- The foundation of the integrated system of care is the delivery of effective primary care services. Doctor's offices will be transformed and linked into Primary Care Networks of team-based primary care practices, called Patient Medical Homes, serving the primary care health needs of a local community.
- Patients will be attached to a Patient Medical Home, meaning they will have an ongoing care relationship with a primary care provider – a family doctor or a nurse practitioner, who will work in a team-based practice that includes nurses and other health professionals, providing primary care services. Patient Medical Homes will be supported by a broader network of practices that together will offer a full suite of primary health care services.
- Services will be designed to meet population and patient health care needs.
- This work will involve practice and service redesign, team work, increased use of digital technology and different business and compensation models.
- Patients will be able to access or contact their doctor or nurse practitioner, or primary care team, in a timely fashion using a variety of channels from face-to-face visits, group visits, telephone consults, email, online and video calls.
- Patients will know how to access advice and care from their Patient Medical Home and the broader Primary Care Network and access to urgent care 24/7.

Specialized Community Care Services:

- Specialized Community Services Programs and Specialized Surgical Programs will be linked to Primary Care Networks:
    - Adults with Complex Medical Conditions and/or Frailty
    - Mental Health and Substance Use
    - Cancer Care
    - Scheduled Surgical Care
- These programs will provide effective and holistic care planning, comprehensive and coordinated service delivery wrapped around the needs of the individual needs of patients and providing a quality service experience. Services will be delivered by an inter-disciplinary team.
- Once referred to a specialized program, patients will have access to the care services and management they need. Any referrals and appointments will be coordinated for them, along with education and self- management support and round the clock access to care or advice.
- Whether they live in a rural area, small town, or big city – specialized and primary care providers will communicate with patients and each other – providing citizens with an understandable, patient-centred system of care.
- Hospitals and more specialized tertiary regional and provincial services will provide expedited access to diagnostics, care and consults to patients from the Specialized Community Services Programs to enhance the quality of care to these patients and reduce pressure on Emergency Departments.

General Policy Direction Overview: Establish Primary Care Networks

- Primary care networks are an integrated system consisting of patient medical homes that are networked with each other and with primary care services delivered or contracted by health authorities and community-based social and health service organizations.
- Primary care networks are designed to provide universal comprehensive primary care services to a geographical community population.
- In a patient medical home, individuals are attached to a regular primary care provider, a family physician or nurse practitioner, who is most responsible for the overall coordination and continuity of their care across the life course. The regular primary care provider maintains this key role regardless of where the service is provided or who provides it.
- Patient medical homes will provide the majority of the populations' primary care needs. The balance of comprehensive primary care services required by a geographic population will be met within the primary care network.
- Primary care networks will provide:
    - An explicit, ongoing care relationship with a regular primary care provider who is most responsible for their care for all people who want one
    - Clear mechanisms for regular primary care providers to contribute to their patient's care planning through Specialized Community Service Programs, Specialized Surgical Programs and/or hospitals, regional and provincial programs
    - Comprehensive primary care services that are holistic, person-centred, culturally safe and responsive to individual needs
    - A centralized waitlist and mechanism for patient-provider attachment
    - Extended hours of care possibly through PMHs and/or linkages with walk-in clinics, urgent care centres, and community health centres. Round the clock access to primary care advice and direction to needed care through a variety of mechanisms including HealthLink BC, email access, call networks and walk-in or urgent care clinics
    - Coordinated service delivery and effective transitions of care with specialized programs (surgical, cancer care, mental health and addictions and medically complex/frail), diagnostic facilities, medical specialists, hospitals, community-based service organizations, including on- and off-reserve First Nations and Aboriginal
    - Regular opportunities for patients, families and caregivers to be engaged and give feedback for quality improvement activities
- Primary care network design will include:
    - Team-based care where providers work to an optimized scope of practice
    - Technology-enabled solutions with virtual care embedded into daily operations to link patients and providers, such as home health monitoring and linked electronic medical records
    - Informational continuity, e.g. appropriate information sharing and single patient health record; and management continuity, e.g. longitudinal care planning, integrated team planning, team-based case management

- Case finding to identify individuals requiring care prior to crisis or hospitalization, including consistent use of upstream assessment tools such as frailty scales
- Rapid consultation services with specialized programs
- Partnership with the local community including school-based health promotion programs and community initiatives with citizens, local government and other organizations focused on areas such as food security, physical activity, and harm or injury prevention
- Services to meet the urgent care needs of the community population, which will be linked with PMHs to ensure continuity and coordination of care.

- The interdisciplinary team provides person-centred relationship-based care that includes the active participation of the individual, their family and caregivers, in collaborative decision making, care planning and service delivery through their words and actions.
- The patient voice, choice and representation anchors team behaviours and a mutually beneficial culture of person-centeredness will be evident and integrated into team design, care and service delivery.
- Team members should be supported to demonstrate values, attitudes and behaviours that make patients true partners in the process of making care decisions.
- Teams utilize a core set of principles that provide direction for the team's service provision. These principles should be visible and consistently portrayed and will include patient centred, cultural safety, self-management, informed decision making, participation and collaboration, efficiency, safety, accessibility and respect.
- Practitioners and support staff work to an optimal scope to meet the needs of the patient population being served. The team provides staffing informed by population data and evidence to integrate an appropriate and optimal mix of knowledge, skills and competencies to meet the needs of the population and enhance team functioning.
- Validated population health data is used to determine the optimal mix of interdisciplinary team members needed to meet population needs.
- Flexible and innovative approaches should be considered for rural and remote communities where the number and mix of providers are limited.
- Ensure interdisciplinary teams are supported by effective on-site clinical leadership that promotes collaborative trust-based practice, facilitates team problem solving, clarifies team members' roles, ensures effective team communications, applies process improvement to optimize team function and ensures shared accountability for patient care and professional performance.
- Employ effective change management strategies to support the optimization of the interdisciplinary team. This includes supporting the transition to team-based approaches, using coaching and mentoring approaches to support team members and establishing a culture of collective competency through improved cooperation, coordination and communication while focusing on the shared goal of achieving optimal outcomes for all patients/clients.
- Utilize digital technology, where possible, to optimize networking within and between interdisciplinary teams and team members to ensure timely access to care, robust communication and effective clinical decision making. Digital technology includes, but is not limited to, virtual care which will be embedded into day to day operations to link clinicians and care providers with patients to improve effectiveness in care delivery.

Primary Care: Glossary of Key Terms

Attachment: The existence of a clear ongoing care relationship between a patient and a family practice or health authority primary care clinic, where a family physician or nurse practitioner is the patient's regular primary care provider and most responsible for their primary care.

Community Health Centres (CHCs): New/existing CHCs (i.e., those that have been refreshed), will provide comprehensive, person- family-and community centred, culturally safe, quality primary health care. CHCs will provide these services to a population residing within a Community Health Service Area or to a sub-population within or across multiple CHSAs where CHCs tailor care to a community of specialized need. CHCs will provide these services with an interdisciplinary team working to their optimized scope of practice. CHCs will coordinate with other service providers to ensure patients and families experience timely access to the care they need and a seamless transition between services.

Community Health Service Area (CHSA): A new geographic unit at a sub-Local Health Area level that is the most detailed level of geography.

Divisions of Family Practice: Community-based groups of family physicians working together to achieve common health care goals. Divisions work collaboratively with community and health care partners to enhance local patient care and improve professional satisfaction for physicians.

Interdisciplinary team: A group of health care providers who work together (in-practice or via a broader community-based team) in a coordinated and integrated manner with patients and populations to achieve health care goals. Effective interdisciplinary teams display collective competency, shared leadership and active participation of each team member involved in patient care.

Patient Medical Home (PMH): A family practice or health authority primary care clinic which has a majority of the person-centred service attributes (commitment, contact, comprehensiveness, continuity, coordination) and relational attributes (team-based care and networks) of the BC PMH model.

Primary Care Network (PCN): A unified system of primary care consisting of patient medical homes that are networked with each other and with primary care services delivered or contracted by health authorities and community-based social and other health service organizations. Within a PCN, patients, families and caregivers, are able to access comprehensive, person-centred, culturally safe, quality primary care. PCNs maintain strong linkages with specialized community services programs as well as the broader health system.

Primary care: Typically a person's first point of contact with the health care system where the majority of health problems are treated by a generalist, and coordinated continuing care occurs with specialists as needed.

Specialized community services program (SCSP): Designed by a health authority to provide continuity, flexibility and rapid mobilization of a set of responsive services to meet the needs of a defined population of people. SCSPs will provide personalized relationships between providers and patients with their families and caregivers, and it may have one or more teams, each with linkages to the health system and broader community.

Team-based care: Team-based care is fundamentally a person-centred approach to care that promotes patient voice, safety, and acceptability in care delivery, thereby creating better experiences for individuals, their families and caregivers, and providers in the health system. Teams will meet the care needs of individuals (across the life course) and the community population by providing access to quality health care services at sustainable per capita costs.

Urgent and Primary Care Centres (UPCCs): UPCCs are aimed at meeting the urgent and primary health care needs of individuals, primarily in large urban centres where a higher percentage of the population is unable to find or access a regular family doctor or nurse practitioner. As a resource to support communities, UPCCs are one of the mechanisms to immediately address the urgent and ongoing care needs of all patients within a community. May be owned and operated by the health authority of by a group practice in which health authority staff are part of the interdisciplinary team.