Background: The South Okanagan Similkameen (SOS) Primary Care Network (PCN) encompasses the entire SOS region. It serves approximately 90,000 residents in 8 communities: Summerland, Penticton, Okanagan Falls, Oliver, Osoyoos, Keremeos, Hedley, and Princeton. The primary SOS PCN partners are the SOS Division of Family Practice, Interior Health and the four Syilx Indian Bands, members of the Okanagan Nation Alliance, and is supported by the First Nation Health Authority. Local government, community agencies and patients are engaged to advise development of the PCN.

The initial SOS PCN plan, submitted July 28, 2018, provided:

- a comprehensive plan for PCN governance in the entire region,
- a change management plan, and
- a partial service plan which addressed the immediate attachment gap in Penticton and Summerland.

The Ministry of Health (MOH) recognized in its SOS PCN Summary of Approval letters (dated Sept. 17th and Nov. 21st, 2018) that impending retirement and rural service plans to address the attachment gap in rural areas were still to be developed. There was also a general recognition that patient access to care, not just patient attachment, would be addressed in subsequent phases.

Purpose: The following table is an environmental scan of issues that have surfaced in our region as we have embarked on implementing the Penticton/Summerland service plan and started to develop a service plan for our rural communities. The content is a reflection of input from physicians, Nurse Practitioners, Interion Health, indigenous partners, local government, and patient voices. We have heard similar concerns echoed by other Wave 1 communities. We are looking forward to addressing these issues to build greater confidence that PCN is going to be able to deliver all that was envisioned in the 2017 MOH Policy Papers.

Lessons Learned from Penticton Summerland PCN Implementation

GP CONTRACTS	OUR ASK
There has been no interest in GP contracts. New physicians have told us that the contracts are not competitive with other opportunities such as hospitalist contracts, Urgent Primary Care Centre (UPCC) service contracts or with compensation offered in other provinces.	*MOH and Doctors of BC review competitiveness of PCN GP contracts in relation to non-family-practice contracts.*
Further, we understand that new MOH expectations around UPCCs appear to replicate much of what we are accomplishing in PCN, except that UPCCs are to be owned and operated by health authorities. With Penticton being eyed for a UPCC, this would create an unnecessarily competitive environment for providers and other healthcare professionals without ensuring integration with the PCN vision.	*MOH allow UPCC resources to be incorporated into the PCN with all partners responsible for integrating the services into the wider community and delivering on expected outcomes.*
We are also finding that newer physicians are not interested in committing to a panel of patients, even under Fee-For-Service (FFS). This is evidenced in our local stats whereby we welcomed 11 new family physicians to our area last fiscal year, but only 3 committed to a panel of patients in that timeframe. Yet, we are having some success in recruiting physicians to work in a FFS model where they share a patient panel.	*MOH allow flexibility around sharing of panel expectations in contracts. We need flexibility to build attachment to teams and/or clinics. We have modelled the success of a team approach to patient care locally in maternity, inpatient and MHSU care. We need this same flexibility to be competitive in a family practice arena.*
And further, the rigidity of the contracts is not reflective of the SOS service plan, which allows for attachment to a team of providers at PIB and MSOC/MHSU.	

NURSE PRACTITIONER CONTRACTS	OUR ASK
Expectations around NP overheads shifted after our funding was approved, without consultation or additional funds. This damaged relationships locally, both among NPs, and between NPs and the PCN Steering Committee. Our PCN budget was predicated on overheads fixed at $75,000 per year, as per the contract templates in circulation at the time. Our approval letters confirm this understanding. But recently GPSC stated that NPs can negotiate liability and professional development into overhead. The lobbying that happened around this decision led to different messaging to NPs in our region, who were told to negotiate overheads, while our PCN Steering Committee knew that our overheads were tied to budgets that were set months ago to cover fixed costs. Additionally, establishing overhead provisions in NP contracts that are different from the GP contracts or the practice for FFS GPs, where insurance is paid outside of clinic overhead, makes it more difficult to integrate NPs into our provider community.	*MOH work to ensure overhead expectations and processes be the same for NPs and GPs, whether under contract or FFS. It makes sense that all liability and professional development be administered by provincial representative associations like Doctors of BC and NNPBC, not at the local level.* *MOH address the fact that SOS NPs have not received benefits for liability or CME directly with NPs.* *MOH provide additional resources to the SOS to cover any unplanned overhead costs that might be offloaded.* *Local PCNs be given the opportunity to advise on any further changes to contract expectations to the extent that they will impact us locally.*
OVERHEAD FOR AHP, RNs, PHARMACISTS	OUR ASK
Allied Health Professional (AH), Registered Nurse (RN) and Pharmacist overhead is not adequate to cover costs. The budget submitted by the SOS PCN Steering Committee anticipated that AHP, RN and Pharmacist overhead costs are half of the overhead costs of providers. This is predicated on the fact that AHP, RNs, and Pharmacists will use half the space of physicians or NPs but incur all of the other costs incurred by a provider. Instead, we received only 33% of what providers pay for the Team-based care clinic (TBC) and less than 20% of what providers pay in the rest of the PCN. This equates to 25%, and 15% outside the TBC Clinic, of AHP/RN/Pharmacist salaries. As a result, providers are subsidizing AHP/RN/Pharmacist overhead costs, which is not sustainable.	*MOH work with all of the PCNs to set a fair overhead rate for AHP, RNs and Pharmacists based on actual overhead costs.*
RESOURCES FOR CHANGE MANAGEMENT	OUR ASK
In our experience, NPs need support to transition into full-service family practice. Many of the NP contracts in the past have had narrow scope, with limited ability for NPs to gain a full range of family practice experience. Local providers are supporting NPs to integrate into full-service practice, including inpatient and long-term care. We are using physician change management funding, but the funds are insufficient to the tasks and take away from the other change management work	*MOH provide targeted funding to support NP transition and learning into full-service family practice.* *MOH reconsider compensated GP and NP champion roles to avoid provider burnout and ensure patient access to providers in leadership*

required to facilitate a fundamental shift to work in teams at the primary care level. If we continue to lean on already tapped GPs and NPs to provide learning opportunities for new providers, continue to carry a full panel, and lead change management, they will burnout.	*positions who are also trying to support the PCN.*
DATA	**OUR ASK**
Data infrastructure design and data collection: **Data infrastructure is not being co-designed with local PCNs.** As a result, we fear an imposition of unrealistic expectations and creation of multiple data collection approaches. In the meantime, we are building a local data collection infrastructure because the Division has a duty to report and the PCN needs data to inform ongoing quality improvement. Lack of coordination of data collection can result in redundancy of work and participation fatigue. Local PCNs are not being meaningfully included in determining the feasibility and impact to operationalize the evaluation frameworks. *Data access and dissemination*: **At steady state, access to 11 sources of data is required for PCN reporting.** Yet there is no clear direction compelling the organizations that hold the data to provide data to the Divisions on time and in a useable format. We understand that MOH intends to integrate access to PCN data, but as this will not be operationalized in the near future, a temporary process must be implemented. While PCN Funding Transfer Agreements tie the Division to a schedule of reporting, no processes have been established to assist with data collection and no data collections schedules have been built. Therefore, there is no way to ensure that the Division can access data. This creates difficulties in streamlining and consolidating data collection with provincial and local goals. *Standardization and optimization of data use and processes*: **There is an overall lack of a standardized approach in operationalizing data infrastructure for PCNs from various sources.** We fear this will lead to limited comparability and usefulness of data, especially for Wave 1s that must deliver before provincial infrastructure is in place.	*Data (including integrated raw data) is timely and accessible to Divisions for reporting and quality improvement activities.* *MOH and GPSC work with local PCNs, that are already responsible for data collection and reporting as per Funding Agreements, to co-design the provincial data infrastructure, frameworks, and processes for collecting and accessing data. This will allow us to ensure capacity, alignment with local processes, and optimization of resources. Aligning approaches at the onset will save costs that would be required to integrate approaches later. Divisions need to be resourced to participate in provincial development of the data infrastructure.* *MOH and GPSC coordinate organizations responsible for collecting and providing data at a provincial level to ensure a standardized approach, respect local capacity and optimize resources.*
REPORTING TIMEFRAMES	**OUR ASK**
Reporting timeframes don't allow adequate time for data collection and vetting. Reporting is due 3 weeks after the period end. Data becomes available only 2 weeks after period end, leaving only a week to compile, vet and submit reports.	*Move our reporting deadlines forward by 4 weeks each month.*

Lessons Learned from Rural Service Plan Development

ATTACHMENT GAP	OUR ASK
Number of unattached patients calculated by MOH for rural SOS communities isn't reflective of local experience. Without agreement on the gap, rural service planning is halted. We suspect that the MOH attachment algorithm is counting patients as attached if they happen to see the same provider too many times in an afterhours setting. This is not surprising when we have communities that have 4 providers sharing afterhours call. But receiving care from the same provider multiple times is not the same as being attached (and having access) to that provider. The SOS is collecting the actual attachment gap through the Patient Attachment List (PAL) to verify the rural attachment gap.	*MOH confirm that it will accept, for PCN service plan development, that the SOS rural attachment gap includes all rural residents who register on PAL and are verified by the Care Connector as unattached.* *MOH ensure that attachment gap algorithms don't include a patients' multiple visits to the same provider as evidence of attachment.* *MOH alter its attachment expectations for existing rural providers to match reasonable panel sizes. For example, if new GPs and NPs on contract are expected to carry panels of 800, provide additional resources to communities where existing full-time providers are carrying more than 800 patients.*
ROLE OF EMERGENCY IN RURAL COMMUNITIES	**OUR ASK**
In the SOS rural communities, emergency rooms serve as the default location for urgent, afterhours and unattached patient care. Until there are enough providers to staff both an emergency department and extended hours clinics, the emergency department will remain a key part of our rural care network. In 2008 and 2017 physicians in Oliver and Osoyoos appealed to MOH to develop an Alternate Payment Plan (APP) for SOGH emergency to try to increase staffing. MOH responded to the 2018 application stating that staffing for emergency be built into broader primary care planning. Accordingly, we addressed emergency staffing, including team support, in the Oliver Osoyoos growth plan. But were told by MOH staff that PCN doesn't include emergency. In the meantime, we are losing providers out of rural communities who cannot keep up with the demands of full-service rural practice.	*MOH commits to allowing us to embed the emergency department in our rural primary care network, to the extent that staffing resources outside of emergency cannot be secured or would cause unnecessary duplication of service. This could open up the possibility of access to GP or NP contracts without panel expectations to work in emergency to help alleviate the burden on existing providers. Or a different compensation model that helps to attract more providers to the area.*
PANEL SIZE	**OUR ASK**
PCN-mandated panel sizes don't reflect full-service family practice. The entire SOS has all full-service practice communities. This means in addition to clinic practices, providers also cover: • Inpatient • Maternity • Palliative • Long-Term care • Emergency (except Penticton Summerland)	*MOH and GPSC work with full-service communities to establish realistic panel size expectations based on data collection and experience to determine reasonable expectations that are going to result in long term sustainability for rural primary care.* *MOH decreases panel size expectations for rural communities for*

Each of these care areas require a significant time commitment that must be deducted from panel expectations for both GPs and NPs, both of whom are expected to participate as full members of the provider community. Working in a geographically remote location also means that rural providers have access to fewer services and specialized care. This often results in more GP/NP time to provide care. Many of our rural providers are close to burnout due to larger panel sizes in addition to their hospital duties, which increases the fragility of the existing networks. This is exacerbated in our most rural communities where geographical-remoteness limits access to specialized care. There are no safety valves for small communities where the same 4+ providers care for a population. Panel size expectations for all providers, even existing ones, must be built on what is sustainable.	*all physicians, not just new PCN resources. We believe that this will require a re-examination of the gap analysis algorithm to ensure that existing panel sizes, where used as a baseline, be examined to see if they are reasonable and sustainable.*
RURAL COMMUNITIES PART OF SOS PCN	OUR ASK
The initial SOS PCN service plan outlines a regional governance and change management approach, with regional representation, that is now operational. We submitted the Penticton Summerland primary care service plan with the understanding that we would be developing and submitting the rural service plans soon after. This approach ensured the cohesiveness of our strong provider community and recognized that our IH representatives have roles in all of our communities and needed to manage capacity. After working with MOH staff around an Oliver Osoyoos PCN service plan, suggestions were made that we sever the rural communities from the Penticton Summerland PCN in order to qualify for additional AHP/RN resources. Establishing 2 PCNs doesn't reflect the cohesiveness of our communities and would result in having to create a new governance structure and would come with extra administrative costs to the system for the duplication in governance, administration, and change management. The Penticton Summerland ratio of allied professionals to GPs is: • 1 RN: 25 GPs • 1 AHP: 7 GPs • 1 Pharmacist: 50 GPs These ratios will not result in true team-based care as envisioned by MOH Policy Papers or as is practiced in other jurisdictions.	*That MOH honours its commitment to add rural service plans to the existing SOS PCN and to approve additional AHP/RN resources as needed to meet the population needs and allow for delivery of true team-based care, without altering our governance, administrative or change management structures. In fact, we would like to see any cost-savings realized due to administrative efficiencies be put into additional staffing.*

Lessons Learned as a Wave 1A Community on the Forefront of System Change

SYSTEM CHANGES REQUIRE ALL SYSTEMS TO ADAPT	OUR ASK
One of the main strengths of the Primary Care Network initiative is that it rests responsibility for outcomes on a partnership, not just one entity. Locally, we have established strong, representative decision-making bodies to manage the Primary Care Network and have named a PCN Manager to facilitate that oversight function. But provincially, and within the health authority, systems haven't adapted to that shared responsibility model. For example, requests for information or meetings are most often coming from Ministry directly to the health authority and not the PCN Manager. That vests responsibility and authority in one partner, not the group. The health authority is then saddled with flowing information or convening meetings that are the responsibility of the PCN Manager. It also leaves open the possibility that the health authority may not share information, not realizing that the other partners haven't received the same information. This reliance on old communication systems doesn't empower the model of shared responsibility that is expected of PCN and has developed at the local level. Without true partnership, which starts with equal access to information, our collective ability to collaborate and leverage the communities' resources among all partners is threatened.	*MOH recognize the PCN Manager as the conduit for flowing requests and information to the PCN.* *That MOH and the health authorities work with local PCNs to adapt all of the systems (finances, HR, communications, etc.) to recognize the partnerships.*

BEING FIRST COMES AT A COST	OUR ASK
As a Wave 1A community, we knew that we would be building and adapting as we built our way forward. It felt as if there was value in the first year to be on the forefront of breaking new ground and operationalizing policy direction in ways that made sense on the ground. However, we have found that expectations of us locally are not always matched with timely follow through on provincial commitments. For example, MOH expected to have a Health Connect Registry (HCR) by January 2019 at the latest. We invested considerable time in HCR co-design, only to have it delayed beyond our first PCN NP intake on May 1st. Without HCR, we scrambled to establish a Patient Attachment List (PAL) by mid-May and then spent two more months stabilizing the platform and processes. This has already taken more than 400 hours, at a cost of $17,000 in staff time alone and additional costs for physician time, additional software and printing to implement PAL. Our entire budget for the Care Connector for the year is only $25,000, which will be used well before the end of the fiscal year. We have a commitment from MOH staff that going forward we will direct any new unattached patients to HCR once it launches, but that we will continue to attach off PAL until that list is complete. That could take years and we know that MOH will have evaluation pressures to show attachments off HCR, which we argued from the beginning as one of the main impetuses to have us transition to HCR early. But HCR still isn't launched and we now have more than 2500 patients on PAL. There is no way of transitioning this list to HealthLink without considerable cost on both a process and information side. And we	*GPSC top up our Care Connector budget to cover past costs in developing PAL.* *MOH recognize that we will continually need to improvise solutions where provincial PCN systems are not yet developed. And that those improvisations be:* • *Resourced adequately, knowing the costs are going to be higher for the early adopters and resources will be needed to transition to meet the provincial approach when it is finally implemented* • *Developed in collaboration and within the intent of the goals of the system* • *Transitioned in an agreed, planned manner to a provincial system in a way that doesn't unnecessarily impact progress in other areas of the PCN.*

cannot invest more staff or provider time in this issue without sacrificing other areas of our PCN. The impact of the HCR delays is just one example of the myriad issues that are going to come our way that require a practical, on-the-ground interim solution and then need to be transitioned into the provincial system once it is in place. But the cost of this cannot continue to be borne by the early adopters without adequate resources and flexibility.	
HUMAN CAPACITY	OUR ASK
From the beginning of the PCN process, we have collectively identified an unrealistic expectation on the pace of change. It has tasked all of the partners in our process. With so few people shepherding such fundamental change to the primary care health system while concurrently managing ongoing health authority operations and existing physician network culture, individual wellbeing and health has suffered to the point where members of our team have spent time in hospital or are choosing to leave their jobs. This pace is unsustainable without more realistic timelines or additional support. The risk that comes with rapid change and too few resources is that the existing strength of a primary care community like that of the SOS is undermined.	*That all partners – health authority, provider and First Nations - to be resourced to come together to deliver on the PCN responsibilities. We need the time and space to make thoughtful decisions together in a collaborative manner.*