creatively with health authority, municipal, non-profit and other partners to address the space challenges in their communities. Please engage with your Ministry PIO Regional Director to discuss PCN space requests.
- Additionally, FPSC continues to provide minor tenant improvement funding to support renovations that enable team-based care.

Will requests from individual clinics/providers, First Nations communities, and/or partner organizations for PCN funding/resources be redirected back to the PCN Steering Committee?

- Yes, all requests will be redirected back to PCN SCs.
- PCNs should not direct individual clinics/providers, First Nations communities or partner organizations to the Ministry for PCN funding or resources.
- PCN SCs allocate resources to priority initiatives and strategies within their geography, as per PCN Service Plan approvals.

What are the growth plans for existing PCNs? Is there PCN expansion funding available?

- Since the initial service plan process, the Ministry and FPSC have expanded and enhanced planning, programming, funding and resources for communities in areas such as:
    - access to New to Practice FP contracts
    - access to NP contracts
    - Longitudinal Family Physician (LFP) Payment Model

  - Nurse in Practice Program
  - Provincial Attachment System (Health Connect Registry, Clinic and Provider Registry, and Panel Registry)
  - FPSC Attachment Mechanism funding for Attachment Coordinators
  - FPSC PCN Governance Support funding
- All these resource investments enabled effective delivery of primary care in communities.

How do Foundry Centres fit into PCNs under the refreshed governance model? Will additional resources be made available for Foundry via the PCN?

- Foundry Centres are one of the models of care funded by government and, therefore, are recognized as a primary care clinic under the PCN Service Plan. It is expected that PCNs are engaged with all community primary care clinic partners, including Foundry Centres.
- PCN funding is available to support all primary care clinics within the PCN geography. The Ministry has approved Foundry family physician hires for Foundry Centres within PCNs in implementation and planning.

Nursing

Can clinics still have health authority-hired nurses if they choose?

- Yes, health authority-hired nurses are still available.

Do changes to the BC Nursing Union's collective agreement mean that family physicians and nurse practitioners can no longer participate in hiring interviews for registered nurses and that hiring will now be purely seniority based?

- In 2019, Health Employers Association of British Columbia (HEABC) negotiated an exemption that allowed PCN clinics to conduct interviews for nursing positions. Primary care positions were also exempted from being subject to interference. This exemption was applicable for the duration of the 2019-2022 collective agreement, which has now expired.
- The current 2022-2025 Nurses' Bargaining Association collective agreement does not have an exception to the hiring process for primary care nurses; however, alternative hiring processes for RNs and LPNs are under design through Nurse in Practice.
- Article 12.01 of the most recent nurses' agreement addresses the hiring process for any vacant positions.

Creating New Opportunities for Innovative PCN Clinic Models

Can the health authority or division continue to run PCN clinics?

- Division-run and health authority-run clinics are not part of this model; however those existing prior to fall 2023 will continue to operate as they have in the past.

How will the Community Led Clinics (CLCs) be different from existing Community Health Centres (CHCs)?

- CLCs will provide primary care and serve the entire population within a PCN geography, whereas CHCs traditionally serve a sub-set of the population who require additional care and social services (e.g., dental), focused on the social determinants of health.

- Additional criteria for and scale of CLCs are under development and information will be provided as it becomes available.

Backbone Support

Is the Division of Family Practice Board accountable for the PCN?

- The PCN SC is accountable for PCN deliverables. Specific accountabilities for PCNs are outlined in the PCN Funding Packages.
- The Division Board appoints the physician convenor, and the convenor is accountable to the Division Board.
- In addition, as with all funding to divisions, the Division Board is accountable for the PCN funds they hold and administer on behalf of the PCN partners.
- Per the Funds Transfer Agreement, the division is responsible for:
    - ensuring funds are utilized appropriately in accordance with Ministry financial policy,
    - reporting expenditures, and
    - providing audited financial statements.

Is it the intention for Divisions to assume PCNs as one of their ongoing operational programs? If so, what additional resources will be provided (e.g., salaries for PCN staff and operations)?

- Divisions are a key partner in PCNs, along with regional health authorities and local First Nations, Métis and Inuit partners.
- With the Refresh, the division provides backbone support for PCNs. In December 2023, the FPSC approved a new 'PCN Governance Support' funding stream for divisions of family practice to enable them to fulfill the backbone support requirements outlined in the PCN SC ToR.

How can PCN Managers be hired by the division of family practice, but be responsible to the PCN Steering Committee? Are PCN Managers accountable to the division as the hiring body or the PCN Steering Committee?

- PCN Managers are hired by the division and receive strategic direction from the PCN SC; they are accountable to both the division and the PCN SC.
- If the PCN Manager has questions or if issues arise, they should contact their Ministry PIO Regional Director and FPSC Primary Care Transformation Partner.

How will PCNs be supported and funded to implement the PCN Refresh? Will PCNs receive base program funds for ongoing HR, change management and integration?

- As outlined in the Ministry PCN Funding Packages, funding for the PCN Manager and Administrative Support is ongoing.
- In December 2023, the FPSC approved a new 'PCN Governance Support' funding stream for divisions of family practice to enable divisions to fulfill the backbone support requirements outlined in the PCN SC ToRs.
- The Ministry and FPSC will continue discussing additional support for PCNs, as priority areas emerge.
- Ministry PIO Regional Directors and FPSC Primary Care Transformation Partners are available to provide support, including attending meetings and providing advice.

Where will funding come from for health authority employed PCN Clinical Operations Managers? How are regional health authorities meant to support PCN reporting with minimal resources and funding?

- Regional health authorities receive global funding from government to enable the delivery of health care in communities.
- If PCN SCs previously decided to utilize PCN funds for health authority PCN Managers, this should be reviewed by the PCN SC to discuss changes of commitment.
- If changes to previous agreements are deemed necessary, adequate timing will be required to allow health authorities to identify a funding source to sustain or reassign staff. Regional health authorities and PCN SCs can contact the Ministry PIO Regional Directors for support.
- Regional health authorities can contact their Ministry PIO Regional Director to discuss resourcing needs to deliver on government priorities.

Strengthening Supports for Attachment

What is the definition of attachment?

- Attachment is the documented existence of a clear ongoing care relationship between a patient and a most responsible practitioner (i.e., FP or NP).
- Attached patients may access healthcare from other sources (e.g., Urgent and Primary Care Centers, Emergency Rooms, etc.) in cases where their health needs are beyond the scope of what a family physician or nurse practitioner provides, or if they are unable to see their FP or NP in a specific time period (e.g., the same day).
- Having attachment to a primary care provider throughout all stages of life has shown to significantly benefit health outcomes, overall patient wellbeing, and trust in healthcare systems.

How will individuals be prioritized for attachment?

- Patients registered on HCR will be prioritized for attachment based on three factors:
    - Age: Seniors will be higher priority because this age group tends to have higher healthcare needs and complexity. Children from birth to age 12 will be higher priority because access to primary care at early stages in life has proven to positively benefit future health outcomes.
    - Previous health diagnoses: For example, patients with a positive cancer screening will be high priority to ensure they can begin cancer treatments as soon as possible.
    - Frequency: Individuals who use the healthcare system more frequently (i.e., have higher healthcare needs) will be prioritized over those who rarely or never access health services.

Are there changes to the $0 fee code?

- All FPs and NPs utilizing PAS should send $0 attachment code 98990 to MSP/Teleplan through their EMR.
- Physicians under new-to-practice and PCN contracts who are currently using the PCN attachment codes should continue to do so until February 1, 2024. The PCN attachment codes will be retired on that date, transitioning to a single attachment code for the province.

What current data is available to PCNs from the Ministry to identify the number of unattached patients in the PCN (including patients unattached due to provider retirement or leaving practice)? Will this data be provided to PCNs each year?

- The Ministry PIO Regional Director can provide regular reports about attachment rates to the PCN Steering Committee. These reports are currently based on information available through the $0 fee codes, Health Connect Registry waitlist and contract FP/NP attachments.
- When FP and NP panels are fully uploaded to the Provincial Attachment System (PAS), the Ministry will be able to identify residents of PCNs who are and are not on panels in each PCN.
- This information will provide a much clearer picture of the number of unattached residents of a given PCN, including demographic information such as age and health status. That is why it is important for all longitudinal FPs and NPs to upload their panels to the PAS.

What is the overall purpose of investing so much into understanding the unattached patient number for the province?

- Having an accurate understanding of the number of unattached patients throughout BC benefits patients and providers, and will help to:
    - Determine where capacity exists throughout the province and match patients with suitable clinics and FPs/NPs as space becomes available.
    - Identify gaps to plan more effectively for the future and measure success.
    - Understand where the highest attachment gaps so primary care supports and infrastructure can be prioritized for those communities.
    - Better support FPs to manage and maintain balanced patient panels.
    - Reduce administrative burden for clinics previously managing their own patient waitlists. With the launch of a single provincial waitlist for patient attachment (the Health Connect Registry), calls from unattached patients looking for a provider can be redirected to HealthLink BC.
- Having a clear idea of who in the province needs primary care, and where, will particularly benefit communities with significant attachment gaps and will allow providers in these communities to focus on direct patient care rather than managing attachment waitlists.

How is the regional health authority accountable for PCN FP and NP contract management? Who sets contract deliverables and expectations? Will the regional authority share progress against deliverables with the PCN Steering Committee?

- The Ministry expects health authorities to manage contracts, working with the PCN and Attachment Coordinators to ensure attachment targets are being met.
- The Ministry will bring data and reports on PCN FP and NP contracts to the PCN SC. Contract management progress reporting will be facilitated by the Ministry's PIO Regional Directors/Managers working with the PCN Managers.
- The Ministry sets the policy on contract management for PCNs. Health authorities report to the Ministry in accordance with financial policies on deliverables and expectations regarding PCN resources.

Additional Questions

The following questions have been received and will be answered in the coming months as the Ministry and FPSC continue to work through details of the PCN Refresh, including details about the new Nurse in Practice model and Community-led Clinics.

- Who will operate these 'innovative PCN clinics'?
- Are existing NP Clinics considered 'innovative PCN clinic models'?
- Will 'other innovative models' be vetted through a division committee or through FPSC directly?
- How are registered nurses and licensed practical nurses being supported or trained to work in primary care clinics?
- Is there clarity on group attachment (i.e., attachment to a clinic rather than an FP/NP)?
- Will the data on patient panels drive PCN resource allocations?