# ISLAND HEALTH PRIMARY CARE ROADMAP

*November 16, 2021*

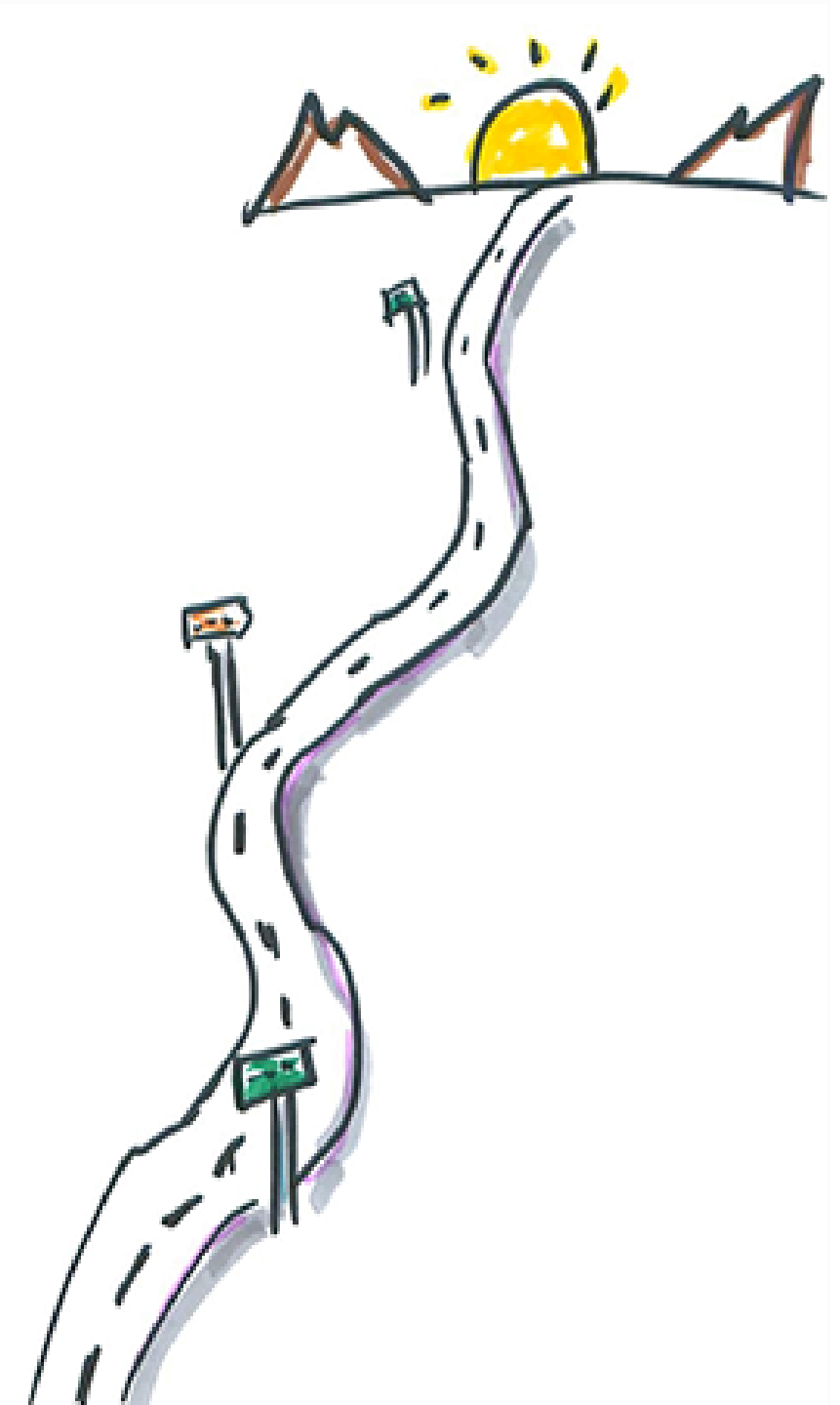
# ROADMAP

**Scope:**

- A primary care strategic plan / roadmap *for* Island Health that can guide, support and stabilize its work over the next 3-5 years.

**Purpose:**

- To identify priority actions, desired outcomes and impacts in terms of the health authority's role in primary care
- To identify shared priorities and potential opportunities for collaborative action with partners



# PROJECT APPROACH

INITIATION | CONSULTATION | STRATEGY DEVELOPMENT | IMPLEMENTATION

## CSC ROADSHOW

## COMPLEMENTARY REVIEWS

Used inputs from multiple prior consultations & projects

Multiple sessions with **Primary Care Strategy Executive & team** to define Roadmap scope, engagement approach and develop initial draft logic model

## LOGIC MODEL

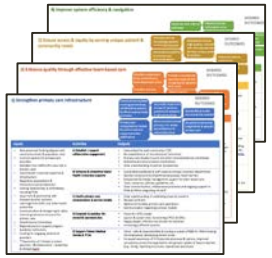
## ISLAND HEALTH

- Primary Care Executive Implementation Committee
- Primary Care Quality Council
- Nursing and Allied Health Advisory Council
- Regional Practice Support Program
- Public Health, MHSU, Seniors Strategy, Palliative/End of Life Care, Home Care, Indigenous Health

## EXTERNAL

- Patients, families & caregivers (x1 session)
- Indigenous partners (x2 sessions)
- Primary care providers (x2 sessions)
- PCN leaders & staff from other organizations who are involved in PCNs (DoFP, CHCs) (x2 sessions)

## MASTER DOC



## SUMMARIES

- Overall themes & findings
- Stakeholder / partner-specific
- Topic / theme-specific

## ROADMAP


Internal endorsement
Oct 25, 2021

## Health Authority WORKPLAN

Led by Primary Care Strategy team

# ENGAGEMENT

- Series of 12 interactive virtual engagement sessions (1-2 hours each) in June/July 2021
  - More than 150 individual participants
  - Generally good diversity in stakeholder roles and broad geographic representation
- Limitations
  - Emphasis on existing networks
  - Lack of direct engagement with all First Nations communities and Indigenous partners
  - Lack of diversity among patient, family & caregiver partners
  - Limited input from CHCs

| Stakeholder group | Participants |
|---|---|
| **EXTERNAL PARTNERS & STAKEHOLDERS** | |
| Patient, family & caregiver partners (x 1 session) | **6** |
| Indigenous partners (x2 sessions) | **9** |
| Primary Care Providers (NPs & FPs) (x2 sessions) | **16** |
| PCN leaders & staff from other organizations who are involved in PCNs (DoFP, CHCs) (x2 sessions) | **24** |
| *External partner sub-total* | **55** |
| **ISLAND HEALTH TEAMS & COMMITTEES** | |
| Regional Practice Support Program | **16** |
| Nursing & Allied Health Advisory Council | **21** |
| Priority populations | **7** |
| Primary Care Executive Implementation Committee | **22** |
| Primary Care Quality Council | **16** |
| Primary Care Strategy team | **13** |
| *Island Health sub-total* | **95** |
| **GRAND TOTAL** | **150** |

# KEY QUESTIONS

**What do you think are the most important actions the health authority could take over the next 3 to 5 years in order to…**

…better support primary care networks and clinics in your community?

…support the shift to team-based primary care?

…support transitions in care and contribute to making primary care services more user-friendly, easy-to-navigate, and integrated with other health services?

…strengthen the primary care infrastructure, improve provider recruitment & retention efforts to ensure greater availability of primary care services across Island Health region?

…ensure better access & equity for all patients and communities?

…better support patient-centred, culturally-safe primary care for First Nations, Métis, Inuit and urban Indigenous patients and communities?

## ALIGNMENT WITH IH STRATEGIC FRAMEWORK

This Roadmap is meant to align with Island Health's *Strategic Framework 2020-25*. In particular, the primary care work aims to support Goal 1:

*Improve the Experience, Quality and Outcomes of Health and Care Services for Patients, Clients and Families*

**1.3.** Teams will provide care to people when and where they need it from birth to end-of-life

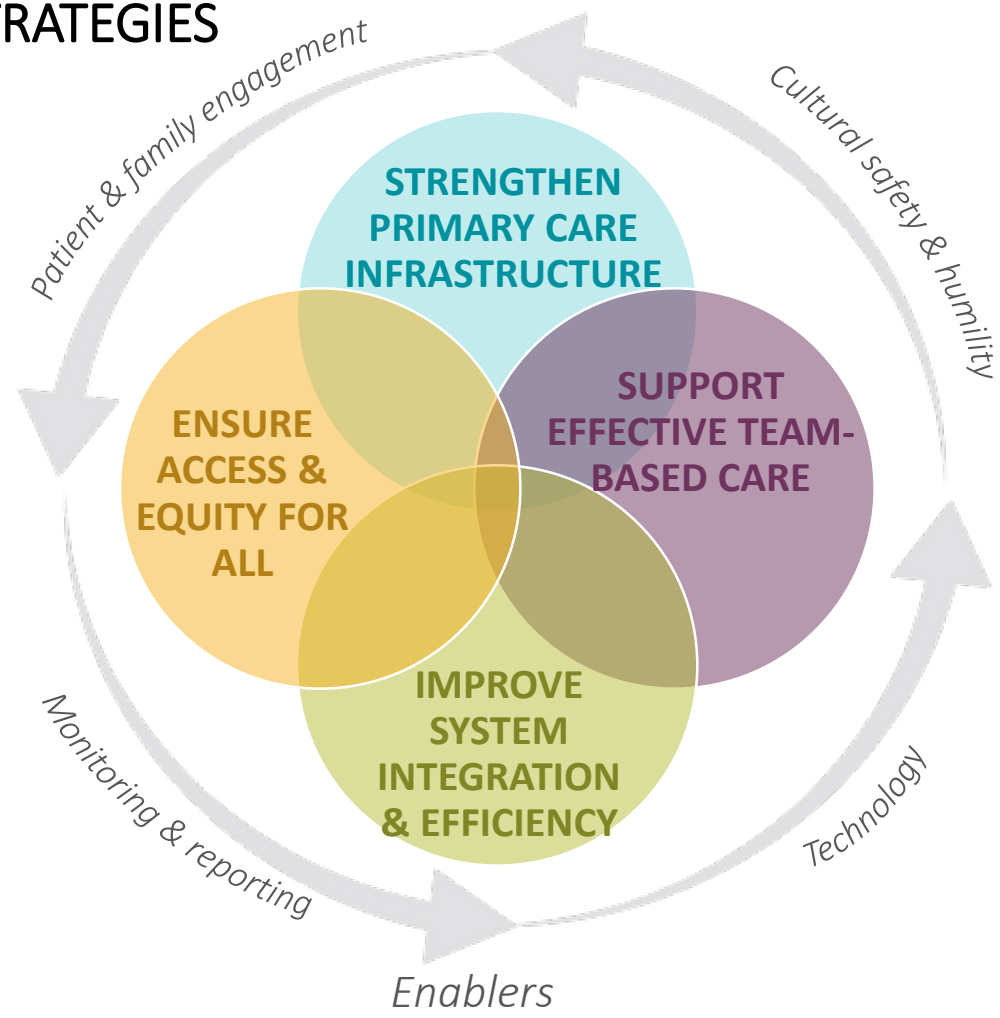
## PRIMARY CARE VISION

High-quality, accessible, culturally safe primary care for everyone.

## MISSION

Together with our partners, we will provide leadership, support innovation and build system capacity to develop an integrated system of team-based primary care, including attachment to primary care providers and access to timely care which meets population and patient health care needs.

## STRATEGIES




## FOCUS AREAS

**INFRASTRUCTURE**
- Workforce planning
- Policy enhancements
- Physical infrastructure
- Innovation & capacity-building
- Partner collaboration

**TEAM-BASED CARE**
- Shared vision & tools
- Education & communication
- Workflows & systems

**ACCESS & EQUITY**
- Data & tools
- Priority populations
- Geographic service equity

**INTEGRATION**
- Data & tools
- Workflows & approaches
- IMIT systems

## DESIRED IMPACTS

- Accessible and sustainable high-quality primary care services that effectively meet community needs
- Improved population health and well-being
- Improved patient & provider experience
- Efficient use of health system resources

*Achieving our desired impacts will require significant collaborative action with our partners. We are committed to working together to collectively achieve the quadruple aim*

# STRENGTHEN PRIMARY CARE INFRASTRUCTURE

## DESIRED OUTCOMES

- Trusting partnerships, collaborative systems and effective governance processes
- Primary care compensation models & practice options support provider stabilization
- Effective workforce planning & sustainable recruitment & retention
- People and families in every community have options for longitudinal and episodic primary care services

## WORKFORCE PLANNING

- Work with provincial & regional partners to pursue proactive, long-term strategic **workforce planning**
- Address current hiring challenges & turnover issues by developing & executing comprehensive **recruitment, retention and redesign strategies** for all primary care team members (FPs, NPs, RNs, allied health practitioners, MOAs)
- Support improved health, wellness and experience initiatives to **build resiliency across primary care teams**
- Advance **team redesign** and improvement efforts to best align skills to tasks based on available roles
- Employ targeted strategies to **train & hire more Indigenous clinicians, staff & leaders** at all levels, and to ensure all communities can offer wraparound holistic services that incorporate Elders and traditional practitioners

## INNOVATION & CAPACITY-BUILDING

- Refine & clarify Island Health's **primary care governance & accountability mechanisms**
- Establish & stabilize **primary care sites owned & operated by Island Health**
- Enhance & **streamline health authority systems and processes** that enable primary care implementation

  *For example:*
  - Develop tools & templates & communicate up-front about expected Corporate processes & timelines, ensuring a consistent approach across all communities
  - Enhance educational & change management capacity to support integration of health authority employees into community settings

## PARTNER COLLABORATION

- Support ongoing **partner engagement & regional coordination** of primary care initiatives
- **Collaboratively define key roles**, processes & expectations of PCN partners
- Provide **tools and resources** that enable & support partners' implementation efforts
- Share information about models, options & **lessons learned** from other communities

## POLICY ENHANCEMENTS

- Identify opportunities to optimize primary care policy implementation & **advocate with provincial partners** for change

## PHYSICAL INFRASTRUCTURE

- Collaborate with partners to facilitate, secure and / or subsidize **infrastructure for clinic spaces** that meet provider & patient needs, including upgrades to First Nations health centre facilities
- Support & coordinate **co-location** efforts

# SUPPORT EFFECTIVE TEAM-BASED PRIMARY CARE

## DESIRED OUTCOMES

All team members consistently optimize their scope and feel recognized and valued in their work

Patient care is consistently planned and delivered collaboratively

Patients in all communities have greater access to timely, high-quality multidisciplinary primary care

All people and families are aware of the recent shifts in primary care, understand where to go & use services appropriately

### SHARED VISION & TOOLS

- Develop an operational **vision for team-based primary care** that speaks to how TBC looks and feels different in primary care than acute care and is inclusive of patients, Indigenous partners, traditional healers & all primary care providers, clinical & administrative staff
- Establish primary care **operational standards, processes & tools** for sites owned & operated by Island Health
- Work with partners to co-develop processes and **tools that support integration of health authority staff** into other settings

### EDUCATION & COMMUNICATION

- Develop team-based care **training curriculum, tools and plans** for all primary care clinical and administrative staff
- Deliver **inclusive whole-team training**, support team-functioning and quality improvement opportunities
- Deliver **public communication / education** about recent shifts toward team-based primary care

### WORKFLOWS & SYSTEMS

- Establish **shared care pathways, charting protocols & communication workflows** to support team members' interaction with each other, and between primary care and other parts of the health system
- Enable **broader access to health authority software and hardware** for team members at private clinics, CHCs and First Nations health centres

# ENSURE ACCESS & EQUITY FOR ALL

## DESIRED OUTCOMES

Patients encounter a welcoming, inclusive first door every time

All patients can effectively access high-quality, culturally safe care appropriate for their unique health needs and location

All Indigenous patients can access traditional medicines, healing practices and practitioners as part of a holistic primary care model

### DATA & TOOLS

- **Collect & analyze population health data** & solicit ongoing feedback about primary care services to **define the needs of local priority populations** & structurally vulnerable or underserved groups
- **Co-develop tools & resources to** support equity initiatives, such as:
  - Expectations for cultural safety & humility, trauma-informed practice & engaging patients and families in primary care
  - Equity-related metrics and data collection / monitoring systems

### PRIORITY POPULATIONS

- **Develop and deliver tools & training** to increase primary care team members' capacity to support priority populations and structurally vulnerable groups
- **Consider accessibility** in all aspects of service design & implementation
- Develop **specialty primary care service models** and spread lessons learned & best practices
- Develop **tailored attachment protocols & service models** to meet the needs of specific subgroups
- Advance and accelerate **cultural safety & trauma-informed care initiatives,** including performance assessment and sustainable funding for in-person relational learning
- Develop avenues for unattached patients to access team-based care services

### GEOGRAPHIC SERVICE EQUITY

- Develop an **inventory of existing health authority services** across all geographies to identify gaps & equity issues
- Facilitate **greater access** (preferably in-community) **to specialist services, labs, diagnostics, pharmacy, dental & MHSU** particularly for rural & remote or underserved communities, as these are foundational supports to high-quality primary care
- **Mitigate regional access issues** related to transportation, internet or virtual care / telehealth challenges

# IMPROVE SYSTEM INTEGRATION & EFFICIENCY

## DESIRED OUTCOMES

Primary care teams can access real-time patient data from other clinicians and services / systems; Patients only have to provide their information once

Seamless referral & shared care pathways and effective regional coordination of local initiatives

More timely, efficient care

Reduced acute care utilization & improved patient outcomes

### DATA & TOOLS

- **Collaboratively map & identify gaps / linkage opportunities for existing services**, including decision pathways and governance structures, particularly for populations and service areas that span multiple programs
- Develop a **primary care service integration plan**, key performance metrics & targets

### WORKFLOWS & APPROACHES

- Optimize **referral pathways, simplify paperwork & streamline health authority processes** to ensure patients are matched with appropriate clinicians in a timely manner
- **Centralize** fragmented Island Health programs where possible and adjust service models to address any gaps
- Develop streamlined **virtual care privacy & consent** processes
- Explore avenues for **patients to directly access allied health resources**
- Consolidate and align **service contracts with community organizations**
- **Coordinate policies & approaches** across the health authority for topics such as COVID-19 recovery, cultural safety, opioid response
- Establish **new roles & information hubs to** support navigation & communication with patients & primary care teams

### IMIT SYSTEMS

- **Support shared care workflows** by improving information flow & interaction between systems in the short- to medium-term:
  - Adjust Island Health systems originally designed for acute care
  - Adjust Cerner to better meet primary care needs (e.g., list all team members not just FP/NP)
  - Streamline privacy & consent
  - Provide enhanced training & support for existing EMRs
  - Enable access to health authority systems for external MOAs
- **Incentivize & support universal systems** in the longer-term:
  - Optimize health authority primary care EMR that meets functional practice requirements
  - Make Island Health's EMR free, voluntary & support clinics to transition from existing systems
  - Increase patient access to health records

# WORK PLAN DEVELOPMENT

**Consultation Summaries**

1. Common themes and stakeholder priorities
2. Master Logic Model
3. Issues for provincial consideration
4. Internal Health Authority
5. PCN Leads
6. Patient and Family
7. Indigenous Populations
8. Primary Care Providers
9. Human Resources
10. IMIT

**Opportunities**

- Inter Divisional Strategic Council
- Collaborative Service Committees
- Health Authorities
- Provincial tables
- Internal Health Authority committees
  - Indigenous Health
  - Provider Recruitment committee
  - HR strategy
  - Capital planning
  - Primary Care IMIT Steering Committee

# 21/22 ISLAND HEALTH WORK PLAN

| | ROADMAP FOCUS AREA | 21/22 DELIVERABLES |
|---|---|---|
| SERVICE EQUITY  | Achieve MoH Bilateral expectations | • Implement PCN Service Plans: Comox, Oceanside, Nanaimo, Cowichan, Saanich Peninsula, Westshore, Victoria<br>• Complete Service Planning: Campbell River and Port Alberni<br>• Implement enhanced or net new Community Health Centre<br>• Implement UPCCs: Westshore, North Quadra, James Bay, Downtown, Esquimalt, Gorge |
| HR  | Work with provincial & regional partners to pursue **proactive workforce planning** | • Develop PCN HR database |
| | Develop & execute a **recruitment & retention** plan for primary care providers and clinical and administrative team | • PCP recruitment and retention strategy<br>• Streamline recruitment and onboarding process for PCPs<br>• HR recruitment strategy for Nursing, Allied and Administrative resources |
| ADVOCACY  | Identify opportunities to optimize primary care **policy implementation & advocate with provincial partners for change** | • Reestablish Interdivisional Strategic Council<br>• Establish Greater Victoria Joint Executive partnership advisory committee |
| CAPITAL  | Collaborate with partners to facilitate and support / sponsor **space solutions** that meet provider needs | • Establish process workflow for PCN capital initiatives<br>• Develop HA guidance on financial support of private practice |
| PARTNER-SHIP  | Communicate **health authority processes** & structures as well as lessons learned | • Implement HA PCN toolkit<br>• Implement PCN Community of Practice<br>• Refine MHSU service model and referral pathways |

# 21/22 WORK PLAN – INITIAL DRAFT

| | ROADMAP FOCUS AREA | 21/22 DELIVERABLES |
|---|---|---|
| VISION  | Define **team-based primary care vision**, such that it includes patients, Indigenous & structurally vulnerable populations | • Create UPCC and Team Based Care Vision document |
| EDUCATION  | Deliver inclusive whole-team **training**, team-functioning and quality improvement opportunities | • Implement Clinical Practice Support Team |
| APPROACHES  | Establish **new roles & infrastructure** to support navigation & communication | • Develop Virtual Care Access Hub proposal |

| | |
|---|---|
| **Initiatives still to be Determined:** | • Increase access to appropriate specialist services, labs, diagnostics, pharmacy & dental |
| | • Increase Patient Engagement in primary care planning and implementation |
| | • Work with Corporate areas to develop workflow and processes for primary care implementation |

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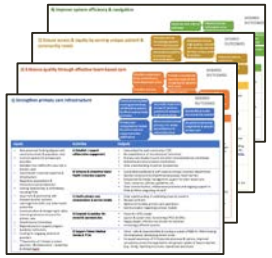

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## ROADMAP


Presentation to PCEIC **September 9**

## RE-ENGAGE PARTNERS

Committed to **share outputs with participants of engagement sessions** ~Oct

**Explore co-developing joint strategy with partners**

## INTERNAL PCS WORKPLAN

To be **led by PCS team**

May also involve joint workplans with Corp. areas

## HA COLLABORATION

Begin **actioning 21/22 activities** across health authority

Continue to validate/ refine out-years

# QUESTIONS / FEEDBACK?

- What mechanisms will enable input to continue identifying key activities for workplan development?
- What opportunities exist to co-develop joint strategy with partners?

This work was made possible thanks to the support and advice of many individuals and organizations. The Primary Care Strategy team would like to acknowledge all participants of the engagement sessions for your thoughtful contributions, which formed the basis of this Roadmap. Your expertise, passion for improving primary care, and openness to possibilities are greatly appreciated.